Understanding and Working with Disordered Eating: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Understanding and Working with Disordered Eating: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that the contact plans and checklists may be copied by the licensee for their own use.

First edition, 2026.

This guide accompanies the Understanding and Working with Disordered Eating programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revision 5. This printing was set on 7 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation’s policies. It does not replace clinical judgement, and its thresholds are guidance: where your service’s policy differs, follow your service’s policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

Contents

How to use this guide 1

Part 1 Before you start 2

1. Who the programme is for 2

Part 2 Delivering it well 5

2. Guided self-help and your part in it 5

How to use this guide

This guide is for qualified practitioners who support clients through the Understanding and Working with Disordered Eating programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 says who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, a plan, how to review the week's worksheets with their answers. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, a plan, and the worksheets with their answers
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

Before you start

Who the programme is for, and how to decide whether it suits a client.

In this part

- Chapter 1, Who the programme is for: who it suits, how to assess for it, and when it is not enough on its own

CHAPTER 1

Who the programme is for

Eating difficulties exist on a spectrum that runs from occasional patterns most adults will recognise (eating when stressed, eating when emotionally low, periods of restricting followed by periods of overeating) through to the clinical eating disorders that require specialist services. This programme is for adults whose pattern sits in the broad middle of that spectrum: more disruptive to daily life than ordinary stress eating, sufficient to warrant structured work, but not at the severity that requires specialist eating disorder services. It is concordant with the recommendation of NICE clinical guideline NG69 that guided self-help based on CBT for eating disorders is the first-line step-2 treatment for adults with bulimia nervosa (without significant purging that creates medical risk) and for adults with binge eating disorder. What this programme is. An eight-module structured programme based on the CBT-E (enhanced cognitive behavioural therapy for eating disorders) protocol developed by Christopher Fairburn at Oxford and the wider clinical literature on CBT-ED. The programme covers psychoeducation about how eating difficulties are maintained, a daily eating record that builds awareness of the pattern, the regular eating intervention that is the foundation of all CBT-ED treatment, work on the dietary rules and forbidden foods that drive much of the cycle, work on body image and the over-evaluation of weight and shape, work on emotional and situational triggers, and a relapse prevention plan for the months after the programme finishes. Who this programme is for. Adults aged eighteen or over with one or more of the following: binge eating that is disruptive to daily life, with or without a sense of loss of control; episodes of overeating without compensatory behaviours; emotional eating patterns that are causing distress; restrictive patterns followed by overeating patterns (the restrict-binge cycle); bulimia nervosa without significant purging or other compensatory behaviours that are causing medical concern; binge eating disorder. The programme is also suitable for adults who have completed specialist eating disorder treatment and want a structured maintenance programme, and for adults whose eating difficulties are not severe enough to access

specialist services but who want structured support beyond what the GP can offer. Who this programme is not for. Several presentations require specialist services rather than self-help, and pursuing self-help for them can delay appropriate care. Anorexia nervosa, at any severity, requires specialist eating disorder service input; the medical risks of low weight and restrictive eating need clinical monitoring that self-help cannot provide. Bulimia nervosa with regular purging (vomiting, laxative use, diuretic abuse) that is causing or could cause electrolyte abnormalities, cardiac concerns, dental damage, or other medical complications requires specialist input. Eating disorders with significant comorbidity (severe depression, suicidal ideation, complex trauma, severe anxiety, substance use disorders) usually require integrated specialist treatment. Anyone who is medically compromised, has a low BMI, has recently been hospitalised for eating disorder reasons, or has been told by a clinician that specialist treatment is recommended needs to follow that advice. Anyone under eighteen needs the child and adolescent eating disorder pathway. ARFID (avoidant restrictive food intake disorder), PICA, and rumination disorder also require specialist assessment. If you are not sure whether this programme is right for you, the practice's clinical team can advise. If you suspect you may have anorexia nervosa, severe bulimia nervosa, or any of the other specialist-care presentations, please contact your GP and request a referral to your local eating disorder service. Beat, the UK eating disorders charity, runs a free, confidential helpline on 0808 801 0677 and online services for adults and young people who need to think about what they have and what to do about it. The work of the programme. CBT-ED is one of the most extensively researched psychological treatments in any area of mental health, with substantial outcome evidence accumulated over four decades. Adults with binge eating disorder typically achieve substantial reduction in binge frequency, with around half achieving full remission of binge eating by the end of treatment. Adults with bulimia nervosa achieve similar reductions in binge-purge cycles. The work is structured and protocol-driven; the modules of this programme follow the standard CBT-ED sequence (assessment, regular eating, broadening intervention to dietary rules and body image and emotional triggers, then relapse prevention) which is the structure used in face-to-face CBT-ED. The guided version of this programme adds weekly contact with a practitioner trained in CBT-ED who reviews your work, provides accountability for the homework, helps with the points where you encounter difficulty, and supports stepping up to face-to-face therapy if that becomes appropriate. The guided version is the NICE-recommended format for moderate severity presentations and is generally more effective than independent self-help for adults whose difficulties are at the more disruptive end. The independent version is suitable for adults whose difficulties are at the milder end and who have done structured psychological work before. Important throughout the programme: this is not about losing weight. CBT-ED is concerned with the restoration of a normal pattern of eating and a less disrupted relationship with food and body. Weight changes are not a goal of the work and weight monitoring is approached carefully. Adults who come to CBT-ED hoping to lose weight often misunderstand what the protocol does; the work focuses on stopping the binge cycle and reducing the restrictive eating that drives it, which for many adults reduces total caloric intake variability without prioritising weight loss as such.

What the programme covers

1. Understanding Eating Difficulties
2. The CBT-E Maintaining Model

3. Mapping Your Eating Pattern
4. Regular Eating
5. Challenging Dietary Rules and Forbidden Foods
6. Body Image and Self-Worth
7. Managing Emotional and External Triggers
8. Maintaining Progress and Preventing Relapse

Who it suits

- Adults whose difficulties are of mild to moderate severity on assessment, in the area the programme addresses.
- Clients who want to work on the difficulty themselves between contacts, and can set aside time each week to read and to complete the worksheets.
- Clients who can read and write in English, or who have the support to do so.

When it is not enough on its own

- Current risk to self or others, including thoughts of ending their life with any plan or intent: assess and manage the risk first, under your service's policy.
- Severe difficulties on assessment, including a PHQ-9 of 20 or more or a GAD-7 of 15 or more: offer high-intensity therapy, or deliver the programme only alongside it.
- Psychosis, mania, or drug or alcohol dependence that is not being treated.
- A previous course of guided self-help that did not help, where the reasons have not changed.

A NOTE ON THIS PROGRAMME

The online version of this programme carries check-ins that prompt a client to step up to more help, which a printed workbook cannot do. Use it as guided self-help with regular contact, or alongside individual therapy, rather than handing the workbook to a client to use alone.

PART 2

Delivering it well

How guided self-help works and what your part in it is: structuring each contact, reviewing the worksheets, keeping the work going, adapting it, the check-ins, and risk.

In this part

- Chapter 2, Guided self-help and your part in it: what guided self-help is, what the research says about support, and what your role is and is not

CHAPTER 2

Guided self-help and your part in it

What guided self-help is

Guided self-help pairs a structured programme, which the client works through on their own, with brief, regular contact with a trained practitioner. The programme carries the teaching: it explains the difficulty, teaches the skills, and sets the practice for each week. Your task is to help the client use it. In Understanding and Working with Disordered Eating that means 8 contacts of about thirty minutes, one after each module, by telephone, video or in person, with the client reading the module and completing its worksheets in between.

This division of labour is what makes guided self-help efficient, and it is also where it most often goes wrong. A practitioner who re-teaches each module in full turns a thirty-minute contact into an under-powered therapy session and leaves no time for the client's own practice, which is where change happens. A practitioner who asks only "How did it go?" leaves the client alone with the hardest parts. The contact plans in Part 3 are built to avoid both: most of each contact is spent on what the client did, what they learned from doing it, and what they will do next.

What the research says about support

Self-help is not a lesser treatment when it is supported. Cuijpers and colleagues (2010) pooled the studies that had compared guided self-help directly with face-to-face psychotherapy for depression and anxiety disorders, and found no significant difference in effect between the two, at the end of treatment or at follow-up. Farrand and Woodford (2013) pooled randomised trials of written cognitive behavioural self-help, found it effective for anxiety and depression, and examined how the support offered alongside it relates to its effect.

Two practical conclusions follow for your contacts. The support needs to be regular and planned, booked in advance and kept, rather than offered when the client asks for it. And it needs to be about the client's use of the programme, rather than a parallel conversation about everything else in their week.

Your part, and its limits

Roth and Pilling (2008) set out the competences needed to deliver cognitive and behavioural therapies well, distinguishing the generic competences of any good therapeutic work (engaging the client, building and keeping a working alliance, ending well) from those specific to an approach. In guided self-help the generic competences carry most of the weight. Your part has five elements:

1. Engage the client and keep the alliance: warmth, interest in the client's own words and examples, and reliability, so that contacts happen when agreed and start and end on time.

2. Review the practice: look at what the client did, with their permission, and help them draw out what they learned from it.

3. Solve problems: when the practice did not happen or did not help, find out why, and agree a smaller and clearer next step.

4. Monitor outcome: score the check-ins with the client, compare them over time, and act on the stepping-up guidance in Chapter 7.

5. Keep the work safe: ask about risk at every contact, and know what you will do with the answer (Chapter 8).

What the role is not matters as much. It is not an assessment of the whole person, a formulation of their history, or open-ended therapy. When a client brings something that needs more than the programme can offer, such as a trauma history that is beginning to surface, a relationship in crisis, or a worsening of their difficulties, acknowledge it, record it, and decide with the client and your supervisor whether a different step of care is needed, rather than stretching the contacts to hold it.

The stance that helps

Clients who do well in guided self-help tend to describe a practitioner who was interested, who noticed the effort they had made, and who was clear about what came next. Specific recognition ("You filled in the diary on five days, including the Thursday you said was the worst of the week") does more than general reassurance. Curiosity about what got in the way ("What was happening on the two days the diary stayed empty?") does more than encouragement to try harder. And a clear, small plan at the end of each contact, written down by the client in their own words, does more than a long list of good intentions.

The stance in a programme for disordered eating

Disordered eating carries physical as well as psychological risk. Before and during the programme, the client's physical health needs to be monitored by their GP or an eating disorder service under your service's policy, and you should know the warning signs that mean the programme should pause while that monitoring happens. In contacts, stay curious and

non-judgemental about eating, weight and shape, and keep the focus on the regular eating and monitoring the programme sets.