Behaviour Research and Therapy 49 (2011) 25–31

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Guided self-help for disordered eating: A randomised control trial

Gemma D. Traviss [a,*], Suzanne Heywood-Everett [b], Andrew J. Hill [a]

[a] Leeds Institute of Health Sciences, Academic Unit of Psychiatry & Behavioural Sciences, Charles Thackrah Building, Clarendon Road, University of Leeds, Leeds LS2 9LJ, UK
[b] Yorkshire Centre for Eating Disorders, Newsam Centre, Seacroft Hospital, Leeds, UK

ARTICLE INFO

Article history:
Received 22 March 2010
Received in revised form
6 October 2010
Accepted 27 October 2010

Keywords:
Guided self-help
Eating disorders
Transdiagnostic approach
Binge eating
EDNOS
Randomised control trial

ABSTRACT

Treatment guidelines recommend evidence-based guided self-help (GSH) as the first stage of treatment for bulimia nervosa and binge eating disorder. The current randomised control trial evaluated a cognitive behavioural therapy-based GSH pack, 'Working to Overcome Eating Difficulties,' delivered by trained mental health professionals in 6 sessions over 3 months. It was congruent with the transdiagnostic approach and so was intended as suitable for all disordered eating, except severe anorexia nervosa. Eighty one clients were randomly allocated to either a GSH or waiting list condition. Eating disorder psychopathology (EDE-Q), key behavioural features and global distress (CORE) were measured at pre- and post-intervention, and 3- and 6-month follow-up. Results showed significant improvements in eating disorder psychopathology, laxative abuse, exercise behaviours, and global distress, with the GSH condition being superior to the waiting list on all outcomes. Treatment gains were maintained at 3 and 6 months. This study adds to the evidence supporting GSH for disordered eating, including EDNOS. However, further work is needed to establish the factors that contribute to observed therapeutic improvements and determine for whom GSH is most suitable.

Introduction

Treatment guidelines place cognitive behavioural therapy (CBT) at the heart of the management of bulimia nervosa and some forms of EDNOS (APA, 2006; NICE, 2004). However, CBT is lengthy, costly, and in relative short supply. In addition, the approach may be unnecessarily intense for some clients with mild to moderate symptoms of disordered eating. Accordingly, following an evidence-based self-help programme is the first step in the treatment of bulimia nervosa recommended by the UK National Institute for Clinical Excellence (NICE, 2004).

Self-help has demonstrated comparable results to CBT delivered individually and in a group format (Bailer et al., 2004; Durand & King, 2003; Thiels, Schmidt, Treasure, Garth, & Troop, 1998; Treasure et al., 1999). Self-help can be used alone (pure self-help, PSH) or with guidance from a mental health professional or layperson (guided self-help, GSH). Looking at relative effectiveness, Carter and Fairburn (1998) compared pure and guided self-help for BED, delivered by non-specialists, to waiting list controls. Remission rates for the groups were 43%, 50% and 8% respectively, with clients in the PSH group more likely to seek additional treatment. Guidance provided by non-specialists for bulimia nervosa was also effective in reducing and maintaining improvements in bingeing, vomiting and eating pathology compared to delayed treatment controls (Banasiak, Paxton, & Hay, 2005). Smaller effect sizes and higher attrition rates were found in a comparable study in Sweden, but conducted without a control group (Ghaderi & Scott, 2003).

Studies have compared pure and GSH for bulimia nervosa and binge eating delivered in specialist clinics. Direct comparisons showed both were effective in reducing binge eating and related psychopathology, however GSH achieved higher remission rates and was superior in reducing binge frequency, restraint and interpersonal sensitivity (Loeb, Wilson, Gilbert, & Labouvie, 2000). Palmer, Birchall, McGrain, and Sullivan (2002) investigated two methods of delivering guidance, compared with PSH and waiting list groups. Face-to-face guidance conferred greater treatment benefits to that delivered by telephone, with little support for PSH which failed to differ from waiting list controls (Palmer et al., 2002). Interventions lasted between 12 and 17 weeks, and the amount and standard of guidance varied, along with completion rates (58–78%).

Overall, evidence shows GSH to have a range of benefits compared with PSH, although compared solely on primary outcomes such as binge episodes there is less difference in effectiveness (Perkins, Murphy, Schmidt, & Williams, 2006). In addition, while intervention effects are modest in size, the evidence may be limited by the differences in guidance and the frequent absence of

* Corresponding author. Tel.: +44 0113 3430825.
E-mail address: g.traviss@leeds.ac.uk (G.D. Traviss).

0005-7967/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.brat.2010.10.007

true control groups. Furthermore, the extent to which such interventions may be useful for mixed patterns of disordered eating, such as EDNOS, is largely unknown.

The present study investigated the effectiveness of a new GSH intervention, 'Working to Overcome Eating Difficulties'. The intervention comprised three main elements that characterise its novelty and distinguish it from previous GSH resources. First, it was a CBT-based written manual congruent with a transdiagnostic perspective, in which all eating disorders share a common core psychopathology and network of inter-related maintaining mechanisms (Fairburn, Cooper, & Shafran, 2003; Fairburn & Harrison, 2003). Accordingly, the manual included all common features of eating disorders, not just bulimic disorders, along with sub-sections specifically focussed around the four additional maintaining mechanisms outlined by Fairburn – perfectionism, low self-esteem, mood intolerance and interpersonal difficulties (Fairburn et al., 2003). For example, it included mindful breathing and eating exercises aimed at encouraging awareness and acceptance of bodily sensations and adverse mood states, which enable individuals to make adaptive choices about responding, rather than reacting to aversive experiences. Mindfulness has shown to be effective in reducing binge eating and managing emotional distress in both bulimia nervosa and BED (Baer, Fischer, & Huss, 2005; Leahey, Crowther, & Irwin, 2008; Proulx, 2008). Also in line with the transdiagnostic approach, there was little focus on specific eating disorder diagnosis. Rather, the treatment content and goals were dictated by individuals' particular psychopathological features and maintaining factors, formulated in the early sessions and revisited throughout. With this in mind, the current manual was designed to be applicable to a range of disordered eating (including EDNOS).

Second, the intervention was guided by a number of non-eating disorder specialist mental health professionals in primary and secondary care settings. Much of the existing evidence on effectiveness of GSH has been conducted either in eating disorder specialist settings or delivered by specialists. And most have only assessed the effectiveness of delivery by a small number of therapists, which tells us little about its potential to be utilised across a range of services, by a range of professionals. Third, pre-intervention mandatory training and intervention-concurrent support was provided for those acting as guides. In some existing GSH programs, guidance was provided by trained therapists such as clinical psychologists, but few describe any GSH-specific training or supervision (Grilo & Masheb, 2005; Loeb et al., 2000; Palmer et al., 2002). Those that do, appear to have relied on instructions provided in a therapist's manual (Carter & Fairburn, 1998), with the exception of Ghaderi and Scott (2003) who describe reviewing and discussing the manual with the students who were to provide guidance. The latter two features are concerned with utility outside of specialist settings. The intervention therefore represented a low intensity approach, directed at all disordered eating, that was delivered by a range of non-specialists who were trained and supported in its delivery.

The study aim was to evaluate the intervention in a randomised controlled trial (RCT) with 6-month follow-up. Accordingly, it was hypothesised that the GSH intervention would lead to maintained reductions in eating disorder psychopathology, key behavioural symptoms, and global distress in clients with a range of disordered eating problems, including EDNOS.

Method

Design

The study was a randomised controlled trial, comparing clients with disordered eating receiving GSH delivered by trained mental health professionals, to those on a waiting list. Both conditions were 12 weeks in duration with follow-up assessments made at 3 and 6 months.

Participants and randomisation

Participants were 81 clients identified with primary and significant patterns of disordered eating, referred to trained guides working in primary and secondary care services in the north of England, between October 2006 and June 2008. Services included Primary Care Mental Health Teams operating primarily within health centres, Child and Adolescent Mental Health Services, Departments of Clinical Psychology located within general hospitals and Inpatient Mental Health Special Care Wards.

Participant inclusion criteria were a primary problem with disordered eating, aged 16 years or above at the time of assessment, and literate in the English language. EDE-Q (v 5.2 see below) was used to ascertain diagnosis in line with DSM criteria. EDNOS was defined when any one of the diagnostic criteria was missing. Clients who failed to meet EDNOS but nevertheless reported disordered eating symptoms that interfered with their everyday lives were included in the current study given the potential of GSH as an effective early intervention for mild and mixed patterns of disordered eating. For this reason, the study did not apply a rule regarding the minimum number of symptoms required for inclusion. The primacy of disordered eating was largely determined by the client, their presentation to the guide and their desire to seek help for their disordered eating, followed by discussion with their guide who had received training in how to recognise eating disorder features.

Clients were excluded if the primary problem was not deemed to be disordered eating, BMI was below 16 kg/m^2 or the client was rapidly losing weight, at high risk of self-harm or suicide, currently abusing drugs or alcohol, experiencing severe depression, or had a major co-morbid physical disorder. Clients were assessed for suitability by their guide following their service's usual assessment procedures which entailed an initial meeting to discuss the nature of the clients problems and treatment options, and for the purposes of this study a clinical assessment sheet, developed by the study team, was completed by the guide following in-depth discussion with the client. This covered the above exclusion criteria i.e. current and past co-morbid conditions and suicidal ideation/intent. Those suitable received a brief medical examination from their General Practitioner and provided informed consent before being allocated to a treatment condition. Ethical permission was obtained from Leeds East Research Ethics Committee and the trial was registered with the International Standard Randomised Controlled Trial Register (ISRCTN07665287).

A priori sample size calculation was carried out using Clinstat (Bland, 1996). The calculation was based on proportions from Palmer et al. (2002) where in a face-to-face GSH group 50% improved compared to 19% in a waiting list group. To obtain a similar outcome, 33 participants in each group were required to have an 80% power of detecting a difference at the 5% significance level. Given a drop-out rate of 25%, the intention was to recruit 41 in each group. Participants were randomly allocated to either the GSH or waiting list control condition by the first author (GT) using randomisation envelopes prepared by AJH, who was uninvolved in the recruitment process. Block randomisation for small samples was used to ensure equality of allocation to each treatment arm. Blocks of 20 were generated using computer software Clinstat (Bland, 1996).

Intervention

Guided self-help

Each client in the GSH condition received an introductory session at which they were given a copy of the Working to