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Guided and unguided self-help for binge eating

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Abstract

This study compared the relative short- and longer-term efficacy of therapist-guided and unguided use of a cognitive behavioral self-help manual for binge eating [Fairburn, C. G. (1995). *Overcome binge eating*. New York: The Guilford Press.] Forty women (82.5% with binge eating disorder) were randomized to one of the two treatment levels. Results indicate that both conditions represent viable means of treating binge eating. Overall, patients improved their eating behavior, eliminated any inappropriate compensatory behaviors, reduced their shape concern, weight concern, and other symptoms of eating-related psychopathology, and improved their general psychological functioning. The guided self-help condition was notably superior in reducing the occurrence of binge eating and its associated symptomatology, as well as lowering interpersonal sensitivity. A high degree of general psychopathology was a negative prognostic indicator. The implications for a stepped-care approach to treating binge eating are discussed. © 2000 Elsevier Science Ltd. All rights reserved.

Keywords: Binge eating; Self-help; Bulimia nervosa; Cognitive behavioral treatment; Treatment outcome

1. Guided and unguided self-help for binge eating

Binge eating is a phenomenon that appears across the spectrum of eating disorders. Bulimia nervosa (BN) is characterized by frequent binge eating accompanied by inappropriate compensatory mechanisms. Binge eating disorder (BED), defined by recurrent binge eating in the absence of purging, appears in the Diagnostic and Statistical Manual of Mental Disorders 4th ed., (DSM-IV) (American Psychiatric Association, 1994) as a disorder in need of

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further study. While cognitive-behavioral therapy (CBT) has come to be regarded as a treatment of choice for binge eating, at least two obstacles exist in disseminating this type of therapy. First, prevalence studies of BN have revealed that the overwhelming majority of individuals afflicted with this disorder do not present for treatment (Fairburn & Cooper, 1982; Whitaker et al., 1990). It is reasonable to assume that this finding reflects both the lack of access to psychotherapy and the perceived embarrassing nature of the disorder, and would apply to other groups of binge eaters (Fairburn, 1997). Second, although CBT is widely employed in clinical research settings, few therapists have had training in the theories and techniques of CBT (Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Recent studies have indicated that guided use of a cognitive-behavioral self-help manual, which is relatively accessible and affordable, may yield results that approximate those obtained with therapist-delivered CBT for BN (e.g., Cooper, Coker & Fleming, 1996). Self-help has several other potential advantages. A self-help manual may be a logical first step for individuals presenting to clinics utilizing a stepped care approach (i.e., programs that begin with the most cost-effective and least intensive treatment, and move upward incrementally) (Fairburn & Peveler, 1990). In addition, patients participating in a form of therapy ineffective for binge eating, but helpful for other problems, could augment it by simultaneously using a cognitive-behavioral self-help manual. Lastly, as Fairburn (1997) points out, self-help is empowering in that individuals are more likely to attribute success to their own efforts.

Several studies have formally evaluated the effectiveness of self-help manuals for binge eating. In an early study, Huon (1985) randomized 90 women meeting DSM-III criteria for bulimia to one of three treatment conditions: seven monthly components of a cognitive-behavioral self-help program plus available contact with a recovered bulimic, the same monthly installments plus available contact with a partially recovered bulimic, or the self-help program alone. Results indicate that the three treatment conditions produced significant improvement at the end of seven months, but were indistinguishable from one another. Follow-up findings, however, suggest that contact was superior to self-help alone. Limitations of this study include measurement exclusively by self-report, and highly variable communication with the recovered or semi-recovered contacts.

Treasure et al. (1994) compared the administration of a cognitive-behaviorally oriented self-help manual (Schmidt, Tiller & Treasure, 1993) with the first stage (8 of 16 weeks) of therapist-delivered CBT and a wait-list control group. Eighty-one women with BN were randomized to one of these three conditions. It was found that within groups, both treatment conditions yielded significant improvement of eating disorder symptoms, while the waiting list did not. Between groups, the two treatments were superior to the control condition but differed little from each other. In a later study by this group (Treasure, Schmidt, Troop, Tiller, Todd & Turnbull, 1996), 125 patients were assigned to either a stepped care approach – 8 weeks of self-help followed by 8 weeks of CBT if insufficiently improved – or a 16-week course of CBT. No group differences emerged, and both conditions yielded a remission rate of 30%. A third study (Thiels, Schmidt, Treasure, Garthe, & Troop, 1997) using the same manual compared 4 months of therapist-guided self-help to 16 sessions of CBT for 62 patients with BN. Again, both treatments produced significant improvement, but were generally indistinguishable from one another.