Cognitive behavioural self help reduced binge eating in women

Carter JC, Fairburn CG. ***Cognitive-behavioral self-help for binge eating disorder: a controlled effectiveness study.*** *J Consult Clin Psychol 1998 Aug;**66**:616–23.*

Questions
Is cognitive behavioural self help effective in women with binge eating disorder (BED)? Does pure self help (PSH) or guided self help (GSH) lead to a better outcome?

Design
Randomised controlled trial with 6 months follow up.

Setting
Community based study at Oxford University, UK.

Participants
72 women (mean age 40 y) with BED who had at least weekly bulimic episodes (defined by the Eating Disorder Examination [EDE]) but had not used vomiting, fasting, laxatives, or diuretics to control their shape or weight during the previous 3 months. Exclusion criteria were *DSM-IV* diagnosis of bulimia nervosa or anorexia nervosa, age <18 years or >65 years, pregnancy, medical disorder or treatment that influenced eating habits or weight, current psychiatric treatment, or previous treatment for binge eating. Follow up was 94% at 3 months and 86% at 6 months.

Intervention
Women were allocated to PSH, GSH, or a waiting list for 12 weeks, after which those on the waiting list (n = 24) were allocated to PSH or GSH. Women allocated to PSH (n = 35) were asked to read and to follow the self help programme outlined in a book on binge eating*. Women allocated to GSH (n = 34) attended six to eight 25 minute sessions in which a facilitator with no formal clinical qualifications supported them in the use of the same self help book.

Main outcome measures
Frequency of binge eating and cessation of binge eating were measured using the EDE.

Main results
After treatment, women in the 2 self help conditions had fewer eating binges than did those on the waiting list (GSH mean 4.3 *v* 13.5 binge eating episodes/28 d, p = 0.001 and PSH 9.3 *v* 13.5 binge eating episodes/28 d, $p<0.05$); the PSH and GSH conditions did not differ in the frequency of binge eating. Cessation rates after treatment were greater for PSH and GSH than for the waiting list (p = 0.001 for GSH and p = 0.008 for PSH) (table). Women allocated to GSH had fewer eating binges at 3 and 6 months than did those allocated to PSH ($p<0.05$). No differences in the cessation rates existed between PSH and GSH at 3 and 6 months (table).

Conclusions
Cognitive behavioural self help reduced the frequency of binge eating and led to greater cessation rates in women with binge eating disorder. Guided self help led to a greater reduction in binge eating than did pure self help.

**Fairburn CG. Overcoming binge eating. New York: Guilford Press, 1995.*

Binge eating cessation rates for guided self help (GSH), pure self help (PSH), and control (waiting list)†

Length of follow up	*GSH*	*PSH*	*Control*	*RBI (95% CI)*	*NNT (CI)*
After treatment	50%		8%	500% (82 to 2129)	3 (2 to 6)
After treatment		43%	8%	414% (53 to 1828)	3 (2 to 9)
After treatment	50%	43%		17% (−30 to 96)	Not significant
3 months	41%	37%		11% (−38 to 100)	Not significant
6 months	50%	40%		25% (−26 to 114)	Not significant

†Abbreviations defined in glossary; RBI, NNT, and CI calculated from data in article.

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Commentary

Limited research is available on the effectiveness of cognitive behavioural self help approaches for BED. Carter and Fairburn make an important contribution to knowledge in this area by publishing the first study to compare types of self help for BED. The results are consistent with those of previous studies of the effectiveness of cognitive behavioural self help models of treatment,[1 2] which show that some people with BED respond to non-specialist interventions. The findings also suggest that some people respond to pure self help without facilitator intervention. PSH may have potential as a secondary prevention strategy.

Compliance in the PSH condition was significantly lower than in the GSH condition. The researchers do not speculate why the PSH and GSH conditions differ in this regard. The main difference in the experimental conditions was the addition of a non-specialist facilitator in the GSH condition. Although this difference does not explain the differences in attendance in this study, it may be worthy of exploration in future research. Compliance merits systematic assessment in studies of this type.[1]

The study results are particularly relevant to primary care and community settings where BED is assessed. This is the first study where researchers administered the self help interventions in a way that is typical of self help programmes for eating disorders in primary care (GSH) and in the community (PSH). Non-specialist intervention offers hope of treatment to the large number of people who are unlikely to receive treatment because of the lack of availability of therapists. It also addresses other barriers to treatment, including patient reluctance to disclose a problem, the practical difficulties of attending appointments, and the high cost of private therapy. Nurses who work in primary care and community settings could administer this programme without specific expertise.

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1 Peterson CB, Mitchell JE, Engbloom S, *et al. Int J Eat Disord* 1998;**24**:125–36.
2 Wells AM, Garvin V, Dohm FA, *et al. Int J Eat Disord* 1997;**21**:341–6.