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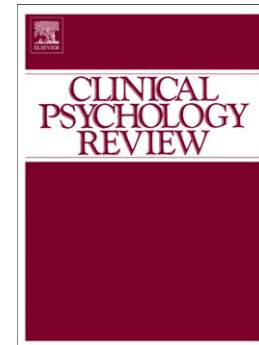
Cognitive-Behavioral Guided Self-Help for Eating Disorders: Effectiveness and Scalability

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Cognitive-Behavioral Guided Self-Help for Eating Disorders: Effectiveness and  
Scalability

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### Abstract

Given the well-documented shortage of cognitive-behavioral therapy (CBT) for eating disorders, there is a compelling need for advances in dissemination. Guided self-help based on cognitive-behavioral principles (CBTgsh) provides a robust means of improving implementation and scalability of evidence-based treatment for eating disorders. It is a brief, cost-effective treatment that can be implemented by a wide range of mental health providers, including non-specialists, via face-to-face contact and internet-based technology. Controlled studies have shown that CBTgsh can be an effective treatment for binge eating disorder and bulimia nervosa, although it is contraindicated for anorexia nervosa. Several studies have shown that CBTgsh can be as effective as more complex specialty therapies and that it is not necessarily contraindicated for patients with comorbid conditions. Mental health providers with relatively minimal professional credentials have in some studies obtained results comparable to specialized clinicians. Establishing the nature of optimal “guidance” in CBTgsh and the level of expertise and training required for effective implementation is a research priority. Existing manuals used in CBTgsh are outdated and can be improved by incorporating the principles of enhanced transdiagnostic CBT. Obstacles to wider adoption of CBTgsh are identified.

*Keywords:* eating disorders; guided self-help; cognitive behavior therapy; implementation; dissemination

## Cognitive-Behavioral Guided Self-Help for Bulimia Nervosa, Binge Eating Disorder, and Eating Disorder Not Otherwise Specified: Effectiveness and Scalability

Evidence-based psychological treatments have been developed for a wide range of clinical disorders (Nathan & Gorman, 2007; Shafran et al., 2009; Weisz & Kazdin, 2010). As impressive as these advances have been, the reality remains that only a small proportion of individuals with mental disorders actually receive psychological treatment let alone interventions that are empirically supported. The situation is exacerbated by the existence of widespread ethnic and racial inequities regarding access to mental health care. In their far-reaching analysis of this unmet need, Kazdin and Blase (2011) point out that individual face-to-face psychotherapy for individuals or relatively small units (groups, family, or couples) is still the “dominant model of treatment delivery” (p.22) in clinical psychology and psychiatry. Yet it is a model that can never by itself provide sufficient access to evidence-based treatment.

Kazdin and Blase (2011) show that even doubling the existing number of mental health providers would have “little discernible impact” (p.23) on the problem. Moreover, it is not simply the inadequate number of necessary professionals but also their profile that is problematic. Consider two examples of this issue. First, too few professionals being trained in clinical psychology in the United States represent underserved ethnic and racial minority groups. Second, there is a shortage of therapists with expertise in newer evidence-based treatments such as CBT (Insel, 2009; Shafran et al., 2009). To become competent in the implementation of evidence-based treatments, mental health professionals require specialized and intensive training that is not readily available.

Kazdin and Blase (2011) call for a major shift in treatment research and clinical practice – the “rebooting of psychotherapy.” The shift would feature a range of models for delivering treatment that would capitalize on advances in technology, non-traditional service providers, and self-help interventions. Interventions are needed that can not only reach many more people than is the case today, but also with particular attention to select subpopulations among whom inequities in service exist. Kazdin and Blase (2011) focus on psychotherapy provided by clinical psychologists in the United States. The analysis dovetails, however, with global concerns and insufficient supply of mental health specialists in general (Lancet Global Mental Health Group, 2007). For example, it has been estimated that up to 90% of individuals with mental disorders in low- and middle-income countries fail to receive even basic mental health care (Wang et al., 2007).

Patel’s (2009) analysis of psychiatry reached essentially the same conclusion as Kazdin and Blase (2011). Using the example of India, Patel (2009) has shown that the work of psychiatrists in both public and private arenas predominantly entails “face-to-face clinical encounters with individuals affected by mental disorders...” (p.1760). In order to close the alarming treatment gap in mental health care, Patel (2009) has detailed strategies that would radically alter the manner in which psychiatrists are trained, as well as how, by whom, and under what conditions specific psychological treatments are delivered. He has advocated the adoption of “task shifting” to increase the scalability of health interventions. In this approach, “mental health care must be devolved to non-specialist health workers who are trained to deliver interventions for specific mental disorders” (p.1760).

In this paper we focus on self-help interventions and their delivery via different means, including technology, for eating disorders with the exception of anorexia nervosa. There is a compelling need for such advances in the field of eating disorders. The lack of training and dearth of therapists with expertise in evidence-based specialty treatments for eating disorders has been well-documented (Hart, Granillo, Jorm, & Paxton, 2011; Mussell et al., 2000; Wilson, Grilo, & Vitousek, 2007). The purpose is to illustrate the potential for the cost-effective and scalable implementation of evidence-based eating disorder treatment in a manner consistent with the agenda laid out by Kazdin and Blase (2011) and Patel, Chowdhary, Rahman, and Verdeli (2011), among others.

### Self-Help

Broadly speaking, self-help interventions entail the independent use of a treatment manual or protocol following step-by-step instructions contained in a book or via a web-based system. The goals are both to educate individuals about the nature of their disorder and to equip them with specific skills to overcome their problems. Self-help interventions can range from purely self-directed strategies (pure self-help) to treatments involving varying degrees of professional contact (guided self-help). Assistance in *guided* self-help (the term first used by Fairburn [1995]) is made available by a mental health provider and is primarily supportive and facilitative in nature. It can be delivered through face-to-face contact with the mental health provider, by telephone, or via the internet (Sanchez-Ortiz & Schmidt, 2010; Williams, 2003). In the case of face-to-face meetings with a provider, the number and length of sessions, as well as their content and structure, differ importantly from traditional psychological therapy.

The advantages of self-help interventions have been well-documented (Fairburn & Carter, 1997; Latner & Wilson, 2007). They are typically brief and less costly than specialty therapies such as cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT) (Birchall & Palmer, 2002). Skilled therapists with expertise in specialty evidence-based treatments are often in short supply. Importantly, guided self-help interventions can be implemented by a wide range of non-specialist health care providers and are hence more readily disseminable. Self-help can overcome obstacles to accessing treatment, such as distance from treatment centers, and allows people to engage in treatment at their own time and pace. Finally, Fairburn and Carter (1997) note that effective self-help interventions may be inherently empowering.

Accumulating evidence shows that guided self-help in particular can be an efficient and effective form of treatment for various clinical disorders. A recent meta-analysis of randomized controlled trials in which guided self-help for depression and anxiety was compared directly with face-to-face psychotherapies revealed no significant differences between the two at post-treatment or follow-up (Cuijpers, Donker, van Straten, Li, & Anderson, 2010). In this meta-analysis, guided self-help consisted of no more than 12 sessions (contacts) with a maximum duration of 20 minutes each. Face-to-face treatments used the same treatment contents and format contained within full individual or group treatment sessions. Similarly, in a comprehensive review of technology-assisted self-help and minimal contact interventions for anxiety and depression, Newman, Szkodny, Llera, and Przeworski (2011) concluded that minimal contact or guided self-help treatment is a “less intensive, cost-effective way to deliver empirically validated treatments” (p. 90). Additional evidence for the effectiveness of

CBT-based guided self-help for anxiety and depression comes from the initial findings of the *Increasing Access to Psychological Treatment* program in the United Kingdom (Richards & Suckling, 2009).

Previous reviews have shown that guided self-help based on cognitive behavioral therapy (CBTgsh) can be effective in treating subsets of patients with bulimia nervosa, binge eating disorder, and eating disorder not otherwise specified (EDNOS) (NICE, 2004; Sanchez-Ortiz & Schmidt, 2010; Sysko & Walsh, 2008). Guided self-help is contraindicated for anorexia nervosa given the special clinical and medical needs of patients with this disorder (Wilson, Vitousek, & Loeb, 2000). Here we provide an updated analysis of the empirical evidence on CBTgsh for the appropriate eating disorders. The focus is then expanded to address high priority issues such as patients for whom CBTgsh is most appropriate, the level of provider expertise and training required for successful implementation, and different methods of delivery. Finally, we suggest ways in which CBTgsh protocols can be enhanced to be more effective and generally applicable to diverse patients.

### Bulimia Nervosa

Prior reviews are consistent in showing that CBTgsh can be an effective intervention for bulimia nervosa (BN) as compared with a minimal control conditions such as a waiting-list (Grilo, 2006; Sysko & Walsh, 2008). The NICE (2004) guidelines recommendation regarding self-help was as follows: “As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help program,” and “Healthcare professionals should consider providing direct encouragement and support” to patients undertaking such a program in order to improve outcomes.



These recommendations received a grade of B that was comparable to the rating of some specialized therapies. Table 1 summarizes the controlled treatment outcome studies that have evaluated the effectiveness of guided self-help interventions for BN. In the following text, we note the findings from clinical trials that have evaluated the specific effects of CBTgsh compared with other interventions.

The Mitchell et al. (2011) multi-site study is the largest controlled study of CBTgsh for bulimia nervosa to date. The overall design is complex. Of primary interest here is the initial comparison of a full program of specialty CBT (20 individual, 50 minute sessions) with CBTgsh (eight, 20 minute sessions using the Fairburn [1995] book) over an 18 week period. Patients who did not show a minimum of 70% reduction in purging by session 6 were offered fluoxetine (60 mg). The rates of patients who received fluoxetine were 65% in the full CBT treatment and 34% in CBTgsh. At the 18 week post-treatment assessment, the abstinence rates (cessation of both bingeing and purging) were 15% and 11% for full CBT and CBTgsh, respectively. The remission rates (defined as no longer meeting DSM-IV diagnostic criteria) were 57% and 52%, respectively. It should be noted that the patients randomized to CBTgsh conditions were significantly more likely to have endorsed a history of anorexia nervosa, shown to be a negative prognostic indicator in some studies (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). Given the lack of significant difference in outcome between the two treatment conditions, Mitchell et al. (2011) concluded that “Therapist-assisted self-help was an effective first-level treatment” (p. 391).

The study had several strengths. Adequately powered and conducted by a very experienced group of investigators, it included state-of-the-art assessment of outcome

(Eating Disorder Examination [EDE] interviews), manual-based treatments, centralized training of therapists, and weekly supervision using audio-recordings of therapy sessions. The finding that CBTgsh produced comparable results at post-treatment is hence noteworthy. Total therapist contact time was 16 to 17 hours for CBT and 2 to 3 hours for CBTgsh. Moreover, therapists who administered CBTgsh had far less experience and training in CBT and eating disorder treatment. The puzzling finding, as the authors point out, is the low abstinence rate in the full CBT condition compared with other major RCTs, including those conducted by the same authors (e.g., Agras, Crow et al., 2000; Mitchell et al., 2002).

Thiels et al. (1998) evaluated whether eight, 50-60 minute sessions of CBTgsh (using the Schmidt and Treasure [1997] manual) would prove as effective as 16 sessions of standard CBT. Both interventions led to significant improvements in eating disorder psychopathology that were maintained at follow-up. No differences were found between groups on outcome measures, including the EDE, the Beck Depression Inventory (BDI), and the Self-Concept Questionnaire. Abstinence rates from bingeing and purging for guided self-help were low (12.9%) at post-treatment and improved to 60.9% over follow-up. No differences were found between groups in the number of patients who sought additional treatment after the trial. The authors concluded that guided self-change and CBT were equally effective in the long-term.

Schmidt et al. (2007) compared CBTgsh to Maudsley-model family therapy for adolescents (aged 13-20) with BN or EDNOS with compensatory behaviors. CBTgsh (using the Schmidt and Treasure [1997] manual) consisted of 13 focal sessions and two optional appointments with a “close other” (e.g., a relative or friend). Both treatments

were provided in a specialty mental health setting over 6 months and delivered by experienced therapists with requisite training and ongoing supervision of audio- and video-taped sessions. Intent-to-treat analyses found a higher proportion of CBTgsh participants abstinent from binge eating (41.9%) than family therapy patients (25%) at post-treatment. The CBTgsh condition also achieved earlier improvement in therapy. At 12 month follow up, abstinence rates for bingeing and purging combined were no longer significantly different: 36% for CBTgsh and 41% for family therapy.

It is instructive to compare the results of the foregoing studies with the Walsh, Fairburn, Mickley, Sysko, and Parides (2004) study. Four treatment conditions were compared: CBTgsh (using the Fairburn [1995] book) with either fluoxetine or pill placebo, and fluoxetine or pill placebo alone. Overall, the fluoxetine treatment was significantly superior to pill placebo across a range of eating disorder outcome measures with its effects comparable to findings from previous RCTs of the drug. Yet “no discernible effect” (p.559) of CBTgsh was found on measures of binge eating, vomiting, or dietary restraint. The CBTgsh plus pill placebo condition showed no within treatment effect nor was it more effective in any way than pill placebo alone. Greater than two thirds of the CBTgsh patients (71.4%) dropped out of the study. As a whole, these are the most disappointing results of any published study of CBTgsh. Walsh et al. (2004) discussed likely reasons for the negative outcome of CBTgsh. As an effectiveness study, it was designed to evaluate CBTgsh in a primary care setting using minimally trained nurses inexperienced in treating eating disorders. Moreover, there was no ongoing monitoring or supervision of treatment during the study.

Steele and Wade (2008) conducted a small study comparing three different forms of guided self-help: targeting BN symptoms (CBTgsh), targeting perfectionism, and active placebo control (i.e., manual teaching mindfulness). Contrary to expectations, these investigators found no differences in outcome across conditions at follow-up. By completer analysis, only 5% of participants in the CBTgsh condition were abstinent from bingeing and purging at post-treatment. This outcome improved to 19% at 6 month follow-up. The duration of treatment (6 weeks) was considerably shorter than previously tested, potentially compromising therapeutic impact. Moreover, using the EDE to assess outcome meant that the focus was on the preceding 28 days. As such, only those patients achieving full symptom remission by week 3 were classified as abstinent at post-treatment. Finally, as acknowledged by the authors, small sample size might have compromised power to detect between-group differences.

In sum, despite the limited number of comparative outcome studies, the findings on CBTgsh for BN are promising. They warrant future research and clinical application.

### Binge Eating Disorder

The NICE (2004) review concluded that CBTgsh had been shown to be effective in treating binge eating disorder (BED). The supporting evidence was given a methodological grade of B which was comparable to some specialty psychological treatments. The Sysko and Walsh (2008) qualitative review reported conclusions consistent with those of the NICE report that CBTgsh is significantly superior to a wait list control condition. Table 2 summarizes the treatment outcome studies that have evaluated the effectiveness of guided self-help interventions for patients with BED. In the text here we highlight the studies bearing on the specific effect of CBTgsh.

Three studies have compared CBTgsh with alternative active treatments. All three employed the Fairburn (1995) self-help manual. In the first, Grilo and Masheb (2005) found that CBTgsh was significantly more effective than a guided self-help version of behavioral weight loss treatment and a control condition designed to control for non-specific attention effects. CBTgsh resulted in a 46% abstinence rate compared with 18% and 13% in the other two treatments. The clinical characteristics of the patients were comparable to those in randomized controlled trials (RCTs) of manual-based specialty therapies (e.g., Wilfley et al., 2002). Overall, 69% of the sample had at least one additional psychiatric disorder, and 46% met criteria for major depressive disorder.

In the second comparative outcome study, Wilson, Wilfley, Agras, and Bryson (2010) pitted CBTgsh against both behavioral weight loss treatment (BWL) and interpersonal psychotherapy (IPT) in a sample of 205 overweight and obese patients. BWL and IPT consisted of 20 sessions of individual treatment administered over a six month period whereas CBTgsh comprised 10 sessions over this period, nine of which had a maximum duration of 25 minutes. CBTgsh was provided by beginning graduate students in clinical psychology with little or no therapeutic experience. IPT was provided by intensively trained and supervised doctoral-level clinical psychologists. Post-treatment analyses revealed no differences among the three treatments on abstinence from binge eating. The abstinence rates were as follows: CBTgsh = 58%; IPT = 64%; and BWL = 54%. At the 2 year follow-up, both CBTgsh and IPT not only successfully maintained their improvement but were also significantly superior to BWL in producing abstinence from binge eating. Consistent with previous research, BWL produced greater weight loss than either IPT or CBTgsh.

In the Grilo and Masheb (2005) and Wilson et al. (2010) studies, CBTgsh was conducted in specialty eating disorder clinic settings. In contrast, Striegel-Moore et al. (2010) evaluated the effects of eight sessions of CBTgsh with treatment-as-usual (TAU) over a 12-week period in a large health maintenance organization (HMO) in the United States. Treatment-as-usual (TAU) was selected as a credible control condition because HMO members have access to a range of health services and treatment options relevant to weight and eating problems in addition to general mental health treatment. The therapists were master's-level psychologists with no previous experience in treating patients with eating disorders. Of the full sample of 123 patients diagnosed with recurrent binge eating (once a week on average for the previous three months), 48% met criteria for BED. The abstinence rates for CBTgsh and TAU at post-treatment were 63.5% and 28.3%, respectively, and 64% and 44.6% at the 12-month follow-up. Effect sizes (using number-needed-to-treat) at six and 12 month follow-up were 3 and 5 respectively, indicating that for every three patients (at 6 months) or five patients (at 12 months) treated with CBT-GSH, one more failure to respond was observed in TAU. The diagnosis of BED did not moderate outcome. Significant CBTgsh-induced improvement was evident on other EDE measures of eating disorder-related psychopathology, as well as depression and functional impairment. CBTgsh proved highly acceptable in this setting with 74% of the sample attending at least seven sessions. Of note, almost two-thirds of patients in both conditions accessed health services within the HMO during the course of the study, although the help they received was not specific evidence-based treatment. Close to 50% of patients in both conditions received psychotropic medication

(antidepressants and anxiolytics) presumably due to the marked presence of comorbid psychopathology in this sample.

A fourth study by Peterson et al. (2009) compared a pure self-help group treatment with what the authors labeled as “therapist-led” and “therapist-assisted” group CBT treatments. Although clearly different from the CBTgsh implemented in the three studies described above, the comparison of the therapist-assisted and therapist-led conditions bears directly on the level of therapist involvement in treatment. Neither at post-treatment nor at follow-up were there any significant differences between the two treatments on abstinence from binge eating. Indeed, neither of these treatments was superior to pure self-help at the one year follow-up.

Collectively the studies summarized here provide robust evidence for the specific effects of CBTgsh in treating BED, with consistent reductions in binge eating, eating disorder psychopathology, and psychiatric comorbidity. The important exception to this pattern is weight loss. Consistent with the findings from more complex evidence-based therapies (Grilo, Masheb, Wilson, Gueorguieva, & White, 2011), CBTgsh does not produce significant weight loss in overweight/obese BED patients.

#### Eating Disorder Not Otherwise Specified (EDNOS) – Recurrent Binge Eating

Table 3 summarizes the treatment outcome studies that have evaluated the effectiveness of guided self-help interventions for patients with EDNOS. The available evidence bears mainly on recurrent binge eating as a form of EDNOS.

In the Striegel-Moore et al. (2010) study discussed above, 41% of the patient sample were characterized by recurrent binge eating in the absence of bulimia nervosa or binge eating disorder. Research has shown that there are few differences either in clinical

characteristics, personality, or response to treatment between individuals who engage in binge eating once a week compared with twice a week (Wilson & Sysko, 2009).

Accordingly, the proposed DSM-5 criteria for both bulimia nervosa and binge eating disorder (American Psychiatric Association, 2011) adopt the once-a-week frequency threshold as a diagnostic criterion. The Striegel-Moore et al. (2010) results showed no differences in outcome between patients identified with BED or recurrent binge eating. Both groups showed significantly greater improvement in terms of remission from binge eating and other measures of eating disorder psychopathology in response to CBTgsh as opposed to TAU.

DeBar et al. (2011) completed a replication and extension of the Striegel-Moore et al. (2010) study in a sample of 160 patients in the same MHO with the same inclusion criteria of recurrent binge eating. The treatment setting and design, CBTgsh intervention, therapists, and supervision were all the same as in the earlier trial. However, in the latter investigation, procedural differences conformed closely with the requirements of routine clinical service: (a) patients were assessed using the self-report version of the EDE (EDE-Q), and (b) individuals were targeted who most commonly present with eating disorder problems in similar, non-specialist treating settings (i.e., women aged 25 to 50 years). At post-treatment, CBTgsh was significantly more effective than TAU in producing remission from binge eating with a large effect size. CBTgsh was also more effective in terms of improvement in dietary restraint, eating concerns, and body shape and weight concerns. As in the earlier study, patients in both treatment conditions utilized other treatment services within the HMO, with large numbers receiving psychotropic medication for mood and other comorbid disorders.



### Acceptability of Guided Self-Help

The acceptability of CBTgsh both to individuals with eating disorders and the professional community is critical to its broad implementation and scalability. For example, as one reason for the dismal showing of CBTgsh in their primary care study of BN patients, Walsh et al. (2004) speculated that the “low intensity” of the CBTgsh treatment might have undermined “the confidence of patients and led to poor compliance” (p. 560).

Few studies have evaluated the acceptability of guided self-help interventions directly. Three studies assessed patient ratings of suitability of CBTgsh for their eating disorder problem at the onset of treatment. Pretorius et al. (2009) administered a three-item expectation questionnaire prior to participation in an online self-help program. The mean score for the program’s expected usefulness was high – namely, 1.3 on a 0 to 4 scale, where 0 indicates very positive expectancy. In their study conducted in a major health maintenance organization, Striegel-Moore et al. (2010) found the mean expectancy rating for the suitability of CBTgsh (obtained at Session 2) was 4.16 on a scale where 5 was the maximum score. In contrast, Wilson et al. (2010) reported that at sessions 1 and 4 patients rated CBTgsh as significantly less suitable than IPT and predicted that CBTgsh would be less effective. The absolute scores for CBTgsh on the 10-point rating scales, however, were a high 7.2 and 7.5 for suitability. These results reflect the very high acceptability of IPT as a treatment for eating disorders (Tanofsky-Kraft & Wilfley, 2010), rather than a problem with CBTgsh per se. Moreover, it should be noted that neither of these ratings predicted treatment outcome.

Schmidt et al. (2007) reported that CBTgsh was more acceptable to adolescents than family therapy because of their reluctance to have family members directly involved in their treatment. Subsequent quantitative and qualitative research in England confirmed that young people (ages 13 to 20 years) with BN or atypical BN reported that internet-based CBT with flexible weekly email support and advice from an experienced clinician was both acceptable and effective (Pretorius et al., 2009; Pretorius et al., 2010). Finally, Durand & King (2003) found no differences on ratings of the perceived helpfulness of treatment in self-help guided by general practitioners as compared to specialist eating disorder treatment.

Treatment drop-out rate may be used as an indirect estimate of the acceptability of the intervention. As summarized in Tables 1, 2, and 3, several studies of BN, BED, and EDNOS have found low drop-out rates (e.g., Carter & Fairburn, 1998; DeBar et al., 2011; Grilo & Masheb, 2005; Striegel-Moore et al., 2010). In addition, multiple studies have reported comparable attrition rates between CBTgsh and alternative treatments within the same study (e.g., Bailer et al., 2004; Mitchell et al., 2011; Schmidt et al., 2007; Thiels, Schmidt, Treasure, Garthe, & Troop, 1998).

#### Cost-Effectiveness

The importance of cost-effectiveness in the scalable implementation of evidence-based therapy is beyond dispute. As a brief and focal intervention, CBTgsh for eating disorders meets this criterion. Three studies have reported formal cost-effective analyses of CBTgsh. A major study of the cost-effectiveness of CBTgsh for BN within a stepped-care framework has yielded encouraging results (Crow, 2006). CBTgsh resulted in a substantially lower cost per effectively treated patient than regular manual-based CBT.

The Schmidt et al. (2007) investigation found that the mean cost of treatment (including supervision) was significantly lower for CBTgsh than for family therapy, although no differences in other cost categories emerged. In an analysis of the findings from Striegel-Moore et al. (2010), Lynch et al. (2010) estimated total societal cost using costs both to patients and the health plan. CBTgsh plus TAU produced significantly more binge-free days and a lower total societal cost over the 12 months following treatment. The lower costs of CBTgsh were due to the reduced use of TAU services within the HMO and were obtained despite the relatively high level of therapist supervision.

Additional evidence documents that CBTgsh is a less costly form of intervention than standard specialty therapy. Thiels et al. (1998) showed that 8 fortnightly sessions of CBTgsh were as effective in treating BN as 16 weekly sessions of individual CBT both at post-treatment and follow-up. The same therapists conducted both treatments, thereby controlling for any therapist effect. Bailer et al. (2004) found that 18 weekly sessions (no more than 20 minutes in duration) were comparable to 18 sessions of group CBT at post-treatment and follow-up in the treatment of BN (see Table 1). As noted above, the therapist contact times in the Mitchell et al. (2011) study of BN were 2 to 3 hours for CBTgsh versus 16 to 17 hours for full CBT. In the Wilson et al. (2010) study of BED, the therapist contact time for CBTgsh was 4 to 5 hours versus 18 to 19 hours for IPT. CBTgsh was as effective as full CBT and IPT in these studies despite the marked discrepancy in therapist time.

An obvious advantage of CBTgsh is that it can be administered by a wider range of health providers than specialty psychological therapies that require specific expertise and training (see below). In addition, it should be noted that even if highly trained

therapists were to deliver CBTgsh, it would still be cost-effective as CBTgsh treatment sessions are fewer in number and shorter in length.

Finally, CBTgsh lends itself well to achieving cost-effective implementation of evidence-based treatment in a manner that is only beginning to be recognized. The standard judgment on guided self-help for eating disorders has consistently been that it works well as the first option in a stepped-care approach (e.g., Musiat & Schmidt, 2010; NICE, 2004). However, another potential use of guided self-help is to complement specialty evidence-based treatment in a way that is less costly and more disseminable in routine clinical care settings (Cuijpers et al., 2010). Although yet to be implemented in the treatment of eating disorders, a compelling illustration of this strategy comes from the transdiagnostic treatment of anxiety disorders in a primary care setting (Craske et al., 2011). The essence of this innovative program was to train treatment providers with little or no mental health experience to treat anxiety disorders in primary care so as to reduce the amount of training and expertise – and hence cost – required. The key was providing a computer-based program that gave guidance to both the provider and the patient in the implementation of the CBT program. The extension of this strategy to eating disorders using CBTgsh is a research priority. Commenting on the applicability of this type of approach, Cuijpers et al. (2010) concluded that “There is no reason not to consider using guided self-help as a complement in clinical practice, and we suspect that face-to-face treatment and guided self-help will blend in with each other increasingly in the near future...” (p.1953).

### Evaluating the Effectiveness of Guided Self-Help

The evidence presented here extends previous reviews by summarizing more recent research attesting to the specific treatment effects of CBTgsh for BED. The data also support the view that CBTgsh is specifically effective for recurrent binge eating as a form of EDNOS. The evidence remains too sparse and methodologically limited to draw a firm conclusion about specific treatment effects for BN, although the Mitchell et al. (2011), Thiels et al. (1998), and Schmidt et al. (2007) studies have provided promising results.

Sysko and Walsh (2008) pointed out that several studies had shown CBTgsh to be as effective as established forms of treatment such as traditional CBT (e.g., Bailer et al, 2004; Thiels et al., 1998). The well-controlled Mitchell et al. (2011) study can be added to this list. However, they noted that since these studies lacked a control or reference condition, the patients might have been responsive to any credible intervention. Although this interpretation cannot be ruled out, it is made less plausible by the well-established evidence showing that CBT is the most effective evidence-based treatment both for BN and BED (NICE, 2004). If CBTgsh shows comparable effects to CBT, it strongly suggests that it has specific treatment effects as well. More importantly, as discussed above, a large and well-controlled study of BED revealed not only that CBTgsh proved to be as effective as the specialty treatment of IPT, but also that both were significantly more effective than BWL in producing remission from binge eating at a two year follow-up (Wilson et al., 2010).

Reviews of the effectiveness of guided self-help treatments have consistently focused on comparisons with specialty therapies such as CBT, IPT, and family therapy.

In addition to controlled comparative outcome studies, the results of open trials of CBTgsh have been benchmarked against the findings of specialty therapies with the goal of ascertaining whether CBTgsh can produce comparable outcomes. The evidence shows that CBTgsh as a sole treatment may be as effective as longer, more complex specialty therapies at least with subsets of patients under certain circumstances. However, this primary if not sole emphasis on optimal therapeutic outcome is incomplete if not misguided. Kazdin and Blase (2011) make the case that whether guided self-help or other alternative treatment delivery models actually match the efficacy of more traditional therapies is only one among many considerations in evaluating treatment effectiveness. As they observe, an “intervention with a larger [effect size] is not invariably better than one with a smaller one. An intervention with a weak but reliable effect that can reach large numbers with little cost would be worth having...” (p.32).

The evidence presented here establishes that CBTgsh, despite the methodological limitations of the evidence base, does appear to have a reliable effect across a range of different settings, patients, and therapists. How large an effect size and whether it is comparable in effectiveness to specialty evidence-based therapies has varied considerably. The point that is insufficiently recognized is that even if CBTgsh were to be shown to have only modest effects, its greater scalability makes it a potentially vital means of addressing the unmet needs of countless individuals suffering from eating disorders.

#### For Whom is Guided Self-Help Most Appropriate?

Our review of the research suggests that CBTgsh is more effective in treating BED than BN (see Tables 1 and 2), as is the case with specialty psychological treatments

in general (Wilson et al., 2007). Systematic identification of nonspecific predictors and moderators of therapeutic change is a priority for treatment outcome research (Kraemer, Wilson, Fairburn, & Agras, 2002). Nonspecific predictors are pretreatment variables that signal a favorable outcome across different treatments. Knowing which patients pose particular challenges would allow for targeted treatment of those patients. Moderators interact with different treatments in producing differential outcome. Identifying moderators of change would permit the matching of specific treatments to particular subsets of patients (Kraemer, Frank, & Kupfer, 2006). Evidence of robust predictors of treatment outcome is sparse for BN and BED, and even less is known about moderators of change (Grilo, 2010; Wilson, 2010b). The evidence regarding CBTgsh is limited to a small number of studies. The research that is required demands sufficiently large sample sizes to provide the necessary statistical power, and it is only recently that studies of CBTgsh have begun to include adequate sample sizes.

The existing evidence on nonspecific predictors of outcome for BN is mixed. Carrard et al. (2011) reported that better overall psychological adjustment as measured by the dimensional Symptom Check List-Revised (SCL-90R) was related to more improvement in BN symptoms over the four months of their internet-based CBTgsh intervention. Whether the SCL-90 predicted post-treatment abstinence was not reported. Interpretation of these results is limited because outcomes were based on completer rather than intent-to-treat analyses.

Based on their results, Carrard et al. (2011) hypothesized that CBTgsh would be less suitable for BN patients with comorbid psychiatric conditions. Mitchell et al. (2011) tested this hypothesis in their stepped-care study. They hypothesized that poor social

adjustment would predict inferior outcome in patients treated with CBTgsh as opposed to standard manual-based CBT. They based this hypothesis on findings from a previous, large study of CBT for BN in which poor social adjustment was identified as a likely predictor variable (Agras, Crow, et al., 2000). What Mitchell et al. (2011) found, however, was just the opposite of their hypothesis. The 18 week post-treatment evaluation showed that CBTgsh did markedly better with patients with poor social adjustment (a 25% abstinence rate) versus the full CBT program (4% abstinent rate). The same pattern was found for global EDE scores and the BDI. A second study that has produced findings at odds with the Carrard et al. (2011) result was reported by Hardy and Thiels (2009). Using latent growth curve modeling to analyze the data from the Thiels et al. (1998) investigation, the authors found that the guided self-help intervention was more effective for patients with more severe problems at baseline.

The research base for BED is also limited but more consistent. In an analysis of their 2005 study (Grilo & Masheb, 2005), Masheb and Grilo (2008a) found that negative affect, defined by the BDI, predicted binge eating frequency (but not abstinence) and eating disorder psychopathology at post-treatment. Greater negative affect at pretreatment was associated with a poorer outcome. Consistent with these findings, Wilson et al. (2010) reported that negative affect as assessed by the BDI was a nonspecific predictor of outcome (abstinence from binge eating in this case) at post-treatment. These findings on negative affect in CBTgsh are in line with those from full manual-based CBT, where high negative affect has proved a negative prognostic indicator (Chen & le Grange, 2007; Stice & Agras, 1999).



As in the case of full manual-based CBT for BN and BED (Agras, Crow et al., 2000; Grilo, White et al., in press), rapid response to treatment (defined as 65%-70% reduction in binge eating by the fourth treatment week) was documented in two studies of CBTgsh (Grilo & Masheb, 2007; Masheb & Grilo, 2008b). Rapid response was associated with significantly greater binge-eating abstinence and reductions in eating-disorder psychopathology. Noteworthy is the finding that rapid response had different prognostic significance and time courses across different treatments for BED. Masheb and Grilo (2008b) found that obese BED patients who received CBTgsh derived similar benefits regardless of whether they experienced rapid response. In contrast, BED patients receiving BWLgsh who had a rapid response were more likely to achieve abstinence than patients without a rapid response plus they achieved significantly greater (but modest) weight loss than patients receiving CBTgsh. Consistent with the evidence from full program manual-based CBT (Grilo et al., in press), rapid response to CBTgsh was not predicted by pretreatment patient characteristics. A similar analysis of rapid response in the Peterson et al. (2009) study showed that an early reduction in binge eating after a single session of therapist-assisted treatment predicted post-treatment outcome (Zunker et al., 2010).

Only two studies have reported moderator analyses of CBTgsh. Grilo and Masheb (2008a) found no moderator effects in an analysis of different pretreatment clinical characteristics of BED patients. In contrast, exploratory analyses in the Wilson et al. (2010) study showed that a composite score of low self-esteem and high global EDE score moderated treatment outcome at the 2-year follow-up. CBTgsh was more effective than BWL and comparable to IPT in low self-esteem in patients with low global EDE

scores. Yet CBTgsh was significantly less effective than IPT in low self-esteem patients with a high global EDE scores. The finding that global EDE moderated treatment outcome is consistent with a latent class analysis of the same sample of patients (Sysko, Hildebrandt, Wilson, Wilfley, & Agras, 2010). Four different latent classes emerged within the sample. The class characterized by the most severe eating disorder psychopathology (i.e., most frequent objective and subjective bulimic episodes and highest body shape and weight concerns), which would be reflected in high global EDE scores, responded the most to IPT. CBTgsh was the most effective treatment for the class defined by high binge eating frequency but low compensatory behaviors and other eating disorder psychopathology. Should these findings be replicated they would have important implications for future treatment. It may be that the Fairburn (1995) CBTgsh protocol is the treatment of choice for that subset of BED patients defined mainly by binge eating. However, those patients with severe associated eating disorder psychopathology, such as body shape and weight over-concern, might benefit more from a specialty therapy like IPT or CBT. Alternatively, CBTgsh might be enhanced to include a focus on overvaluation of body shape and weight (see below).

Another moderator finding from the Wilson et al. (2010) study concerned attrition. Patients with high negative affect dropped out of BWL (46%) more often than patients in CBTgsh did (24%), whereas the pattern was reversed among the patients with low negative affect (BWL, 14%; CBTgsh, 35%). This adds to the evidence indicating that CBTgsh is applicable to patients with more severe comorbid problems.

In summary, available research on nonspecific predictors and especially moderators is too limited and inconsistent to draw any firm conclusions for guiding

clinical practice. Nonetheless, it would be premature to rule out treating either BN or BED patients with a comorbid psychiatric condition or a dimensional measure of negative affect with CBTgsh.

### Reaching Ethnic and Racial Minority Populations

Eating disorders occur among a wide range of diverse ethnic and racial population groups. In the United States, recent epidemiological evidence indicates that the prevalence is roughly comparable across Latinos, Asians, and African Americans and non-Latino Whites (Marques et al., 2011). Yet barriers to receiving care for eating disorders, such as cultural stereotyping among social networks and clinicians, have been identified (Becker, Arrindell, Perloe, Fay, & Stiegel-Moore, 2010; Cachelin & Striegel-Moore, 2006). These results are consistent with the overall findings of disparities in mental health service utilization in ethnic and racial minorities.

Evidence-based guided self-help lends itself to two demonstrably effective strategies for making psychological interventions accessible to minority populations. The first is the cultural adaptation of specific evidence-based treatments. Although this option is much discussed in the literature (Whaley & Davis, 2007), there is relatively little direct research on the topic. Qualitative research using focus groups to investigate the expectations and cultural perspectives of defined minority groups is one strategy (Interian, Martines, Rios, Krejci, & Guarnaccia, 2010). Shea and colleagues (in press) adopted this approach in assessing the views of Mexican-American women about the cultural relevance and personal value of CBTgsh for eating disorders. CBTgsh was rated favorably both as feasible and acceptable. Themes that emerged as worthy of consideration in adapting CBTgsh included balancing familial responsibilities with

personal goals and negotiating social situations involving eating and its larger meaning in the culture. Of note, this explicit focus on interpersonal issues is a recent development in manual-based CBT for eating disorders (Fairburn, 2008).

The second follows the model of Patel et al. 2011). Instead of training the typical, predominantly White professional therapist to be more broadly culturally competent as is the default policy in clinical psychology in the United States, the strategy is to train non-specialist, indigenous members of the targeted minority population to provide evidence-based interventions. As a brief, focal, and structured treatment, CBTgsh meets the criteria for an intervention suitable for such an implementation strategy.

#### Who Can Implement Guided Self-Help?

Given the shortage of well-trained practitioners in evidence-based psychological treatments, an important feature of guided self-help interventions is that, in principle, they can be implemented by a wide variety of mental health providers.<sup>1</sup> Indeed, studies of CBTgsh for eating disorders have employed providers as diverse as nurses (Walsh et al., 2004), beginning residents in psychiatry with no experience treating eating disorders or formal training in psychotherapy (Bailer et al., 2004), beginning graduate students in clinical psychology with little or no experience in CBT (Wilson et al., 2010), physicians (Banasiak, Paxton, & Hay, 2005), and even non-specialist “facilitators” with no formal clinical qualifications (Carter & Fairburn, 1998). The settings in which CBTgsh has been implemented have ranged from primary care (Carter & Fairburn, 1998; Walsh et al., 2004) to university-based, specialty eating disorders clinics (e.g., Grilo & Masheb, 2005; Palmer et al., 2002; Wilson et al., 2010).

At least in some studies, providers with lesser professional credentials and experience in treating eating disorders have achieved outcomes comparable to therapists with more advanced training and credentials. Consider the following group of BED treatment studies discussed above. Using non-specialist “facilitators” with no formal training, Carter and Fairburn (1998) reported an outcome of 50% abstinence from binge eating at post-treatment with a low attrition rate of 12%. Wilson et al. (2010), employing beginning graduate students in clinical psychology, achieved a 58% abstinence rate with a 30% attrition rate. Although these student therapists were highly selected from competitive programs, their level of training and clinical experience was minimal. In the Striegel-Moore et al (2010) study, Master’s level psychologists with no prior experience treating eating disorders produced abstinence rates of 63.5% and 64% at post-treatment and one year follow-up, respectively.

The results compare favorably with those obtained with full program specialty CBT and IPT – currently the two best evidence-based therapies for BED (NICE, 2004; Tanofsky-Kraft & Wilfley, 2010; Wilson, 2010a). It is safe to conclude from this analysis that a therapist’s degree or professional credentials do not necessarily translate into therapeutic effectiveness. This finding from research on CBTgsh should come as no surprise. Rather, it is consistent with the evidence on psychological therapies as a whole (Baker, McFall, & Shoham, 2009), which reveals an absence of reliable evidence that doctoral level therapists are more effective than those with lesser professional credentials (Christensen & Jacobson, 1994; Dawes, 1994) or that clinicians become more competent with experience per se (Bickman, 1999).

### Quality of Guidance and Training in How to Deliver Guided Self-Help

The term “guided self-help” is typically used in a somewhat vague and undeveloped manner in the literature to describe any assistance or support provided to the patient during treatment. It is defined more by what it is not, namely, “pure” self-help that involves no contact with a provider or “guide” (e.g., Cuijpers et al., 2010). Trivett, Heywood-Everett, and Hill (2011) note that few studies “describe any GSH-specific training or supervision” (p.26). Yet, as Birchall and Palmer (2002) observed, “it would be good to know what is the optimal form and pattern of guidance” (p.381). Answering this question should be a priority for future research on CBTgsh.

### Optimal Implementation of Guided Self-Help

Consistent with evidence-based treatment in general, optimal application of CBTgsh requires training to competency in specific therapist procedures. The general admonition to the provider in guided self-help to be “supportive and facilitative” is insufficient to guarantee optimal implementation. Whether the health care providers in question be professional psychologists or non-specialist facilitators, effective implementation of CBTgsh requires that therapists do some things competently and not do others. The need to set priorities and focus on limited but core objectives in CBTgsh is easier said than done, and explicit training is required to promote treatment adherence.

We propose the following framework for training in CBTgsh: Step 1. The process begins with patients receiving an evidence-based treatment protocol or manual provided via a book or the internet. As summarized above, the Fairburn (1995) book has been most intensively investigated and supported, which is unsurprising given that it is a more focal, abridged version of the full CBT manual (Fairburn, Marcus, & Wilson,

1993). Step 2. The provider needs a therapist-manual to guide patients to use the treatment protocol effectively – as in manual-based treatment in general. The Fairburn (1995) program has such an accompanying manual for providers (Carter & Fairburn, 1998). Step 3. The provider would require training in the use of the therapist-manual. Training would necessarily involve supervision or patient monitoring to address specific problems that arise.

The foregoing three-part framework for optimal implementation of CBTgsh draws from procedures that have been followed in some of the studies discussed above that focused on treatment integrity. These investigations also happened to produce some of the best results to date (e.g., Grilo & Masheb, 2005; Mitchell et al., 2011; Striegel-Moore et al., 2010). It is noteworthy that the Walsh et al. (2004) study included only Step 1 of the framework we propose. The inexperienced nurse providers were not given a therapist-manual for the Fairburn (1995) program, nor were they given any ongoing supervision or guidance after the brief initial training they received. The absence of specific guidance and training, as would be required in Steps 2 and 3, invites idiosyncratic and variable implementation of CBTgsh by different providers. For example, Carrard et al. (2011) reported that different providers in their internet-based CBTgsh study had widely differing attrition rates that likely reflected variations in the type of guidance that was provided. This finding mirrors the psychotherapy literature showing large effects of individual therapists (Okiishi et al., 2006). However, studies that have implemented quality control procedures (e.g., careful selection, training, and supervision of therapists and the use of treatment manuals) eliminate therapist effects (Crits-Christoph & Mintz, 1991; Wilson et al., 2011).

The framework described here can be adapted to implementation in routine primary care settings that will of necessity fall on the low end of the “guided” component of CBTgsh. Steps 1 and 2 are essential and practical as they involve no more than the provision of the treatment protocol and a therapist-manual for guiding patients. The available evidence suggests that providing Steps 1 and 2 alone can be sufficient to help a subset of patients overcome their eating disorders. The challenges in providing Step 3 – provider training and ongoing supervision – are real. They require time and resources that will be hard to come by in many primary care settings.

Little research exists on training to competence in evidence-based psychological therapies in general (Fairburn & Cooper, 2011) let alone in CBTgsh. The current method of training therapists typically consists of a workshop and providing a treatment manual, a strategy that has not been shown to be effective in increasing specific therapist skills (Beidas & Kendall, 2010; Hershell, Kolko, Baumann, & Davis, 2010). Future research must focus on how to train providers to a level of competence in implementing CBTgsh. A potentially more practical and cost-effective method is to train a staff member from within a primary care or routine clinical care center both to implement CBTgsh and to train other staff members within the center in the approach – the training-the-trainer strategy. The goal would be to monitor treatment fidelity and facilitate the sustainability of the intervention without the need for external consultation or resources. An instructive example of this implementation strategy comes from the evidence-based prevention of eating disorders (Perez, Becker, & Ramirez, 2010). The *Reflections* dissonance-based prevention program was not only successfully implemented by non-specialist facilitators



(peer sorority members), but its effects were sustained by having those peer facilitators train other facilitators within the sorority setting.

#### Methods of Delivery: Internet-Assisted Guided Self-Help

Increasingly, the internet is being employed as an alternative delivery method for evidence-based therapies. Internet-based delivery provides a cost-effective platform for expanding the reach of CBTgsh, addressing several barriers common to face-to-face treatments. These include inaccessibility to service centers, scheduling conflicts, child care demands, and patient shame in presenting for therapy. Internet-based treatments carry the advantage of anonymity and can be completed conveniently from home at times of the patient's choosing, with the therapist providing support by email or internal messaging board. Research on internet-based treatment for various clinical conditions suggests that therapist contact promotes greater treatment efficacy than "pure" online self-help and that favorable therapeutic alliances can be formed through therapist-patient email contact (Andersson, 2009). Internet-based CBTgsh may be particularly acceptable to adolescent and young adult clients (Pretorius et al., 2009), who represent a central demographic for early intervention of eating disorders and are progressively more adept with this communication medium.

To date, a limited number of randomized controlled trials have been conducted comparing internet-based guided self-help to waitlist control. Ljotsson et al. (2007) evaluated CBTgsh using the book *Overcoming Binge Eating* with internet-based guidance, namely, up to twice weekly email contact with graduate student therapists and access to a private online discussion forum over three months. CBTgsh resulted in a 37% abstinence rate from bingeing and purging at post-treatment. Treatment was significantly

superior to waitlist on primary (i.e., binge eating; EDE-Q) and secondary (i.e., depression; life satisfaction) outcomes. Among treatment completers, results were maintained at a 6-month follow-up.

A more comprehensive internet-based approach combines email guidance with online self-help materials. Sanchez-Ortiz et al. (2011) evaluated *iCBT*, an 8-session online program for bulimia nervosa, supplemented with once weekly or biweekly therapist support via email. Following three months of access to the program, abstinence from binge eating, vomiting, and laxative abuse was reported by 25.8% of *iCBT* participants. *iCBT* produced statistically significant reductions on EDE general scores, frequency of binge eating, and measures of depression and anxiety compared to waitlist control. Moreover, the average amount of therapist time invested per participant was 45 minutes, which included therapist review of client self-reports. Carrard et al. (2011) obtained similar findings for the *SALUT* internet-based program in the treatment of BED. In this study, weekly email contact was provided by psychologists over a 6-month period. At post-treatment and 6-month follow-up, 35.1% and 43.2% of participants were abstinent from binge eating, respectively.

These findings provide promising preliminary support for internet-based delivery of CBTgsh and the use of email guidance. Future research is required to assess the efficacy of such programs against other treatments and treatment delivery formats (e.g., face-to-face delivery) with longer term follow-up. Although the attrition rates reported in the above investigations (16.2 – 31%) are within the average range for eating disorder treatments, completion of all available online modules appears to be atypical. For example, only one third of *SALUT* participants completed the program in its entirety

(Carrard et al., 2011). The mean number of completed online sessions in *iCBT* was 5.5 out of an available 8 (Sanchez-Ortiz et al., 2011). Additional research with larger sample sizes will be necessary to evaluate what pre-treatment variables and therapist support factors are associated with participant retention and adherence.

### Enhancing the Effectiveness of Guided Self-Help

The majority (56%) of published studies summarized in Tables 1-3 used the Fairburn (1995) text “*Overcoming Binge Eating*.” The protocol represents a truncated version of CBT treatment. For example, it omits a core component of the original CBT manual for professionals (Fairburn et al., 1993), namely, a focus on addressing overvaluation of body shape and weight that is widely regarded as a core feature of eating disorder psychopathology (Goldschmidt et al., 2010). By contrast, the state-of-the-art CBT treatment for eating disorders is CBT-E, a transdiagnostic approach that emphasizes the commonalities across all eating disorders (Fairburn, 2008; Fairburn et al., 2009). CBT-E embodies significant and far-reaching changes from the first generation CBT manual (Fairburn et al., 1993). Among those changes are a focus on dysfunctional body shape and weight concerns, an innovative emphasis on negative affect or “mood intolerance” as a core maintaining mechanism of eating disorders, and flexible options for targeting interpersonal issues, perfectionism, and low self-esteem if a particular patient’s psychopathological profile demands it.

In principle it should be possible to develop a CBTgsh protocol based on the principles of CBT-E. Steps towards this goal have already been taken. The CBTgsh treatment in the Striegel-Moore et al. (2010) and DeBar et al. (2011) studies used the Fairburn (1995) protocol with the addition of a module explicitly designed to help

patients overcome excessive body-checking and body-avoidance behaviors as a means of modifying overvaluation of body shape and weight concerns. In their guided self-help approach, Schmidt and Treasure (1997) featured many of the CBT principles of the Fairburn (1995) book but also included a focus on addressing interpersonal issues using assertiveness training. In their internet-based self-help program, Carrard et al. (2011) similarly included a focus on assertiveness training for interpersonal problems. The most comprehensive self-help intervention based on CBT principles to date is that reported by Traviss et al (2011). It comprised an introductory session and six subsequent sessions totaling roughly seven hours. The program is transdiagnostic and modeled after CBT-E in that provision is made for addressing the maintaining mechanisms of perfectionism, low self-esteem, mood intolerance and interpersonal difficulties.

The challenge is how to implement an expanded CBT program within a brief, guided self-help framework. A more complex, CBT-E-like program would require the health care provider to make choices about what elements of the patient's eating disorder to target and with which treatment component. Such a requirement would seem to demand a higher level of expertise than the simpler, more focal CBTgsh described in the Fairburn (1995) program, for example. Determining the degree of expertise and training required is a research priority for the future. In this connection, it would be well to underscore one of the core tenets of CBT-E that "simpler procedures are preferred over more complex ones" and "...it is better to do a few things well than many things badly" (p. 27). Nevertheless, it needs reiterating that even if therapists with advanced training and skills were to administer a more sophisticated and potentially elaborate form of CBTgsh, the savings in terms of number of sessions and overall therapist contact would

still result in a more cost-effective intervention than current specialty psychological therapies.

### Obstacles to the Adoption of Guided Self-Help Interventions

The acceptability of guided self-help and other innovative models of delivering treatment will vary across countries and different health care systems. The groundbreaking “*Increasing Access to Psychological Therapy*” (IAPT) initiative in the United Kingdom relies heavily on “low intensity” adaptations of CBT for anxiety disorders and depression. These interventions involve fewer and shorter face-to-face sessions with a therapist, as well as telephone sessions and computerized CBT with an overall emphasis on self-help (Richards & Suckling, 2009). The evidence thus far indicates that such low intensity interventions are both acceptable and effective (Clark et al., 2009) and thus strongly encourages the use of CBTgsh in the treatment of other clinical problems, such as the eating disorders discussed here.

Elsewhere, the use of guided self-help is more problematic. Patel et al. (2011) have suggested that mental health specialists themselves pose a barrier to adoption due to perceptions about the risks of non-specialist health workers or those with more minimal professional credentials. In their analysis of psychotherapy in the United States, Kazdin and Blase (2011) observed that “It is heresy within psychology to mention that one does not need to have a PhD [we would add a Psy.D. as well] to deliver effective or evidence-based individually tailored treatments” even though “it would be difficult to support empirically that Ph.D. trained individuals are more effective than those with less training” (p.30). Consistent with Kazdin and Blase’s (2011) proposal, we envisage complementing the existing roles of doctoral level experts in evidence-based therapies with innovative

treatment delivery models, including guided self-help and internet-based interventions provided by non-specialists. Indeed, doctoral level training could well be expanded to include training in novel roles such as how to train and supervise other professionals and non-specialists in the appropriate provision of guided self-help treatments.

### Summary and Future Directions

CBTgsh is a promising evidence-based intervention for eating disorders other than anorexia nervosa that has been shown to be especially effective with BED and recurrent binge eating. It is feasible, highly cost-effective, and acceptable to diverse patients in different treatment settings across different countries. CBTgsh should not simply be relegated to being the first-line treatment in a stepped-care approach, as it can be an effective independent intervention in its own right. In many settings no other more intensive options will be available.

Research is needed to enhance the effectiveness of CBTgsh. The two most widely used self-help treatment manuals protocols – Fairburn (1995) and Schmidt and Treasure (1997) – are both dated and inferior to modern day CBT. CBT-E (Fairburn, 2008) is the state-of-the-art treatment for eating disorders, and a revised guided self-help protocol modeled on this approach is indicated. As is the case with the treatment of eating disorders as a whole, identification on nonspecific predictors and moderators of treatment outcome would constitute a welcome advance.

The specification of what “guidance” is necessary for efficient and effective CBTgsh, and how best to implement it, is essential. The answers will likely blend more than one of the innovative models of delivering treatment described by Kazdin and Blase (2011). Research on the necessary and sufficient competencies of providers of CBTgsh

is similarly important. Finally, the impediments to the wider use of CBTgsh mirror those faced by evidence-based treatment in general – the need to acknowledge that there are empirically-supported treatments that are more effective than other therapies for specific problems, and that optimal therapy consists of their use by well-trained practitioners (Shafran et al., 2009).

#### Footnote

1. Health care providers who implement guided self-help interventions are variously described in the literature as “therapists,” “facilitators,” “guides,” and “coaches.”

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**TABLE 1. Summary of controlled studies of guided self-help for bulimia nervosa (BN)**

Reference	n	Patients	Self-Help Manual	Guidance	Therapists	Duration	Comparison	Follow-Up	Attrition	Results
Mitchell et al. (2011)	293	BN	<i>Overcoming Binge Eating</i>	Eight, 20 minute sessions in the context of a stepped care sequence*	MA and PhD psychologists and psychiatric nurses	18 wks	CBT (20 sessions)*	12 mo.	25%	ITT: 11% abstinent from binge eating and purging at post-treatment and 26% at follow-up. 66% of GSH participants achieved 70% reduction in purging by session 6 (vs. 35% in CBT). Stepped care patients showed significantly greater improvement at 12 month follow-up than the CBT group.
Sanchez-Ortiz et al. (2011)	76	BN (51.3%) and EDNOS (48.7%)	<i>iCBT Overcoming Bulimia Online</i>	Therapist email support once every 1-2 weeks and response to Client emails. Average amount of therapist time per participant: 45 minutes.	CBT therapists with eating disorder experience	12 wks	Delayed treatment control (DTC)	3 mo.	21.1%**	ITT: 25.8% abstinent from binge eating, vomiting, and laxative use over the preceding 28 days at post-treatment. 39.1% abstinent at three month follow-up. Significant differences between iCBT and DCT on EDE-G scores, binge eating, general psychopathology, and quality of life.
Steele & Wade (2008)	48	BN (93%) and EDNOS w/compensatory behaviors once per week and/or purging without OBE	<i>Bulimia Nervosa and Binge Eating</i>	Eight, 40 minute sessions	Post-graduate psychology students	6 wks	Self-help targeting perfectionism  Self-help targeting mindfulness	6 mo.	23%	ITT not reported. Completer analyses: 5% abstinent at post-treatment. At follow-up, 19% abstinent. No significant difference between treatment conditions.
Schmidt et al. (2007)	85	BN (68.2%) and EDNOS (31.8%) w/compensatory behaviors less than twice per week and/or compensatory behaviors without OBE Aged 13-20	<i>Getting Better Bit(e) by Bit(e)</i>	Thirteen sessions of undisclosed length and two optional sessions with a loved one	Therapists from diverse backgrounds	24 wks	Maudsley Family Therapy	12 mo.	30%	ITT: 41.9% abstinent from binge eating at post-treatment and 52% at follow-up. Of those who reported bingeing and purging at baseline, 19.4% were abstinent from both behaviors at post-treatment; 36% at follow-up. A higher proportion of participants in GSH achieved abstinence from binge eating at post-treatment compared to family therapy, with earlier improvement reported. No differences found between groups at 12 month follow-up.
Ghaderi (2006)	29	BN (55%), BED (21%), and EDNOS (24%)	<i>Overcoming Binge Eating</i>	Six, 25 minute sessions	Undergraduate psychology students	12 weeks	PSH	6 mo.	37.5%	ITT: 44% abstinent from binge eating and purging at post-treatment. Gains maintained at follow-up. No significant differences between GSH and PSH.

TABLE 1. (Continued)

Reference	n	Patients	Self-Help Manual	Guidance	Therapists	Duration	Comparison	Follow-Up	Attrition	Results
Banasiak et al. (2005)	109	BN (90.7%) & EDNOS w/compensatory behaviors once per week	<i>Bulimia Nervosa and Binge Eating: A Guide to Recovery</i>	One, 30-60 minute session followed by nine, 20-30 minute sessions	General Practitioners	17 wks	Delayed treatment control (DTC)	3 & 6 mo.	33%	ITT: 28% abstinent from all symptoms, 46% showed cessation from bingeing, and 33% achieved cessation from purging at post-treatment. GSH was superior to DCT on all indices of eating and general psychopathology. Gains maintained at 3 and 6 month follow-up. At follow-up (by completer analyses), 35% abstinent from all symptoms, 58% cessation from bingeing, and 39% from purging.
Walsh et al. (2004)	91	BN (83.5%) and EDNOS w/compensatory behaviors once per week and/or compensatory behaviors without OBE	<i>Overcoming Binge Eating</i>	Six-eight, 30 minute sessions + medication management sessions for Fluoxetine or Placebo	Nurses without ED specialization	16 wks	Fluoxetine or Placebo	None	71.4%	ITT: Abstinence rate not reported in GSH plus placebo condition. GSH did not provide any additive benefit over placebo-alone.
Durand & King (2003)	68	BN	<i>Bulimia Nervosa: A Guide to Recovery</i>	Regular contact with referring general practitioners (mean number of visits: 4.9)	General Practitioners	24-36 wks	Specialist treatment at outpatient clinics, including CBT and IPT	None	0%	Abstinence rates not reported. ITT (LOCF): Both groups improved significantly over time, with no significant difference between conditions. 29.4% of GSH clients achieved diagnostic remission based on the Bulimic Investigatory Test, Edinburgh.
Ghaderi & Scott (2003)	31	BN (29%), EDNOS subthreshold BN (35.5%), and BED (35.5%)	<i>Overcoming Binge Eating</i>	Six-eight, 25 minute sessions	Undergraduate psychology students	16 wks	PSH	6 mo.	43.8%	ITT: 18.8% abstinent from binge eating at post-treatment (abstinence from purging not reported). No differences found between GSH and PSH on ED psychopathology. GSH participants showed greater reductions in depression. Improvements maintained at follow-up based on completer analyses.

TABLE 1. (Continued)

Reference	n	Patients	Self-Help Manual	Guidance	Therapists	Duration	Comparison	Follow-Up	Attrition	Results
Palmer et al. (2002)	121	BN (59%), BED (23%), EDNOS (18%)	<i>Overcoming Binge Eating</i>	Four, 30 minute face-to-face (FF-GSH) sessions; OR four, 30 minute telephone sessions (T-GSH). Minimal support condition received one explanatory session only.	Nurses with ED experience	16 wks	Waitlist	12 mo.	23%(FF) 25%(T)	ITT not reported. Completer analyses: 10% abstinent from binge eating and purging in FF-GSH condition at post-treatment; 14% in T-GSH condition; 6% in minimal guidance condition. Both FF-GSH and T-GSH were significantly superior to waitlist in producing abstinence.
Thiels et al. (1998)	62	BN	<i>German translation of Getting better Bit(e) by Bit(e)</i>	Eight, 50-60 minute sessions	2 Psychologists and 1 Health Sciences graduate student	16 wks	CBT (16 sessions)	6-24 mo.	29%	ITT (LOCF): 12.9% abstinent from bingeing and purging during the week preceding post-treatment (vs. 54.8% in CBT). No differences between GSH and CBT on outcome measures. At follow up (completer analyses), 60.9% abstinent from symptoms in GSH (vs. 70.8% in CBT).
Huon (1985)	120	BN	Seven mailed components (chapters) developed by the author	Participants randomized to one of two GSH conditions: Contact with a "cured" BN patient (cured-contact) or contact with an "improved" BN patient (improved-contact). Type or amount of contact uncontrolled.	"Cured" or "Improved" BN patients who were graduates of group therapy for bulimia	12 wks	PSH  Waitlist	3 & 6 mo.	0% ***	ITT: 23.3% abstinent in the cured-contact condition and 16.6% in the improved-contact condition at post-treatment. No statistically significant difference between self-help groups. All were superior to waitlist. At 6 month follow-up, a significantly greater proportion of GSH participants were abstinent compared to PSH: 46.6% in the cured-contact condition and 33.3% in the improved-contact condition.

Note: GSH, guided self-help; PSH, pure self-help (i.e., unguided); CBT, cognitive behavioral therapy; IPT, interpersonal psychotherapy; ED, eating disorder; OBE, objective binge eating; ITT, intention-to-treat analyses using baseline carried forward; LOCF, analyses using last observation carried forward. Completer analyses are reported only in the absence of ITT. Attrition rates refer exclusively to the GSH condition.

\*Mitchell et al. (2011): Fluoxetine was offered in both GSH and CBT treatment conditions given less than 70% reduction in purging by session 6.

\*\* Sanchez-Ortiz et al. (2011): The reported attrition rate (21.1%) refers to patients assigned to iCBT who did not complete any sessions. Of those who started treatment, mean number of completed online sessions was 5.5 out of 8.

\*\*\* Huon (1985): 22.4% did not return the prerequisite binge monitoring records and were therefore not randomized.



**TABLE 2. Summary of controlled studies of guided self-help for binge eating disorder (BED)**

Reference	N	Patients	Self-Help Manual	Guidance	Therapists	Duration	Comparison(s)	Follow-Up	Attrition	Results
Carrard et al. (2011)	74	BED (54.1%) & Sub. BED (45.9%)	<i>SALUT</i> internet-based program adapted for BED	Weekly email contact	Psychologists	24 wks	Waitlist	6 & 12 mo.	16.2%	ITT: 35.1% abstinent from binge eating at post-treatment. At follow-up, 43.2% abstinent. Significant difference between GSH and waitlist at post-treatment favoring GSH.
Wilson et al. (2010)	205	BED	<i>Overcoming Binge Eating</i>	Ten, 20-25 minute sessions	Graduate students	24 wks	BWL (20 sessions); IPT (20 sessions)	6, 12, 18, & 24 mo.	30%	ITT: 58% abstinent at post-treatment. No differences between treatments found on binge eating rates, eating disorder psychopathology, negative affect, or self-esteem. At two year follow-up, GSH and IPT maintained treatment gains and were superior to BWL in producing abstinence.
Stiegel-Moore et al. (2010)	123	BN (10.6%), BED (48%), & EDNOS (41.4%)	<i>Overcoming Binge Eating</i>	One, 60 minute session follow by seven, 20-25 minute sessions	Masters level therapists	12 wks	Treatment as Usual (TAU)	6 & 12 mo.	28.8%	ITT: 63.5% abstinent from binge eating at post-treatment. GSH showed large effect size and significantly superior results as compared to TAU. At 12 month follow-up, 64.2% abstinent.
Peterson et al. (2009)	259	BED	Developed by authors	Fifteen, 80 minute group sessions consisting psychoeducational videotapes, followed by therapist-assisted homework and discussion	Doctoral-level psychotherapists	20 wks	Waitlist; Therapist-Led CBT groups; Un-guided groups (PSH)	6 & 12 mo.	31.7%	ITT: 33.3% abstinent in the therapist-assisted condition at post-treatment (vs. 51.7% in the therapist-led condition). There were no statistically significant differences between therapist-assisted and therapist-led groups at post-treatment, and both conditions proved significantly superior to waitlist. At 12 month follow-up, no differences in abstinence rates were observed between therapist-led (20.8%), therapist-assisted (27.0%), and PSH (25.4%) conditions.
Cassin et al. (2008)	108	BED	<i>Defeating Binge Eating</i>	One, 80 minute motivational interviewing session	Graduate students	4-16 wks	PSH	1, 2, & 4 mo.	13%	ITT: 27.8% abstinent from binge eating at post-treatment (vs. 11.1% in PSH). Significant difference between groups favoring GSH.

TABLE 2. (Continued)

Reference	n	Patients	Self-Help Manual	Guidance	Therapists	Duration	Comparison(s)	Follow-Up	Attrition	Results
Ljotsson et al. (2007)	73	BED (51.4%) & Full and Sub. BN (48.6%)	<i>Overcoming Binge Eating</i>	Up to twice weekly email contact and online discussion forum	Graduate Psychology Students	12 wks	Waitlist	6 mo.	31%	ITT: 37% abstinent from bingeing and purging at post-treatment. GSH superior to waitlist on primary and secondary outcome measures. At follow-up, improvements were maintained.
Grilo & Masheb (2005)	90	BED	<i>Overcoming Binge Eating</i>	Six, 15-20 minute biweekly sessions	Doctoral-level research clinicians	12 wks	Behavioral Weight Loss Self-Help  Attention Control (Self-monitoring & support sessions)	None	13%	ITT: 46% abstinent at post-treatment. GSH obtained significantly higher diagnostic remission rates than BWL (18%) or control (13%).
Grilo et al. (2005)	50	BED	<i>Overcoming Binge Eating</i>	Six, 15-20 minute sessions + placebo	Doctoral research clinicians experienced with CBT and BED	12 wks	GSH plus Orlistat	3 mo.	20%	ITT: 36% abstinent at post-treatment in GSH plus Placebo condition; 64% in GSH plus Orlistat. At follow-up, both groups showed 52% remission rates.
Loeb et al. (2000)	40	BED (82.5%), BN (5%), Sub. BED (7.5%), & Sub. BN (5%).	<i>Overcoming Binge Eating</i>	Six, 30 minutes sessions	1 licensed clinical psychologist and 1 advanced doctoral student	10 wks	PSH	6 mo.	32.5%	ITT: 50% abstinence rate at post-treatment (vs. 30% in PSH). GSH superior to PSH on reduction of binge eating and associated symptoms, but not rates of remission.
Carter & Fairburn (1998)	72	BED	<i>Overcoming Binge Eating</i>	Six-eight, 25 minute sessions	Non-specialist facilitators w/out clinical qualifications	12 wks	Waitlist PSH	3 & 6 mo.	33.3%	ITT: 50% abstinent at post-treatment (vs. 43% PSH). Both self-help conditions were significantly superior to waitlist, with a trend toward the superiority of GSH over PSH. At 6 month follow-up, 50% abstinent (vs. 40% PSH). No differences between GSH and PSH at 3 or 6 month follow-up.

Note: GSH, guided self-help; PSH, pure self help (i.e., unguided); CBT, cognitive behavioral therapy; IPT, interpersonal psychotherapy; ED, eating disorder; Sub., subthreshold diagnosis; OBE, objective binge eating; ITT, intention-to-treat analyses using baseline carried forward; LOCF, analyses using last observation carried forward. Completer analyses are reported only in the absence of ITT. Attrition rates refer exclusively to the GSH condition.

**TABLE 3. Summary of controlled studies of guided self-help for eating disorder not otherwise specified (EDNOS)**

Reference	n	Patients	Self-Help Manual	Guidance	Therapists	Duration	Comparison	Follow-Up	Attrition	Results
DeBar et al. (2011)	160	Recurrent binge eating with purging (27%) or without purging	<i>Overcoming Binge Eating</i>	One, 60 minute session followed by seven, 20-25 minute sessions	Masters-level therapists	12 wks	Treatment As Usual (TAU)	6 & 12 mo.	32%*	ITT: 33% abstinent from binge eating at post-treatment. GSH showed greater cessation from binge eating than TAU (5%) and greater improvements in dietary restraint and eating, shape, and weight concerns. At 6 and 12 month follow-up, abstinence rates for GSH were 38% and 35%, respectively.
Traviss, G., Heywood-Everett, & Hill (2011)	81	BN (27%); BED (24.3%); EDNOS (24.3%); & no ED diagnosis (24.3%)	<i>Working to Overcome Eating Difficulties</i>	Seven, 1 hour sessions	Non-ED specialist clinicians e.g., counselors, psychologists, and cognitive behavioral therapists	12 wks	Waitlist	3 & 6 mo.	35%	ITT: Of those who reported binge episodes at pre-treatment, 30.4% were abstinent at post-treatment. Authors note similar cessation rates for compensatory behaviors (exact percentages not reported). Significant difference favoring GSH over waitlist on overall eating psychopathology and global distress, but no difference in cessation of binge and purge behaviors. Gains maintained at 3 and 6 month follow up.
Dunn, Neighbors, & Larimer (2006)	90	BN (23.3%), BED (27.8%), ED-NOS (33.3%)	<i>Overcoming Binge Eating</i>	One, 45 minute session of motivational enhancement training	Psychology graduate students and senior undergrad. research assistants	8-16 wks	PSH	None	34%	ITT: 24.4% abstinent from binge eating at post-treatment (vs. 8.9% in the PSH condition) Significant difference between groups favoring guided condition

Note: GSH, guided self-help; PSH, pure self help (i.e., unguided); ED, eating disorder; ITT, intention-to-treat analyses using baseline carried forward. Attrition rates refer exclusively to the GSH condition. Studies were included in this section a higher percentage of EDNOS was reported than either BN or BED.

\*DeBar et al. (2011): 32% of the sample attended fewer than 6 sessions

### Highlights

- CBTgsh can improve the implementation and scalability of evidence-based treatment
- CBTgsh is a feasible and cost-effective treatment for eating disorders
- CBTgsh may be as effective as more complex specialty therapies for some eating disorders although there are few controlled comparative trials
- CBTgsh can be effectively implemented by a wide range of mental health providers
- optimal guidance in CBTgsh and the level of expertise for use needs specification