Guided self-help group therapy for women with binge eating disorder

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Background
Self-help was found to be beneficial in terms of reduced binge eating, improved abnormal eating attitudes, and higher abstinence rates. They are typically brief and less costly compared with other therapies.
Objectives
The present study was designed to assess the outcome of guided self-help group therapy on female patients with binge eating disorder (BED).
Patients and methods
In the present experimental clinical trial, 27 female patients between 18 and 45 years of age diagnosed with BED were enrolled in guided self-help group therapy once weekly for 12 consecutive weeks. Prepsychometric and postpsychometric assessment was carried out to measure eating pathology, frequency of binge eating episodes, and self-esteem using Eating Disorder Examination, Symptom Checklist (SCL90-R), and Rosenberg's self-Esteem Scale in addition to BMI.
Results
Patients showed a significant decrease in frequency of binge eating episodes (P=0.000), less over concern of body weight and shape, less BMI (P=0.000), and less psychological distress with no difference in self-esteem.
Conclusion
Guided self-help therapy is effective in reducing the severity of BED.

Keywords:
binge eating disorder, BMI, guided self-help, group therapy

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Introduction

The American Psychiatric Association outlined the following criteria for the diagnosis of binge eating disorder (BED): an individual having recurrent episodes of binge eating in which the amount of food eaten is larger than what one can and during which the individual experiences a loss of control and the individual experiences 'marked distress' from the binge eating episode (American Psychiatric Association, 2013). Lifetime prevalence for BED is reportedly 3.5% for women and 2% for men (Summar and Saules, 2011). It is more common among women than among men, from all ethnicities, usually beginning by the end of adolescence. BED is common in patients presenting for weight management and bariatric surgery, particularly those with severe obesity. Obese individuals with BED have reported higher levels of body image concerns compared with their counterparts without BED (Barry *et al.*, 2003). The primary goal for BED treatment is to achieve abstinence from binge eating. In overweight individuals with BED, treatment goals are often two-fold: abstinence from binge eating and sustainable weight loss. It has been found that self-help, regardless of the degree of facilitator involvement, is beneficial in terms of reduced binge eating, improved eating attitudes, and higher abstinence rates, but not in terms of reducing BMI (Peterson *et al.*, 2001).

On the other hand, studies have compared pure and guided self-help for binge eating delivered in specialist clinics. Direct comparisons showed that both were effective in reducing binge eating and related psychopathology; however, guided self-help achieved higher remission rates and was superior in reducing the frequency of binge eating, restraint. Self-help programs have been suggested to be more cost-effective and more readily available to patients compared with other evidence-based therapies (Palmer *et al.*, 2002).

Patients and methods

Study design

This study was a prospective experimental clinical trial with prepsychometric and postpsychometric

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assessment performed in the Outpatient Clinic of the Department of Psychiatry in Al Kasr Al Ainy Hospitals, Cairo University.

Participants

Screening of patients attending private nutrition clinic from March 2013 to November 2013 was performed using the eating attitude test (EAT-26) that was carried out in the clinic for the patients to complete during their visits, and those who reached a cutoff score of 20 or had behavioral symptoms on the EAT-26 were interviewed face-to-face to assess the presence of BED using a structured clinical interview.

Patients between 18 and 45 years of age, fulfilling the Diagnostic and Statistical Manual (DSM)-IV criteria of BED, not adherent to medical or psychotropic medications for the last 6 months, and educated until preparatory stage at least were included in the study. Pregnant women or those suffering from any mental disorders such as schizophrenia, bipolar disorder, substance abuse/dependence assessed by means of the Structured Clinical Interview for DSM-IV, or those suffering from organic disease affecting the weight (diabetes and thyroid gland disorders) were excluded.

According to the mentioned inclusion and exclusion criteria, 27 female patients were enrolled in a guided self-help program. Patients attended the group once weekly for 12 consecutive weeks; each session lasted 60 min.

Procedure

Patients were subjected to a baseline assessment 1 week before the beginning of the group together with brief explanation of the program and an endpoint assessment upon completion of the program (12 weeks after baseline).

Measures

The assessment included the following:

(1) BMI: calculated as weight in kilograms divided by the square of height in meters.
(2) The EAT-26 (Garner*et al.*, 1982): it is the most widely used standardized self-report measure of symptoms and concerns characteristics of eating disorders.
(3) Structured clinical interview for DSM-IV AXIS I Disorders (SCID-I) (First*et al.*, 1996): the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a semistructured interview based on an efficient clinical evaluation. The Arabic version was used.
(4) Eating Disorder Examination (EDE) (12th ed.) (Fairburn*et al.*, 1993): it is an investigator-based interview to assess eating disorder symptoms. It includes four subscales (restraint diet, eating concern, shape concern, and weight concern).
(5) Symptom Checklist (SCL90-R) Arabic version (El Beheiry, 2004): it is a psychometric instrument devoted to the identification of psychopathological distress as indicated by the General Severity Index.
(6) The Rosenberg's Self-Esteem Scale (Rosenberg, 1979): it is a measurement of global self-esteem. The scale measures state self-esteem by asking the respondents to reflect on their current feelings.

Treatment

Guided self-help program was adopted from patient manual 'Overcoming Binge Eating' (Fairburn, 1995), which consists of six steps that address how to assess and change eating behaviors (including binge eating) and associated features. The six steps are additive and designed to be followed sequentially, such that progress on one step is required before moving on to subsequent steps. All materials were translated to Arabic.

Schedule of the guided self-help program:

(1) Step 1: self-monitoring and weekly weighing.
(2) Step 2: establish a pattern of regular eating.
(3) Step 3: alternative to binge eating and substituting alternative activities.
(4) Step 4: practice problem solving skills.
(5) Step 5: tackle the three forms of diet and forms of avoiding.
(6) Step 6: prevent relapse and dealing with other problems.

Each step took two sessions before proceeding to the following step. This program mainly shows behavioral interventions, whereas no cognitive restructuring was introduced. Thus, core eating psychopathological features of binge eating were not addressed in this treatment.

Ethical considerations

The study was approved by the Scientific and Ethical Committee of Department of Psychiatry, Cairo University. Written consent was taken from the patients after discussing with them the aim and the details of the study.

Data analysis

Data were statistically described in terms of mean and SD. Comparison of numerical variables was made

using the paired *t*-test for comparing pregroup and postgroup assessment. *P* values less than 0.05 were considered statistically significant. All statistical calculations were carried out using computer programs statistical package for the social science, version 15 for Microsoft Windows (SPSS; SPSS Inc., Chicago, Illinois, USA).

Results

As regards the age of the participants, their mean (SD) age was 31.19 (3.711) years ranging from 18 to 45 years. Significant differences were found across pretreatment and post-treatment scores. EDE scores indicated a significant reduction in frequency of binge eating episodes (*P*=0.000) and significantly lower mean scores on subscales of core eating psychopathology: dietary restraint (*P*=0.000), weight concern (*P*=0.001), shape concern (*P*=0.007), and eating concern (*P*=0.000). Moreover, a slight reduction in the BMI (*P*=0.000) of patients was found after guided self-help. However, no significant difference in self-esteem score was found (Table 1).

Discussion

This study was selectively for women, as they show more abnormal eating behavior, making them more risky for eating disorders. Women experience more food-related conflict compared with men in that they like fattening foods but perceive that they should not eat them. Women are more dissatisfied with their body weight and shape compared with men, in addition to the sociocultural and psychological factors that may be important in the etiology of eating disorders, which are much more prevalent in women (American Psychiatric Association, 2010).

In the present study, the age of all patients was from 18 to 45 with a mean age of 31.19. Although the majority of disordered eating research has focused on young adult women, recently, increasing attention has been paid to women of middle age, commonly defined as the period between 35 and 55 years (Hockey and James, 2003). Several studies have reported substantial increases in eating disorders in this population (Cumella and Kally, 2008). Among middle-aged women, body dissatisfaction is commonly reported (Grippo and Hill, 2008), and, as with younger women, is consistently associated with dieting and disordered eating attitudes, mainly binge eating (McLean *et al.*, 2009).

It has been proved that reduction in the frequency of binge eating episodes and improvement in core eating psychopathology are considered an index for treatment efficacy (Brownley *et al.*, 2007). Therefore, certain outcome measures in this study were selected to be assessed using psychometric tools. These psychometric tools were selected to measure the change that occurred during the course of treatment, such as measuring the frequency of binge episodes (behavioral change) and measuring core eating psychopathology (excessive concern with body weight and shape) and low self-esteem.

In this study, post-guided self-help assessment showed a slight reduction in BMI and this was not expected as the treatment did not focus on weight loss. However, this can be attributed to patients already being on a diet program that aimed at losing their weight, in addition to our treatment, thus reducing their overall intake of calories and not only eliminating calories of the binge episodes. Significant improvement was found after guided self-help treatment as regards core eating psychopathology symptoms (weight concern, shape concern, and eating concern) in addition to the significant reduction in frequency of binge eating episodes. In contrast, a previous study (Jones *et al.*, 2012) for testing the effectiveness of guided self-help program in BED in which participants were offered an existing guided self-help program

Table 1 Pretherapy and post-therapy results

	Pregroup (mean±SD)	Postgroup (mean±SD)	*t*-Value	*P* value
BMI	30.796±1.98	30.537±2.03	4.240	0.000*
EDE				
Restraints	4.57±0.28	3.98±0.20	10.766	0.000*
Eating concern	3.45±0.272	2.69±0.36	9.028	0.000*
Shape concern	5.311±0.292	5.13±0.379	2.922	0.007*
Weight concern	5.41±0.146	5.20±0.25	3.849	0.001*
Objective bulimic episode	8.19±1.07	5.81±10178	7.713	0.000*
SCL				
General score	58.67±5.41	55.52±4.51	3.288	0.003*
Rosenberg's self-esteem	12.0±1.074	12.19±1.32	–1.095	0.284

EDE, Eating Disorder Examination; SCL, Symptom Checklist. *$P<0.05$ (statistical significant).

(Fairburn, 1995) showed a reduction in frequency of binge eating episodes and improvement in eating subscale only, whereas no significant difference was found in weight and shape concern.We could interpret this finding in our study (improvement in weight and shape concerns) by the ability of participants to put weight and shape concerns into perspective after intervention. As patients showed a significant decrease in the frequency of binge eating episodes, their fears of weight gain and fatness decreased and that resulted in lessening their concern about weight and shape. It is noteworthy to mention that, in our study, there was no significant difference in dietary restraint subscale that was measured with EDE 12th edition post-guided self-help treatment. This finding was similar to the results of a study by Traviss *et al.*, (2011), who reported that guided self-help reduced overall eating psychopathology, whereas restraint scores remained unchanged. This may be attributed to the patients' conflicting treatment goals with regard to dietary restraint. Comorbid psychological distress was assessed before and after treatment. Improvement in psychological distress after guided self-help program comes in line with other studies (Traviss *et al.*, 2011) as BED is usually associated with distress due to its long-term negative consequences such as obesity, shame, and sense of guilt. Therefore, reduction in binge eating episode is associated with less psychological distress.

Strengths

To our knowledge this study represents the first study that used a guided self-help program in Egypt for Arabic-speaking patients with BED.

Limitations

(1) Patients were recruited from a diet clinic and that could affect the remission of binge eating episodes as diet is considered a trigger to binge eating episodes.
(2) No wait list condition as a control group to evaluate the effect of time on the course of BED.
(3) No follow-up assessment was carried out after several months from the end of both treatments for proper verification of the tested hypothesis.

Conclusion

Guided self-help program is effective in reducing the severity of BED.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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