Participant reactions to a cognitive-behavioral guided self-help program for binge eating: developing criteria for program evaluation

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PARTICIPANT REACTIONS TO A COGNITIVE-BEHAVIORAL GUIDED SELF-HELP PROGRAM FOR BINGE EATING: DEVELOPING CRITERIA FOR PROGRAM EVALUATION

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Abstract—This article evaluates the effectiveness of a telephone-based guided self-help program for women who binge eat. We report how key program components (e.g., phone sessions, the self-help book) contribute to the four self-help goals identified in the clinical literature: (1) decrease isolation/increase support; (2) increase knowledge of the problem; (3) broaden coping skills; and (4) improve self-esteem. Using the example of our feasibility study, we illustrate that even minimal interventions create a relational context which can promote entry into and engagement with treatment. We conclude that program evaluation should include not only traditional measures of outcome (e.g., reduction in symptomatology), but utilize outcome measures related to the specific goals of minimal interventions (e.g., changes in help-seeking behavior). © 1998 Elsevier Science Inc.

Keywords: Binge eating; Eating disorders; Guided self-help; Program evaluation.

INTRODUCTION

Recurrent binge eating, estimated to affect approximately 10% of the population, is associated with impairments in physical, psychological, and social functioning [1]. Despite the chronic course of binge eating, only a small percentage of women who binge eat seek treatment specifically for their eating disorder [2]. Barriers to treatment include personal factors, such as shame and denial, and resource limitations, such as the scarcity of specialist therapists, prohibitive cost, and geographic inaccessibility.

In view of these barriers, it is important to develop novel forms of service delivery. Self-help programs, which can be brief, inexpensive, nonstigmatizing, and potentially empowering, may be appropriate for a subset of women who binge eat. Recent pilot studies have investigated the feasibility of applying the pure self-help model and the guided self-help model (self-help with the addition of a nonspecialist therapist) with individuals and groups, using various modes of service delivery (e.g., videotape, in-person, telephone-based) [3–8].

Although initial data from these pilot studies are encouraging, findings should be interpreted cautiously. Study samples generally are small (for exceptions, see Coo-
per [3] and Treasure et al. [8]) and highly select (often drawn from specialty clinics), with limited follow-up data available. To date, little is known about who benefits, for how long, and in what ways. While pressures from the health care industry are mounting to adopt shorter and less staff-intensive treatments, researchers have an ethical and scientific obligation to evaluate more thoroughly the short- and long-term impact of these novel interventions [9].

Program effectiveness traditionally has been assessed in terms of symptom reduction and improvements in role functioning and subjective well-being. These assessments provide essential information about treatment efficacy, yet they do not help us understand what promotes program access and participation. Learning how specific program features help a client enter and engage in treatment is especially important in this shame-prone population who, as just reported, experiences considerable barriers to treatment. Programs are not effective unless clients utilize them. Successful interventions both have to produce the desired outcome (for instance, reduce binging), and appeal to a broad-based clientele — not just to a select, presumably highly motivated specialty clinic sample. We therefore need to learn more about the participant’s subjective experience of an intervention: What is perceived as engaging, helpful, frightening, or damaging?

We also need to learn more about the self-help model and the impact of novel modes of service delivery. Our review of the self-help literature suggests that self-help programs generally aim to meet four related and mutually reinforcing goals: (1) decrease isolation/increase support; (2) increase knowledge of the problem; (3) broaden coping skills; and (4) improve self-awareness/self-esteem. Traditional assessment measures do not directly provide data in these areas.

We recently completed a pilot study exploring the feasibility of a telephone-based guided self-help program for women with binge eating disorder (BED). Eligible participants, recruited from the community, met DSM-IV criteria for BED [10] based on diagnostic interview [11]. Of nine women initially admitted into the study, seven completed the self-help program. Following the program, binge eating frequency decreased markedly, as did overall psychiatric symptomatology (results reported in Wells et al. [12]). In this study we examine how participants’ experiences of key program components contributed to the four self-help goals identified in the clinical literature. Special attention is paid to factors that facilitated participants’ engagement with the intervention.

METHODS

Participants received a copy of Overcoming Binge Eating [13], a self-paced self-help book based on cognitive-behavioral principles. Thirty-minute telephone sessions with a lay therapist were scheduled weekly for the first month and biweekly for the remaining 2 months. Participants were also asked to keep daily self-monitoring logs and weekly summary sheets. Following the 12-week program, participants completed the 31-item program evaluation questionnaire (PEQ) developed for this study (available upon request). In this article we report participant responses to the 16 open-ended questions designed to evaluate the various program components. For the daily logs, weekly summary sheets, telephone sessions, and the self-help book participants were asked: (1) What was most helpful?; (2) What was least helpful?; (3) What was difficult?; and (4) How could we improve this particular program component? Based on qualitative analysis performed independently by two reviewers, we report how specific program components met or failed to meet each of the four self-help goals.
RESULTS AND DISCUSSION

Decrease isolation/increase support

Phone sessions with the lay therapist helped participants stay on task and remain motivated. Participants commented favorably about “having support” and receiving “reassurance or clarification.” Upon program completion, over half the participants reported that they wished that the phone sessions could have been more frequent and that there had been more opportunity to discuss emotional problems related to disordered eating.

The psychoeducational chapters of the self-help book, which describe the symptoms and course of binge eating, helped several participants feel less isolated and humiliated by their symptoms. One participant commented with relief that the book taught her “how similar the problems I’ve had are to those of others.” Another participant, although reassured in no longer being alone with her symptoms, seemed to mourn the loss of her unique status.

Although we expected that the lay therapist would provide connection and support, we were surprised that several participants also experienced the book, and to a lesser extent the daily logs, in relational or interpersonal terms. Sections of the book were identified as “conversations”; another participant commented on how she “... felt the program and I were together.” Two participants felt that the logs provided feedback and support. Apparently, the structure of the program—daily logs, weekly summary sheets, weekly reading assignments, weekly and biweekly phone contact—provided contact and continuity, thereby decreasing isolation and promoting support in a reliable and stable context. Thus, it is important to consider the relational nature of any intervention; even “pure” self-help involves interaction with a manual, an author, and people portrayed in clinical vignettes. Traditional assessments, which focus on changes in the self, do not take into account these nontraditional “therapeutic relationships” and how they affect the course of treatment.

Increase knowledge of the problem

The self-help book’s detailed description of eating disorder symptomatology helped participants acknowledge the reality and severity of their eating problems. Completion of the daily logs and weekly summary sheets further helped participants overcome denial and shame and learn more about their individual bingeing patterns. One participant noted that the daily logs “helped me to realize just how much I put in my mouth without really noticing it; they also helped me to recognize trigger foods.” Another participant learned that “often my memory of things is very different than what actually happens.” Although “actually seeing patterns was very helpful,” participants also commented on how difficult it was to review what they had eaten. As one participant admitted, “I forgot some days to record a meal or snack and struggled with ‘doing it wrong.’” Helping the participant acknowledge this conflict (i.e., wishing to learn more about the problem; wanting to deny the problem), or recognize that additional treatment may be needed to address the conflict, should be considered positive program outcomes.

The extent to which participants benefited from the psychoeducational portions of the book varied according to prior knowledge, current eating problems, and reading level. Reactions ranged from finding the book material illuminating (“the
description of the eating disorders was helpful . . . causes was very interesting; really hit home”), irrelevant (“I do not purge so the conversations about ‘normal weight’ binge eaters were frustrating and not helpful”), to overly technical (“It was in medical jargon that was hard to understand”).

Such varied responses point to an inherent challenge of self-help programs: how to engage readers who differ in symptomatology, prior knowledge, and personality style. Anecdotal comments suggest that the self-pacing of the book, the individualized scheduling of phone sessions, and most importantly, the personal guidance provided by the lay therapist, helped participants tailor the program to their specific needs. For self-help programs and similar minimal interventions to have broad-based applicability, we need to learn more about ways in which programs can be titrated, while preserving the integrity of program content and without losing the benefits of standardization (e.g., cost-effectiveness, ease of dissemination).

Broaden coping skills

Of the specific cognitive-behavioral strategies introduced in the book and reinforced by the lay therapist, participants seemed to benefit most from the daily monitoring, the avoidance of unstructured time, and changes in the “all or nothing” attitude. Over half the participants established “a regular plan of eating,” rather than focusing on dieting. Conceptualizing certain foods as “forbidden” was quite entrenched, but several participants noted that they were trying to eat a small portion of “taboo foods” without precipitating a binge. Several participants wished that the program had provided more direct help in managing their concerns around weight and shape.

The overall structure of the program also modeled specific interpersonal skills and coping strategies. The combination of self-help and guidance seemed to activate tensions between autonomy and dependence, private and public presentation, and empowerment and support. These tensions, which are common among women with eating disorders [14], were summarized by one participant, who wrote that the program “made me realize how much dedication (on my part) is going to have to go into changing my life, and that I’m really the only one who can do it but that I also need to ask for support.”

If program outcome is defined only as changes in symptomatology or role-functioning, we will fail to assess these important shifts in self—other orientation and help-seeking behavior. A positive attitude toward help-seeking is particularly important in this population, as binge eating is known to have a cyclical and recurrent course [15]. Therefore, it is important that even participants who successfully reduced their binging feel they can return to the program (or other forms of help), when needed.

Improve self-esteem

Participants who regularly completed the logs and weekly summary sheets, participated in the phone sessions, and experienced a reduction in binging reported feeling empowered and competent. Increased mastery and control, “a sense that I could really do something I set my mind to,” captured the experience of these women.

Even participants who did not achieve eating-related symptom reduction did re-
port feeling less alone, less ashamed, and more supported. Recognizing the extent of their disordered eating and beginning to tackle the problem can increase hope and motivation. The supportive, collaborative stance of the book, as well as the interested, accepting, and respectful attitude of the lay therapist, helped some participants maintain self-esteem. As one participant noted, “the tone of the book was good—comforting but not overly sympathetic, motivating but not overly exuberant, neither overly personal nor too distant.” Clearly, even minimal interventions create a therapeutic climate and alliance, which can promote or damage self-esteem.

Not surprisingly, participants who had more difficulty reading the book, completing the logs, or attending the phone sessions struggled with feeling “bad,” “that I wasn’t . . . doing things correctly.” Reading the book made one participant feel that she was not progressing as quickly as the women portrayed in the clinical vignettes. Self-recriminations suggested the extent to which some participants struggled with self-criticalness, perfectionism, and intense competitiveness. These personality characteristics can complicate the evaluation process, as it is sometimes difficult to distinguish self-recriminations, expressed as projections about the program’s ineffectiveness, from accurate complaints about the inadequacy of various program features.

CONCLUSION

To evaluate fully the benefits and limits of self-help, we need to broaden the conceptualization and measurement of treatment outcome. Even minimal interventions, like self-help, create a relational context that can promote entry into and engagement with treatment. Program evaluation should include not only traditional measures of outcome (e.g., reduction in symptomatology), but additional measures of outcome related to the goals specific to minimal interventions (e.g., changes in help-seeking behavior). To understand how self-help fits in the broader context of interventions available for the treatment of eating disorders, researchers should investigate further how process and outcome criteria are similar and different for the various treatment modalities.

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