REVIEW ARTICLE

A Critical Evaluation of the Efficacy of Self-Help Interventions for the Treatment of Bulimia Nervosa and Binge-Eating Disorder

Robyn Sysko, MS[1,2]*
B. Timothy Walsh, MD[1,2]

ABSTRACT

Objective: Cognitive behavioral therapy (CBT) is efficacious for the treatment of bulimia nervosa (BN) and binge-eating disorder (BED). As a number of factors limit the availability of CBT, self-help manuals have been developed to make the treatment more widely available.

Method: Published studies evaluating the efficacy of self-help programs in the treatment of BN and BED were reviewed.

Results: Controlled studies of self-help programs for BN and BED have often employed a waiting list control group, and indicate that self-help provides more benefit than remaining on a waiting list. However, fewer studies have utilized a more active control group, and these studies have not been as positive.

Conclusion: In general, open and wait-list trials indicate that self-help is helpful in treating BN and BED, but there is little evidence for the specific efficacy of self-help in comparison to other treatments. Additional studies of self-help are needed to determine the specific utility of self-help interventions for BN and BED. © 2007 by Wiley Periodicals, Inc.

Keywords: self-help; bulimia nervosa; binge-eating disorder

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Introduction

Cognitive behavioral therapy (CBT) is an effective treatment for bulimia nervosa (BN) and binge-eating disorder (BED).[1] However, there are limits on the widespread implementation of this form of treatment. Well-trained and experienced CBT therapists, ideally, mental health professionals with an advanced degree (i.e., PhD, PsyD, or MD), are in short supply, and it is difficult to train mental health professionals because of the time needed for specialized training in CBT (e.g., classes, workshops, listening to therapy tapes, supervision). In addition, the treatment is time consuming, with CBT typically consisting of twenty 50-min sessions over 4–5 months. In the United States, the time commitment and financial burden of a course of CBT, especially among those with limited financial means, restrict access to CBT. To make CBT techniques more accessible to patients with BN or BED, self-help programs utilizing CBT principles have been developed. These programs, provided in book or CD-ROM form, outline the cognitive behavioral model of BN or BED, and provide a systematic approach to help the reader reduce binge eating and/or purging behaviors. Self-help manuals can be utilized without the aid of a mental health professional, in a "pure self-help format" (PSH), where individuals are not provided with direct feedback about their progress or any assistance in applying the concepts described by the program (e.g., simply reading the book and following the treatment program). In contrast, "guided self-help" (GSH) refers to a combination of self-help programs, with brief visits by a therapist designed to help patients implement the treatment program.

Ideally, before recommending pure or guided self-help programs for the treatment of BN and BED, there should be evidence that self-help approaches are effective in the treatment of these disorders. A recent review of self-help studies published between 2002 and 2003[2] found that CBT-based guided self-help programs were more effective than a wait-list control, and that CBT GSH

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Correspondence to: Robyn Sysko, Division of Clinical Therapeutics, Eating Disorders Research Unit, 1051 Riverside Dr., Unit 98, New York, NY 10032.
E-mail: syskor@childpsych.columbia.edu
[1] Department of Psychiatry, College of Physicians and Surgeons of Columbia University, New York, New York
[2] New York State Psychiatric Institute, New York, New York
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"may be as effective as specialist treatments such as CBT or interpersonal therapy" (p. 99). The current study aimed to complete a more extensive review of the literature by including all published self-help studies (PSH or GSH) for BN and BED to evaluate the utility of these programs in reducing eating disorder symptoms.

Method

Articles evaluating self-help for the treatment of BN or BED were obtained by searching computer databases (e.g., MEDLINE, PsychInfo) and reviewing the reference sections of published literature reviews or studies of self-help. Search terms included, but were not limited to self-help, guided self-help, eating disorders, treatment of BN, and treatment of BED. Studies were included in this review if they described an evaluation of acute self-help treatment for individuals with BN or BED using a pure or guided format. Hereafter, the designation "self-help" in this article refers to studies using either PSH or GSH. Any specific comparisons of PSH versus GSH will be delineated using these acronyms in the text. We chose not to exclude studies on the basis of publication date, sample size, whether the study was controlled, had comparison treatments, or involved medication.

Results

We identified 26 studies of self-help in BN or BED patients. Studies that included (1) only individuals with BN, (2) patients with BN or subthreshold BN, or (3) a mixed group of patients with the majority classified as BN were all designated as BN self-help studies for the purpose of our evaluation. Of the 20 BN self-help studies, seven were open trials of self-help,[3–9] five compared self-help to a waiting-list control,[10–14] eight compared self-help to another intervention, including treatments such as CBT, medication, or other forms of self-help,[11,13,15–20] and two evaluated self-help combined with CBT.[21,22] Two studies[11,13] used multiple comparisons with self-help (patients were randomized to self-help, another intervention, or a waiting list), and these studies are described in all applicable categories (e.g., comparisons of self-help to a waiting list and comparisons of self-help to a comparison treatment). Eight studies of patients with BN utilized a PSH intervention,[3,9–11,13,18,19,21] 11 employed a GSH intervention,[4–6,8,12,14–17,20,22] and one compared PSH and GSH.[7] Six studies of self-help for BED were identified, one was an open trial,[23] two compared self-help to a waiting list,[24,25] one compared self-help to a control condition,[26] two compared self-help to another intervention, such as other forms of self-help,[26,27] and one combined self-help with medication.[28] A PSH condition was employed in one study,[24] three studies used a GSH condition,[23,26,28] and two studies compared PSH and GSH.[25,27] **Tables 1–5** present the sample size, patient population studied, type of intervention used, retention rates, significant findings, and conclusions for all 24 self-help studies for BN and BED (open trials, wait-list comparisons, comparisons to another intervention, self-help combined with medication, and self-help combined with CBT).

The open trials of self-help for BN or EDNOS[3–9] (**Table 1**) suggested that self-help interventions can be effective, with reductions in binge eating between 33 and 85%, reduction in self-induced vomiting between 17 and 80%, and abstinence rate of 12.8%–47% for binge eating, 27%–65.2% for vomiting, and 26.8%–50% for binge eating and vomiting. Similarly, the open trial of self-help for BED[21] also reported positive outcomes, with five of seven completers ceasing binge eating or demonstrating a clinically significant reduction in binge eating, suggesting a potential utility for self-help interventions.

A more rigorous design incorporated the random assignment of patients to receive a self-help intervention or to receive no immediate treatment while remaining on a waiting list. Seven studies using such a design were identified (**Table 2**). In all but one study,[13] the comparisons of self-help and a waiting-list control for BN and BED[10–12,14,22,23] found a significant advantage for self-help, with percent improvement ranging from 25 to 87% with self-help versus 6–19% for the waiting list, and abstinence rates ranging from 6–53% for self-help versus 0–13% for the waiting list. These studies provide evidence that self-help interventions are more useful than no treatment at all.

An even more challenging design compares the utility of self-help to another active treatment. Six studies utilizing this design were identified (**Table 3**). Two studies[26,27] found a significant difference between interventions on reductions in binge eating or abstinence rates. Loeb et al.[27] reported that, in a mixed population of binge eaters, most of whom had BED (82.5%), guided self-help was associated with a greater reduction in binge-eating episodes than that was with pure self-help. In a study of patients with BED, Grilo and Masheb[26] found that guided self-help was superior to a standard weight-management program in reducing the frequency of binge eating. The other studies,[11,13,15–18]

TABLE 1. Summary of open trials of self-help for bulimia nervosa (BN), binge-eating disorder (BED), and eating disorder not otherwise specified (EDNOS)

Study	Sample	Intervention	Retention	Findings	Follow-Up	Conclusions
Schmidt et al.[3]	*N* = 28 BN or atypical BN	PSH using a handbook emphasizing CBT techniques, later published as *Getting Better Bit(e) by Bit(e)*.[29] Patients returned for an assessment after "work[ing] through the book" for 4–6 weeks and no additional treatment was provided	26 (92.9%) patients completed the study	46.2% were considered very much or much improved 65.2% were abstinent from vomiting and laxative abuse	No follow-up data presented	Use of a pure self-help manual helped to significantly reduce bulimic symptoms
Cooper et al.[4]	*N* = 18 BN	GSH using *Bulimia Nervosa: A Guide to Recovery*, a CBT self-help manual.[30] Over 4–6 months, a nonspecialist social worker provided a mode of eight 20–30 min sessions encouraging the use of the manual	Information on dropout was not provided	85% reduction in binge eating, 80% reduction in vomiting 50% were abstinent from binge eating and vomiting	No follow-up data presented	
Cooper et al.[5]	*N* = 82 BN	GSH using *Bulimia Nervosa: A Guide to Recovery*[30] in the same manner as the 1994 study (a mode of eight supportive sessions with a non-specialist social worker [range 4–13] over 4–6 months).	67 (81.7%) patients completed the study	80% reduction in binge eating, 79% reduction in vomiting 26.8% were abstinent from binge eating and vomiting	At follow-up (*n* = 50 patients), 1 year after treatment was initiated, reductions of 84% in binge eating and 87% in vomiting from baseline were observed. In addition, 72% were abstinent from binge eating, 74% were abstinent from vomiting, and 64% were abstinent from both behaviors in the previous month Patients did not receive additional treatment during the follow-up	In both studies, a guided self-help intervention significantly reduced bulimic symptoms. The 1996 study found that these gains were maintained after 1 year
Wells et al.[23]	*N* = 9 BED	GSH using *Overcoming Binge Eating*.[31] Participants received eight 30-min phone sessions to assess progress with the manual over 12 weeks (weekly during the first month, biweekly for the second 2 months) with a psychology graduate student	8 (88.8%) patients completed the study, 7 (77.7%) engaged in phone calls until week 12	Three participants stopped binge eating, 2 had a clinically significant reduction in binge eating, 1 was unchanged, and 1 had a slightly increased frequency of binge eating Three patients (33.3%) were abstinent from binge eating	No follow-up data presented	More than half of patients who received guided self-help demonstrated improvements in binge eating

TABLE 1. (Continued)

Study	Sample	Intervention	Retention	Findings	Follow-Up	Conclusions
Bell and Newns[6]	$N = 46$ BN	GSH with *Getting Better Bit(e) by Bit(e)*,[29] including weekly 30-min sessions with an assistant psychologist. Individuals who completed treatment received a mean of 9.48 sessions (range 4–15). The time between the baseline and follow-up assessments is not provided	30 (65.2%) patients completed the study	BITE symptom scores decreased from 24.59 to 15.33 among "multiimpulsive" BN patients, and from 22.91 to 8.35 among "nonimpulsive" BN patients Patients reported significant improvements in symptom and severity scales	No follow-up data presented	Guided self-help produced similar changes in bulimic symptoms for patients with and without multi-impulsivity
Ghaderi and Scott[7]	$N = 9$ BN, $N = 11$ EDNOS (subthreshold BN), and $N = 11$ BED	PSH ($n = 15$) and GSH ($n = 16$) using *Overcoming Binge Eating*.[31] Individuals in the PSH condition received a copy of the manual and no additional information or contact for 16 weeks. The GSH condition consisted of six to eight 25-min structured sessions over 16 weeks with an undergraduate psychology student designed to provide support and guidance to participants	18 (58.1%) patients completed the study, with 60.0% ($n = 9$) in the PSH condition and 56.3% ($n = 9$) in the GSH condition completing	33% reduction in binge eating (33% GSH, 33% PSH), and 17% reduction in vomiting across both groups 18.7% ($n = 3$) of the GSH group and 26.67% ($n = 4$) of the PSH group were abstinent from binge eating at the end of treatment	Patients who completed the treatment were assessed after 6 months, with the analyses demonstrating no significant changes in eating disorder symptoms from treatment termination to follow-up	Pure and guided self-help produced equivalent improvements in binge eating and vomiting, although less than observed in other studies. No additional improvements were observed during follow-up
Pritchard et al.[8]	$N = 20$ BN or subthreshold BN	GSH using portions of *Bulimia Nervosa: A Cognitive Therapy Programme for Clients*,[32] a manual for BN with a cognitive emphasis. Patients received six 30-min weekly sessions for ~2 months, with either a doctoral candidate ($n = 6$) or a therapist with a masters degree in clinical psychology ($n = 1$) focused on homework review, overview of work for the next week, and support and encouragement	15 (75%) of the patients completed treatment	~50% reduction in binge eating, ~22% reduction in vomiting 47% were abstinent from binge eating and 27% from vomiting	Data from the 3-month follow-up indicated no significant improvement or deterioration in eating disorder symptoms, with the exception of a significant improvement in eating concern over the follow-up period	The guided self-help intervention produced significant reductions in bulimic symptoms, and sizeable abstinence rates. These gains were maintained at the 3-month follow-up

TABLE 1. (Continued)

Study	Sample	Intervention	Retention	Findings	Follow-Up	Conclusions
Bara-Carril et al.[9]	$N = 36$ BN and 9 EDNOS (subthreshold BN)	PSH CD-ROM with a CBT + motivational and educational strategies self-help package.[33] Each module was ~45 min in length, and participants completed homework tasks and received feedback about their progress. Participants were asked to complete the program over 4–8 weeks, accessing 1–2 modules per week, and received no additional support during this time	19 patients (42.2%) completed eight sessions	A moderate effect size of 0.7 was found for binge eating and 0.6 for vomiting 12.8% were abstinent from binge eating, 46% were abstinent from vomiting	No follow-up data presented	A computerized pure self-help program demonstrated efficacy for reducing binge eating and vomiting

Note: PSH, pure self-help; CBT, cognitive behavioral therapy; GSH, guided self-help; BITE, Bulimic Investigatory Test, Edinburgh.[34]

all of which focused on individuals with BN, failed to find significant differences between self-help interventions and other treatments, which included a nonspecific program emphasizing self-assertion, another form of CBT for BN, and individual or group CBT.

Three studies examined the combination of self-help with medication for patients with BN or BED[19–20,28] (**Table 4**). Two studies combined self-help and antidepressant medication for the treatment of BN. One study, conducted in a specialist eating disorder clinic, found that self-help combined with fluoxetine or placebo was more helpful than medication or placebo alone in reducing self-induced vomiting but not binge eating at mid treatment, but the effect of the manual was not significant for binge eating or vomiting at the end of treatment.[19] The other, conducted in a primary care setting, found no evidence of utility for either binge eating or vomiting from combining guided self-help with fluoxetine or placebo.[20] Grilo et al.[28] combined self-help with a weight-loss medication (orlistat) or placebo for the treatment of BED. The combination of self-help and orlistat was associated with greater weight loss and higher rates of remission from binge eating at the end of treatment than the combination of self-help and placebo.[28]

Two studies compared a combination of self-help and individual CBT provided at a reduced intensity with usual CBT for patients with BN[21,22] (**Table 5**). Neither study found a significant difference between the two forms of treatment.

The completion rates for patients with BN or BED reported across the self-help studies ranged from very low (30.8%) to very high (100%). Among the open trials of self-help, completion rates in the self-help groups ranged between 42.2%and 92.9%. Self-help studies using a waiting list found completion rates of 73.3% and 100% in the self-help groups in comparison to that of 70.4% and 100% on the waiting list. Studies that compared self-help and another intervention observed completion rates of between 31.3% and 87% in self-help participants, and that of 48.3% and 87% in the comparison groups. Finally, the combination of self-help and another intervention (medication or CBT) found completion rates ranging from 30.8% to 86.3%.

A comparison of findings from studies employing PSH for BN, EDNOS,[3,9–11,13,18,19,21] or BED[24] versus GSH for BN, EDNOS,[4–6,8,12,14–17,20,22] or BED[23,26,28] is complicated by the substantial difference in outcome measures across trials. However, the improvements are of a similar magnitude, with PSH interventions associated with 50.2%–86.7% decrease in eating disorder symptoms and with

TABLE 2. Summary of trials of self-help in comparison to a wait list for bulimia nervosa (BN), binge-eating disorder (BED), and eating disorder not otherwise specified (EDNOS)

Study	Sample	Intervention	Retention	Findings	Follow-Up	Conclusions
Huon[10]	*N* = 120 BN	PSH using an "eclectic" seven-component program (program alone; *n* = 30), PSH + contact with "cured" BN patient (*n* = 30), PSH + contact with "improved" BN patient (*n* = 30), and wait-list (*n* = 30). Components were provided on a monthly basis, but the type and amount of contact with cured or improved patients with BN was not controlled	All participants (100%) completed the study	Percent improved all PSH (contact with "cured" or "improved" patient): 86.7%,[a] WL: 16.6% 18.8%[a] (all PSH) and 0% on the WL were abstinent from binge eating and vomiting	At the 3-month follow-up, 21.7% of all the PSH (contact with "cured" or "improved" patient), 16.6% of the program only, and 6.6% of the WL were abstinent from binge eating and vomiting. By the 6-month follow-up, in comparison to the program alone group, a significantly greater proportion of individuals assigned to the PSH + contact with a "cured" patient (46.6%) or PSH + contact with an "improved" patient (33.4%) were abstinent from binge eating and vomiting	All of the self-help conditions reduced binge eating and vomiting in comparison to the waiting list, and there were few differences between the self-help groups. A significant difference in abstinence rates emerged after 6 months, favoring contact with a "cured" or "improved" patient
Treasure et al.[11]	*N* = 110 BN or atypical BN	PSH with *Getting Better Bit(e) by Bit(e)*[29]; *n* = 55), CBT (*n* = 28), and WL (*n* = 27). For PSH, participants were provided with the manual and reassessed after 8 weeks. Information about the comparison between the PSH and CBT conditions are provided in Table 3	81 (73.6%) patients completed the study, 74.5% (*n* = 41) in the PSH group and 70.4% (*n* = 19) on the WL	Symptom score rating decreased in PSH from 3 to 1,[a] and the WL started at 3 and did not change 22% in the PSH condition and 11% on the WL were abstinent from binge eating and vomiting	Additional follow-up data from participants in this study are reported in Treasure et al.,[21] described in Table 5	Participants receiving pure self-help were significantly improved in comparison to those assigned to the waiting list
Peterson et al.[24]	*N* = 61 BED	Manual-based group CBT adapted for BED (fourteen 1-h sessions including psychoeducation and review of homework over 8 weeks[35]) in a therapist-led (*n* = 16), partial PSH (*n* = 19), or structured PSH condition (*n* = 15), or a WL (*n* = 11). The therapist-led sessions were conducted by a trained PhD psychologist, the partial PSH viewed a tape of the psychologist providing psychoeducation, and the structured PSH participants viewed the videotape of the psychologist and conducted a group discussion	51 (83.6%) of patients completed the study, 87.5% of the therapist-led condition (*n* = 14), 89.5% of the partial PSH group (*n* = 17), 73.3% of the structured PSH group (*n* = 11), and 81.8% of those on the WL (*n* = 9)	18.8%[a] in the therapist-led condition were abstinent, 36.8%[a] in the partial PSH were abstinent, 53.3%[a] in the structured PSH condition were abstinent, and 0% were abstinent on the WL from binge eating	No follow-up data presented	Significantly fewer episodes of binge eating were observed in all three self-help conditions in comparison to the wait-list group

TABLE 2. (Continued)

Study	Sample	Intervention	Retention	Findings	Follow-Up	Conclusions
Carter and Fairburn[25]	$N = 72$ BED or EDNOS (subthreshold BED)	PSH ($n = 35$) or GSH ($n = 34$) using *Overcoming Binge Eating*,[31] or WL ($n = 24$). Participants in the PSH condition received the manual in the mail and had no further study contact for 12 weeks, and the GSH consisted of six to eight 25-min sessions over 12 weeks with a nonspecialist facilitator without clinical qualifications	63 (87.5%) completed, with 95.8% ($n = 23$) WL, 26 (76.5%) GSH completing, and 100% of ($n = 35$) the PSH group completing the posttreatment assessment (considered completing)	43%[a] in the PSH group, 50%[a] in the GSH group, and 8% on the WL were abstinent from binge eating	WL participants were randomized to PSH or GSH after 12 weeks. At the 3-month follow-up, 37% in the PSH group, and 41% in the GSH group were abstinent from binge eating, respectively. Abstinence rates for binge eating increased to 40% for PSH and 50% for GSH at the 6-month follow-up	Binge eating was significantly lower in both the pure and guided self-help groups than in the wait-list, and patients from both the PSH and GSH groups maintained their gains over the 6-month follow-up
Palmer et al.[12]	$N = 71$ BN, $N = 22$ partial BN, $N = 28$ BED	WL ($n = 31$), GSH using *Overcoming Binge Eating*[31] + minimal guidance (GSH-MG; $n = 32$), GSH + face-to-face guidance (GSH-FF; $n = 30$), or GSH + telephone guidance (GSH-T; $n = 28$). Individuals on the WL were reassessed after 4 months. The GSH-MG group received the manual and a brief explanation in use of the manual with a therapist, but had no other therapist contact for 4 months. The GSH+FF condition consisted of four 30-min sessions over 4 months, and the GSH-T also included four 30-min sessions with a therapist over 4 months, but sessions were provided over the phone. Sessions in the GSH-FF and GSH-T conditions were provided 2 weeks, 4 weeks, 2 months, and 3 months after randomization. Therapists were nurses experienced with the treatment of eating disorders	91 (75.2%) completed treatment, with 71.0% WL ($n = 22$), 78.1% GSH-MG ($n = 25$), 75% GSH-FF ($n = 23$), and 76.7% GSH-T ($n = 21$) completed	50%[b] in the GSH-FF group, 36% in the GSH-T condition, 25% in the GSH-MG condition, and 19% of the WL group showed some improvement (25–75% improved) 10%[a] in the GSH-FF condition, 14%[a] in the GSH-T condition, 6% in the GSH-MG condition, and 0% on the WL were abstinent from binge eating and vomiting	Patients were assessed at 8- and 12-months, but only 12-month follow-up data were provided ($n = 77$). After the initial 4 months of the study, patients on the WL or individuals who had "not improved" were provided with CBT or IPT, patients with "some improvement" (25–75% reduction in symptoms) received additional GSH sessions, and "importantly improved" patients received no additional treatment. Using the original groups, 23% in the GSH-FF condition, 21% in the GSH-T condition, 22% in the GSH-MG condition, and 23% on the WL were abstinent from binge eating and vomiting	In comparison to the wait-list group, the face-to-face and telephone guidance groups were significantly improved, but this was not true for the minimal guidance self-help condition. At the 12-month follow-up, when additional treatment was provided to individuals on the wait-list or who had not improved, there were no differences in eating disorder symptoms between the original treatment groups
Carter et al.[13]	$N = 85$ BN	CBT PSH (*Overcoming Binge Eating*[31] ($n = 28$), nonspecific PSH (*Self-Assertion for Women*[36]; $n = 28$), or WL ($n = 29$). Patients randomized to either PSH group met with research staff for a description of the nature of the intervention, but did not receive any additional support during the 2-month intervention	65 (76.5%) completed, including 23 (82.1%) from CBT PSH, 21 (75%) from the nonspecific PSH group, and 21 (72.4%) from the WL	53.6% of the CBT PSH group and 31.0% of the WL showed a 50% or greater decrease in binge eating or purging Data not provided for abstinence	No follow-up data provided	There was a larger proportion of responders in the two self-help groups than in the wait-list condition, although the difference did not reach statistical significance

TABLE 2. (Continued)

Study	Sample	Intervention	Retention	Findings	Follow-Up	Conclusions
Banasiak et al.[14]	$N = 109$ BN or subthreshold BN	GSH using *Bulimia Nervosa and Binge-Eating: A Guide to Recovery*[37] ($n = 54$) or WL ($n = 55$). Individuals on the WL were provided with GSH after 17 weeks, but data for their response to GSH treatment are not provided. The GSH condition consisted of an initial (30–60 min) session with a general practitioner trained in the use of the manual covering the treatment rationale and goals, followed by nine 20- to 30-min sessions for support and encouragement for 16 weeks. Patients were seen weekly during the first month, every other week for the next 6 weeks, and every 3 weeks for the last 6 weeks. Thirteen of the 16 general practitioners had a special interest in the treatment of eating disorders	75 (68.8%) patients completed	Binge eating frequency was reduced by 60%[a] in GSH condition, and 6% on the WL, and purging episodes were reduced by 61%[a] in the GSH condition compared to 10% on the WL 46%[a] in the GSH condition were abstinent from binge eating and 33%[a] from purging, and 13% on the WL were abstinent from binge eating and 12% from purging at the end of treatment	Among those completing the follow-up assessments (GSH group only), 58% were abstinent from binge eating at the 3-month follow-up and 60% at the 6-month follow-up. At the 3-month follow-up, 39% were abstinent from purging and 35% were abstinent from binge eating and purging, with the comparable numbers rising to 50% and 42% at the 6-month follow-up	Participants in the self-help condition demonstrated significant improvements in binge eating and purging symptoms in comparison to those assigned to the wait-list. At the 3- and 6-month follow-up, treatment gains for the GSH group were generally maintained

Note: PSH, pure self-help; CBT, cognitive behavioral therapy; IPT, interpersonal psychotherapy; GSH, guided self-help; WL, wait-list.
[a] Indicates a significant difference from the waiting list.
[b] Indicates a difference between the face-to-face condition and all other conditions combined.

TABLE 3. Summary of trials of self-help in comparison to another intervention for bulimia nervosa (BN), binge-eating disorder (BED), and eating disorder not otherwise specified (EDNOS)

Study	Sample	Intervention	Retention	Findings	Follow-Up?	Conclusions
Treasure et al.[11]	$N = 110$ BN or atypical BN	PSH with *Getting Better Bit(e) by Bit(e)*[29]; $n = 41$), CBT ($n = 21$), and WL ($n = 19$). For PSH, participants were provided with the manual and reassessed after 8 weeks. The CBT consisted of a total of eight sessions with a therapist before being reassessed. Information about the comparison between the PSH and WL conditions are provided in Table 2	81 (73.6%) patients completed the study, 74.5% ($n = 41$) in the PSH group, and 75.0% ($n = 21$) in the CBT group	Symptom score rating decreased in PSH from 3 to 1, and from 4 to 1 in the CBT group 22% in the PSH condition and 24% in the CBT condition were abstinent from binge eating and vomiting	Additional follow-up data from participants in this study are reported in Treasure et al.,[21] described in Table 5	There were no significant differences between self-help and CBT after 8 weeks of treatment; however, CBT produced higher rates of abstinence
Loeb et al.[27]	$N = 40$ BN, BED, or EDNOS (subthreshold BN or BED)	PSH or GSH using *Overcoming Binge Eating*.[31] In the PSH condition, participants followed the manual for 10 weeks and completed food records. Study staff would contact participants if problems arose. The GSH consisted of six 30-min sessions occurring weekly for the first two sessions, and biweekly thereafter with a licensed clinical psychologist of advanced graduate student in clinical psychology with a specialization in eating disorders	27 (67.5%) patients completed the study	Patients in the PSH condition had a 55% reduction in OBEs and patients in the GSH condition had a 68% reduction in OBEs[a] 30% in the PSH condition and 50% in the GSH condition were abstinent from OBEs at the end of treatment	Individuals in the PSH condition were offered ten 50-min sessions of individual CBT if they failed to demonstrate a 75% reduction in binge eating during the study ($n = 2$). Eighteen participants (45% of the original sample) completed the 6-month follow-up and objective bulimic frequency was analyzed, but no specific data are presented	In comparison to the pure self-help group, the guided self-help group experienced significantly fewer binge episodes at the end of treatment. In both the PSH and GSH conditions, improvements in binge eating from posttreatment were maintained, but no additional gains were made
Carter et al.[13]	$N = 85$ BN	CBT PSH (*Overcoming Binge Eating*[31], $n = 28$) non-specific PSH (*Self-Assertion for Women*,[36] $n = 28$), or WL ($n = 29$). Patients randomized to either PSH group met with research staff for a description of the nature of the intervention, but did not receive any additional support during the 2-month intervention	65 (76.5%) patients completed, 23 (82.1%) from CBT PSH and 21 (75%) from nonspecific PSH. Data on the WL group are provided in Table 2	53.6% of the CBT PSH group and 50.0% of the nonspecific PSH group showed a 50% or greater decrease in binge eating or purging, and 31.0% similarly decreased on the WL Data not provided for abstinence	No follow-up data provided	No differences were observed in the proportion of patients responding in the CBT or nonspecific self-help groups
Durand and King[15]	$N = 68$ BN	GSH with general practitioner (GP) support using *Bulimia Nervosa: A Guide to Recovery*[30]; $n = 34$) or specialist treatment (ST; $n = 34$). Patients receiving GSH were asked to keep in "regular" contact with their nonspecialist GP while reading the manual, with an average of 4.9 visits over 6 months (range 0–28 visits). In the ST condition, participants received weekly or biweekly CBT or IPT for "as long as deemed appropriate." The mean number of ST sessions was 4.8 over 6 months (range 0–25)	64.7% of GSH patients ($n = 22$) and 82.4% of specialist patients ($n = 28$) had data at the 6-month assessment	OBEs decreased from 19.0/28 days (∼4.75/week) to 16.4/28 days (∼4.10/week) in the GSH group, and from 20.4/28 days (∼5.10/week) to 12.6/28 days (∼3.15/week) in the ST group Vomiting decreased from 35.1/28 days (∼8.78/week) to 25.0/28 days (∼6.25/week) in the GSH group, and from 37.8/28 days (∼9.45/week) to 16.5/28 days (∼4.13/week) in the ST group	At the 9-month assessment, 3 months after the end of treatment, GSH patients were experiencing 15.0 OBEs per 28 days (∼3.75/week) and 20.3 episodes of vomiting per 28 days (∼ 5.08/week), and patients in the ST group were experiencing 14.9 OBEs per 28 days (∼3.73/week) and 20.5 episodes of vomiting per 28 days (∼5.13/week) In addition, 29.4% of the GSH group and 26.5% of the ST group had a total score < 20 on the BITE, indicating that they did not meet full BN diagnostic criteria	Both the guided self-help and specialist treatment groups demonstrated significantly improved BITE scores over time, but the groups did not differ from one another. Changes in binge eating and vomiting frequencies were largely unchanged from posttreatment to follow-up

TABLE 3. (Continued)

Study	Sample	Intervention	Retention	Findings	Follow-Up?	Conclusions
Bailer et al.[16]	*N* = 81 BN	GSH (*n* = 40) with *Getting Better Bit(e) by Bit(e)*[29] or group CBT (*n* = 41). The GSH group received 18 weekly 20-min visits with 1st or 2nd year psychiatry residents with no formal training in the treatment of eating disorders providing assistance and encouragement. The group CBT consisted of 18 weekly 90-min sessions with an experienced therapist and cotherapist	56 (69.1%) completed, with 30 (75%) patients in the GSH condition and 26 (63.4%) patients in the group CBT condition completing	7.5% in the GSH condition and 12.2% in the group CBT condition were abstinent from binge eating or purging in the previous month 40% in the GSH condition and 29.3% in the group CBT condition no longer met DSM-IV criteria for BN at the end of treatment	Fifty-five patients (68%) completed a follow-up assessment 1 year after the end of treatment. In the intent-to-treat sample, 22.5% in the GSH condition and 14.6% in the group CBT condition were abstinent from binge eating or purging in the previous month. Fifty percent in the GSH condition and 36.6% in the group CBT condition no longer met DSM-IV criteria for BN at the end of treatment	The proportion of patients who were abstinent from bulimic symptoms or who no longer met DSM-IV BN criteria were not different between the GSH and CBT groups at the end of treatment. After 1 year, there were no statistically significant improvements in eating disorder symptoms or significant differences between the GSH and CBT conditions among the intent-to-treat sample
Grilo and Masheb[26]	*N* = 90 BED	GSH CBT using *Overcoming Binge Eating*[31] (*n* = 37), GSH behavioral weight loss (BWL) using the *LEARN Program for Weight Management*[43] (*n* = 38), or a control condition (*n* = 15). Both GSH conditions included six 15–20 min biweekly sessions over 12 weeks focused on the manuals, and specifically, motivation, clarifying information, problem-solving, and reinforcing homework (e.g., self-monitoring, record keeping). Sessions were provided by doctoral research-clinicians experienced with the therapies (CBT and BWL) and the treatment of BED. Individuals in the control condition attended the same number of sessions; however, they did not receive a manual and only completed self-monitoring records and reviewed their records with the therapist	70 (78%) completed, with 87% (*n* = 13) in the control condition, 66% (*n* = 25) in GSH BWL, and 87% in GSH CBT completing[29]	OBEs decreased from 14.0/28 days (∼3.5/week) to 8.1/28 days (∼2.03/week) in the CON group, from 13.4/28 days (∼3.35/week) to 6.7/28 days (∼1.68/week) in the GSH BWL group, and from 12.1/28 days (∼3.03/week) to 2.8/28 days (∼0.7/week) in the GSH CBT group 13.3% in the control condition, 18.4% in the GSH BWL condition, and 46% in the GSH CBT condition were abstinent from OBEs in the last month at the end of treatment[b]	No follow-up data provided	The CBT guided self-help condition had significantly higher rates of abstinence from binge eating, and lower rates of binge eating episodes, at the end of treatment than either the control condition or the BWL self-help condition

TABLE 3. (Continued)

Study	Sample	Intervention	Retention	Findings	Follow-Up?	Conclusions
Schmidt et al.[17]	*N* = 40 BN, 20 EDNOS (subthreshold BN), 1 unknown	GSH with *Getting Better Bit(e) by Bit(e)*[29] and personalized feedback (*n* = 32) or without feedback (*n* = 29). Participants in both conditions received 10 weekly sessions and 4 monthly booster sessions/follow-up sessions (all 50 min in length) with therapists (psychologists, psychiatrist, nurses, occupational therapists) experienced in the treatment of eating disorders and trained to write letters and deliver feedback. The personalized feedback condition included four additional components, including a personalized feedback letter after the initial assessment, a symptom feedback form to help articulate ambivalence about change, an end of treatment letter summarizing the treatment, and normative and every other week computerized feedback regarding symptoms of BN, depression, and anxiety	10 patients (31.3%) in the GSH with personalized feedback and 14 patients (48.3%) in the GSH without feedback condition completed at least 10 sessions of a 14-session treatment	Symptom scores for binge eating decreased from pre- to posttreatment from 3.4 to 1.8 for the feedback group and from 3.3 to 3.2 for the no feedback group, and for vomiting from 3.1 to 2.1 in the feedback group and from 2.7 to 2.3 in the no feedback group.	At the 6-month follow-up, symptom scores were 2.5 and 2.6 for binge eating and 2.0 and 2.1 for vomiting in the feedback and no feedback conditions, respectively.	Patients receiving a CBT guided self-help intervention with personalized feedback experienced a significantly greater reduction in dietary restriction and a trend for a larger reduction in vomiting than patients receiving the guided self-help intervention without feedback. No differences were observed between the two conditions at follow-up
Dunn et al.[18]	*N* = 21 BN, 25 BED, 6 subthreshold BN, 8 subthreshold BED, and 30 EDNOS (partial BN or BED)	PSH with *Overcoming Binge Eating*[31] (*n* = 45) or PSH plus a motivational enhancement therapy (MET) session (*n* = 45). Individuals in the PSH condition were provided with the manual and received 20 min worth of instruction about following the program. The PSH + MET consisted of a 45-min session with a trained interventionist (a senior undergraduate research assistants or a master's level graduate students in a clinical psychology program) using motivational interviewing strategies, such as eliciting change talk, providing personalized feedback, evaluating pros/cons of eating disordered behavior, and assessing readiness to change	65.5% of patients (*n* = 59) had data at the 4-month follow-up	Binge eating decreased from an average of 3.04 episodes to 1.89 episodes per week in the PSH + MET condition and from 2.80 episodes to 2.11 episodes per week in the PSH condition, and vomiting decreased from an average of 0.81 episodes to 0.62 episodes per week in the PSH + MET condition and from 1.82 episodes to 1.71 episodes per week in the PSH condition 24% in the PSH + MET condition and 9% in the PSH condition were abstinent from binge eating at the end of treatment[c]	No follow-up data provided	Binge eating decreased significantly in both self-help groups, and the self-help with motivational enhancement condition had significantly higher rates of abstinence from binge eating. Vomiting did not decrease significantly in either condition

Note: PSH, pure self-help; CBT, cognitive behavioral therapy; GSH, guided self-help; IPT, interpersonal psychotherapy; BITE, Bulimic Investigatory Test, Edinburgh[34]; OBE, objective bulimic episode.
[a] Significant difference between PSH and GSH.
[b] The remission rate in the GSH CBT condition was significantly greater than both the CON and GSH BWL conditions.
[c] Significant difference between PSH + MET and PSH.

TABLE 4. Summary of trials of self-help combined with medication for bulimia nervosa (BN), binge-eating disorder (BED), and eating disorder not otherwise specified (EDNOS)

Study	Sample	Intervention	Retention	Findings	Follow-Up?	Conclusions
Mitchell et al.[19]	*N* = 91 BN	PSH with a manual including aspects of a group CBT program[44] + fluoxetine (60 mg qd; *n* = 21), PSH + placebo (*n* = 22), fluoxetine alone (60 mg qd; *n* = 26), placebo alone (*n* = 22). After a 2-week placebo lead-in, patients were encouraged to utilize the manual and complete homework assignments. Participants received medication or placebo for 16 weeks and were seen every other week by a physician for assessment of side effects and discussion of overall status	Information on dropout was not provided	Vomiting decreased on average 50.2% in the PSH + placebo group, 22.8% in the placebo group, 66.7% in the PSH + fluoxetine group, and 52.8% in the fluoxetine alone group[a,b] 24% in the PSH + placebo group, 26% in the PSH + fluoxetine group, and 16% in the fluoxetine alone group were abstinent from binge eating and vomiting at the end of treatment	No follow-up data presented	There was a trend or significant reduction in vomiting at mid- and posttreatment for the main effects of therapy and medication
Walsh et al.[20]	*N* = 91 BN or subthreshold BN	GSH using *Overcoming Binge Eating*[31] + fluoxetine (60 mg qd; *n* = 24), GSH + placebo (*n* = 25), fluoxetine alone (60 mg qd; *n* = 20), or placebo alone (*n* = 22). Over 16 weeks, all participants received seven brief (~15 min) visits for medical management with a medical doctor without prior experience treating individuals with BN. The GSH condition consisted of an additional 6–8 sessions (~30 min) with nonspecialist nurses encouraging use of the self-help manual	A total of 28 (30.8%) of the 91 patients completed treatment, (14 [28.6%] of 49) for the self-help groups, and (14 [33.3%] of 42) in the medication only conditions	Vomiting increased on average 18.8% in the GSH + placebo group, and decreased on average 25.1% in the placebo alone group, 44.6% in the GSH + fluoxetine group, and 41.3% in the fluoxetine alone group 1.1% in the GSH + placebo group, 2.2% in the placebo alone group, 5.5% in the GSH + fluoxetine group, and 2/2% in the fluoxetine alone group were abstinent from binge eating and vomiting at the end of treatment	No follow-up data presented	Participants receiving fluoxetine demonstrated significant reductions in binge eating and vomiting. There were no benefits of guided self-help
Grilo et al.[28]	*N* = 50 BED	GSH using *Overcoming Binge Eating*[31] + orlistat (120 mg tid; *n* = 25) or GSH + placebo (*n* = 25). The GSH involved six 15–20 min sessions over 12 weeks focused on motivation, clarifying information, problem-solving, and reinforcing self-monitoring provided by doctoral research clinicians experienced with CBT and the treatment of patients with BED	A total of the 39 (78%) patients completed the treatment, 76% (*n* = 19 of 25) from the GSH + orlistat and 80% (*n* = 20 of 25) from the GSH + placebo groups	OBEs decreased from 16.4/28 days (~4.18/week) to 3.2/28 days (~0.80/week) in the GSH + orlistat group, and from 13.5/28 days (~3.38/week) to 3.6/28 days (~0.90/week) in the GSH + placebo group 64% in the GSH + orlistat group and 36% in the GSH + placebo were abstinent from binge eating at the end of treatment	At the 3-month follow-up, among the intent-to-treat sample, remission rates for binge eating were 52% both the in the GSH + orlistat group and the GSH + placebo. OBEs occurred on average 3.4/28 days (~0.85/week) in the GSH + orlistat group and 2.8/28 days (~0.7/week) in the GSH + placebo group	At the end of treatment, participants in the orlistat + guided self-help condition had significantly higher rates of remission from binge eating and likelihood of achieving a 5% weight loss goal than participants in the placebo + guided self-help condition. End of treatment differences were no longer evident at follow-up; however, patients receiving orlistat during the study were more likely to maintain their 5% weight loss at follow-up

Note: PSH, pure self-help; GSH, guided self-help.
[a] Patients taking fluoxetine had a greater reduction in binge eating and vomiting than do patients taking placebo.
[b] Patients who received PSH had a greater improvement in binge eating and vomiting at the end of the study.

TABLE 5. Summary of trials of self-help combined with CBT for bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS)

Study	Sample	Intervention	Retention	Findings	Follow-Up?	Conclusions
Treasure et al.[21]	$N = 110$ BN or atypical BN	Sequential treatment with PSH using *Getting Better Bit(e) by Bit(e)*[29] followed by eight sessions of CBT ($n = 55$), or CBT ($n = 55$). For PSH, participants were provided with the manual and reassessed after 8 weeks, and individuals who were symptomatic after 8 weeks of SH were provided with up to eight CBT sessions. The CBT consisted of a total of 16 weekly sessions with a therapist. No additional data is provided regarding therapist characteristics. Information about the outcome at week 8 of the PSH and CBT conditions are provided in Tables 2 and 3	86 (78.2%) of patients completed, with 72.7% of the CBT group ($n = 40$), and 86.3% of the sequential treatment ($n = 46$) completing	Median scores for bulimic symptoms decreased from 6 to 2 in both the sequential and CBT groups Among completers, 30% in the PSH + CBT group and 30% in the CBT group were abstinent from binge eating and vomiting at the end of treatment	A total of 64 (58.2%) participants completed at least one follow-up measure ~18 months after the end of treatment (range 14–26 months). No additional improvements were observed at the follow-up. Individuals in the SH + CBT and CBT conditions had a median bulimic symptom scores of 1.5 and 1.0, respectively. Remission rates were 40% in the SH + CBT group and 41% in the CBT group at follow-up	When eight sessions of CBT were added to the self-help treatment, the improvements were similar to 16 sessions of CBT. The changes observed after 16 weeks of acute treatment were maintained at the 18-month follow-up
Theils et al.[22]	$N = 62$ BN	GSH with *Getting Better Bit(e) by Bit(e)*[29] and reduced intensity CBT ($n = 31$), or CBT ($n = 31$). In the SH + CBT condition, participants received eight 50–60 min sessions every other week, which focused less on educational and skills-training aspects of treatment than the CBT group. The CBT condition included 16 weekly 50–60 min sessions. Therapists for both conditions included two psychologists and an individual completing her postgraduate diploma in Health Sciences trained in the implementation of the treatments	49 (79.0%) completed, with 71.0% ($n = 22$) in the GSH condition, and 87.1% ($n = 27$) in the CBT condition completing	Vomiting decreased from 3.02/28 days to 2.27/28 days in the GSH + CBT group, and from 2.95/28 days to 1.53/28 days in the CBT group 12.9% in the SH + CBT group and 54.8% in the CBT group were abstinent from binge eating and vomiting at the end of treatment	A mean of 43 weeks after the conclusion of treatment (range 23–123 weeks), 48 (77.4%) of participants were re-assessed. At follow-up, 60.9% in the SH + CBT group and 70.8% in the CBT group were abstinent from binge eating and vomiting	Similar improvements were observed in bulimic symptoms in both the guided self-help + CBT and CBT groups, which were maintained at follow-up

Note: PSH, pure self-help; GSH, guided self-help.

rates of abstinence between 9% and 65.2% for binge eating or vomiting; three studies demonstrated statistical superiority of PSH in comparison to waiting list.[10,11,24] Similar levels of improvement were observed with GSH, as changes in eating disorder symptoms ranged between an 18.8% increase and an 85% decrease, and abstinence rates were between 6 and 50%; five studies found a significant advantage for GSH over a waiting list,[12,14,25] a control treatment, or another form of GSH.[25–27] Of the three studies directly comparing PSH and GSH for BN, EDNOS,[7] or BED,[25,27] two demonstrated no difference in outcome of the treatments on measures of eating disorder symptoms.[7,25] The third trial[27] found a statistically significant advantage for GSH over PSH with regard to reduction in binge-eating frequency, but not in rate of abstinence from binge eating.

Conclusion

This review found mixed results regarding the utility of self-help interventions for patients with BN and BED. On one hand, the data from open trials and, with one exception,[13] from studies comparing self-help to a waiting list are quite consistent in demonstrating that self-help is associated with a greater reduction in symptoms than is no treatment. This evidence supports the utilization of self-help interventions when no other treatment is available, a conclusion that is consistent with those of a recent review of self-help studies between 2002 and 2003.[2] However, while these open trials demonstrate benefits from self-help, the studies often lack adequate statistical power and do not include a control group, so it is impossible to assess rigorously how much of the improvement was due solely to the passage of time.

The results of studies in which the utility of self-help interventions is compared to that of other treatments are more difficult to interpret. Several studies of self-help in BN[11,13,15,16] reported that self-help was similar in efficacy to better established forms of treatment, such as individual CBT. However, none of these studies included an internal reference treatment condition, such as IPT or supportive psychotherapy, interventions to which CBT has been found superior in previous trials.[29,40–42] Without such an internal reference, it is not possible to distinguish two possible conclusions from these studies. One possibility is that self-help and individual CBT are equally effective and superior to other forms of psychological treatment; the other possibility is that the patients in these trials were equally responsive to any credible intervention, and that the benefits of self-help are nonspecific. The latter conclusion is suggested by the results of several studies included in the review. In comparing two psychological self-help treatments, Carter et al.[13] found equivalent results from a CBT-based self-help program and a self-help program intended to enhance self-assertion without any focus on changing eating disorder symptoms. When evaluating the combination of self-help and antidepressant medication, one study[19] reported limited benefit from a self-help program combined with a medication-based intervention, and another[20] found a clear benefit of fluoxetine for patients with BN, but no effect of guided self-help on symptom reduction. These results suggest that self-help programs for BN may do no more than provide the nonspecific benefits of a therapeutic relationship, and that, if one is already established, as in the studies in which patients were also receiving medication, self-help programs may not provide additional benefit.

One consistent finding across the trials included in this review was that improvements in eating disorder symptoms were typically maintained at follow-up,[5–8,12,14–17,21,22,25,27,28] which occurred between 3 and 18 months after the completion of treatment. However, only one study documented additional gains during the follow-up period.[10] Thus, the reductions in binge eating and/or vomiting observed during acute treatment do not appear transient, but the treatments provided in self-help studies do not appear to provide additional benefit over time.

Two studies[26,27] suggest that guided self-help may have more specificity in the treatment of BED, which is surprising, given a general lack of specificity observed among other studies utilizing psychological treatments for BED.[30] The superiority of guided self-help in one study could be attributed to the level of treatment intensity, as the comparison was between guided and pure self-help,[25] although two other studies comparing guided and pure self-help did not find contact with a therapist to confer any particular advantage.[7,25] Grilo and Masheb[26] found that guided self-help was superior to a widely used manual for obesity, and this single study suggests a potential specificity for guided self-help among patients with BED.

Differences in research methodology also contribute to the complexities in interpreting the findings of self-help studies. The results of self-help studies may be related to the abilities and training of the therapist providing the treatment, the inten-

sity of the treatment, the type of patient presenting for treatment, or other factors. Among the studies included in our review, the addition of brief sessions with a mental health professional did not produce a noticeable benefit for individuals with BN or BED in comparison to pure self-help. Across studies, programs were delivered by individuals with different professional degrees and levels of training (e.g., nurses with no prior experience, graduate students with specialized training in eating disorders). Variations among self-help providers could result in substantial differences in the way in which the self-help treatments are formulated, operationalized, and provided even within the same type of clinical setting (e.g., primary care). For example, in the study by Banasiak et al.,[14] the primary care physicians in Australia who provided guided-self help to patients with BN were interested in treating patients with eating disorders and spent a substantial amount of time delivering the treatment. Primary care physicians in the United States are unlikely to be able to provide a similar intensity of treatment. When guided self-help was studied in a primary care setting in the United States, and the treatment was provided by nurses without an expressed interest in treating patients with eating disorders, the self-help treatment did not augment the reduction in binge eating or vomiting among patients with BN who were also receiving medication or placebo from a physician. The characteristics of the patients presenting for treatment are also likely to have a major influence on the degree of change and patient retention, as the observed improvement associated with self-help varied widely, as did the rate of attrition across studies (ranging from 0 to 69.2% of patients terminating treatment prematurely). Differences in sample characteristics, treatment setting, or treatment program across studies limit the generalizability of the existing self-help literature, and it is uncertain where self-help should be used, and by whom.

In summary, the available information suggests that self-help and guided self-help, based on the principles of CBT, provide some benefit to individuals with BN and with BED. Thus, they may be useful and appropriate to offer when no other established treatment intervention is available. However, the studies conducted till date have observed significant variability in response to treatment and have not convincingly demonstrated that self-help or guided-self help provide any greater benefit than that of other credible interventions. Future research should consider the comparison of self-help treatments both to established interventions, such as individual CBT, and to credible comparison treatments. Such studies would help clarify the place of self-help interventions in the treatment options available for BN and BED.

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