## Summary of Findings: CBT compared to any other psychological therapy for binge eating disorder at end of treatment

### Patients and setting:
Adults aged >16 years diagnosed with BED at specialist settings (eating disorder centre or clinic, or inpatient units) in Canada, Italy, the Netherlands, Switzerland and the USA.

### Comparison:
Cognitive behavioural therapy (face-to-face) versus any other psychological therapy (face-to-face), including behavioural weight loss therapy, psychodynamic interpersonal psychological therapy, integrated multimodal medically managed inpatient program, and brief strategic therapy.

### Plain language summary
- **Number of people who did not show 100% abstinence from binge eating**
  - CBT may make little or no difference to reducing 100% abstinence from binge eating in people with BED compared to any other psychological therapy at EOT.
  - Absolute effect: 376 per 1000 vs. 349 per 1000 (RR 0.93 (0.67 to 1.28)). Based on data from 408 participants in 5 studies.

- **Mean binging symptoms**
  - Measured by binge days per week, binge days per month and BES, assessed by binge days per week.
  - CBT probably slightly reduces mean binging symptoms in people with BED compared to any other psychological therapy at end of treatment.
  - Absolute effect: Mean 1.11 binge days/week vs. Mean 0.597 binge days/week (MD 0.513 (-0.836 to 0.171))*. Based on data from 511 participants in 7 studies.

- **Mean depressive symptoms**
  - Measured by BDI, CES-D and SCL-90-D, assessed by BDI.
  - CBT probably makes little or no difference to mean depressive symptoms in people with BED compared to any other psychological therapy at EOT.
  - Absolute effect: Mean 11.1 points** vs. Mean 11.4 points (MD 0.332 (1.162 lower to 1.826 higher)). Based on data from 280 participants in 7 studies.

- **Mean general psychiatric symptoms**
  - Measured and assessed by GSI.
  - We are uncertain about the effect of CBT on general psychiatric symptoms compared to any other psychological therapy at EOT.
  - Absolute effect: Mean 32.3 points** vs. Mean 32.8 points (MD 0.5 (-2.2 to 3.2)). Based on data from 158 participants in 1 study.

- **Mean psychosocial/interpersonal functioning**
  - Measured by FLZ, IIP and SAS, assessed by SAS.
  - CBT may make little or no difference in improving psychosocial/interpersonal functioning in people with BED compared to any other psychological therapy at EOT.
  - Absolute effect: Mean 1.9 points** vs. Mean 1.875 points (MD -0.025 (-0.145 to 0.09)). Based on data from 280 participants in 3 studies.

- **Weight (BMI preferable)**
  - Measured by BMI or kg, assessed by BMI.
  - CBT probably does not reduce weight in people with BED compared to any other psychological therapy at EOT.
  - Absolute effect: Mean BMI 35.7** vs. Mean BMI 36.9 (MD 1.239 (0.295 to 2.183)). Based on data from 611 participants in 9 studies.

### Notes:
- *P < 0.05
- **P < 0.01
BDI=Beck Depression Inventory; BED=Binge Eating Disorder; BES=Binge Eating Scale; BMI=Body Mass Index; CBT=Cognitive Behavioural Therapy; CES-D= Center for Epidemiological Studies-Depression Scale; CI= confidence interval; EOT=End of treatment; FLZ=Fragebogen zur Lebenszufriedenheit; GSI=Global Symptom Index; IIP= Inventory of Interpersonal Problems; MD= mean difference; RR= risk ratio; SAS=Social Adjustment Scale; SCL-90-D=Symptom Checklist-90-Revised Depression Subscale; SMD=standardised mean difference

*Analysed with SMD and back-estimated to MD to enable interpretation (12.6.4 Re-expressing SMDs using a familiar instrument), see footnotes. **Based on mean score for representative study, see footnotes.

1 Downgraded one level for risk of bias: Most studies reported inadequately on randomisation procedures. 2 Downgraded one level for inconsistency: Heterogeneity was considerable ($I^2=42\%$). 3 Three of the seven studies measured this outcome with binge days/week. Scores were back-estimated to binge days/week from SMD -0.27 (-0.44 to -0.09) using control group SD 1.9 from representative study Tasca 2002. 4 Five of the seven studies measured this outcome with BDI. Scores were back-estimated to BDI from SMD 0.04 (-0.14 to 0.22) using control group SD 8.3 from representative study Grilo 2011. 5 Downgraded one level for risk of bias: The included study reported inadequately on randomisation procedures. 6 Downgraded two levels for imprecision: only one study with 158 participants was included, and confidence intervals were very wide including appreciable benefit for both types of intervention. 7 One of the three studies measured this outcome with SAS. Scores were back-estimated to SAS from SMD -0.05 (-0.29 to 0.18) using control group SD 0.5 from representative study Wilfley 2002. 8 Downgraded one level for imprecision: only 280 participants were included. 9 Five of the nine studies measured this outcome with BMI. Scores were back-estimated to BMI from SMD 0.21 (0.05 to 0.37) using control group SD 5.9 from representative study Grilo 2011.