
Targeted Update

Cognitive behavioural therapy compared with psychodynamic psychological therapy for binge eating disorder

This is a Targeted Update of the Cochrane Review

Latest search was performed: 6 January 2016

Results of the search, list of new references, details of updates to methods, study characteristics, risk of bias assessments, and details of data analyses with forest plots can be found in the Supplementary material.

This Targeted update was prepared by Hanna Bergman¹ and Nuala Livingstone². Data were taken from the published full review and results of the updating process, carried out by Hanna Bergman¹, Molly Grimes¹, Sarah R Davies³ and Sarah Dawson³. The abstract was adapted from the published full review.

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What’s a Targeted Update?

Targeted Updates are two to three-page documents that use the Cochrane Review as their foundation, but focus on updating only one or two important comparisons, and the seven most relevant outcomes. They include an updated Summary of Findings table and Abstract, and use Cochrane methodology. The full search results, risk of bias assessments, analyses, and references do not form part of the Targeted Update, but are available as supplementary information. Targeted Updates are intended for use by policy makers.

What’s the context for this Targeted Update?
The Norwegian Health Directorate commissioned this Targeted Update to help develop a guideline.

What’s new

The comparison ‘CBT versus interpersonal psychological therapy’ was included in this Targeted Update. One new included study with 135 participants was identified.

At end of treatment CBT may make little or no difference to bingeing symptoms compared with interpersonal psychological therapy, and the effect on 100% abstinence from bingeing is very uncertain.

The Cochrane review this Targeted Update is based on has a wider scope, included 48 studies, and concluded that there is a small body of evidence for the efficacy of CBT in bulimia nervosa and similar syndromes, but more and larger trials are needed, particularly for binge eating disorder. Further, there is a need to develop more efficacious therapies for those with both a weight problem and an eating disorder.

The Targeted update ‘Cognitive behavioural therapy compared with any other psychological therapy for binge eating disorder’ covers another comparison from the same Cochrane review.
Cognitive behavioural therapy for binge eating disorder:

- May make little or no difference to mean bingeing symptoms compared with interpersonal psychotherapy;
- Has an uncertain effect on 100% abstinence from binge eating compared with interpersonal psychotherapy; the certainty of the evidence is very low.

**Background**

A specific manual-based form of cognitive behavioural therapy (CBT) has been developed for the treatment of binge eating disorder (BED). Other psychotherapies, including psychodynamic psychotherapies are also used to treat BED.

**Objectives**

To evaluate the efficacy of CBT compared with psychodynamic psychotherapies in the treatment of adults with BED.

**Search methods**

The CCMD-CTR-Studies and References Register was searched on 6 January 2016. ClinicalTrials.gov and the World Health Organization’s trials portal (ICTRP) were also searched. Reference lists of all included studies and relevant systematic reviews were checked to identify additional studies.

**Selection criteria**

Randomised controlled trials of CBT compared with psychodynamic psychotherapy for adults with BED which applied a standardised outcome methodology and had less than 50% drop-out rate.

**Data collection and analysis**

Relative risks (RRs) were calculated for binary outcome data. Mean differences (MDs) or standardised mean differences (SMDs) were calculated for continuous variable outcome data. A random effects model was applied.

**Main Results**

We included 2 RCTs, published 2002 and 2006, involving 297 participants in this Targeted Update. No studies evaluating psychoanalytic psychodynamic psychological therapy were found; the included studies compared CBT with interpersonal psychotherapy (IPT).

The risk of bias was unclear for both studies, as the randomisation process and allocation concealment were not adequately described in the reports. Further, blinding is difficult to achieve in this type of study, which could lead to risk of performance and detection bias.

There was low quality evidence that CBT may make little or no difference to bingeing symptoms (MD -0.437, 95% CI -0.912 to 0.057, 2 studies, 232 participants), depressive symptoms (MD 1.29, 95% CI -0.946 to 3.526, 2 studies, 232 participants), and psychosocial/interpersonal functioning (MD -0.045, 95% CI -0.19 to 0.095, 2 studies, 232 participants), compared with IPT. We are uncertain about the effect on 100% abstinence from bingeing, general psychiatric symptoms, and weight; certainty of evidence was very low.

**Implications and conclusions**

There is some evidence that CBT compared with IPT in people with BED may make little or no difference to bingeing symptoms, and we are very uncertain about the effect on 100% abstinence from bingeing. The quality of the evidence was low to very low due to imprecision in the results and unclear risk of bias. Therefore, further research is very likely to have an important impact on these estimates.

### Included studies

Two parallel, placebo-controlled RCTs evaluated the efficacy of group CBT compared with group IPT in doses from 16 to 20 weekly sessions. 257 female and 26 male participants with a DSM-IV diagnosis of BED, mean age from 42.8 to 45.6 years, and BMI >30 were randomized. We report outcomes at end of treatment.

No ongoing studies were identified.

**References:**


Summary of Findings: CBT compared with interpersonal psychotherapy for binge eating disorder at end-of-treatment

Patients and setting: Adults diagnosed with binge eating disorder aged >16 years at eating disorder centre or clinic in Canada and the USA.

Comparison: Group cognitive behavioural therapy (face-to-face) versus group psychodynamic interpersonal psychological therapy (face-to-face).

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Plain language summary</th>
<th>Absolute effect</th>
<th>Relative effect (95% CI)</th>
<th>Nº of participants &amp; studies</th>
<th>Certainty of the evidence (GRADE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people who did not show 100% abstinence from binge eating</td>
<td>We are uncertain about the effect of CBT on 100% abstinence from binge eating in people with BED compared with IPT at end-of-treatment.</td>
<td>272 per 1000 209 per 1000</td>
<td>RR 0.77 (0.44 to 1.34) Based on data from 162 participants in 1 study</td>
<td>1,2,3</td>
<td>VERY LOW 1.7</td>
</tr>
<tr>
<td>Mean bingeing symptoms Measured by binge days per week and binge days per month, assessed by binge days per week3</td>
<td>CBT may make little or no difference on mean bingeing symptoms in people with BED compared with IPT at end-of-treatment.</td>
<td>Mean: 1.11 binge days/week** Mean: 0.673 binge days/week</td>
<td>MD -0.437 (-0.912 to 0.057)* Based on data from 232 participants in 2 studies</td>
<td>4,5</td>
<td>LOW 4.5</td>
</tr>
<tr>
<td>Mean depressive symptoms Measured by CES-D and SCL-90-D, assessed by SCL-90-D6</td>
<td>CBT may make little or no difference to mean depressive symptoms in people with BED compared with IPT at end-of-treatment.</td>
<td>Mean: 33.6 points** Mean: 34.89 points</td>
<td>MD 1.29 (-0.946 to 3.526)* Based on data from 232 participants in 2 studies</td>
<td>4,5</td>
<td>LOW 4.5</td>
</tr>
<tr>
<td>Mean general psychiatric symptomsMeasured and assessed by GSI</td>
<td>We are uncertain about the effect of CBT on general psychiatric symptoms in people with BED compared IPT at end-of-treatment.</td>
<td>Mean: 32.3 points** Mean: 32.8 points</td>
<td>MD 0.5 (-2.2 to 3.2) Based on data from 158 participants in 1 study</td>
<td>4,5</td>
<td>VERY LOW 1.7</td>
</tr>
<tr>
<td>Mean psychosocial/interpersonal functioning Measured by IIP and SAS, assessed by SAS5</td>
<td>CBT may make little or no difference in improving psychosocial/interpersonal functioning in people with BED compared with IPT at end-of-treatment.</td>
<td>Mean: 1.9 points** Mean: 1.855 points</td>
<td>MD -0.045 (-0.19 to 0.095)* Based on data from 232 participants in 2 studies</td>
<td>4,5</td>
<td>LOW 4.5</td>
</tr>
<tr>
<td>Mean weight Measured and assessed by BMI</td>
<td>We are uncertain about the effect of CBT on weight in people with BED compared with IPT at end-of-treatment.</td>
<td>Mean: BMI 37.2** Mean: BMI 37.73</td>
<td>MD 0.53 (-1.03 to 2.09)* Based on data from 232 participants in 2 studies</td>
<td>4,5</td>
<td>VERY LOW 4.9</td>
</tr>
</tbody>
</table>

BED=Binge Eating Disorder; BMI=Body Mass Index; CBT=Cognitive Behavioural Therapy; CES-D=Center for Epidemiological Studies-Depression Scale; CI= confidence interval; GSI=Global Symptom Index; IIP=Inventory of Interpersonal Problems; IPT=Interpersonal psychotherapy; 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 (Cochrane Handbook 13.6.4 Re-expressing SMDs using a familiar instrument), see footnotes for further details. **Based on mean score for representative study, see footnotes for further details.

1 Downgraded one level for risk of bias: The included study reported inadequately on randomisation procedures. 3 Downgraded two levels for imprecision: only one study with 162 participants was included, and confidence intervals were very wide including appreciable benefit for both types of intervention. 4 One of the two studies measured this outcome with binge days per week. Scores were back-estimated to binge days per week from SMD -0.23 (-0.48 to 0.03) using control group SD 1.9 from representative study Tasca 2006. 5 Downgraded one level for risk of bias: The included studies reported inadequately on randomisation procedures. 6 Downgraded one level for imprecision: only 232 participants were included. 7 One of the two studies measured this outcome with SCL-90-D. Scores were back-estimated to SCL-90-D from SMD 0.15 (-0.11 to 0.42) using control group SD 8.6 from representative study Wilfley 2002. 8 One of the two studies measured this outcome with SAS. Scores were back-estimated to SAS from SMD -0.09 (-0.38 to 0.19) using control group SD 0.5 from representative study Wilfley 2002. 9 Downgraded two levels for imprecision: only 232 participants were included, and confidence intervals were very wide including appreciable benefit for both types of intervention.
### 100% abstinence from binge eating at the end of therapy

We are uncertain about the effect of CBT on 100% abstinence from binge eating in people with BED compared with IPT at end-of-treatment because evidence was of very low certainty.

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>CBT</th>
<th>Comparison therapy</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Events</td>
<td>Total</td>
<td>Events</td>
</tr>
<tr>
<td>Wilfley 2002</td>
<td>17</td>
<td>81</td>
<td>22</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>81</td>
<td>81</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total events</td>
<td>17</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

### Mean bingeing symptom scores

CBT may make little or no difference on mean bingeing symptoms in people with BED compared with IPT at end-of-treatment.

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>CBT</th>
<th>Comparison therapy</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Total</td>
</tr>
<tr>
<td>Tava 2003</td>
<td>0.57</td>
<td>0.93</td>
<td>37</td>
</tr>
<tr>
<td>Wilfley 2002</td>
<td>0.6</td>
<td>1.6</td>
<td>79</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>115</td>
<td>117</td>
<td>100.0%</td>
</tr>
<tr>
<td>Heterogeneity: Taxa$^*$ = 0.68, Chi$^2$ = 4.48, df = 1 (P = 0.50), P = 0%</td>
<td></td>
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<tr>
<td>Test for overall effect: Z = 1.71 (P = 0.09)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Forest plot for primary outcomes. Forest plots for all outcomes are presented in Supplementary materials.