The Cognitive Behaviour Therapist (2021), vol. 14, e17, page 1 of 8
doi:10.1017/S1754470X21000131

BABCP
www.babcp.com

ORIGINAL RESEARCH

Brief cognitive behavioural therapy for binge-eating disorder: clinical effectiveness in a routine clinical setting

Elana Moore[1], Michelle Hinde[1] and Glenn Waller[2]*

[1]South Yorkshire Eating Disorders Association, 26–28 Bedford Street, Sheffield S6 3BT, UK and [2]Department of Psychology, University of Sheffield, Cathedral Court, 1 Vicar Lane, Sheffield, UK
*Corresponding author. Email: g.waller@sheffield.ac.uk.

(Received 23 December 2020; revised 21 March 2021; accepted 30 March 2021)

Abstract

Brief cognitive behavioural therapy (CBT) is effective in working with non-underweight eating disorder patients across transdiagnostic groups. However, it is not clear whether it will be as effective in the treatment of binge-eating disorder, where emotional eating is likely to play a larger role than starvation-driven eating. This case series tested whether brief, 10-session CBT (CBT-T) would be effective in a case series of 53 patients with binge-eating disorder. Attrition rates were comparable to previous research. Eating attitudes, binge frequency, anxiety and depression were measured. Remission was measured comparing different categorical methods: 'cut-off'; reliable change index (RCI); and clinically significant change (CSC). CBT-T was effective for binge-eating disorder patients, at comparable levels to other non-underweight patients. All measures of pathology were significantly reduced, with large to moderate effect sizes. When categorical changes were used to indicate remission, RCI and CSC levels were more appropriate than existing cut-off methods, potentially because of the lower levels of initial restrained eating in this clinical group. CBT-T's effectiveness in transdiagnostic groups is replicated in binge-eating disorder patients, despite their greater level of emotionally driven eating. More stringent definitions of remission (CSC and RCI) should be used more widely, to ensure realistic estimates.

Key learning aims

(1) What is necessary for brief CBT to be effective for binge-eating disorder (BED)?
(2) Is CBT for BED effective in the absence of purging behaviours?
(3) What is the most appropriate way to measure remission in CBT for BED?

Keywords: binge-eating disorder; cognitive behavioural therapy; intervention; remission

Introduction

Cognitive behavioural therapy for eating disorders (CBT-ED) is an effective intervention for a range of eating disorders. Randomised controlled trials and case series have shown that patients make significant improvements with CBT-ED (Byrne *et al.*, 2011; Fairburn *et al.*, 2009; Ghaderi, 2006; Knott *et al.*, 2015; Signorini *et al.*, 2018; Turner *et al.*, 2015b; Waller *et al.*, 2014). Consequently, the UK's National Institute for Health and Clinical Excellence [National Institute for Health and Care Excellence (NICE), 2017] has recommended different forms of CBT-ED for a range of eating disorders. When individual CBT-ED is most

appropriate, NICE (2017) recommends 16–20 sessions, which is relatively long and expensive compared with CBT for other disorders (e.g. anxiety and depression). Recent research has demonstrated that a 10-session CBT-ED (CBT-T) is effective for non-underweight transdiagnostic eating disorder groups (Pellizzer *et al*., 2019; Waller *et al*., 2018), making it viable to offer to people with varied symptoms. However, its specific effectiveness for individual diagnostic groups has not yet been assessed, where the presence and function of symptoms differs. In particular, it remains to be determined whether CBT-T is specifically effective among patients with binge-eating disorder, who are not marked by use of compensatory behaviours and whose bingeing is more likely to be driven by emotional factors than by starvation.

In determining the effectiveness of therapy for eating disorders, it is important to consider the definition used, as reductions in core pathology are relatively meaningless if the change is small. For example, it is common to use a reduction in key scores to below a cut-off (Kendall *et al*., 2009). In eating disorders, this has been operationalised as a reduction in Eating Disorder Examination Questionnaire (EDE-Q; Fairburn, 2008) scores to below 2.77 (in the UK), where falling to below that level is commonly used as a cut-off for achieving remission. However, such changes might be very small and still meet that criterion, and binge-eating disorder patients often start with lower EDE-Q scores than other eating disorder groups, due to their lack of strong restrictive patterns. Therefore, it is also important to consider more meaningful categorical indices of change. To address this issue, reliable change index (RCI) and clinically significant change (CSC) methods can be used (Jacobson and Truax, 1991). These measures of remission have been widely used outside of eating disorder research. The application of more stringent measures of remission ensures that clinicians and researchers can be more certain of the effectiveness of therapies for binge-eating disorder.

Therefore, the aim of this study was to test the effectiveness of brief CBT-ED (CBTT), specifically for binge-eating disorder treated in a routine clinical setting. Outcomes will include eating pathology, as well as comorbid mood and anxiety. Different indices of remission in such a population will be compared, in order to provide realistic estimates of remission rates.

Method

Design

An open label pre–post trial design was used to evaluate the effectiveness of CBT-T for a case series of patients with binge-eating disorder, with no control group. Outcomes were measured at early in treatment (session 4), the end of therapy (session 10), and 3-month follow-up. Intention-to-treat analyses were used, with multiple imputations to correct for missing data.

Participants

Sample size analysis indicated that a total of 15 patients would be sufficient to ensure adequate power to detect small effects on the primary outcome variable (EDE-Q Global score), assuming 95% power at a 5% significance level, given the large effect sizes observed in previous studies (Waller *et al*., 2018). Fifty-three patients began CBT-T (41 females, 11 males, 1 transgender person), meaning that the study was well-powered. Patients were recruited as a successive case series of individuals referred to the service. They were able to self-refer, or were referred by the relevant General Practitioner or mental health service to this specialist eating disorders service, which accepted all such National Health Service referrals in the area. All patients were assessed prior to entering the case series.

https://doi.org/10.1017/S1754470X21000131 Published online by Cambridge University Press

Table 1. Baseline characteristics for the group of patients with binge-eating disorder

Baseline characteristics	Mean	*SD*
Age (years)	35.24	12.27
Body mass index	35.66	11.52
EDE-Q Global	3.28	1.15
EDE-Q Restraint	2.01	1.63
EDE-Q Eating concerns	3.06	1.49
EDE-Q Shape concerns	3.78	1.41
EDE-Q Weight concerns	3.97	1.38
Objective bingeing per week	4.76	3.27
Patient Health Questionnaire-9 (PHQ-9) Depression	12.62	6.34
General Anxiety Disorder-7 (GAD-7) Anxiety	10.78	5.61

$n = 53$, ITT analysis with multiple imputations. EDE-Q, Eating Disorder Examination Questionnaire.

At assessment, all patients met criteria for a *DSM-5* diagnosis (American Psychiatric Association, 2013) of binge-eating disorder. All reported at least one objective binge per week. Exclusion criteria for the purpose of this study included episodes of purging or laxative use (during therapy or over the month preceding therapy), low weight [body mass index (BMI) <17.5], active suicidality, or self-harm. No patient manifested any of these exclusion criteria following the start of therapy. The group's characteristics at the beginning of therapy are provided in Table 1.

Measures and procedure

The following measures were used to assess eating pathology and associated mood states. All the measures are well-validated and are widely used to assess progress in eating disorders. Patients completed all measures at sessions 1, 4 and 10 (end of treatment), and at the 3-month follow-up:

- eating attitudes (EDE-Q, version 6; Fairburn, 2008)
- depression [Personal Health Questionnaire-9 (PHQ-9); Kroenke *et al.*, 2001]
- anxiety [Generalized Anxiety Disorder-7 (GAD-7); Spitzer *et al.*, 2006].

Diary records were used to measure weekly frequency of objective binge eating. BMI was calculated from weight and height measured objectively during therapy sessions.

Intervention

CBT-T is a brief cognitive behavioural therapy designed for non-underweight eating disorder patients (Waller *et al.*, 2019). The therapy focuses on restoring nutrition, exposure therapy, behavioural experiments, work on emotional triggers, and body image work. It has shown to be effective in transdiagnostic eating disorder groups (Pellizzer *et al.*, 2019; Waller *et al.*, 2018). However, the effectiveness of CBT-T in a binge-eating disorder group has not previously been tested. The therapy was delivered individually by the lead author, supervised by the other authors. The therapy consists of phases that aim to: normalise and regularise eating patterns to reduce starvation-based cravings (particularly due to carbohydrate deprivation), using exposure with response prevention; address fears of specific foods, using behavioural experiments; reduce emotionally driven bingeing and other behaviours, using stimulus control, exposure therapy, and challenges to underlying core beliefs; enhance body image, using psychoeducation, perceptual challenges, imagery rescripting for body shame, behavioural experiments, and exposure therapy); and reduce risk of relapse.

https://doi.org/10.1017/S1754470X21000131 Published online by Cambridge University Press

A proportion of the data were collected during the COVID-19 pandemic. A total of nine patients (17%) were transferred to video calling platforms during therapy, and a further 11 patients (20.8%) had their follow-ups moved to online meetings during this time. The therapy was adapted to make it effective when delivered remotely (Waller *et al.*, 2020). Specific examples of the adaptations made include: self-weighing; use of online diet records or scanned diaries that could be sent to the clinician in advance; using online whiteboards to formulate behaviours and discuss psychoeducation; using either the videocall screen and mirrors for body exposure, rather than a mirror; adapting social behaviours (e.g. eating in front of others) to be done online; and preparation of body image surveys to be delivered online and/or using social media.

Data analysis

Data analysis took place using SPSS (v24). Intention-to-treat analyses were used, with multiple imputations (five iterations) to replace missing data. For dimensional changes, paired *t*-tests were used to evaluate change over the course of therapy in eating attitudes (EDE-Q), binge frequency, depression (PHQ-9), anxiety (GAD-7) and BMI. Effect sizes (Cohen's *d*) were calculated for paired *t*-tests.

For categorical remission, the percentage of patients achieving meaningful change in EDE-Q Global scores was calculated based on the number of patients who met each of the following indices of meaningful change: 'cut-off' on EDE-Q Global score (dropping to below 2.77); RCI (Jacobson and Truax, 1991); and CSC (Jacobson and Truax, 1991). Achievement of RCI indicates that change is not due to measurement error. Achievement of CSC indicates that change is substantial, relative to the clinical and non-clinical ranges of EDE-Q scores. The criterion for RCI was a reduction in EDE-Q Global score of $\geq$1.38, while the criterion for CSC was an EDE-Q reduction of $\geq$1.70 [both calculated using Evans' (1998) online calculator].

Results

Attrition

A total of 41 patients completed the 10 sessions of CBT-T (or agreed an earlier finish as therapy had met its targets). Thus, the attrition rate was 22.6%, which is at the lower end of the range found in previous CBT-ED effectiveness studies (Byrne *et al.*, 2011; Dalle Grave *et al.*, 2015; Knott *et al.*, 2015; Raykos *et al.*, 2013; Rose and Waller, 2017; Signorini *et al.*, 2018; Turner *et al.*, 2015a; Turner *et al.*, 2015b).

Symptom reduction across therapy

Eating attitudes, binge frequency, depression, anxiety and BMI were assessed at sessions 1, 4 and 10, and at 3-month follow-up. Table 2 shows the means and standard deviations for eating attitudes (EDE-Q), binge frequency per week, depression (PHQ-9), anxiety (GAD-7) and BMI over the course of therapy. Outcomes are tested (intention-to-treat) using paired *t*-tests (n=53) and effect sizes (Cohen's *d*).

There were significant reductions in eating attitudes, binge frequency, depression and anxiety from sessions 1 to 10, with significant reductions made in the first 4 weeks. All the effect sizes from by the end of therapy were large, apart from a medium effect for anxiety. Very large effect sizes were observed between sessions 1 and 10, with a substantial amount of that change achieved by session 4. All changes were maintained at follow-up.

https://doi.org/10.1017/S1754470X21000131 Published online by Cambridge University Press

https://doi.org/10.1017/S175447 0X2100013 1 Published online by Cambridge University Press

Table 2. Mean eating characteristics over the course of treatment and follow-up, compared using paired *t*-tests (intention-to-treat analyses; $n = 53$)

	Session 1		Session 4		Session 10		Follow-up		Session 1 to session 4			Session 1 to session 10			Session 10 to follow-up		
	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)	*t*	*p*	*d*	*t*	*p*	*d*	*t*	*p*	*d*
EDE-Q Global	3.28	(1.15)	2.17	(1.24)	1.57	(1.22)	1.36	(1.42)	6.26	<0.001	0.93	8.43	<0.001	1.23	0.97	n.s.	–
EDE-Q Restraint	2.01	(1.63)	0.74	(1.12)	0.61	(1.31)	0.51	(0.75)	5.42	<0.001	0.72	5.76	<0.001	0.83	0.59	n.s.	–
EDE-Q Eating concerns	3.06	(1.49)	2.09	(1.49)	1.11	(1.00)	0.88	(1.06)	4.42	<0.001	0.65	9.23	<0.001	1.29	1.19	n.s.	–
EDE-Q Shape concerns	3.78	(1.41)	3.13	(1.41)	2.28	(1.26)	1.92	(1.36)	3.43	0.001	0.45	6.43	<0.001	0.92	1.44	n.s.	–
EDE-Q Weight concerns	3.97	(1.38)	2.95	(1.70)	2.15	(1.31)	2.08	(1.83)	4.87	<0.001	0.68	8.08	<0.001	1.14	0.27	n.s.	–
Objective binges per week	4.76	(3.27)	0.76	(1.36)	0.49	(1.16)	0.51	(0.79)	8.50	<0.001	1.16	9.49	<0.001	1.28	−0.09	n.s.	–
Depression (PHQ-9)	12.6	(6.34)	9.48	(5.45)	7.73	(5.10)	5.84	(6.04)	3.69	<0.001	0.50	5.55	<0.001	0.82	2.37	0.03	0.37
Anxiety (GAD-7)	10.8	(5.61)	8.92	(5.21)	7.68	(5.45)	7.30	(4.34)	3.08	0.002	0.44	3.76	0.002	0.55	0.54	n.s.	–
Body mass index	35.7	(11.5)	36.9	(11.1)	37.5	(8.78)	38.7	(7.36)	2.25	0.03	0.32	1.51	n.s.	–	1.02	n.s.	–

EDE-Q, Eating Disorder Examination Questionnaire; PHQ-9, Patient Health Questionnaire-9; GAD-7, General Anxiety Disorder-7; n.s., not significant.

Categorical measures of remission

Three categorical measures of remission were used: 'cut-off' (an EDE-Q score below 2.77 at session 10); RCI (EDE-Q Global reduction ≥1.38); and CSC (EDE-Q Global reduction ≥1.70). Multiple imputations for missing data and intention-to-treat analyses were used.

Considering the 'cut-off' method, 46 patients (87.2%) were below the 2.77 score at the end of therapy, and 50 patients (94.3%) met this criterion at follow-up. However, these findings have to be tempered by the fact that 37.6% started therapy at EDE-Q<2.77 (as binge-eating disorder patients often have very low EDE-Q Restraint scores at the start of therapy). Therefore, those rates reflect a shift to below the cut-off by approximately 50% of patients. The RCI showed that 62.4% (n=33) met the criterion for remission at the end of treatment, and that 66.0% (n=35) met that criterion at follow-up. Taking the more stringent CSC index, 47.6% (n=25) met the criterion for remission by the end of therapy, while 61.5% (n=33) met the criterion for remission at follow-up.

Discussion

This study has assessed the effectiveness of CBT-T for adults with binge-eating disorder in routine settings. Effectiveness was determined by dimensional changes (with large effect sizes on most measures of pathology) and by three categorical measures of remission. Improvements were shown by session 4, developed further by the end of therapy (session 10), and maintained at 3-month follow-up. These outcomes are comparable to those achieved using 20-session versions of CBT-ED for binge-eating disorder (NICE, 2017) and other eating disorders (Byrne *et al.*, 2011; Fairburn *et al.*, 2009; Knott *et al.*, 2015; Raykos *et al.*, 2013), and are similar to those found in transdiagnostic groups of non-underweight patients when using CBT-T (Pellizzer *et al.*, 2019; Waller *et al.*, 2018).

The proportion of patients who ended at below the commonly used criterion of EDE-Q mean+1*SD* (2.77 in the UK) was very high. However, this outcome cannot be treated as indicating remission in a valid way, as many patients began at below that point (due to low EDE-Q Restraint scores). Therefore, such cut-offs should not be treated as meaningful in treatment of binge-eating disorder. Instead, use of the RCI and CSC criteria is critical to understand meaningful change in this patient group.

Overall, CBT-T is a clinically effective and cost-effective therapy for binge-eating disorder (BED), compared with longer forms of CBT-ED. As raised in the Introduction, it was not known whether CBT-T would be effective with BED, given the lack of purging behaviours and the higher likelihood that emotional triggers would be critical. Therefore, it is reassuring that the outcomes for this group of patients with BED were as strong as for other non-underweight eating disorders (Pellizzer *et al.*, 2019; Waller *et al.*, 2018). It can be hypothesised that this impact on the more emotionally driven element of BED was a result of the phase of CBT-T that addresses emotional factors (as detailed in the Method section).

Furthermore, these results were achieved despite COVID-19 and some therapy moving online (although that group is too small to analyse separately), supporting the case that such online delivery can be effective with appropriate adaptations (e.g. Waller *et al.*, 2020). Further research is needed to replicate this finding, and to determine whether greater efficiencies can be achieved through delivering CBT-T in groups, given that NICE (2017) recommended the use of CBT-ED groups for this population. That research should use more meaningful measures of change (RCI and CSC) to ensure that the most effective therapies are recommended to service providers. Clinicians should be encouraged to use the RCI and particularly the CSC criteria in routine practice, to ensure the best remission targets are used.

https://doi.org/10.1017/S1754470X21000131 Published online by Cambridge University Press

Acknowledgements. None.

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflicts of interest. Author G.W. receives royalties on the treatment manual used in this research. The other authors have no conflicts of interest.

Ethics statements. Ethical permission was not sought as the study evaluated existing practice (National Health Service Research Authority, 2011). All patients included in the analysis gave written consent for their outcomes to be used anonymously for review of outcomes.

Data availability statement. The anonymised data are available to other researchers on reasonable request.

Key practice points

(1) Brief CBT is effective in treating binge-eating disorder.
(2) Remission rates are comparable to those achieved with longer therapies.
(3) Brief CBT's benefits are maintained into follow-up.
(4) Clinicians should use more stringent definitions of improvement, which are not influenced by low initial scores on key variables.

Further reading

Dingemans, A., Danner, U., & Parks, M. (2017). Emotion regulation in binge eating disorder: a review. *Nutrients*, *9*, 1274. doi: 10.3390/nu9111274

Leehr, E. J., Krohmer, K., Schag, K., Dresler, T., Zipfel, S., & Giel, K. E. (2015). Emotion regulation model in binge eating disorder and obesity – a systematic review. *Neuroscience & Biobehavioral Reviews*, *49*, 125–134. doi: 10.1016/j.neubiorev.2014.12.008.

References

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th edn). American Psychiatric Association.

Byrne, S. M., Fursland, A., Allen, K. L., & Watson, H. (2011). The effectiveness of enhanced cognitive behavioral therapy for eating disorders: an open trial. *Behaviour Research and Therapy*, *49*, 219–226. doi: 10.1016/j.brat.2011.01.006

Dalle Grave, R., Calugi, S., Sartirana, M., & Fairburn, C. G. (2015). Transdiagnostic cognitive behaviour therapy for adolescents with an eating disorder who are not underweight. *Behaviour Research and Therapy*, *73*, 79–82. doi: 10.1016/j.brat.2015.07.014

Evans, C. (1998). Reliable Change Criterion Indicator. https://www.psyctc.org/stats/rcsc1.htm

Fairburn, C. G. (2008). *Cognitive Behavior Therapy and Eating Disorders*. New York, USA: Guilford Press.

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Bohn, K., Hawker, D. M., … & Palmer, R. L. (2009). Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: a two-site trial with 60-week follow-up. *American Journal of Psychiatry*, *166*, 311–319. doi: 10.1176/appi.ajp.2008.08040608

Ghaderi, A. (2006). Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behaviour therapy for bulimia nervosa. *Behaviour Research and Therapy*, *44*, 273–288. doi: 10.1016/j.brat.2005.02.004

Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12–19. doi: 10.1037/0022-006X.59.1.12

Kendall, P. C., Marrs-Garcia, A., Nath, S. R., & Sheldrick, R. C. (1999). Normative comparisons for the evaluation of clinical significance. *Journal of Consulting and Clinical Psychology*, *67*, 285–299. doi: 10.1037/0022-006X.67.3.285

Knott, S., Woodward, D., Hoefkens, A., & Limbert, C. (2015). Cognitive behaviour therapy for bulimia nervosa and eating disorders not otherwise specified: translation from randomized controlled trial to a clinical setting. *Behavioural and Cognitive Psychotherapy*, *43*, 641–654. doi: 10.1017/S1352465814000393

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*, 606–613. doi: 10.1080/13642537.2017.1386226

National Health Service Health Research Authority (2011). *National Research Ethics Service Guidance: Does My Project Require Review by a Research Ethics Committee?* Downloaded from: https://www.hra.nhs.uk/documents/2013/09/does-my-project-require-rec-review.pdf

National Institute for Health and Care Excellence (NICE) (2017). *Eating Disorders: Recognition and Treatment*. London, UK: National Institute for Health and Care Excellence.

Pellizzer, M., Waller, G., & Wade, T. (2019). Ten-session cognitive behaviour therapy (CBT-T) for eating disorders: outcomes from a pragmatic pilot study of Australian non-underweight clients. *Clinical Psychologist*, *23*, 124–132. doi: 10.1111/cp.12170

Raykos, B. C., Watson, H. J., Fursland, A., Byrne, S. M., & Nathan, P. (2013). Prognostic value of rapid response to enhanced cognitive behavioral therapy in a routine clinic sample of eating disorder outpatients. *International Journal of Eating Disorders*, *46*, 764–770. doi: 10.1002/eat.22169

Rose, C., & Waller, G. (2017). Cognitive-behavioral therapy for eating disorders in primary care settings: does it work, and does a greater dose make it more effective? *International Journal of Eating Disorders*, *50*, 1350–1355. doi: 10.1002/eat.22778

Signorini, R., Sheffield, J., Rhodes, N., Fleming, C., & Ward, W. (2018). The effectiveness of enhanced cognitive behavioural therapy (CBT-E): a naturalistic study within an out-patient eating disorder service. *Behavioural and Cognitive Psychotherapy*, *46*, 21–34. doi: 10.1017/S1352465817000352

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, *166*, 1092–1097. doi: 10.1001/archinte.166.10.1092

Turner, H., Bryant-Waugh, R., & Marshall, E. (2015a). The impact of early symptom change and therapeutic alliance on treatment outcome in cognitive-behavioural therapy for eating disorders. *Behaviour Research and Therapy*, *73*, 165–169. doi: 10.1016/j.brat.2015.08.006

Turner, H., Marshall, E., Stopa, L., & Waller, G. (2015b). Cognitive-behavioural therapy for outpatients with eating disorders: effectiveness for a transdiagnostic group in a routine clinical setting. *Behaviour Research and Therapy*, *68*, 70–75. doi: 10.1016/j.brat.2015.03.001

Waller, G., Gray, E., Hinrichsen, H., Mountford, V., Lawson, R., & Patient, E. (2014). Cognitive-behavioral therapy for bulimia nervosa and atypical bulimic nervosa: effectiveness in clinical settings. *International Journal of Eating Disorders*, *47*, 13–17. doi: 10.1002/eat.22181

Waller, G., Pugh, M., Mulkens, S., Moore, E., Mountford, V. A., Carter, J., Wicksteed, A., Maharaj, A., Wade, T. D., Wisniewski, L., Farrell, N. R., Raykos, B., Jorgensen, S., Evans, J., Thomas, J. J., Osenk, I., Paddock, C., Bohrer, B., Anderson, K., Turner, H., Hildebrandt, T., Xanidis, N., & Smit, V. (2020). Cognitive-behavioral therapy in the time of coronavirus: clinician tips for working with eating disorders via telehealth when face-to-face meetings are not possible. *International Journal of Eating Disorders*, *53*, 1132–1141. doi: 10.1002/eat.23289.

Waller, G., Tatham, M., Turner, H., Mountford, V. A., Bennetts, A., Bramwell, K., ... **& Ingram, L.** (2018). A 10-session cognitive behavioral therapy (CBT-T) for eating disorders: outcomes from a case series of nonunderweight adult patients *International Journal of Eating Disorders*, *51*, 262–269. doi: 10.1002/eat.22837

Waller, G., Turner, H., Tatham, M., Mountford, V. A., & Wade, T. D. (2019). *Brief Cognitive Behavioural Therapy for Non-Underweight Patients: CBT-T for Eating Disorders*. Hove, UK: Routledge.

Cite this article: Moore E, Hinde M, and Waller G. Brief cognitive behavioural therapy for binge-eating disorder: clinical effectiveness in a routine clinical setting. *The Cognitive Behaviour Therapist*. https://doi.org/10.1017/S1754470X21000131