IN RESPONSE: Dr. Wilfley and colleagues highlight several critical gaps in the evidence base on effective treatments for patients with BED, including information about treatment durability, generalizability, and tradeoffs between benefits and harms. They recommend longer-term outcome studies to address such shortcomings, including comparative effectiveness studies, and express concern about the adverse effects of some pharmacologic agents. In many respects, their observations echo our conclusions about treatment efficacy and harms as presented in our article and comparative effectiveness (1). Nonetheless, we note some important caveats for readers to consider.

First, today's evidence base is sufficient only to single out CBT as a first-line option for psychological treatment—not because of the methods or outcomes of our meta-analyses but because of the number, size, and diversity of the studies available. We followed best practices for systematic reviews (2) by framing the key questions for analyses in terms of internationally known PICOTS (population, intervention, comparator, outcomes, timing of outcomes measurement, and setting) (3), critically deliberating a priori study inclusion and exclusion criteria, and setting a minimum threshold (that is, at least 3 studies with reasonably homogeneous populations and outcomes) for pooled analysis. As for pharmacologic studies, considerable literature offers precedents for analyzing second-generation antidepressants as a class, and our analysis of lisdexamfetamine was limited to the therapeutic doses approved by the U.S. Food and Drug Administration.

Second, we agree that CBT and IPT have shown considerable promise in conferring benefits that carry over beyond the active treatment period. Nonetheless, long-term data from available published studies are insufficient or overly diverse for pooled analysis of comparisons of psychological treatments. Of the 2 included trials of CBT versus IPT, 1 compared CBT with IPT delivered via therapist-led group treatment and the second compared guided self-help CBT with individual IPT.

Finally, we respectfully disagree that psychological treatments pose only minimal risks; rather, evidence is lacking because potential harms have not been widely conceptualized or measured.

Drawing from our own clinical experiences and past and present research, we endorse psychotherapy, especially CBT, for patients with BED. We consider IPT to be a highly promising treatment option. What we cannot conclude is whether specialist psychological treatment should have any priority over pharmacologic treatment on the basis of comparative effectiveness or risk. Studies addressing that question directly simply have not been done. The good news is that clinicians, and their patients, have several proven options for therapy for BED that can accommodate their shared treatment goals and patients' preferences and values. On these matters, we are certain that Dr. Wilfley and colleagues are in complete agreement with us.

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