



# Cognitive Behavioral and Metacognitive Approaches for Binge Eating Disorder: A Narrative Review of Evidence on Symptoms, Beliefs, Body Image, and Cognitive Flexibility

Roya Masoumi<sup>1</sup>, Azam Davoodi<sup>1,\*</sup>, Marjan Albehbahani<sup>1</sup>, Najmeh Fath<sup>1</sup>

<sup>1</sup>Department of Psychology, Shi.C., Islamic Azad University, Shiraz, Iran

\*Corresponding Author: Department of Psychology, Shi.C., Islamic Azad University, Shiraz, Iran. Email: azam.davoodi@iau.ac.ir

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## Abstract

**Context:** Binge eating disorder (BED) is associated with maladaptive cognitive patterns, body image disturbance, and impaired cognitive flexibility. Cognitive behavioral therapy (CBT) and metacognitive therapy (MCT) are among the primary psychological approaches proposed for its treatment.

**Evidence Acquisition:** This narrative review synthesizes findings from recent empirical studies and randomized controlled trials that evaluate the effects of CBT and emerging metacognitive-based interventions in patients with BED.

**Results:** Evidence indicates that CBT is an established and effective intervention for reducing binge-eating symptoms and improving related psychological outcomes. MCT and related metacognitive interventions remain at an early stage of development, with preliminary findings suggesting potential benefits in modifying metacognitive beliefs, enhancing cognitive flexibility, and reducing maladaptive self-focused cognitive processes. However, the evidence base for MCT remains limited compared with that for CBT.

**Conclusions:** CBT is currently the most evidence-supported psychological treatment for BED. MCT appears promising; however, additional high-quality research is needed to confirm its effectiveness and clarify its therapeutic mechanisms.

**Keywords:** Binge Eating Disorder, Metacognitive Therapy, Cognitive Behavioral Therapy, Maladaptive Beliefs, Body Image, Cognitive Flexibility

## 1. Context

Binge eating disorder (BED) is among the most prevalent and disabling eating disorders. It is characterized by recurrent episodes of consuming an unusually large amount of food within a discrete period, accompanied by a perceived loss of control and psychological distress (1). Recent research indicates that BED affects approximately 1% to 4% of adults (2) and about 1% of youth populations (3). Unlike other eating disorders, BED is not characterized by regular compensatory behaviors, such as purging or excessive exercise, and is associated with obesity, metabolic complications, emotional dysregulation, and reduced quality of life (3).

Several interventions are available for BED, including psychological, behavioral, pharmacological, and surgical treatments. Among these, CBT is widely recognized as the leading psychological treatment because it targets maladaptive cognitions and behaviors associated with eating, weight, and self-image. However, residual symptoms persist after CBT in many cases, highlighting the need for alternative or complementary approaches (4).

MCT offers a transdiagnostic framework that focuses on modifying metacognitive beliefs and reducing features of cognitive-attentional syndrome (CAS), such as worry, rumination, and self-focused attention. Emerging evidence suggests that MCT may improve cognitive flexibility and disrupt rigid cognitive patterns typical of BED.

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This review synthesizes theoretical and empirical evidence on CBT and MCT for BED, focusing on their effects on binge-eating symptoms, metacognitive beliefs, body image disturbance, and cognitive flexibility, with the aim of informing clinical practice and future research.

### 1.1. Cognitive Behavioral Therapy in Binge Eating Disorder

CBT is a structured, time-limited psychotherapy aimed at identifying and modifying dysfunctional thoughts and behaviors that cause psychological distress. In BED, CBT focuses on maladaptive beliefs about eating, body shape, weight, and self-worth (5). Core components include psychoeducation, self-monitoring of eating, cognitive restructuring, and the development of alternative coping strategies (6). Enhanced CBT (CBT-E) protocols are also used and have demonstrated efficacy across diverse populations.

Clinical trials consistently report significant reductions in binge-eating episodes and improvements in psychological well-being and body image after CBT, with some patients also achieving modest weight loss (7). However, CBT primarily targets the content of cognition rather than metacognitive processes, which may partly explain partial remission or relapse in some patients (4).

### 1.2. Metacognitive Therapy in Binge Eating Disorder

MCT targets metacognitive beliefs, or beliefs about thinking itself, rather than the content of thoughts. In contrast to CBT, which addresses distorted thought content, such as “I am fat,” MCT challenges beliefs such as “worrying is uncontrollable” or “if I think about food, I will lose control.”

Emerging studies indicate that individuals with BED may have metacognitive dysfunction, including increased self-focused attention, reduced cognitive flexibility, and repetitive negative thinking patterns (8). Network analyses also implicate impaired self-monitoring and impulse control as central factors in BED psychopathology (9). Preliminary clinical evidence, including case studies of metacognitive interpersonal therapy for eating disorders (MIT-ED), suggests the feasibility and potential efficacy of metacognitive approaches in reducing binge behaviors and maladaptive metacognitive beliefs (10). However, randomized controlled trials of MCT for BED remain limited, and further research is needed.

### 1.3. Body Image Disturbance

Body image disturbance is a core feature of BED and is closely associated with low self-esteem, depression, and binge eating (11). CBT targets body image through cognitive restructuring, mirror exposure, and behavioral experiments, leading to significant reductions in body dissatisfaction (12).

Although MCT does not directly target body image, it may indirectly improve this domain by reducing maladaptive rumination and self-focused attention to body-related concerns (9, 10). MCT's focus on cognitive processes rather than thought content may support more adaptive self-perceptions and enhanced cognitive flexibility.

### 1.4. Metacognitive Beliefs and Cognitive Flexibility

Metacognitive beliefs influence emotional regulation and eating behaviors in BED. Dysfunctional beliefs, such as the belief that worrying helps a person cope, may contribute to binge eating, whereas deficits in cognitive flexibility may hinder adaptive thinking (13).

MCT directly addresses maladaptive metacognitions and reduces CAS, thereby promoting detached mindfulness and self-regulation. Studies have shown significant reductions in positive and negative metacognitive beliefs after metacognitive interventions in patients with eating disorders (9, 10).

CBT primarily targets thought content but includes components, such as cognitive restructuring and problem-solving, that may indirectly enhance cognitive flexibility. Nevertheless, its effect on metacognition is less direct than that of MCT (14).

Because cognitive inflexibility is associated with rigid dieting and impulsivity in BED (15), combining the content-focused strategies of CBT with the process-focused approach of MCT may optimize treatment outcomes.

## 2. Evidence Acquisition

### 2.1. Review Design

This study was conducted as a structured narrative review of the literature on MCT and CBT for BED. A narrative approach was selected instead of a systematic review because the aim was to synthesize available evidence across multiple outcome domains, including binge-eating symptoms, maladaptive beliefs, body image, and cognitive flexibility, and across different therapeutic approaches, including CBT, MCT, MIT-ED, and metacognitive training, rather than to conduct a quantitative meta-analysis.

## 2.2. Search Strategy and Sources

Relevant studies were identified through targeted searches in PubMed, Scopus, Web of Science, and Google Scholar. The search covered studies published from 2007 to 2025, with priority given to recent evidence, particularly studies published from 2017 to 2025. Foundational theoretical works were retained as needed to support the conceptual framework.

## 2.3. Search Terms

Core search terms included binge eating disorder, BED, cognitive behavioral therapy, CBT, CBT-E, metacognitive therapy, MCT, metacognitive training, MIT-ED, metacognitive interpersonal therapy, body image, metacognitive beliefs, metacognition, cognitive flexibility, and executive function. These terms were used individually and in combination to identify literature relevant to the review questions.

## 2.4. Eligibility Criteria

Studies were included if they were published in English, addressed BED directly or examined eating-disorder populations with clear relevance to BED, and evaluated CBT, MCT, metacognitive training, MIT-ED, or related interventions. Empirical studies, randomized controlled trials, systematic reviews, and clinically relevant case reports were eligible if they provided information relevant to the review aims.

Studies were excluded if they focused exclusively on non-eating-disorder populations without clear relevance to BED, lacked intervention or outcome data, or were editorials, commentaries, or purely descriptive reports without sufficient empirical or theoretical value.

## 2.5. Study Selection and Synthesis

Studies were selected for discussion based on their relevance to the four primary outcome domains of the review: binge-eating symptoms, maladaptive beliefs, body image, and cognitive flexibility. Priority was given to studies that directly examined BED. Indirect evidence from other eating-disorder or risk-factor samples was included when it helped clarify mechanisms or contextualize emerging findings. Such evidence is identified as indirect in the text.

The review did not employ a formal screening protocol, a risk-of-bias assessment, or a meta-analytic synthesis. Instead, findings were narratively synthesized to highlight areas of convergence, uncertainty, and clinical relevance.

## 3. Results

### 3.1. Effects on Binge-Eating Symptoms

Recent randomized controlled trials provide strong support for CBT as an effective intervention for reducing binge-eating frequency, improving psychological well-being, and decreasing body dissatisfaction among individuals with BED. In a large randomized controlled trial, CBT-E produced clinically significant reductions in binge-eating episodes, with many participants achieving remission or marked symptom improvement (16). Recent meta-analytic evidence also supports the efficacy of individual CBT for eating disorders, including BED, reinforcing the position of CBT as a first-line treatment (17). In addition, emerging research has begun to clarify mechanisms of change in CBT for BED, including reductions in maladaptive beliefs and improvements in cognitive processes such as executive function and cognitive flexibility (18). Web-based guided self-help CBT-E has also shown efficacy in reducing binge eating in adults with BED, suggesting that digital formats may help extend access to effective treatment (19).

Evidence for metacognitive approaches is promising but remains preliminary. Preliminary randomized controlled trial evidence suggests that MIT-ED may be comparable to CBT-E in reducing eating-disorder symptoms, impairment, and binge eating in non-underweight adults with eating disorders, including those with BED. However, no meaningful between-treatment differences were observed in this small proof-of-concept trial (10). A pilot randomized controlled trial comparing MIT-ED with CBT-E is currently in the protocol stage and may provide direct comparative evidence for these approaches in the future (20). These findings suggest that MIT-ED may be a useful alternative approach, but the current evidence base remains substantially smaller than that for CBT in BED.

Overall, strong evidence supports CBT for reducing binge-eating symptoms in BED, whereas evidence for metacognitive interventions remains preliminary and requires further validation in larger BED-specific trials.

### 3.2. Effects on Maladaptive Beliefs

CBT addresses maladaptive beliefs related to eating, weight, body shape, and self-worth through cognitive restructuring and behavioral interventions. Emerging evidence suggests that CBT may also contribute to changes in underlying cognitive mechanisms associated with BED (18).

**Table 1.** Comparison of Cognitive Behavioral Therapy and Metacognitive Therapy for Binge Eating Disorder

| Feature                                | Cognitive Behavioral Therapy (CBT)                                                                     | Metacognitive Therapy (MCT)                                                                       |
|----------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Therapeutic focus</b>               | Modifies distorted thoughts and maladaptive behaviors related to food, weight, and self-image          | Changes metacognitive beliefs about thinking processes and reduces perseverative thinking and CAS |
| <b>Core techniques</b>                 | Psychoeducation, cognitive restructuring, behavioral experiments, and self-monitoring                  | Challenging metacognitive beliefs, detached mindfulness, and reducing rumination and worry        |
| <b>Evidence base</b>                   | Extensive randomized controlled trials and meta-analyses demonstrating efficacy                        | Emerging evidence from preliminary studies and case reports                                       |
| <b>Impact on body image</b>            | Directly targets body dissatisfaction and cognitive distortions                                        | May indirectly improve body image by reducing self-focused attention and rumination               |
| <b>Impact on metacognitive beliefs</b> | Has limited direct effect, with some indirect improvement through cognitive restructuring              | Directly targets and modifies maladaptive metacognitive beliefs                                   |
| <b>Impact on cognitive flexibility</b> | May provide indirect benefits through problem-solving and cognitive restructuring                      | May directly enhance cognitive flexibility by targeting CAS                                       |
| <b>Limitations</b>                     | Residual symptoms may remain in some patients, and the approach focuses less directly on metacognition | Large-scale evidence remains limited, and the evidence base is primarily preliminary              |

Metacognitive approaches specifically target maladaptive metacognitive beliefs, including beliefs about the uncontrollability and usefulness of worry, rumination, and self-focused attention. Studies examining MIT-ED and related metacognitive interventions have reported improvements in metacognitive awareness and reductions in maladaptive metacognitive beliefs (10, 21). However, much of this evidence remains preliminary and is partly derived from broader eating-disorder populations rather than BED-specific samples.

CBT has established efficacy in modifying maladaptive cognitive beliefs, whereas early evidence suggests that metacognitive interventions may target additional metacognitive processes relevant to BED.

### 3.3. Effects on Body Image Disturbance

Across studies, both CBT and metacognitive interventions appear to improve body image dissatisfaction, although CBT generally has a stronger and more direct effect because it explicitly targets body-related thoughts and beliefs. Metacognitive approaches may contribute indirectly by reducing rumination, worry, and self-focused attention through changes in CAS and detached mindfulness processes (10). Nevertheless, evidence for the effects of metacognitive interventions on body image remains less direct and less established than the evidence for CBT.

Evidence for CBT-related improvements in body image is strong and direct, whereas evidence for metacognitive interventions remains indirect and preliminary.

### 3.4. Effects on Cognitive Flexibility

Recent studies highlight the importance of executive functioning, emotion regulation, and cognitive flexibility as predictors of treatment response in BED (22, 23). Adding executive function training to CBT has been associated with greater improvements in inhibitory control and reductions in binge-eating episodes (23).

Metacognitive approaches are theoretically well positioned to enhance cognitive flexibility by targeting repetitive negative thinking and maladaptive cognitive-attentional processes. Preliminary studies suggest potential benefits in this domain; however, the evidence remains limited and is often derived from broader eating-disorder populations or feasibility studies rather than large BED-specific randomized controlled trials.

Moderate evidence supports the importance of cognitive flexibility and executive functioning in BED treatment outcomes, but evidence specifically supporting metacognitive interventions in this domain remains preliminary.

## 4. Discussion

CBT and MCT represent distinct therapeutic approaches for the treatment of BED. CBT remains the most established psychological intervention, with substantial evidence supporting its effectiveness in reducing binge-eating behaviors and improving body image by modifying maladaptive cognitions and behaviors. Nevertheless, some patients continue to experience residual symptoms, underscoring the need for additional therapeutic strategies.

MCT has emerged as a promising intervention that targets metacognitive beliefs and processes implicated in the maintenance of BED. Preliminary findings suggest that MCT may contribute to improvements in cognitive flexibility, emotional regulation, and

maladaptive thinking patterns. However, the current evidence base remains limited, and available studies are characterized by relatively small samples and methodological heterogeneity. Therefore, conclusions regarding its comparative effectiveness should be interpreted with caution.

With respect to body image, CBT appears to exert more direct effects through cognitive restructuring of appearance-related beliefs, whereas the effects of MCT may occur indirectly through changes in metacognitive processes. Further research is needed to clarify these mechanisms and to determine the extent to which such effects are sustained over time.

Given the emerging nature of the evidence, MCT should currently be considered a complementary or adjunctive approach rather than a replacement for established CBT protocols. Future well-designed randomized controlled trials with larger samples and longer follow-up periods are needed to evaluate its efficacy and to identify patient groups that may derive the greatest benefit. Integrating selected metacognitive components into existing CBT frameworks may also represent a valuable direction for future clinical research.

#### 4.1. Conclusions

CBT remains the most evidence-based psychological treatment for BED and continues to be the primary therapeutic approach for reducing binge-eating symptoms and addressing body-image concerns. MCT represents an emerging and promising intervention that may address metacognitive processes not directly targeted by CBT and could be particularly relevant for individuals with persistent symptoms or specific metacognitive difficulties. However, the current evidence supporting MCT remains limited, and further high-quality research is required before firm conclusions can be drawn regarding its role in the treatment of BED. At present, MCT may be best viewed as a complementary or adjunctive approach that warrants further investigation.

#### 4.2. Overall Conclusions

CBT remains the most evidence-based psychological treatment for BED and continues to be the primary therapeutic approach for reducing binge-eating symptoms and addressing body-image concerns. MCT represents an emerging and promising intervention that may address metacognitive processes not directly targeted by CBT and could be particularly relevant for individuals with persistent symptoms or specific

metacognitive difficulties. However, the current evidence supporting MCT remains limited, and further high-quality research is required before firm conclusions can be drawn regarding its role in the treatment of BED. At present, MCT may be best viewed as a complementary or adjunctive approach that warrants further investigation.

#### 4.3. Limitations

The current review has several limitations. First, few randomized controlled trials have examined MCT directly in BED populations; therefore, much of the evidence remains preliminary or is derived from other eating-disorder populations. Second, differences in study design, sample size, intervention format, and outcome measures complicate direct comparisons across studies. Third, most studies assess short-term outcomes, and the long-term sustainability of MCT effects remains uncertain.

#### 4.4. Future Directions

Future research should conduct rigorous randomized controlled trials that directly compare CBT and MCT in BED using adequate sample sizes. Studies should also investigate combined or sequential CBT-MCT treatments to determine whether these approaches have synergistic effects. Long-term outcomes and the maintenance of gains in cognitive flexibility and metacognitive beliefs should be explored. In addition, future work should identify patient characteristics that predict better responses to each therapy so that interventions can be more effectively tailored. A comparative summary of CBT and MCT is presented in [Table 1](#).

#### Footnotes

**AI Use Disclosure:** The authors declare that no generative AI tools were used in the creation of this article.

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