Targeted Updates

Get timely access to up-to-date evidence from Cochrane Reviews, tailored to your needs, and delivered in a concise and accessible format.

What are they?

Targeted Updates are targeted four-page documents that use Cochrane Reviews as their foundation, but focus on updating only one or two important comparisons, and the seven most relevant outcomes.

The final choice of comparisons and outcomes are made in consultation with the commissioner and Cochrane content experts, including the original review authors and Cochrane editorial team.

Cochrane methods are used so that any new data can then be used by Cochrane Review authors to facilitate a full Cochrane Review update where appropriate.

Targeted Updates are accessible evidence reports produced in a short timeline by using focused questions, a short review format, and Cochrane methodology.

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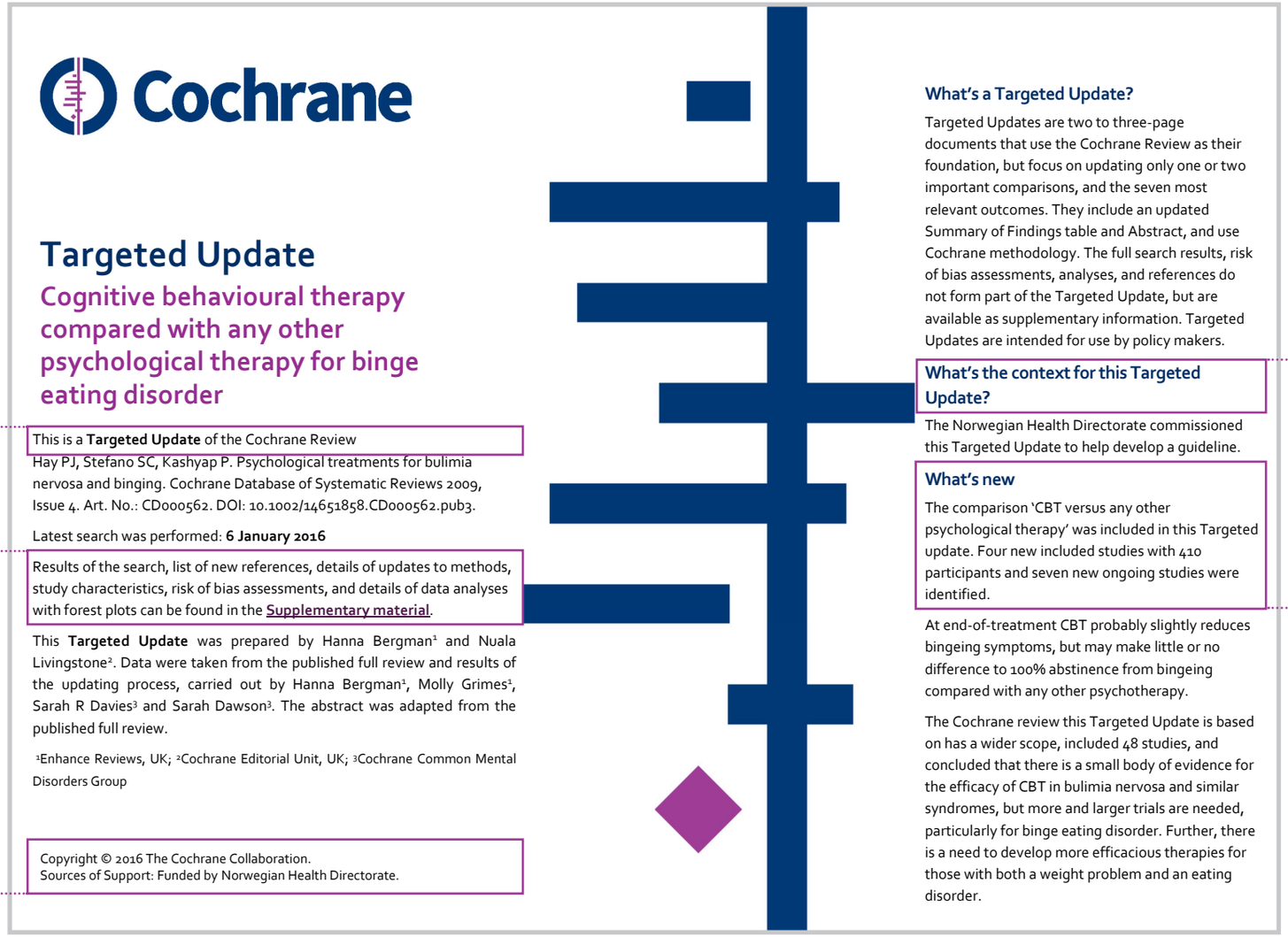
What's included?

The report includes an updated 'Summary of Findings' table, a detailed plain language abstract, and summary evidence statement. The search results, risk of bias assessments, analyses, and references are made available in a supplementary report.

Targeted Updates are customizable, and analyses can be included in the main report, along with other information that needs to be readily available in your evidence reports.



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Targeted Update

Cognitive behavioural therapy compared with any other psychological therapy for binge eating disorder

This is a **Targeted Update** of the Cochrane Review

Hay PJ, Stefano SC, Kashyap P. Psychological treatments for bulimia nervosa and binging. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD000562. DOI: 10.1002/14651858.CD000562.pub3.

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 Bergman[1] and Nuala Livingstone[2]. Data were taken from the published full review and results of the updating process, carried out by Hanna Bergman[1], Molly Grimes[1], Sarah R Davies[3] and Sarah Dawson[3]. The abstract was adapted from the published full review.

[1]Enhance Reviews, UK; [2]Cochrane Editorial Unit, UK; [3]Cochrane Common Mental Disorders Group

Sources of Support: Funded by Norwegian Health Directorate.

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 any other psychological therapy' was included in this Targeted update. Four new included studies with 410 participants and seven new ongoing studies were identified.

At end-of-treatment CBT probably slightly reduces bingeing symptoms, but may make little or no difference to 100% abstinence from bingeing compared with any other psychotherapy.

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.

Cochrane Review cited

Link to supplementary material

All sources of funding stated

Reason for the commissioned Targeted Update

Summary of new evidence included in the Targeted Update

Cognitive behavioural therapy for binge eating disorder compared with any other psychological therapy:

- May make little or no difference to 100% abstinence from binge eating;
- Probably slightly reduces mean bingeing symptoms.

Background

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

Objectives

To evaluate the efficacy of CBT compared with any other 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 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 9 RCTs, published 1994 to 2013, involving 851 participants in this Targeted Update. Ten ongoing RCTs were identified, and three studies are awaiting classification.

CBT was compared with interpersonal psychotherapy in two studies, behavioural weight loss therapy in five studies, integrated multimodal medically managed inpatient program in one study, and brief strategic therapy in one study. No studies evaluating psychoanalytic psychodynamic psychological therapy were found.

For most of the included studies the risk of bias was unclear, as the randomisation process and allocation concealment were not adequately described in the report. 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 100% eating (RR 0.93, 95% CI 0.67 tc participants) or to mean psych functioning (MD -0.025, 95% C studies, 280 participants), com psychotherapy. There was mo that CBT probably slightly red symptoms (MD -0.513, 95% CI studies, 511 participants), that little or no difference to mean (MD 0.332, 95% CI -1.162 to 1.8 participants), and that CBT pr weight (MD 1.239, 95% CI 0.29 participants), compared with a The effect on general psychiat uncertain; quality of evidence

Implications and conclusions

There is some evidence that CBT probably slightly reduces binging symptoms compared with any other psychological therapies, but that it may make little or no difference to 100% abstinence from bingeing. The quality of the evidence was moderate to low due to imprecision in the results and unclear risk of bias. Therefore, further research may have an important impact on these estimates.

Included studies

Agras WS, Telch CF, Arnow B, et al. *Behavior Therapy* 1994;**25**:225-238.

Castelnuovo G, Manzoni GM, Villa V, et al. *Clinical*

Summary of Findings: CBT compared with 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.**

Outcome	Plain language summary	Absolute effect		Relative effect (95% CI) Nº participants & studies	Certainty of the evidence (GRADE)
		Any psychological therapy (except CBT)	CBT		
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 with any other psychological therapy at EOT.	376 per 1000	349 per 1000	RR 0.93 (0.67 to 1.28) Based on data from 408 participants in 5 studies	⊕⊕OO LOW [1,2]
		Difference 26 fewer per 1000 (from 124 fewer to 105 more)			
Mean bingeing symptoms Measured by binge days per week, binge days per month and BES, assessed by binge days per week[3]	CBT **probably slightly reduces** mean binging symptoms in people with BED compared with any other psychological therapy at end of treatment.	Mean: 1.11 binge days/week**	Mean: 0.597 binge days/week	MD -0.513 (-0.836 to -0.171)* Based on data from 511 participants in 7 studies	⊕⊕⊕O MODERATE [1]
		Difference 0.513 lower (0.836 to 0.171 lower)			
Mean depressive symptoms Measured by BDI, CES-D and SCL-90-D, assessed by BDI[4]	CBT **probably makes little or no difference** to mean depressive symptoms in people with BED compared with any other psychological therapy at EOT.	Mean: 11.1 points**	Mean: 11.4 points	MD 0.332 (-1.162 to 1.826)* Based on data from 489 participants in 7 studies	⊕⊕⊕O MODERATE [1]
		Difference 0.332 higher (1.162 lower to 1.826 higher)			
Mean general psychiatric symptoms Measured and assessed by GSI	We are uncertain about the effect of CBT on general psychiatric symptoms compared with any other psychological therapy at EOT.	Mean: 32.3 points**	Mean: 32.8 points	MD 0.5 (-2.2 to 3.2) Based on data from 158 participants in 1 study	⊕OOO VERY LOW [5,6]
		Difference 0.5 higher (2.2 lower to 3.2 higher)			
Mean psychosocial/interpersonal functioning Measured by FLZ, IIP and SAS, assessed by SAS[7]	CBT **may make little or no difference** in improving psychosocial/interpersonal functioning in people with BED compared with any other psychological therapy at EOT.	Mean: 1.9 points**	Mean: 1.875 points	MD -0.025 (-0.145 to 0.09)* Based on data from 280 participants in 3 studies	⊕⊕OO LOW [1,8]
		Difference 0.025 lower (0.145 lower to 0.09 higher)			
Weight (BMI preferable) Measured by BMI or kg, assessed by BMI[9]	CBT **probably does not reduce weight** in people with BED compared with any other psychological therapy at EOT.	Mean: BMI 35.7**	Mean: BMI 36.9	MD 1.239 (0.295 to 2.183)* Based on data from 611 participants in 9 studies	⊕⊕⊕O MODERATE [1]
		Difference 1.239 higher (0.295 to 2.183 higher)			

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.

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Case studies

Targeted Updates have successfully been used by the Australian National Blood Authority and Norwegian Health Directorate as an efficient and cost effective way to update recommendations within their guidelines. The Targeted Updates also allowed them to commission updates for questions of interest when their PICO differed slightly from the Cochrane Review.

Targeted Updates helped Cochrane Skin to prioritize future work. The commissioned Targeted Updates indicated that there was no need for a fully updated Cochrane Review, and helped to accelerate the updating of a large Cochrane Review within which there were rapidly developing interventions that could be targeted.

Testimonials

"I love the format - easy to read and fit for purpose."
Professor Hywel Williams, Co-ordinating Editor, Cochrane Skin.

"Our Targeted Update was a joy to do. It took about four weeks for the Cochrane Group to produce the update, which was extraordinary; and was of really high quality."
Jennifer Roberts, Director Clinical Evidence, National Blood Authority.

Contact us

For more information about how to commission a Cochrane Targeted Update please contact:

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