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.

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.

Targeted Update
Cognitive behavioural therapy compared with any other 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 Grimes2, Sarah R Davies3 and Sarah Dawson1. The abstract was adapted from the published full review.

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

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.

Reason for the commissioned 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 binging symptoms, but may make little or no difference to 100% abstinence from binging 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.

Summary of new evidence included in the Targeted Update

Cognitive behavioural therapy probably reduces binging symptoms compared with any other psychological therapy for binge eating disorder.
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 Reference 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 little or no difference to 100% abstinence from binge eating (RR 0.93, 95% CI 0.67 to 1.29, 9 participants) or to mean psych function (MD -0.05, 95% CI -0.21 to 0.11, 3 studies, 511 participants), that little or no difference to mean (MD -0.33, 95% CI -1.16 to 1.21, 28 participants), compared with any other psychotherapy. There was moderate quality evidence that CBT probably slightly reduces bingeing symptoms compared with any other psychotherapy, 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.

**Implications and conclusions**

There is some evidence that CBT probably slightly reduces bingeing symptoms compared with any other psychotherapies, 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**


**Summary of Findings:**

**Cognitive behavioral therapy (face-to-face) versus any other psychological therapy (face-to-face), including behavioural weight loss therapy, psychodynamic interpersonal therapy, integrated multimodal medically managed inpatient program, and brief strategic therapy.**

**Outcome**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Plain language summary</th>
<th>Relative effect (95% CI)</th>
<th>Certainty of the evidence (GRADE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean depressive symptoms</td>
<td>Measured by BD, CES-D and SCL-90-R, assessed by BD</td>
<td>MD -0.513 (-0.836 to -0.171 lower)</td>
<td>VERY LOW</td>
</tr>
<tr>
<td>Absolute effect</td>
<td>Any psychological therapy (except CBT)</td>
<td>CBT</td>
<td>N=0 participants &amp; studies</td>
</tr>
<tr>
<td>Number of people who did not show 100% abstinence from binge eating</td>
<td>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.</td>
<td>Difference 0.513 lower (0.836 to 0.171 lower)</td>
<td>LOW</td>
</tr>
<tr>
<td>Mean bingeing symptoms</td>
<td>Measured by binge days per week, binge days per month and BES, assessed by binge days per week</td>
<td>MD -0.513 (-0.836 to -0.171 lower)</td>
<td>MODERATE</td>
</tr>
<tr>
<td>Summary of Findings: CBT compared with any other psychological therapy for binge eating disorder at end-of-treatment</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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 therapy, integrated multimodal medically managed inpatient program, and brief strategic therapy.

**Mean depressive symptoms**

- CBT probably makes little or no difference to mean depressive symptoms in people with BED compared with any other psychological therapy at EOT.
- We are uncertain about the effect of CBT on general psychiatric symptoms compared with any other psychological therapy at EOT.

**Mean psychosocial/interpersonal functioning**

- CBT may make little or no difference to mean psychosocial/interpersonal functioning in people with BED compared with any other psychological therapy at EOT.
- Based on data from 489 participants in 7 studies

**Weight (BMI preferable)**

- CBT probably does not reduce weight in people with BED compared with any other psychological therapy at EOT.
- Based on data from 615 participants in 9 studies

**References**

BDD-100 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-Fuglegraven et al Laboratory Findings; GSI-General Psychosocial Symptom Index; IIP-Inventory of Interpersonal Problems; MD-mean difference; RR-risk ratio; SAS-Social Adjustment Scale; SCL-90-R-Symptom Checklist-90-Revised Depression Subscale; SMD-standardised mean difference

*4 Downgraded to low for imprecision. 5 Downgraded one level for imprecision and risk of bias. Most studies 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 negligible benefit for both types of intervention. 7 One of the three studies measuring this outcome with SAS and no cases of 100% abstinence from bingeing. 8 Downgraded one level for imprecision, only one study with 158 participants was included, and confidence intervals were very wide including negligible benefit for both types of intervention. 9 One of the three studies measuring this outcome with SAS. Scores were back estimated to BMI from SMD of 0.93 (CI 0.67 to 1.29) using control group SD of 0.9 from representative study Garli 2010. 10 One of the seven studies measuring this outcome with BMI. Scores were back estimated to BMI from SMD of 0.93 (CI 0.67 to 1.29) using control group SD of 0.9 from representative study Garli 2010. 11 One of the three studies measuring this outcome with BMI. Scores were back estimated to BMI from SMD of 0.93 (CI 0.67 to 1.29) using control group SD of 0.9 from representative study Garli 2010.
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:
contact@cochraneresponse.com

Systematic review services tailored to your evidence needs.