NKR23 - PICO7 - Bulimia Nervosa: Motivational intervention

Characteristics of studies

Characteristics of included studies

Allen 2012

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** MFT+CBT-E ● *BMI (SD)*: 19.18 (3.78) ● *BN/BN-like (% of sample (N))*: 38.5 (20) ● *Sex*: no info ● *Age (SD)*: 26.52 (8.98) CBT-E ● *BMI (SD)*: 20.38 (5.52) ● *BN/BN-like (% of sample (N))*: 39.5 (17) ● *Sex*: no info ● *Age (SD)*: 26.44 (8.98) **Included criteria:** Participants were adult outpatients (≥ 16 years) attending a statewide, government-funded eating disorder service in Western Australia. Details regarding the service and the patient population have been described previously (Byrne et al., 2011; Raykos, Byrne,& Watson, 2009). **Excluded criteria:** 52 patients commenced treatment in the MFT + CBT-Econdition. An additional seven patients commenced treatmentover this 20-month time frame but were not offered MFT becauseof prior commencement of behaviour change. These individualswere excluded from the current study.
Interventions	**Intervention Characteristics** MFT+CBT-E ● *Frequency*: MFT: 1/week for 4 weeks + CBT-E: Fairburn (2008) recommends 20 treatment sessions forindividuals in the healthy weight range and 40 treatment sessionsfor individuals who are underweight. This was treated as standardprocedure in the current study. However, as the study wasconducted under routine clinical conditions, treatment durationwas adapted if clinical need required this. Treatment completerswho were underweight at pretreatment received an average of 39sessions (SD 24.83), with a range of 15 to 100 sessions, and thosewho were not underweight received an average of 22 sessions(SD 10.88), with a range of 10 to 51 sessions. There were nosignificant differences in the number of sessions received acrossthe MFT + CBT-E and CBT-E as-usual groups (details areprovided in Table 3). ● *Content*: MFT: Sessions were based on motivational interviewing principles, andtherapists were instructed to maintain a style that was collaborative,calm and caring, whilst showing genuine concern, avoidingconfrontation and being guided by patients' responses. CBT-E: same as in comparison group. CBT-E ● *Frequency*: Fairburn (2008) recommends 20 treatment sessions forindividuals in the healthy weight range and 40 treatment sessionsfor individuals who are underweight. This was treated as standardprocedure in the current study. However, as the study wasconducted under routine clinical conditions, treatment durationwas adapted if clinical need required this. Treatment completerswho were underweight at pretreatment received an average of 39sessions (SD 24.83), with a range of 15 to 100 sessions, and thosewho were not underweight received an average of 22 sessions(SD 10.88), with a range of 10 to 51 sessions. There were nosignificant differences in the number of sessions received acrossthe MFT + CBT-E and CBT-E as-usual groups (details areprovided in Table 3). ● *Content*: CBT-E: Sessionscovered the following: formulation of the eating problem; real-time self-monitoring; psychoeducation and guided self-reading; regulareating; behavioural and mood regulation strategies (to managebinge eating, purging, excessive exercise and/or feelings offullness as applicable); and strategies for addressing bodychecking, weight and shape over-evaluation, 'feeling fat', dietaryrestraint and dietary rules and the eating disorder mindset.
Outcomes	*Continuous*: ● Spiseforstyrrelsesadfærd (SE) ● Somatiske komplikationer ● Psykologiske symptomer ● Remission af SF ● Funktionsevne ● Livskvalitet ● Psykologiske symptomer ● Binge per week ● Purge per week *Dichotomous*: ● Dropout
Identification	**Sponsorship source:** **Country:** **Setting:** **Comments:**

	Authors name: **Institution:** **Email:** **Address:**
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** *Tine Pedersen* Psykologiske symptomer: EDE-Q global score **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	
Allocation concealment (selection bias)	High risk	
Blinding of participants and personnel (performance bias)	High risk	
Blinding of outcome assessment (detection bias)	High risk	
Incomplete outcome data (attrition bias)	High risk	
Selective reporting (reporting bias)	Low risk	
Other bias	Low risk	

Dunn 2006

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** MET+TAU ● *Age (SD)*: ● *Sex (% of sample female)*: ● *BMI (SD)*: ● *BN/BN-like (% of sample (N))*: TAU ● *Age (SD)*: ● *Sex (% of sample female)*: ● *BMI (SD)*: ● *BN/BN-like (% of sample (N))*: **Included criteria:** **Excluded criteria:**
Interventions	**Intervention Characteristics** MET+TAU ● *Frequency*: ● *Content*: TAU ● *Frequency*: ● *Content*:
Outcomes	*Continuous*: ● Overspisninger ● Somatiske komplikationer ● Psyk. SF-symptomer ● Livskvalitet ● Funktionsevne ● Remission af SF ● Opkastninger ● Brug af laksantia ● Faste ● Tvangsmotion *Dichotomous*: ● Dropout

Identification	**Sponsorship source:** Partial support for this research was provided by National Institute onAlcohol Abuse and Alcoholism Grant NIAAA R01AA12547-04, awardedto Mary E. Larimer. **Country:** **Setting:** **Comments:** **Authors name:** Erin C. Dunn **Institution:** Department of Psychology, University of Washington **Email:** **Address:**
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** *Tine Pedersen* baseline characteristics are described for the group as a whole. There were no intergroup differences at baseline. *Louise Klokker Madsen* Not reported for each group - but the authors state:"No significantdifferences were found among those randomized to the MET andSH conditions for any measured variable."Participants included 90 undergraduate college students, 79women (87.8%) and 11 men (12.2%). Participants ranged from 17to 42 years old, with a mean age of 19 (SD 2.64). Participantswere primarily Caucasian (59.6%), with the rest of the samplecomprising Asian/Pacific Islander (29.2%), Hispanic/Latino(4.5%), and other (6.7%). No participants indicated that they wereof African American or Native American descent. Calculation ofbody mass index (BMI) indicated that, on average, participantswere of typically developing weight (M 23.80, SD 4.05).However, 95% of participants reported a desired weight that wasless than their current weight. On average, participants desired toweigh approximately 19 pounds less (SD 11.2).Of the 90 participants who completed the baseline assessment,21 (23.3%) participants met full DSM–IV criteria for BN and 25(27.8%) participants met full DSM–IV criteria for BED. Six participants(6.7%) met criteria for subthreshold BN, and 8 participants(8.9%) met criteria for subthreshold BED. The remaining 30participants (33.3%) met partial criteria for either BN or BED andwere considered to have an Eating Disorder Not Otherwise Specified(EDNOS). **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** *Louise Klokker Madsen* psychological symptoms = weight concern **Dichotomous outcomes:** *Louise Klokker Madsen* Finally, 34% of participants were lost to follow-up (N=90 at baseline, distribution in groups not reported). **Adverse outcomes:**

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	no info
Allocation concealment (selection bias)	Unclear risk	no info
Blinding of participants and personnel (performance bias)	High risk	
Blinding of outcome assessment (detection bias)	High risk	
Incomplete outcome data (attrition bias)	Low risk	
Selective reporting (reporting bias)	Unclear risk	no info
Other bias	Low risk	

Katzman 2010

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** MET+TAU ● *Age (SD)*: 28.9 (8.1) ● *Sex (% of sample female)*: no info ● *BMI (SD)*: 23.5 (5.9) ● *BN/BN-like (% of sample (N))*: 100 TAU ● *Age (SD)*: 27.8 (6.3) ● *Sex (% of sample female)*: no info ● *BMI (SD)*: 25.5 (8.9) ● *BN/BN-like (% of sample (N))*: 100 **Included criteria:** All patients fulfilling the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria for BN or EDNOS were eligible for the study. We defined EDNOS as subthreshold BN—a clinically relevant eating disorder (i.e., significant impairment of physical health or psychosocial functioning) where the patient met the criteria for BN except that the binge eating and/or inappropriate compensatory behaviors occurred at a frequency of less than twice a week or for a duration of 3 months. **Excluded criteria:** The exclusion criteria were pregnancy, diabetes mellitus, severe mental illness (such as schizophrenia or bipolar illness), severe learning disability, inability to commit to treatment from the outset, or referral for assessment only.

Interventions	**Intervention Characteristics** MET+TAU ● *Frequency*: four sessions of individual MET followed byeight sessions group CBT (MET-G) ● *Content*: In MET, the therapist used principles of motivational interviewing andaccompanying worksheets guided by the manual “A Clinician’s Guide toGetting Better Bit(e) by Bit(e)” (17). Treatment focused on a consideration ofthe benefits of changing and the barriers to be overcome to change, movingfrom the here and now by envisioning key values and how these would fit intothe whole life story. No unsolicited advice about eating was given. Allparticipants in this condition received a letter providing personalized feedbackon physical symptoms, laboratory tests, and detailed social, family, educational,and vocational problems found at the time of assessment. This feedbackwas reviewed by patient and therapist during the first session. Behaviorchange techniques included: outcome expectancies, personal relevance, descriptivenorms, developing personal and moral norms and if the patientshowed a commitment to change, concrete planning and contracting ofbehavioral goals (17).+ group CBT TAU ● *Frequency*: four sessions of individual CBTfollowed by eight sessions of group CBT (CBT-G). ● *Content*: In the CBT condition, therapists followed the instructions of the first fourchapters of “bulimia nervosa“ (18) and included active strategies of behaviorchange from session 1, including nutritional/food monitoring sheets, mealplanning, activity lists, and problem-solving activities. At the time of thestudy, this was the only CBT self-help manual available with proven efficacyin the treatment of BN. This manual does not specifically focus on increasingmotivation.+ group CBT
Outcomes	*Continuous*: ● Spiseforstyrrelsesadfærd ● Somatiske komplikationer ● Remission af SF ● Psyk. SF-symptomer ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Overspisninger ● Opkastninger ● Brug af laksantia
Identification	**Sponsorship source:** The authors have not disclosed any potential conflicts of interest. **Country:** USA **Setting:** busy outpatient setting **Comments:** **Authors name:** MELANIE A. KATZMAN **Institution:** Department of Psychiatry (M.A.K.), Weill Cornell Medical Center, New York **Email:** mkatzman@katzmanconsulting.com **Address:** 10 East 78th Street, Suite 4A, New York, NY 10075
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** *Louise Klokker Madsen* 165 out of 225 met the criteria for BN:"In our sample of 225, 60 were diagnosedwith EDNOS". No reports on gender distribution. **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** **Dichotomous outcomes:** *Louise Klokker Madsen* NB: outcomes for ED behaviour is ABSTINENCE of behavior **Adverse outcomes:**

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	
Allocation concealment (selection bias)	Low risk	
Blinding of participants and personnel (performance bias)	High risk	
Blinding of outcome assessment (detection bias)	High risk	
Incomplete outcome data (attrition bias)	Unclear risk	no info
Selective reporting (reporting bias)	Unclear risk	no info
Other bias	Low risk	

Weiss 2013

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** MFT/MI+TAU ● *BMI (SD)*: 17.7 (2.9) ● *BN/BN-like (% of sample (N))*: 25 (4) ● *Sex*: 94% female ● *Age (SD)*: 28 (9.5) TAU ● *BMI (SD)*: 18.4 (4.8) ● *BN/BN-like (% of sample (N))*: 37.5 (6) ● *Sex*: 94% female ● *Age (SD)*: 28.4 (7.8) **Included criteria:** All participants in this study were female and met DSMIVcriteria for AN, BN, or Eating Disorder Not OtherwiseSpecified (EDNOS). These assessments were completed bypsychologists, psychiatrists, and Master's level therapists inthe Toronto General Hospital Eating Disorders program.Participants also were required to have a BMI greater thanor equal to 13, as we were concerned that patients with aBMI of less than 13 would be too medically unstable to participate.It was decided that clients who were suicidal (i.e.,those who expressed suicidal intent and plans for how theywould hurt themselves) would be included in the studysince suicidality is so common in eating disordered populations **Excluded criteria:** onepatient demonstrated severe suicidal ideation,One participant in the MI condition wasexcluded because she attended a different hospital's treatmentprogram after completing her MI sessions.a Twoparticipants in the control condition were excluded; onehad a disruption in her intensive treatment due to unrelatedmedical issues and one had significant missing questionnairedata.
Interventions	**Intervention Characteristics** MFT/MI+TAU ● *Frequency*: The MI condition received weekly 50-minute sessions ofMI over four consecutive weeks. ● *Content*: Treatment followed theprinciples and techniques outlined in Miller and Rollnick'sMI manual. At the end of each session, participants completeda measure of therapeutic alliance. It should benoted that we considered our MI intervention to be "brief"only in comparison to the typical length of treatment foran eating disorder. MI as an adjunct to other treatments isusually done over 1–2 one hour sessions. However, wewanted our intervention to include all of the key componentsto Miller and Rollnick's MI manual. Participants inthe MI condition were also able to continue to receive"treatment-as-usual," meaning they could carry on as theynormally would (e.g., seeing a family doctor, taking medication,etc.). This treatment most often included regularmedical monitoring by their physician or psychiatrist andthe use of anti-depressant medication. Some participantswere also receiving psychotherapy with psychologists andclinical social workers, and some were seeing dietitians, asis common. TAU ● *Frequency*: Wait-list. If admitted within the first four weeks:Patients who donot require weight gain are given a maximum admissionof eight weeks, whereas those who have weight to gain areadmitted until they reach a BMI of 20.The ambulatory treatment program is comprised entirelyof outpatients. However, the program is intensive, as patientstypically attend the program from 10 am until 6 pm,Monday to Friday, and complete two staff-supervisedmeals and one supervised snack each day in hospital. ● *Content*: Participants assigned to the control condition did not receiveany MI treatment over the four-week treatmentperiod, but remained on the waiting list and receivedtreatment as usual. Admission to intensive treatmentwas not delayed for any participant as a function ofcondition.
Outcomes	*Continuous*: ● Spiseforstyrrelsesadfærd (SE) ● Somatiske komplikationer ● Psykologiske symptomer ● Remission af SF ● Funktionsevne ● Livskvalitet ● Psykologiske symptomer ● Binge per week ● Purge per week *Dichotomous*: ● Dropout
Identification	**Sponsorship source:** This study was partially funded by the Social Sciences and HumanitiesResearch Council of Canada doctoral fellowship awarded to the first author. **Country:** Canada **Setting:** waitlist for admission to an intensive, hospital-based treatment program **Comments:** **Authors name:** Weiss, Carmen V. **Institution:** Department of Psychology, York University, Toronto, Ontario, Canada **Email:** jsmills@yorku.ca **Address:** Department of Psychiatry, St. Joseph's Healthcare, Hamilton, Ontario,Canada.
Notes	**Identification:** **Participants:** **Study design:**

	Baseline characteristics: **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	
Allocation concealment (selection bias)	Unclear risk	no info
Blinding of participants and personnel (performance bias)	Low risk	
Blinding of outcome assessment (detection bias)	High risk	
Incomplete outcome data (attrition bias)	Low risk	
Selective reporting (reporting bias)	Low risk	
Other bias	Unclear risk	no info

Footnotes

Characteristics of excluded studies

Berg 2013

Reason for exclusion	Wrong study design

Dean 2007

Reason for exclusion	Wrong study design

Dean 2008

Reason for exclusion	Wrong patient population

Feld 2001

Reason for exclusion	Wrong study design

Golan 2013

Reason for exclusion	Wrong study design

Hotzel 2014

Reason for exclusion	Wrong comparator

Jakubowska 2013

Reason for exclusion	Wrong study design

Leung 2013

Reason for exclusion	Wrong study design

Treasure 1999

Reason for exclusion	Wrong intervention

vonBrachel 2014

Reason for exclusion	Wrong study design

Waller 2012

Reason for exclusion	Wrong study design

Willinge 2010

Reason for exclusion	Wrong intervention

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

References to studies

Included studies

Allen 2012

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Excluded studies

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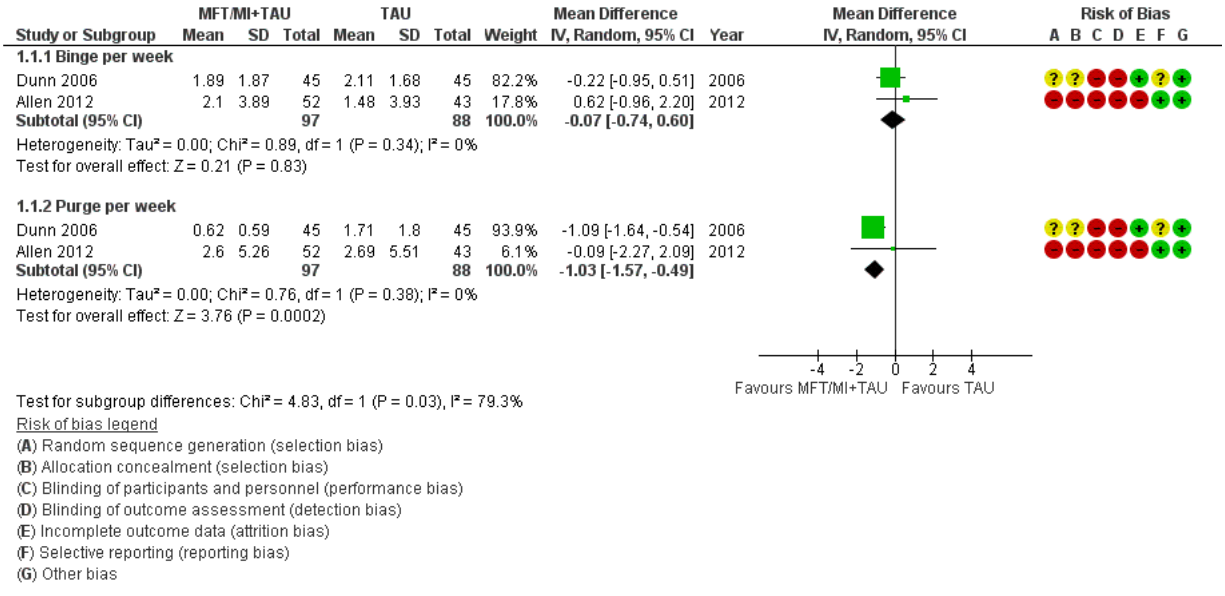
Data and analyses

1 MFT/MI+TAU versus TAU

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Eating Disorder Behavior (cont. data), end of treatment	2		Mean Difference (IV, Random, 95% CI)	Subtotals only
1.1.1 Binge per week	2	185	Mean Difference (IV, Random, 95% CI)	-0.07 [-0.74, 0.60]
1.1.2 Purge per week	2	185	Mean Difference (IV, Random, 95% CI)	-1.03 [-1.57, -0.49]
1.2 Eating Disorder Behavior (dichotomous data), end of treatment	1		Risk Ratio (M-H, Random, 95% CI)	Subtotals only
1.2.1 Binge eating	1	53	Risk Ratio (M-H, Random, 95% CI)	1.26 [0.84, 1.90]
1.2.2 Purging	1	53	Risk Ratio (M-H, Random, 95% CI)	1.26 [0.84, 1.90]
1.3 Remission of ED, longest FU	1		Risk Ratio (M-H, Random, 95% CI)	Subtotals only
1.3.2 Binge eating abstinence	1	34	Risk Ratio (M-H, Random, 95% CI)	0.67 [0.31, 1.47]
1.4 Dropout, end of treatment	3	280	Risk Ratio (IV, Random, 95% CI)	1.19 [0.93, 1.51]
1.5 Psychological ED-symptoms (EDE global), end of treatment	2	185	Std. Mean Difference (IV, Random, 95% CI)	-0.09 [-0.38, 0.20]
1.6 Psychological ED-symptoms, end of treatment	1		Std. Mean Difference (IV, Random, 95% CI)	Subtotals only
1.6.1 EDE weight concern	1	90	Std. Mean Difference (IV, Random, 95% CI)	-0.17 [-0.58, 0.25]
1.6.2 EDE eating concern	1	90	Std. Mean Difference (IV, Random, 95% CI)	-0.24 [-0.66, 0.17]
1.6.3 EDE shape concern	1	90	Std. Mean Difference (IV, Random, 95% CI)	-0.18 [-0.59, 0.23]
1.6.4 EDE restraint	1	90	Std. Mean Difference (IV, Random, 95% CI)	0.01 [-0.41, 0.42]
1.7 Somatic complications, end of treatment	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable
1.8 Level of Functioning, longest FU	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable
1.9 Quality of Life, longest FU	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable
1.10 Remission of ED, longest FU	0		Risk Ratio (M-H, Random, 95% CI)	Subtotals only

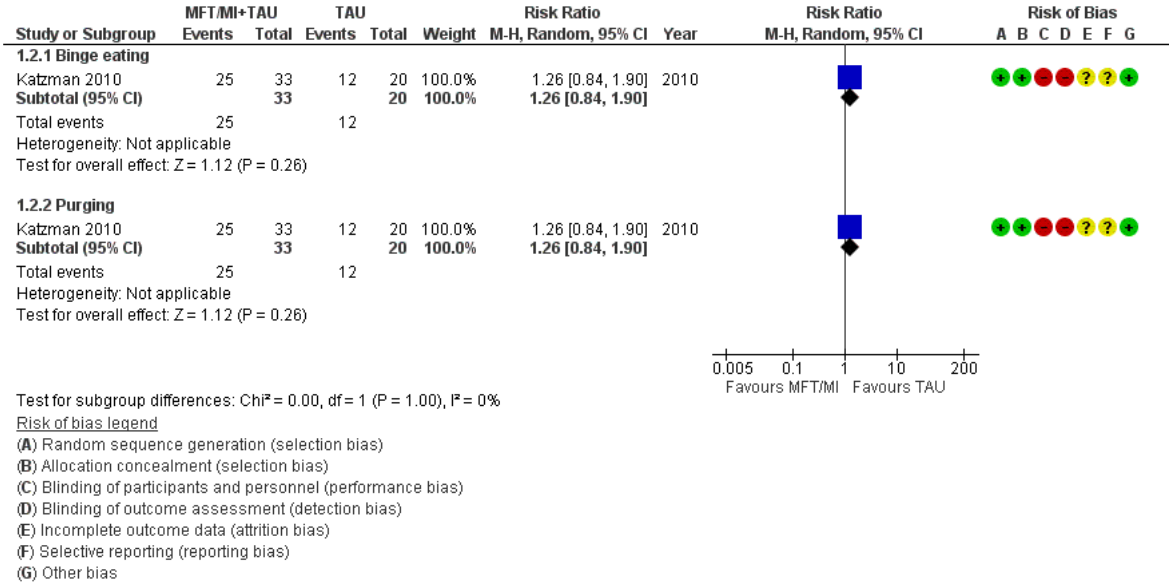
Figures

Figure 1 (Analysis 1.1)



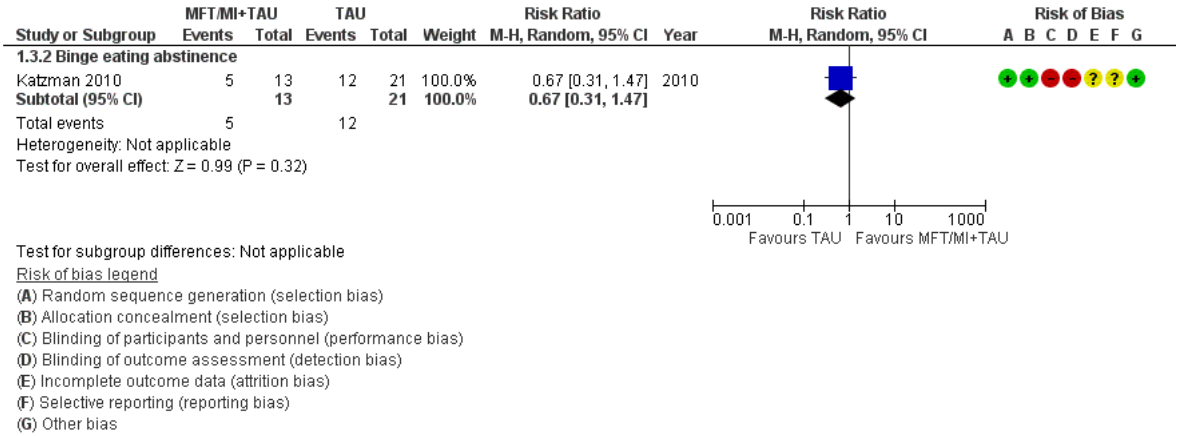
Forest plot of comparison: 1 MFT/MI+TAU versus TAU, outcome: 1.1 Eating Disorder Behavior (cont. data), end of treatment.

Figure 2 (Analysis 1.2)



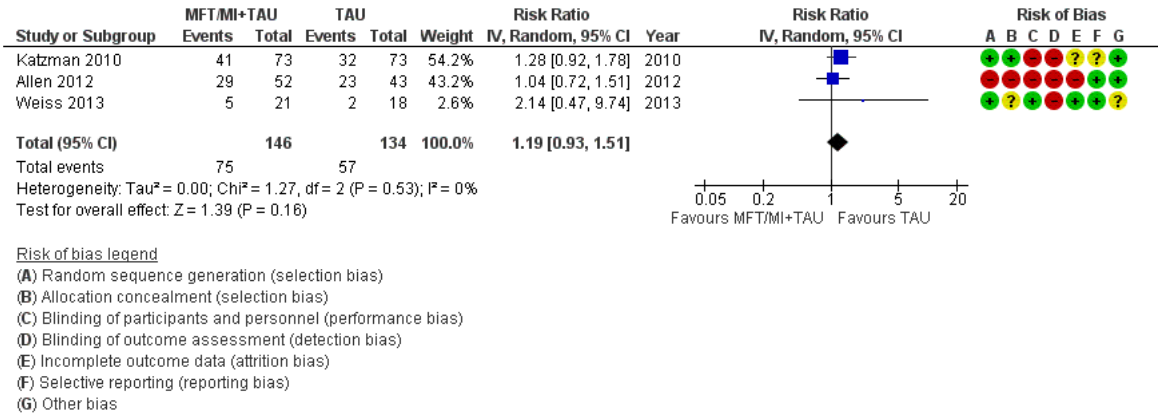
Forest plot of comparison: 1 MFT/MI+TAU versus TAU, outcome: 1.2 Eating Disorder Behavior (dichotomous data), end of treatment.

Figure 3 (Analysis 1.3)



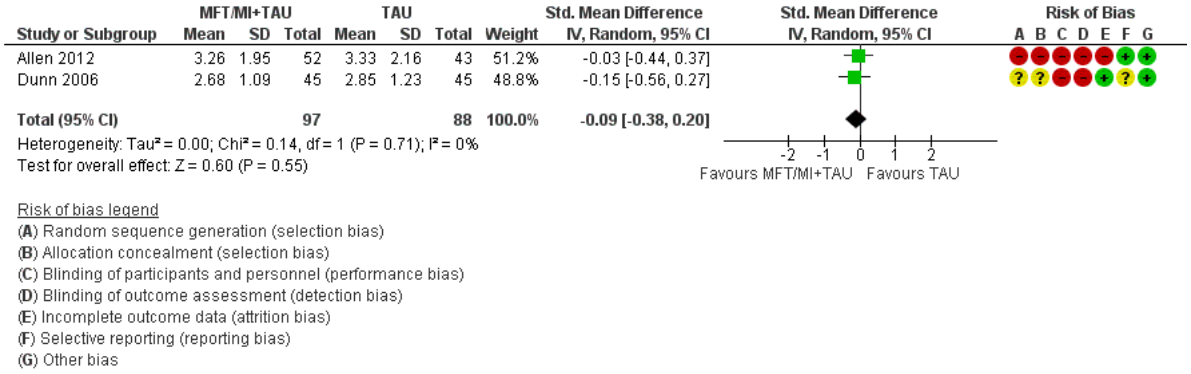
Forest plot of comparison: 1 MFT/MI+TAU versus TAU, outcome: 1.3 Remission of ED, longest FU.

Figure 4 (Analysis 1.4)



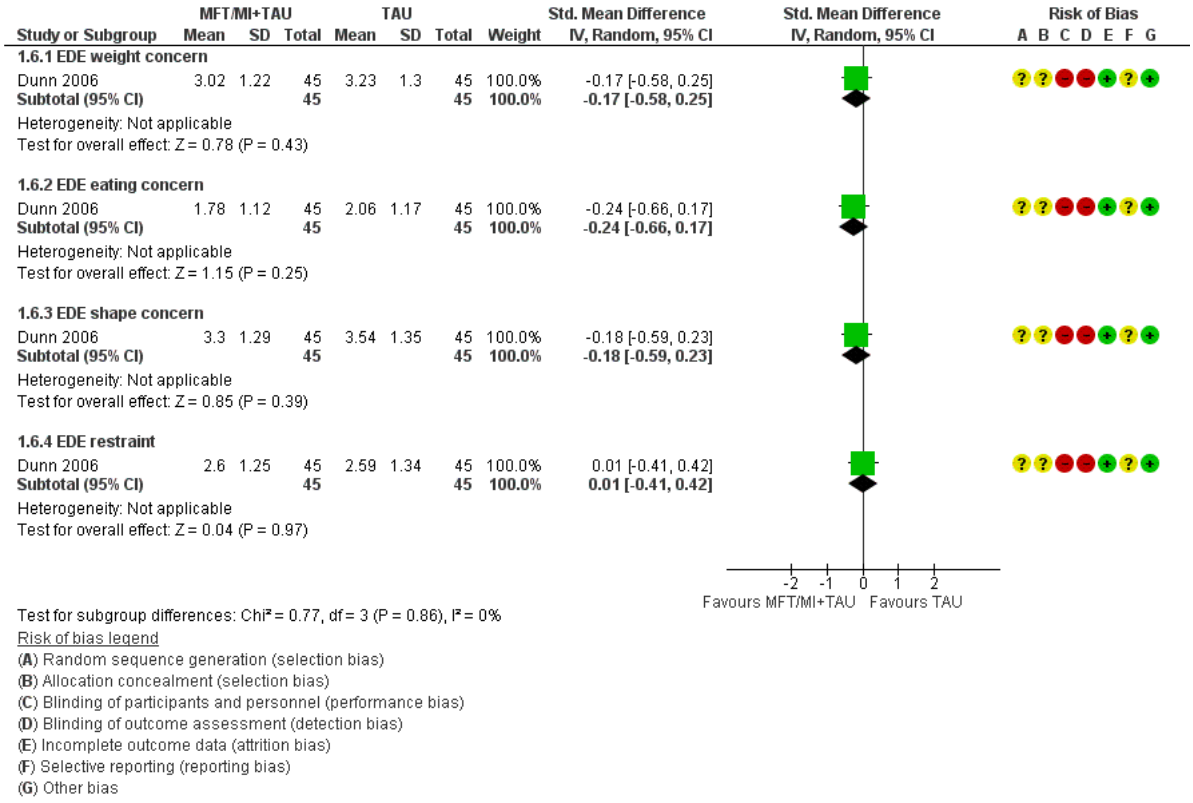
Forest plot of comparison: 1 MFT/MI+TAU versus TAU, outcome: 1.4 Dropout, end of treatment.

Figure 5 (Analysis 1.5)



Forest plot of comparison: 1 MFT/MI+TAU versus TAU, outcome: 1.5 Psychological ED-symptoms (EDE global), end of treatment.

Figure 6 (Analysis 1.6)



Forest plot of comparison: 1 MFT/MI+TAU versus TAU, outcome: 1.6 Psychological ED-symptoms, end of treatment.