

Eating Disorders: recognition and treatment

Full guideline

Clinical Guideline

Methods, evidence and recommendations

May 2017

Final

*Developed by the National Guideline
Alliance, hosted by the Royal College of
Obstetricians and Gynaecologists*

Update information

December 2020: We amended the recommendation on managing diabetes to highlight the importance of rotating insulin injection sites within the same body region, in line with an [MHRA Drug Safety Update on insulins \(all types\): risk of cutaneous amyloidosis at injection site](#).

For the current recommendations, see:

www.nice.org.uk/guidance/NG69/chapter/recommendations.

March 2020: Cross reference to NICE's guideline on supporting adult carers added to the recommendation on offering family members or carers assessments of their own needs 1.1.10.

Disclaimer

Healthcare professionals are expected to take NICE clinical guidelines fully into account when exercising their clinical judgement. However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.

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1 Guideline summary

1.1 Preface

Background

There are over 700,000 individuals in the UK with an eating disorder (Beat, 2015). While the prevalence is relatively stable, the number of cases identified in clinical settings is increasing as clinicians become more aware of these disorders and patients come forward more readily (Currin et al., 2005; Soundy et al., 1995). However, many cases remain unidentified.

People that have an eating disorder (i.e. anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding and eating disorders) experience physical complications, psychological comorbidity, poor quality of life, disrupted relationships, emotional distress, social isolation and economic disadvantage (Beat, 2015). The risk of early death in this population is among the highest among patients with psychiatric disorders, whether due to physical complications (e.g., malnutrition) or mental health issues (e.g., suicide) (Beat, 2015). Their families, carers and loved ones also suffer as a result of the eating disorder, experiencing high levels of stress (Treasure et al., 2001).

About 90% of eating disorder cases are female and most are of normal weight or above (only about 15-20% meet criteria for anorexia nervosa) (Beat, 2015; Fairburn and Harrison, 2003; Soundy et al., 1995). Consistent with this, Beat (2015) - using figures for UK hospital admissions from 2012-2013 - estimated a similar figure. There is little evidence of any difference in prevalence rates among different ethnic groups. Some groups are at greater risk of developing eating disorders (e.g., those who work or study in areas where there is a strong focus on physical appearance, such as dancers, models or athletes). Others are at particularly high risk of complications if they develop an eating disorder (e.g., those with type 1 diabetes). Therefore, these groups are the subject of particular consideration in this guideline. Risk management should always be seen as the first consideration.

Eating disorders commonly have their origins in adolescence, but are often not identified or picked up by services until adulthood. Early intervention is strongly advocated (Treasure and Russell, 2011). However, the necessary early identification and prevention or treatment of eating disorders is a difficult task, due to the low base rate of such cases and limitations in tools suggested for early identification and prevention. Even very underweight patients routinely go unidentified or their needs are not responded to by clinicians and non-underweight patients are likely to be missed by clinicians and families alike. Such patients are unlikely to self-report in the early years of the disorder. Furthermore, most eating disorders have low rates of spontaneous remission. Therefore, this guideline focuses substantially on the evidence as to how clinicians can effectively treat and manage eating disorders that might have been present for many years.

The causes of eating disorders are not fully understood, with evidence of a mixture of social, biological, psychological and interpersonal causes. However, given that these disorders develop across their course (often several years), it is more important to consider the role of the factors that maintain the eating problems when planning and delivering treatment. Those maintaining factors are interlinked, but include (though are not limited to):

- malnutrition and semi-malnutrition;
- social isolation and avoidance;
- emotional responses (particularly anxiety and depression);
- cognitive difficulties (for example, concentration, narrowed thinking, memory, attentional biases);
- body image disturbance (negative body self-esteem, overestimation of body size);

- 1 • behaviours that maintain the problem (for example, avoidance of food; purging
2 behaviours, body checking).

3 Therefore, treatment needs to address these maintaining factors, while ensuring that risks
4 are managed appropriately.

5 **Key principles of evidence-based treatments for eating disorders**

6 The first principle behind any treatment is to maintain life and avoid doing harm. The first of
7 these is an important issue in a disorder with such a high mortality rate and the importance of
8 medical care is undoubted. The risk of doing harm is addressed below – the danger of
9 undertaking ineffective treatment, resulting in patients having a loss of engagement or belief
10 in their ability to change.

11 The second principle is the need to engage the patient, family and carers in the process of
12 change. Family and carers should be kept informed as far as possible and can be active
13 agents in treatments. However, there is evidence that the process of engaging patients in the
14 process of treatment differs according to the type of therapy (Graves et al., 2016).
15 Developing the therapeutic alliance is a primary task when working with younger children and
16 young people receiving family therapy, but with cognitive and behavioural treatments in
17 adults work by Brown et al. (2013) suggests it is the process of behavioural change that
18 results in the development of positive therapeutic alliance (Brown et al., 2013).

19 It is important to use all of the evidence-based approach that is advocated, rather than
20 omitting elements that the clinician dislikes or feels uncomfortable delivering (Turner et al.,
21 2014). Clinicians need to use protocols in a non-rigid, patient-centred way (Wilson, 1996),
22 rather than omitting key requirements.

23 Nutritional restoration is a key part of most of the effective approaches to food, whether
24 considering patients' physical health or psychotherapy outcomes (e.g., family meals; weight
25 restoration; cessation of binge eating and purging). Its impact is, amongst other things,
26 biological (e.g., resumption of menstruation and repair of bone structure); cognitive (e.g.,
27 flexibility of thought); emotional (e.g., stabilisation of mood); and interpersonal (e.g.,
28 restoration of social skills). While it is sometimes contended that anorexia nervosa in
29 particular, might have some neuropsychological underpinning that would limit such benefits,
30 it is important to remember that the evidence for this contention is limited (studies that are
31 poorly designed, have too small a number, or they fail to replicate). Therefore, clinicians
32 should certainly not regard anorexia nervosa as a 'diagnosis of despair', especially given that
33 some interventions can affect the aforementioned factors.

34 **The need for this guideline**

35 The most recent NICE guideline for eating disorders was published in 2004. That guideline
36 had relatively few recommendations based on level 'A' and 'B' evidence, reflecting the lack of
37 high quality evidence at that time. Most noticeably, there were no evidence-based
38 recommendations regarding the treatment of most atypical cases and the treatment of
39 anorexia nervosa was in part based on the expert opinion of the guideline committee rather
40 than strong evidence. Two important strands of evidence have emerged since 2004, relating
41 to:

- 42 • Enhanced evidence of treatment outcomes
43 • Evidence about problems regarding how therapies for eating disorders are delivered.

44 **Recent evidence of treatment outcomes**

45 Since the 2004 NICE guideline, there has been a substantial increase in this empirical
46 literature, including studies that might consolidate or amend the recommendations that were
47 made at that time. In particular, the studies to be considered in this guideline include:

- 1 • Further studies of treatments (psychological therapies and medications) for bulimia
2 nervosa and binge eating disorder
- 3 • Studies comparing treatments (both psychological and biological) for anorexia nervosa
- 4 • Studies on the impact of treatments on atypical cases (OSFED)

5 These studies have been carried out with individuals across the young people-adult age
6 span, involving parents and carers where appropriate to the cases in question. However,
7 Avoidant/Restrictive Food Intake Disorder (ARFID) is not included in this guideline, as the
8 evidence relating to treatment of this newly established diagnosis (APA, 2013) was
9 considered too limited to allow for recommendations to be made at this stage. Similarly,
10 obesity in the absence of an eating disorder is not considered in this review, as it is the
11 subject of a separate NICE guideline.

12 **Evidence of treatment delivery**

13 This guideline also considers other studies that have emerged in the past decade, including.

- 14 • Continuing gaps in case identification in non-specialist primary care settings (Waller et al.,
15 2014b).
- 16 • Evidence that areas without specialist outpatient eating disorders services have lower
17 rates of case identification (between 2 to 3 times) than those with them (House et al.,
18 2012).
- 19 • The need for use of relatively intensive treatments (e.g., day and in-patient) (Gowers
20 2007; (Lock et al., 2015; Turner et al., 2015).
- 21 • The need for appropriate implementation of evidence-based therapies in routine NHS and
22 comparable settings Byrne et al., 2011; Couturier et al., 2010; Fairburn and Cooper 2011;
23 Turner et al., 2016; Waller et al., 2014a) (Fairburn and Cooper, 2011).
- 24 • Evidence on the effective delivery of evidence-based therapies (Byrne et al., 2011;
25 Couturier et al., 2010; Turner et al., 2015; Turner et al., 2016; Waller et al., 2014a).

26 The guideline also addresses a clear issue in routine practice when working with eating
27 disorders: so-called 'therapist drift' (Waller, 2009; Waller, 2016), the tendency of clinicians to
28 fail to deliver the optimum evidence-based psychological treatment adequately (or to fail to
29 use it at all), either due to a personal preference for another approach or due to lack of
30 competence or training in the evidence-based treatment.

31 **Summary**

32 In summary, eating disorders are poorly identified in non-specialist NHS settings. These
33 disorders are usually long-lasting and have serious implications, including risk of death,
34 impaired health, psychiatric comorbidity and poor quality of life for the patient and those
35 around them.

36 Since the 2004 NICE guideline, two strands of evidence have emerged that necessitate a
37 new eating disorders guideline in 2017. First, there is now far more evidence of efficacious
38 treatments (both physical and psychological). Second, it has become clear that clinicians
39 vary substantially in their identification of cases and their delivery of the evidence-based
40 treatments that are recommended.

1.2 Committee membership, National Guideline Alliance (NGA) staff and acknowledgements

Table 1: Committee members

Name	Role
Anthony Bateman (Chair)	Visiting Professor in the Psychoanalysis Unit, University College London. Consultant Psychiatrist and Psychotherapist and Honorary Senior Lecturer, University College and Royal Free Medical Schools, Barnet, Enfield and Haringey Mental Health NHS Trust and St Ann's Hospital, London.
Jane Dalglish	Mental Health Nurse, Nurse Practitioner/Team Manager/Head of Service, Eating Disorders Service, South Essex University Foundation Trust (SEPT).
Ivan Eisler	Emeritus Professor of Family Psychology and Family Therapy, Kings College Institute of Psychiatry, Psychology and Neuroscience Consultant Clinical Psychologist and Joint Head of Child and Adolescent Eating Disorders Service, South London and Maudsley NHS Foundation Trust. Lead for Psychological Treatments, CAMHS, South London and Maudsley NHS Foundation Trust.
Christopher Fairburn	Principal Research Fellow and Professor of Psychiatry, University of Oxford. Honorary Consultant Psychiatrist, Oxford Health NHS Foundation Trust. Governor, MQ: Transforming Mental Health through Research, London. Governor, Oxford Mindfulness Foundation.
Lee Hudson	Consultant General Paediatrician at Great Ormond Street Hospital and Eln Meade Eating Disorder Unit, London.
Mike Hunter	Consultant Psychiatrist; Clinical Director (Inpatient Services); Associate Medical Director (Research & Strategy), Sheffield Health and Social Care NHS Foundation Trust.
Dasha Nicholls	Consultant Child and Young People Psychiatrist, Great Ormond Street Hospital, London and Honorary Senior Lecturer, UCL Great Ormond Street Institute of Child Health, London
Jessica Parker	Lay member
Daniel Perry	Lay member
Ursula Philpot	Senior Lecturer in Nutrition and Dietetics, Leeds Beckett University. Freelance Consultant Dietitian.
Susan Ringwood	Lay member
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Christine Vize	Retired Consultant Psychiatrist, Cotswald House Eating Disorders Unit, and Wiltshire Community Eating Disorder Service, and Medical Lead, Oxford Health NHS Foundation Trust.

Name	Role
Glenn Waller	Professor of Psychology, Department of Psychology, University of Sheffield.

1 **Table 2: NGA staff**

Name	Role
Annabel Flint	Senior Project Manager (from August 2016)
Linyun Fou	Research Assistant
Timothy Kendall	Clinical Advisor and Guideline Lead (until September 2016)
Stephen Pilling	Clinical Advisor (from September 2016)
Elena Marcus	Research Assistant
Leanne Saxon	Senior Systematic Reviewer (until January 2017)
Eric Slade	Health Economist
Sarah Stockton	Information Scientist
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Jo Wolfreys	Project Manager (until August 2016)
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2 Additional support was received from Gary Waltham and Sabrina Naqvi of the NGA, Nuala
3 Ernest of UCL, Dr Sofia Dias, TSU Director, University of Bristol and Edna Keeney, TSU
4 Scientific Coordinator, University of Bristol.

5 **1.3 Other versions of the guideline**

6 NICE produce a number of versions of this guideline:

- 7 • The 'short guideline' lists the recommendations, context and recommendations for
8 research
- 9 • 'Information for the public' is written using suitable language for people without specialist
10 medical knowledge
- 11 • NICE Pathways brings together all connected NICE guidance.

12 **1.4 Schedule for updating the guideline**

13 For the most up-to-date information about guideline reviews, please see the latest version of
14 the NICE guidelines manual available from the NICE website

1 2 Introduction

2 2.1 What is an eating disorder?

3 Eating disorders have been described as “a persistent disturbance of eating behaviour or
4 behaviour intended to control weight, which significantly impairs physical health or
5 psychosocial functioning” (Fairburn & Walsh, 2002), although more recent definitions have
6 reduced the emphasis on ‘intent’. The relevant behaviours include: restriction of dietary
7 intake; overeating with a sense of loss of control; and compensatory behaviours (e.g.,
8 vomiting, exercise, laxative abuse). These behaviours are accompanied by cognitive
9 disturbances (e.g., overvaluation of weight; body image disturbance), emotional triggers and
10 consequences (e.g., anxiety, shame) and social difficulties (e.g., isolation). The majority of
11 individuals with eating disorders (80-85%) are not underweight (Fairburn 2003). However,
12 regardless of weight status, patients with eating disorders are at increased physical risk as a
13 result of malnutrition (e.g., cardiac problems; bone deterioration), binge eating (e.g., physical
14 damage; complications of excess weight, such as diabetes), purging (e.g., electrolyte
15 imbalance) and mood (e.g., suicidality) (Treasure et al., 2010).

16 2.1.1 What do we know about the causes of eating disorders?

17 While there are many theories regarding the causes of eating disorders, the evidence to date
18 is weak for any one causal factor. There is some evidence suggesting roles of genetic,
19 neurobiological and sociocultural factors though their specificity and generalisability are
20 limited at present. The limitations of the research are due in part to the low prevalence rate of
21 the disorders, making early screening for risk factors impractical. However, the time between
22 onset of the disorders (which is not always a clear point) and identification of the disorders is
23 often several years (due to issues such as control and shame), meaning that determining
24 causality is very difficult. Consequently, there is a greater focus on the maintaining factors,
25 which can be identified much more readily. These include the cognitive, emotional, physical
26 and social consequences of malnutrition, binge eating, purging, etc., which have been built
27 into models that have been tested in empirical studies and treatments.

28 2.1.2 The natural course of eating disorders

29 The majority of eating disorders have their origins in adolescence and young adulthood,
30 though a substantial number of cases begin at younger or older ages. If left untreated (or if
31 treated inadequately), the maintaining factors mean that many cases continue for decades,
32 though severity can vary over time and there can be temporary periods of remission. Many
33 cases will change from one diagnostic status to another, usually away from low-weight
34 presentations (e.g., an individual whose diagnosis changes over several years from
35 restrictive anorexia nervosa to binge/purge anorexia nervosa to bulimia nervosa).

36 2.1.3 Special issues regarding children with eating disorders

37 Children and adults can each have the full range of eating disorders (see following sections).
38 However, there are important differences in how treatment should be focused at different age
39 points relative to the development level of the person. First, because child cases are usually
40 those that are identified earlier in the process, the patients are more commonly underweight.
41 Second, while early intervention is to be encouraged at all ages, the long-term physical
42 complications of malnutrition that are specific at this age (e.g., growth, pubertal delay, dental
43 problems, osteoporosis, fertility problems) makes such early intervention critical in children
44 with eating disorders. The role of the family in addressing the disorders tends to be
45 emphasised in younger cases, while the focus is more commonly on the individual in adult
46 cases.

1 2.1.4 The cultural context of eating disorders in Western societies

2 Eating disorders are found globally, though they have been identified for longer in Western
3 cultures. It can be argued that this is a result of such societies placing stress on the value of
4 specific body types, particularly among women. There is some evidence that encroaching
5 'westernisation' is followed by a greater level of eating disorders in 'non-Western' societies,
6 as those values are spread via a range of media and individuals strive to fit to the newly
7 incorporated standards.

8 It is also important to consider whether there are cultural differences within societies. While it
9 is clear that females are more likely to experience eating disorders than males, there has
10 been a noticeable increase in identification of men with eating disorders in recent years.
11 There is also a greater prevalence among those in 'at-risk' professions where there is a focus
12 on body shape and weight (e.g., athletes, dancers, models). Despite this, there is no evidence
13 that other differences (e.g., ethnicity; socioeconomic status; sexuality) make it more likely
14 that a member of any one group will have an eating disorder. However, cultural factors do
15 play one important role. For example, professionals are less likely to identify an eating
16 disorder if the person does not fit the stereotype for such cases (e.g., non-Caucasian or
17 male).

18 2.2 Epidemiology

19 2.2.1 Anorexia nervosa

20 The prevalence of anorexia nervosa in young females in Western Europe and the US has
21 been estimated to be approximately 0.3% (range = 0.2 – 0.8%) (van Hoeken et al., 2003).
22 Incidence rates range from 4.2 to 12.6 per 100,000 person-years (Currin et al., 2005; Micali
23 et al., 2013; Steinhausen and Jensen, 2015). The incidence of anorexia nervosa among
24 males is lower, at 1 per 100,000 person-years (Currin 2005). Anorexia nervosa is relatively
25 rare in children under 13 years, with a reported incidence rate of 1.1 per 100,000 person-
26 years (Nicholls et al., 2011). It is also relatively rare among middle-aged and elderly women
27 (Lapid et al., 2010) with an estimated lifetime prevalence in the UK of almost 4% (Micali et
28 al., 2017). The incidence of anorexia nervosa, as identified by GPs, has remained stable
29 over the past decade, with a peak age of onset of 15-19 years (Micali 2013).

30 Anorexia nervosa has the highest rate of mortality among all mental disorders. Its weighted
31 crude mortality rate (CMR) is approximately 5.1 deaths per 1,000 person-years. The most
32 common causes of death are suicide (20%) and cardiac complications (Arcelus et al., 2011).

33 2.2.2 Bulimia nervosa

34 There is a lack of epidemiological evidence specific to the UK context. In Western Europe
35 and the US, the one-year prevalence of bulimia nervosa has been estimated to be
36 approximately 1% in women and 0.1% in men (van Hoeken 2003), although the people in
37 this study were predominantly under 35 years of age. Recent studies have also suggested
38 that the prevalence of bulimia nervosa in men may be higher than previously thought
39 (Hudson et al., 2007; Sweeting et al., 2015). Incidence studies suggest an increase in
40 diagnoses in the 1980s and mid-1990s, followed by a decrease in incidence in the late 1990s
41 (Currin 2005), with stability since that time (Micali 2013). The incidence of bulimia nervosa
42 showed a similar pattern of increase and decrease over that time period, peaking at 12.2 per
43 100,000 person-years in 1993 but reducing to 6.6 per 100,000 in 2000 (Currin 2005). Age at
44 identification also appears to be decreasing, currently sitting among 15 – 24-year-old females
45 (Smink et al., 2012), though it is not clear whether this reflects earlier detection or earlier age
46 of onset. Bulimia nervosa has a weighted crude mortality rate of 1.74 per 1,000 person years
47 and an overall standardised mortality ratio of 1.93 (Arcelus 2011).

1 **2.2.3 Binge eating disorder**

2 The lifetime prevalence of BED in Europe has been estimated to be approximately 1.9% for
3 women and 0.3% for men (Preti et al., 2009). Compared with the other eating disorders, BED
4 is more common in males and older individuals. BED is commonly associated with obesity,
5 which in turn is associated with increased risk of mortality.

6 **2.2.4 Atypical eating disorders**

7 Such cases are labelled as eating disorder not otherwise specified (EDNOS) or other
8 specified feeding or eating disorder (OSFED) in different editions of the Diagnostic and
9 Statistical Manual of Mental Disorders (DSM) (APA, 1994; APA, 2013). Atypical cases form
10 the largest single category of eating disorders (Fairburn and Harrison, 2003). Lifetime
11 prevalence of EDNOS in the US has been estimated to be around 4.8% in young people and
12 4.6% in adults (Le Grange et al., 2012). More cases have been identified in recent years
13 (Micali 2013), from 17.7 per 100,000 in 2000 to 28.4 per 100,000 in 2009. Those authors
14 showed that EDNOS is the most commonly diagnosed eating disorder in males (4.2 per
15 100,000) and its female to male ratio for EDNOS was 7.7:1 in 2009. It should be noted that
16 due to the recent introduction of the OSFED category in DSM 5, the prevalence of OSFED is
17 less clear.

18 **2.3 Anorexia Nervosa**

19 Anorexia nervosa is characterised by the individual maintaining their weight as low as
20 possible by controlling their overall energy balance. Primarily this is done through restricting
21 food, but some patients exhibit other behaviours that both reduce energy intake and increase
22 energy expenditure, such as exercise, taking medications (e.g., metabolic stimulants,
23 laxatives, diuretics), exposing themselves to cold, purging, or chewing and spitting food.

24 Low weight is defined as less than minimally normal in adults, or minimally expected in
25 children and young people. For adults, this would typically mean a body mass index (BMI) of
26 less than 18.5. For children and young people, it would mean a BMI-for-age at less than the
27 5th percentile. While hormonal disturbance is a common feature, amenorrhea is no longer
28 treated as a criterion among females and is only one of a number of markers of hormonal
29 insufficiency due to low weight. (Physical complications are detailed below in Section 2.7).

30 Many individuals have poor insight into their condition and do not consider themselves to be
31 ill. In other cases, there is a level of secrecy about the symptoms, for example hiding weight
32 loss. This lack of clarity can have implications for treatment, as it is likely to delay the time
33 between the onset of the illness and contact with medical professionals. This duration of
34 untreated illness might indicate a marker of poor prognosis. Family or friends often play a
35 role initiating the pathway into care, as they notice that the individual loses weight, becomes
36 irritable, and withdraws (especially around meal times or events that involve food). Patients
37 might become selective about food and choose to prepare their own meals, absenting
38 themselves at family meal times, saying they aren't hungry or that they have already eaten,
39 or expressing a dislike for food they once enjoyed. They might develop unusual habits
40 around meal times, for example only eating at certain times, always using the same cutlery
41 or breaking the food into small pieces. Other behaviours that might be observed are regular
42 monitoring of their shape or weight, with persistent weighing, measuring and mirror checking.

43 The preoccupation with food and weight is often related to a pursuit of thinness, or later in
44 the development of the disorder, a fear of gaining weight. Patients often have low self-
45 esteem and a drive for perfection, resulting in a desire for control. Some individuals believe
46 they do not deserve to eat, or that their behaviours will result in increased happiness and
47 self-worth and/or positively influence how others perceive them. However, in some cases it is
48 not possible to ascertain any reason for the poor intake of food, especially in children and
49 young people who may find it difficult to articulate why they are restricting their eating.

1 **2.4 Bulimia Nervosa**

2 Bulimia nervosa is characterised by recurrent binge eating, extreme weight-control behaviour
3 and over concern about body shape and weight. ["Binges" are episodes of eating in which
4 large amounts of food are consumed accompanied by a sense of loss of control at the time.]
5 Bulimia nervosa is substantially more common than anorexia nervosa in the population,
6 though services are often more focused on the care of anorexia nervosa.

7 The disorder generally starts in late adolescence or early adulthood. It usually begins in
8 much the same way as anorexia nervosa (weight loss, experienced positively) but after some
9 months or years the dietary restriction becomes punctuated by repeated binges (resulting in
10 fear of weight gain). These binges are followed by compensatory behaviours, in most cases
11 self-induced vomiting or the misuse of laxatives, in an attempt to minimise their impact on
12 body weight. In-between binges there are also typically continuing attempts to restrict eating.
13 Despite this, any weight lost tends to be gradually regained and further weight gain is a
14 common outcome. People with an eating disorder are able to keep the problem secret for
15 many years, as their appearance is usually unremarkable and they can often eat normally in
16 public. Most delay seeking help because of the shame associated with this way of eating or
17 for other reasons such as a lack of awareness of available treatments.

18 Once fully developed, bulimia nervosa tends to be highly self-perpetuating, with adverse
19 effects on mood, self-esteem and relationships. It also carries substantial physical risks (see
20 below).

21 **2.5 Binge Eating Disorder**

22 Individuals with binge eating disorder regularly binge on large amounts of food in a discrete
23 period, with an accompanying sense of loss of control. However, they do not fast or use
24 other compensatory behaviours to a significant degree. Binge eating is accompanied by
25 significant distress and can involve high levels of guilt and shame, eating in secret and eating
26 despite not being hungry or until feeling uncomfortably full. Recurrent binges might occur
27 against a background of a general tendency to overeat, or the individual might eat normally
28 between binges. As a result, many (but not all) people with binge eating disorder are
29 overweight or obese. Binge eating disorder is particularly common among individuals
30 referred for bariatric surgery. The demographic distribution of binge eating disorder is
31 distinctive compared to anorexia nervosa or bulimia nervosa, in that the majority of patients
32 are middle-aged and about a third are male. The course of binge eating disorder is also quite
33 different from other eating disorders (Beat 2015; Fairburn 2003). Rather than being
34 persistent, it tends to remit and recur, with extended periods, often lasting many months, free
35 of the eating disorder. It is generally recognised that treatment should be focused around
36 reducing or eliminating binge eating rather than on weight loss, as a target of weight loss is
37 likely to result in greater levels of binge eating.

38 **2.6 Atypical eating disorders (eating disorders not otherwise 39 specified/other specified feeding and eating disorders)**

40 Many patients present to eating disorder services with the features of anorexia nervosa or
41 bulimia nervosa combined in such a way (or at a level of severity) that makes it impossible to
42 make either diagnosis fully. There is no consensus over how to denote these presentations
43 and they are often referred to as 'atypical' eating disorders, even though they are more
44 common than the 'typical' states. The terminology and criteria have changed over the years
45 in the DSM framework, including a change in labels from EDNOS, as it is in DSM-IV, to the
46 current OSFED of DSM 5.

47 In DSM-IV, the atypical eating disorders were taken to resemble anorexia nervosa and
48 bulimia nervosa, with an absence of some features or emphasis on some rather than others.

1 With the introduction in DSM 5 of BED as a diagnostic category in its own right on a par with
2 anorexia and bulimia nervosa, atypical eating disorders now also include cases that
3 resemble BED. In addition to atypical cases of BED, purging disorder and night eating
4 syndrome are also currently classified as atypical eating disorders. All such disorders share
5 the same over concern about eating, shape and weight and the same tendency to engage in
6 persistent and extreme dieting and other forms of weight control or disordered eating
7 behaviour, for example binge eating, purging and restriction. Body weight tends to be low if
8 the dietary restriction is marked. The atypical eating disorders do not include avoidant
9 restrictive food intake disorder, pica disorder nor rumination disorder, in which weight and
10 shape concerns are not a feature.

11 Most people with an atypical eating disorder are female and in their 20s. Many people with
12 an atypical eating disorder have a history of anorexia nervosa, bulimia nervosa or both, or
13 will go onto develop a typical eating disorder, reflecting the diagnostic migration that is
14 common among the eating disorders (Eddy et al., 2008; Schmidt et al., 2008). The atypical
15 eating disorders can be as impairing as the other eating disorders, with a similar duration and
16 impact on everyday functioning. Atypical eating disorders are also common in those with
17 other primary mental health diagnoses (Beat 2015, Fairburn & Harrison 2003).

18 2.7 Physical Complications

19 The physical complications of eating disorders are common, especially in anorexia nervosa,
20 where physical causes are implicated in around half of patients who die from an eating
21 disorder. Such complications arise as a result of malnutrition, binge eating and compensatory
22 behaviours (including vomiting, diuretic and laxative misuse, or excessive exercise), or
23 misuse of other drugs or alcohol. Physical complications can be considered as either acute
24 and longer term/chronic complications.

25 Acute complications typically relate to how underweight the individual is or to the rate of
26 weight loss. They include effects in a range of physiological systems:

- 27 • Cardiovascular effects include low heart rate, low blood pressure, postural hypotension,
28 poor peripheral circulation or conduction problems (e.g., prolonged QTc interval,
29 arrhythmias). Pericardial effusion and heart failure may also occur. Myocardial fibrosis may
30 be a cause of sudden cardiac death in these patients.
- 31 • Haematological effects due to a reduction in bone marrow activity and the quantity and
32 quality of blood cells, in particular, reduced amounts of platelets and neutrophils. This can
33 result in an impaired immune response, anaemia and a higher risk of stroke.
- 34 • Metabolic effects include electrolyte abnormalities (particularly low potassium, sodium,
35 phosphate and magnesium levels), vitamin and iron deficiencies and a reduction in bone
36 mineral density, which can be severe enough to cause osteoporosis even in young
37 patients) This results in an increased risk of fractures. There may be a loss of stature in
38 fully grown patients. Patients may experience hypothermia and temperature regulation is
39 impaired. Skin may be dry or easily bruised and pressure sores can develop, which are
40 slow to heal.
- 41 • Muscular effects are found throughout the body as fat stores are depleted and protein is
42 used as fuel, producing complications such as muscle weakness and proximal myopathy,
43 pain in skeletal muscles and joints, cardiomyopathy and delayed gut transit, causing
44 discomfort, bloating and constipation. Lung function may be compromised (e.g.,
45 emphysematous changes). Pulmonary oedema can develop. Hepatitis and more rarely
46 pancreatitis, can occur.

47 Effects on other systems are widespread. With severe weight loss, the brain is reduced in
48 size with widened ventricles and sulci. In such cases, cognitive deficits become noticeable as
49 weight drops, with memory and concentration impairment. Peripheral neuropathy can occur.
50 Frequent vomiting by people with an eating disorder can cause both short- and long-term

1 damage to dental health and in particular to appearance, which exacerbates body image
2 related psychological issues. Dental damage can occur quickly, after as little as only a few
3 months of frequent vomiting and is caused mainly by stomach acids washing over the tooth
4 surfaces thereby causing dissolution of the dental enamel and dentine, which is often termed
5 'erosion'. Eating too much fruit and drinking carbonated drinks can also cause similar
6 problems. Another common appearance in patients with eating disorders, in particular people
7 with bulimia nervosa, is an enlargement of the salivary glands, particularly the parotid gland
8 (up to 36% enlarged) which gives an appearance of swollen cheeks.

9 **Chronic/longer term complications include:**

- 10 • Growth and development in children and young people. Growth may be slowed or cease,
11 so that the person does not reach their potential height. Puberty can be delayed,
12 incomplete or not start.
- 13 • Reproductive system effects include amenorrhoea in females and loss of potency in
14 males. Fertility may be sub-optimal, even in recovered patients. There is a higher rate of
15 obstetric complications in women who do conceive.
- 16 • Bone mineral density is commonly affected in males and females with longer standing low
17 weight (generally longer than six months), especially when being underweight coincides
18 with key periods of bone mineral acquisition (e.g., adolescence). Patients with anorexia
19 nervosa have a greater risk of contemporary and lifetime fractures.
- 20 • Weight gain and mechanical effects of binge eating, weight gain and obesity are also
21 important to note in many cases. In particular, type 2 diabetes can develop with
22 associated complications. There can also be pain and mobility problems associated with
23 such consequences of disturbed eating patterns. There can also be other mechanical
24 complications associated with binge eating and purging behaviours, including damage
25 and tears to the gastrointestinal tract.

26 **2.8 Comorbidities**

27 In addition to the physical complications outlined above, psychiatric comorbidity is common
28 in eating disorders (Anderson et al., 2002; Godart et al., 2015; Martinussen et al., 2016;
29 Swinbourne and Touyz, 2007). These include:

- 30 • a range of anxiety disorders (particularly social anxiety/phobia and obsessive compulsive
31 disorder), which commonly predate the eating disorders but which are exacerbated by the
32 eating pathology
- 33 • mood disorders, such as depression (with attendant suicidal thoughts and behaviours),
34 which are often secondary to the effects of malnutrition (including weight loss, but also
35 resulting from low carbohydrate intake resulting in low serotonin levels), loss of control
36 over eating behaviours, shame, etc.
- 37 • Compulsive behaviours, such as skin-picking, hair-pulling and compulsive exercise (even
38 in the absence of obsessive-compulsive disorder)
- 39 • Impulsive behaviours, such as self-harm, alcohol use, drug use and aggression

40 Other disorders are less common, for example psychotic disorders, but are still present on
41 occasion.

42 Personality-level pathology is also commonly comorbid with eating disorders. This can
43 include:

- 44 • pathological levels of perfectionist traits, which again commonly predate the eating
45 disorder but are exacerbated by the consequences of the eating pathology
- 46 • autistic spectrum disorder and attention deficit hyperactivity disorder appear to be over-
47 represented in patients with eating disorders and might be vulnerability factors

- 1 • personality disorders, particularly obsessive-compulsive personality disorder, borderline
2 personality disorder and avoidant personality disorder

3 However, given that these personality-level comorbidities are often alleviated by successful
4 treatment for the eating disorder (particularly dietary and weight normalisation), their role as
5 triggers or maintaining factors for eating disorders is uncertain.

6 **2.9 The treatment and management of eating disorders in the** 7 **NHS**

8 **Variation in existing provision**

9 There is wide variation in how eating disorders are treated and managed in the NHS. This
10 variation can be seen across the whole care pathway from the initial referral, through primary
11 psychological services, outpatient child and young people mental health services (CAMHS),
12 as well as across adult services. Some teams provide generic support, while others offer
13 more specialist input. This variation is also applicable to inpatient services, with some service
14 users being treated in specialist eating disorder units and others being admitted to generic
15 mental health units.

16 Significant geographical inconsistencies exist, with different areas providing widely
17 contrasting services. This pattern of geographical difference is likely to be influenced by
18 variations in funding across the country, as well as differences in referral criteria to specialist
19 services. For example, NHS England Specialised Commissioning has contracts with both
20 NHS and private inpatient units, with admission criteria largely dependent on where the
21 service user lives. Consequently, people can sometimes be admitted to units geographically
22 distant from both their home and community-based services.

23 **Primary and secondary care pathways**

24 Most patients with eating or feeding symptoms initially present in primary care, though not
25 necessarily with these symptoms as their presenting problem. The nature of an eating
26 disorder and the inherent ambivalence (e.g., control issues, shame) often make it very
27 unlikely that the individual with the eating disorder will seek help, and so treatment may
28 initially be sought by a family member or carer, particularly in the case of children and young
29 people. Clinicians working in primary care will have very different levels of experience, skill
30 and confidence in diagnosing, assessing and managing such patients. Some primary care
31 doctors and nurses lack the experience to offer the robust initial assessment that is needed
32 to ensure that appropriate onward referral is made. Furthermore, referral pathways from
33 primary care into secondary services will vary for adults, although these pathways are now
34 being standardised for patients aged 18 and under. In some areas, much more specialised
35 primary care assessment and triage services have developed in response to increasing
36 demand from patients and link into very well developed secondary care pathways. Following
37 an initial assessment GPs will consider referral to specialist secondary services where these
38 are available locally. They will also consider medication, if relevant, and follow up as
39 appropriate. Physical investigations may be carried out in primary care if indicated.

40 Due to the fact that many people see their dentists frequently, dentists may be the first
41 professionals to recognise eating problems as a result of identifying patterns of dental
42 erosion (Aranha et al., 2008). Recognition of the effects of eating disorders is taught by all
43 dental schools in the UK. Dental treatment can affect outcomes and appearance is important
44 for these patients. Current additive techniques with tooth coloured composite resins provide
45 simple, aesthetic, effective and protective treatment.

1 **Access pathways for children and young people**

2 In relation to children and young people, there have historically been inconsistencies in
3 service provision across the country, some young people being treated in generic CAMHS
4 teams rather than specialist eating disorder teams. In areas where there are specialist
5 services for younger patients, some will provide treatment and management of eating
6 disorders up until the age of 18 years. In some areas, the treatment and management of 16 –
7 18-year-olds will be delivered within adult services, whilst a small number of specialist
8 services take patients aged 14 years and over. In 2015, NHS England published a
9 commissioning guide to access and waiting Times, designed to redress some of this
10 variation in care for younger patients by setting standards for access and waiting times to
11 receive an evidence based psychological intervention (NCCMH, 2015).

12 Very few age inclusive teams that cover the full period of biological maturation (12-25 years)
13 exist across the country. Service access criteria related to age are likely to impact important
14 aspects of care, such as the extent to which parents/family are involved and the level of
15 responsibility the young person is encouraged to take. It is best practice for CAMHS and
16 adult services to have a clear transition protocol thus enabling a smooth transition between
17 services when required.

18 **Access pathways for adults**

19 Access to adult services tends to be either directly via primary care or through secondary
20 adult mental health services. As in CAMHS, referral criteria vary, often influenced by funding
21 and historical practice. In some areas, services will accept referrals of a wide range of eating
22 disorder presentations, but in areas where funding is more limited, services may have strict
23 referral criteria, such as a BMI cut-off or therapy only being offered to those within a specific
24 BMI range.

25 A further transition issue is the care of University students with eating disorders, as they are
26 often based at home for part of the year and at University for the remainder. Therefore, these
27 individuals require particularly high levels of coordination between services (and with
28 funders) to ensure that their access to care and their therapy is not compromised.

29 **Treatment diversity**

30 Waiting times for treatment vary significantly. Alongside offering out-patient treatment, some
31 community services will also provide more intensive day-care treatment, but again there is
32 significant variation across the country. Specialist in-patient treatment for children and young
33 people, as well as adults, is currently funded by NHS England. In-patient beds tend to be
34 accessed via specialist community services.

35 There is great variety in current therapeutic choices (interventions) offered and in the skill-set
36 of the clinicians delivering these interventions. At times this can leave both patients and
37 healthcare professionals in some confusion as to how best to manage these clinical cases. It
38 is a clinical area in which a diverse range of therapies have evolved over the last few years,
39 adding to the potential for challenging medical, nursing and psychotherapeutic decision-
40 making. The Access and Waiting Times initiative (NHS England 2015) aims to address this
41 variation in the type of therapy as well as the referral pathway. At present this only applies to
42 those aged 18 and under.

43 **Inpatient care**

44 Inpatient care, particularly for anorexia nervosa, was central to the management of eating
45 disorders in the twentieth century. However, there has been a move to more community-
46 centred care with hospital care restricted to the patient group with severe medical risk and/or
47 a failure to respond to outpatient care. The main goal of inpatient treatment is to reduce

1 medical risk by improving nutrition. This usually involves meals supervised by nurses.
2 Facilities with less than 24 hours per day care such as partial hospitalisation or day care are
3 used as an alternative to inpatient care, or as the second phase in a form of stepped care.
4 Inpatient care is less often used for bulimia nervosa unless comorbidity with problems such
5 as diabetes increase the medical risk.

6 **Clinical Practice**

7 In in-patient care levels of anxiety are high before, during and after meals. This may be
8 marked by intense emotional displays, but more often patients have a 'poker face' with
9 restricted facial expression of emotions. This blocks an empathic reaction from staff who can
10 become frustrated and hostile. On the other hand, if others recognise the terror associated
11 with food, they may be drawn into accommodating the illness enabling eating disorder
12 behaviours to persist. Thus, careful planning and supervision is needed to achieve a balance
13 between avoidance and coercion. Eating is non-negotiable. On the other hand, the form and
14 content of food-related activities can be individualised to a degree. Advance planning and
15 review and a rule of no negotiations during meals themselves are helpful strategies.

16 **Tube Feeding**

17 Nasogastric (NG) feeding is used in in-patients settings and is recommended over other
18 enteral routes or parenteral nutrition when nutrition cannot be taken orally. NG feeding is
19 relatively common in children and young people with anorexia nervosa but not so often in
20 adults in the UK, although the Care Quality Commission aims to ensure all units are
21 equipped and competent to do it when needed. It is important that patients, parents and
22 carers are involved and understand the rationale for its use as a way to provide adequate
23 and safe quantities of calories where patients appear unable to do this orally. Conversely,
24 efforts must be given to avoid either explicit or implicit punitive application.

25 The lower threshold for use in young people is multifactorial and includes the fact that the
26 impact of malnutrition in young people can be more acute and have lasting consequences on
27 growth and development. The law also puts emphasis on adults being responsible for the
28 care of young people up to the age of 18, taking into consideration increasing autonomy and
29 capacity. Additionally, there is evidence that early weight restoration has an impact on
30 outcome, justifying an aggressive approach to refeeding in the early stages of the illness.
31 However, randomised trials looking at how this weight gain is achieved (NG versus oral)
32 have not been undertaken in young people. A case series of young people fed by NG tube
33 found that, at follow up two thirds of patients thought the intervention had been necessary,
34 while the remaining third still had negative views (Neiderman et al., 2001). A proportion of
35 young people (and adults) want to be tube fed as it can be preferable not to feel responsible
36 for eating (Neiderman 2001). Clinical practice varies widely on use of NG feeding in children
37 and young people, with some units using it continuously (Kohn et al., 2011) and others only
38 as a last resort (for example by offering meal support instead) (Couturier and Mahmood,
39 2009).

40 **Rate of refeeding**

41 There are existing guidelines on refeeding such as the NICE guideline on nutrition support
42 for adults (NICE, 2006). There is now concern in the field that if these guidelines are applied
43 to people with an eating disorder they may be underfed. Several studies have been
44 examining this question (Madden et al., 2015; Redgrave et al., 2015). The only randomized
45 controlled trial of refeeding to date found that young people randomized to high energy intake
46 (1200 kilocalories versus 500 kilocalories) had greater weight gain than those on a more
47 conservative regime, without a statistically significant increase in risk (O'Connor et al.,
48 2016a). There is considerable variation in the amounts of starting calories internationally and
49 between units.

1 **Treatment Environment**

2 For young people, the inpatient or day patient environments can be a place to practice family
3 meals and develop a structure for mealtime management with staff support. Such
4 environments may also provide time, space and motivation for psychological change to
5 begin. Home leave is an important aspect of care, providing opportunities for skills to be put
6 into practice. The value of inpatient care in those with severe and enduring anorexia nervosa
7 is more questionable, other than as a life saving measure when appropriate.

8 It is challenging to develop a strong evidence base regarding interventions on inpatient and
9 day patient settings, as randomisation to different forms of intervention within such settings
10 can be problematic and it is difficult to find effects over and above those resulting from
11 standard care.

12 **Admission Criteria**

13 There is no international agreement on the admission criteria for in-patient care and the
14 thresholds specified in national guidelines vary. Healthcare settings also differ internationally;
15 in some paediatrics/medical models of care predominate, in others eating disorders form part
16 of generic mental health services, and yet others specialist eating disorder units are the
17 norm. In part, admission criteria depend on the facilities available and the amount of risk they
18 are able to manage. Patients with extreme medical risk and multiple organ failure are usually
19 admitted to general medical hospitals. In the UK, the 'Management of Really Sick Patients
20 with Anorexia Nervosa' (MARSIPAN) protocol has been developed to describe the care
21 pathway for such cases, in both adults and children and young people, and to optimise the
22 liaison between physical and psychiatric care (Royal College of Psychiatry, 2012; Royal
23 College of Psychiatry, 2014).

24 **Discharge Criteria**

25 The traditional goal of inpatient care was to restore weight to normal. The underlying
26 assumption was that normal physiology and eating habits would then resume. Indeed, low
27 weight at discharge increases the likelihood of relapse and readmission. However, the
28 outcome of inpatient care is confounded by many factors such as the level of motivation, and
29 further randomised controlled trials are essential to interpret findings. Shorter periods of
30 inpatient stay and lower discharge BMIs are part of current practice.

31 **Aftercare**

32 The relapse rates following a first admission to inpatient care are 20-30% rising to 50-75%
33 for those with more than one admission (Lay et al., 2002; Steinhausen and Seidel, 1993;
34 Strober et al., 1997). Psychological interventions for patients and/or carers delivered face-to-
35 face or through various form of technology have been found to reduce the rate of relapse. On
36 the other hand, dietary advice or medication appears to have no impact. A systematic review
37 of the longer term follow up of inpatient/aftercare treatment in two RCTs (Eisler et al., 1997;
38 Godart et al., 2012) have found that involving families in the post intensive treatment
39 aftercare of young people improves outcomes. One pilot RCT has found that involving carers
40 in the aftercare of adults improves outcomes (Hibbs et al., 2015; Magill et al., 2016).

41 **2.10 Use of health service resources**

42 In keeping with the variable patterns of service provision and delivery, the level of resource
43 allocation differs across settings in the UK. There are also substantial differences across
44 countries.

1 **UK resources**

2 Beat (2015) has reported on the costs associated with eating disorders in the UK. Their
3 calculation included three cost categories:

- 4 • treatment costs (including both NHS and private providers) amount to £8,850 per
5 individual per annum (in likely 2011 prices);
- 6 • direct financial burden to those with an eating disorder and their carers (excluding any
7 payments for private treatment) amount to £4,300 per annum;
- 8 • indirect financial burden on those with an eating disorder and their carers, resulting from
9 disruption to education, employment and professional development amount to £10-15.4
10 thousand per annum (according to educational and employment status of the sufferer).

11 Thus, the cost to health service resources of the treatment element was £8,850 per individual
12 per annum. However, that cost will be much higher for in-patients and lower for out-patients.

13 Using a broader basis for assessing treatment costs, including costs to the educational and
14 voluntary sectors, Byford and colleagues (2007) showed that the cost per annum of treating
15 young people was £26,738 in a specialist outpatient service and £34,531 in a specialist in-
16 patient unit (in 2003/2004 prices). However, both were less expensive than treating them in
17 general CAMHS services (annual cost of £40,794).

18 **Comparison with resource use in other countries**

19 Comparative resource costs are provided for other countries, with the provision that the
20 baseline costs of care vary across countries, for example, the level of staffing and staff costs
21 and the greater use of in-patient resources in some countries, reducing immediate
22 comparability. In addition, the following figures need to be corrected upwards to allow for the
23 year in which they were assessed.

- 24 • In Germany, the cost of a treatment episode was €5,251 for anorexia nervosa and €3,265
25 for bulimia nervosa (Haas et al., 2012) in likely 2011 Euros.
- 26 • In an earlier German study, the annual cost was €5,300 for anorexia nervosa and €1,300
27 for bulimia nervosa (Krauth and Buser, 2002) in likely 2001 Euros, indicating that the
28 length of treatment episode for bulimia nervosa may have increased or become more
29 hospital-based over the decade between the studies

30 Overall resource costs have been shown to be higher than the comparable costs for non-
31 eating disordered individuals:

- 32 • Overall, in the US, those with eating disorders spent \$1,869 per annum more on
33 healthcare costs than those without eating disorders (Samnaliev et al., 2015) in likely
34 2014 US dollars.
- 35 • In the US, healthcare costs for eating disorders were substantially higher for eating
36 disorders (\$37,125 over five years) than for a non-disordered group (\$13,725 over the
37 same time period), though the figures for people with an eating disorder were similar to
38 those for people with depression (Mitchell et al., 2009) in likely 2008 US dollars.
- 39 • In the US, one-year healthcare costs are higher for people with binge eating disorder than
40 for those with EDNOS (by as much as \$5,589) and higher than those for controls who do
41 not have an eating disorder (by as much as \$18,152) (Bellows et al., 2015) in likely 2014
42 US dollars.

43 Inpatient care is particularly costly. For example:

- 44 • In Germany, mean costs over three months of care for anorexia nervosa patients was
45 costed at €5,866, but most of this accounted by the cost of hospitalisations (Stuhldreher et
46 al., 2014) in likely 2014 prices.

- 1 • Health service costs in the US for acute inpatient care in a general hospital were \$12,141
2 for anorexia nervosa and \$8,697 for bulimia nervosa (O'Brien and Ward, 2003) in likely
3 2002 US dollars.
- 4 • Considering different eating disorders (Striegel-Moore et al., 2004), inpatient care has
5 been shown to be considerably more expensive than outpatient care:
6 ○ anorexia nervosa: \$16,740 (inpatient) versus \$2,242 (outpatient);
7 ○ bulimia nervosa: \$9,380 (inpatient) versus \$1,848 (outpatient);
8 ○ EDNOS: \$12,748 (inpatient) versus \$2,146 (outpatient); in likely 1999 US dollars.
- 9 • Among children and young people with eating disorders in the US, the mean cost of an
10 inpatient stay (mean duration of 18.4 days) was \$10,019 (Robergeau et al., 2006) in likely
11 2005 US dollars.
- 12 • In a further study of young people treated in the US, the annual cost of treatment was
13 \$33,105 (Lock et al., 2008) in likely 2007 US dollars. However, the medical element
14 (inpatient and outpatient monitoring) accounted for 81% of this cost.
- 15 • Again in the US, Lock and colleagues (2003) costed a mean period of 23.2 days of
16 inpatient treatment for young people with anorexia nervosa at \$25,750 in likely 2002 US
17 dollars.
- 18 • In 22 residential eating disorder treatment programmes (including people with anorexia
19 nervosa and bulimia nervosa) in the US, the mean length of stay was 83 days and the
20 mean cost per person was \$79,348 (Frisch et al., 2006) in likely 2005 US dollars.

21 Non-health-service costs are also significant. For example:

- 22 • Disability payments to individuals with anorexia nervosa in British Columbia, Canada were
23 calculated to be \$101.7 million per year, which is approximately 30 times the cost of all
24 tertiary care services of eating disorders in the province (Su and Birmingham, 2003) in
25 likely 2002 Canadian dollars.

26 **Additional resources**

27 There are also substantial healthcare resource costs that are related to the use of non-eating
28 disorder services. For example:

- 29 • In the US, people with binge eating disorder had higher generic healthcare costs (\$1,379
30 in six months) than age- and gender-based norms (Grenon et al., 2010) in likely 2009 US
31 dollars.
- 32 • In the US, substantial amounts of herbal and alternative medications were used, with an
33 estimated cost of \$33.88 per individual per month (Steffen et al., 2006) in likely 2005 US
34 dollars.

35 **Conclusion**

36 To summarise, the health service costs per eating-disordered patient in the UK are
37 approximately £8,850 per individual per annum year. This cost refers to people with an
38 eating disorder, but does not distinguish across the type of eating disorder. However, the
39 cost of anorexia nervosa treatment is likely to be higher than that of other eating disorders as
40 this relatively small group of cases receives substantially more inpatient care. These figures
41 are not directly comparable with those from other countries, though such figures do support
42 the conclusion that eating disorders (in particular, anorexia nervosa) result in a substantial
43 economic burden on healthcare resources. Efficient use of available healthcare resources
44 will maximise the health benefit for people with eating disorders and can potentially reduce
45 costs to the healthcare system as well as to society as a whole.

3 Methods used to develop this guideline

3.1 What is a NICE clinical guideline?

National Institute for Health and Care Excellence (NICE) clinical guidelines are recommendations for the care of individuals in specific clinical conditions or circumstances within the NHS – from prevention and self-care through primary and secondary care to more specialised services. We base our clinical guidelines on the best available research evidence, with the aim of improving the quality of healthcare. We use predetermined and systematic methods to identify and evaluate the evidence relating to specific review questions.

NICE clinical guidelines can:

- provide recommendations for the treatment and care of people by healthcare professionals
- be used to develop standards to assess the clinical practice of individual healthcare professionals
- be used in the education and training of healthcare professionals
- help patients to make informed decisions
- improve communication between patients and healthcare professionals.

While guidelines assist the practice of healthcare professionals, they do not replace their knowledge and skills.

We produce our guidelines using the following steps:

- The guideline topic is referred to NICE from the Department of Health.
- Stakeholders register an interest in the guideline and are consulted throughout the development process.
- The scope is prepared by the former National Collaborating Centre for Mental Health (NCCMH (National Guideline Alliance (NGA) from April 2016)).
- The NGA establishes a Guideline Committee.
- A draft guideline is produced after the group assesses the available evidence and makes recommendations.
- There is a consultation on the draft guideline.
- The final guideline is produced.

The NGA and NICE produce a number of versions of this guideline:

- The 'full guideline' contains all the recommendations, together with details of the methods used and the underpinning evidence.
- The 'short guideline' lists the recommendations, context and recommendations for research.
- 'Information for the public' is written using suitable language for people without specialist medical knowledge.
- NICE Pathways brings together all connected NICE guidance.

3.2 Remit

NICE received the remit for this guideline from the Department of Health. It commissioned the NGA to produce the guideline.

1 The remit for this guideline is to develop a clinical guideline on eating disorders: Core
2 interventions in the treatment and management of anorexia nervosa, bulimia nervosa and
3 related eating disorders (update).

4 **3.3 Who developed the guideline?**

5 A multidisciplinary committee comprising healthcare professionals, researchers and lay
6 members developed this guideline (see the list of group members and acknowledgements).

7 NICE funds the NGA and thus supported the development of this guideline. The committee
8 was convened by the NGA and chaired by Anthony Bateman in accordance with guidance
9 from NICE.

10 The group met every four to six weeks during the development of the guideline. At the start
11 of the guideline development process all group members declared interests including
12 consultancies, fee-paid work, shareholdings, fellowships and support from the healthcare
13 industry. At all subsequent group meetings, members declared arising conflicts of interest.

14 Members were either required to withdraw completely or for part of the discussion if their
15 declared interest made it appropriate. In such cases, the relevant members were sometimes
16 consulted for points of clarification only and did not play a role in the committee's decision
17 making. The details of declared interests and the actions taken are shown in Appendix B.

18 Staff from the NGA provided methodological support and guidance for the development
19 process. The team working on the guideline included a guideline lead, a project manager,
20 systematic reviewers, health economists and information scientists. They undertook
21 systematic searches of the literature, appraised the evidence, conducted meta-analysis and
22 cost-effectiveness analysis where appropriate and drafted the guideline in collaboration with
23 the committee.

24 **3.4 What this guideline covers**

25 **3.4.1 Groups that will be covered**

26 This guideline covers the following groups:

- 27 • Children, young people and adults with an eating disorder, including atypical
28 presentations, or a suspected eating disorder.

29 **3.4.2 Key clinical issues that will be covered**

30 The following clinical issues will be covered in this guideline:

- 31 • Identification, assessment and monitoring:
 - 32 ○ recognition and early identification of eating disorders (including formal recognition
 - 33 tools)
 - 34 ○ assessment in people with an eating disorder (including formal assessment tools)
 - 35 ○ monitoring in people with an eating disorder.
- 36 • Interventions to treat eating disorders through all phases of the disorder including:
 - 37 ○ psychological interventions, including low-intensity interventions such as self-help and
 - 38 Internet-based therapies, high-intensity interventions such as family therapy and family-
 - 39 based treatments and individual therapies such as psychodynamically informed
 - 40 therapies, cognitive behavioural therapy (CBT), interpersonal psychotherapy and
 - 41 behavioural interventions
 - 42 ○ pharmacological interventions (note that guideline recommendations will normally fall
 - 43 within licensed indications; exceptionally, and only if clearly supported by evidence, use

- 1 outside a licensed indication may be recommended. The guideline will assume that
2 prescribers will use a drug's summary of product characteristics to inform decisions
3 made with individual patients)
- 4 ○ nutritional interventions, including tube feeding
5 ○ other physical interventions, such as transcranial magnetic stimulation and
6 physiotherapy.
- 7 • The management of physical health problems caused by an eating disorder.
8 • Interventions for eating disorders in the context of common physical and psychological
9 comorbidities.
10 • Interventions to support families and carers.
11 • Organisation and delivery of services to support practitioners in the effective and
12 competent delivery of interventions.
13 • Consent and compulsory treatment.
14 • Note that guideline recommendations will normally fall within licensed indications.
15 Exceptionally, and only if clearly supported by evidence, use outside a licensed indication
16 may be recommended. This guideline will assume that prescribers will use a drug's
17 summary of product characteristics to inform decisions made with individual patients.
18 • For further details please refer to the scope in Appendix A and review questions in
19 Appendix D.

20 **3.5 What this guideline does not cover**

21 **3.5.1 Groups that will not be covered**

- 22 • People with disordered eating because of a separate physical or other primary mental
23 health problem of which a disorder of eating is a symptom
24 • People with feeding disorders, such as avoidant restrictive food intake disorders
25 • People with obesity without an eating disorder.

26 **3.5.2 Clinical areas that will not be covered**

- 27 • The diagnosis or treatment of people with disordered eating in the context of a separate
28 physical or other primary mental disorder of which a disorder of eating is a symptom (such
29 as loss of appetite in depression)
30 • The management of loss of appetite, psychogenic disturbance of appetite or other
31 conditions that involve significant weight loss but which are due to known physical illness.
32 • The management of the wider range of eating disturbances typically but not exclusively
33 occurring in children (for example, Pica or avoidant restrictive food intake disorders such
34 as food avoidance emotional disorder or picky/selective eating).
35 • Obesity in the absence of an eating disorder.

36 **3.6 Relationships between the guideline and other NICE** 37 **guidance**

38 **3.6.1 Related NICE guidance**

- 39 • Patient experience in adult NHS services (2012) NICE guideline CG138
40 • Service user experience in adult mental health (2011) NICE guideline CG136
41 • Medicines Adherence (2009) (2009) NICE guideline CG76
42 • Nutritional Support in Adults (2006) NICE guideline CG32

- 1 • Behaviour change: individual approaches (2014) NICE guideline PH49
- 2 • Behaviour change: the principles for effective interventions (2007) NICE guideline PH6
- 3 • Transition from children's to adult's services for young people using health or social care
- 4 services (2016) NICE guideline NG43

5 **3.7 Methodology**

6 The development of this guideline followed the NICE guideline manual (NICE, 2014). A team
7 of health and social care professionals, lay representatives and technical experts known as
8 the Guideline committee with support from the NGA staff, undertook the development of a
9 person-centred, evidence-based guideline. There are eight basic steps in the process of
10 developing a guideline:

- 11 • Define the scope, which lays out exactly what will be included (and excluded) in the
- 12 guidance.
- 13 • Define review questions that cover all areas specified in the scope.
- 14 • Develop a review protocol for each systematic review, specifying the search strategy and
- 15 method of evidence synthesis for each review question.
- 16 • Synthesise data retrieved, guided by the review protocols.
- 17 • Produce evidence profiles and summaries using the GRADE system.
- 18 • Consider the implications of the research findings for clinical practice and reach
- 19 consensus decisions on areas where evidence is not found.
- 20 • Consider the economic costs for each review question.
- 21 • Answer review questions with evidence-based recommendations for clinical practice.

22 The clinical practice recommendations made by the committee are therefore derived from the
23 most up-to-date and robust evidence for the clinical and cost effectiveness of the
24 interventions and services covered in the scope. Where evidence was not found or was
25 inconclusive, the committee discussed and attempted to reach consensus on what should be
26 recommended, factoring in any relevant issues. In addition, to ensure a service user and
27 carer focus, the concerns of service users and carers regarding health and social care have
28 been highlighted and addressed by recommendations agreed by the whole committee.

29 **3.8 Developing the scope**

30 Clinical guideline topics are referred from the Department of Health or the NHS
31 Commissioning Board and the letter of referral defines the remit, which defines the main
32 areas to be covered; see NICE (2014) for further information. The NGA developed a scope
33 for the guideline based on the remit (see Appendix 1). The purpose of the scope is to:

- 34 • provide an overview of what the guideline will include and exclude
- 35 • identify the key aspects of care that must be included
- 36 • set the boundaries of the development work and provide a clear framework to enable work
- 37 to stay within the priorities agreed by NICE and the NGA and the remit from the
- 38 Department of Health
- 39 • inform the development of the review questions and search strategy
- 40 • inform professionals and the public about expected content of the guideline
- 41 • keep the guideline to a reasonable size to ensure that its development can be carried out
- 42 within the allocated period.

43 An initial draft of the scope was sent to registered stakeholders who had agreed to attend a
44 scoping workshop. The workshop was used to:

- 45 • obtain feedback on the selected key clinical issues

- 1 • identify which population subgroups should be specified (if any)
- 2 • seek views on the composition of the Guideline Committee
- 3 • encourage applications for committee membership.

4 The draft scope was subject to consultation with registered stakeholders over a four week
5 period. During the consultation period, the scope was posted on the NICE website.
6 Comments were invited from stakeholder organisations The NGA and NICE reviewed the
7 scope in light of comments received and the revised scope was signed off by NICE.

8 **3.9 The Guideline Committee**

9 During the scope consultation phase, members of the committee were appointed by an open
10 recruitment process. Committee membership consisted of: professionals in psychiatry,
11 clinical psychology, nursing, social work, general practice; academic experts in psychiatry
12 and psychology; and service users and carers. The guideline development process was
13 supported by staff from the NGA, who undertook the clinical and health economic literature
14 searches, reviewed and presented the evidence to the committee, managed the process and
15 contributed to drafting the guideline.

16 **3.9.1 Guideline committee meetings**

17 There were 12 committee meetings, held between May 2015 and July 2016. During each
18 day-long committee meeting, in a plenary session, review questions and clinical and
19 economic evidence were reviewed and assessed and recommendations formulated. At each
20 meeting, all committee members declared any potential conflicts of interest (see Appendix B)
21 and service user and carer concerns were routinely discussed as a standing agenda item.

22 **3.9.2 Service users and carers**

23 The committee included one carer member and two service users who contributed as full
24 committee members to writing the review questions, providing advice on outcomes most
25 relevant to service users and carers, helping to ensure that the evidence addressed their
26 views and preferences, highlighting sensitive issues and terminology relevant to the guideline
27 and bringing service user research to the attention of the committee. Input from both service
28 users and carers was central to the development of the guideline and they contributed to
29 writing the guideline's introduction and the recommendations from the service user and carer
30 perspective.

31 **3.9.3 Expert advisers**

32 No Expert Advisors were used in the development of this guideline.

33 **3.9.4 National and international experts**

34 National and international experts in the area under review were identified through the
35 literature search and through the experience of the committee members. These experts were
36 contacted to identify unpublished or soon-to-be published studies, to ensure that up-to-date
37 evidence was included in the development of the guideline. They informed the committee
38 about completed trials at the pre-publication stage, systematic reviews in the process of
39 being published, studies relating to the cost effectiveness of treatment and trial data if the
40 committee could be provided with full access to the complete trial report. Appendix E lists
41 researchers who were contacted.

1 3.10 Review protocols

2 Review questions drafted during the scoping phase were discussed by the committee at the
3 first few meetings and amended as necessary. The review questions were used as the
4 starting point for developing review protocols for each systematic review (described in more
5 detail below). The final list of review questions can be found in Appendix F.

6 For questions about interventions, the PICO (Population, Intervention, Comparison and
7 Outcome) framework was used to structure each question (see Table 3).

8 **Table 3: Features of a well-formulated question on the effectiveness of an**
9 **intervention – PICO**

Population:	Which population of service users are we interested in? How can they be best described? Are there subgroups that need to be considered?
Intervention:	Which intervention, treatment or approach should be used?
Comparison:	What is/are the main alternative/s to compare with the intervention?
Outcome:	What is really important for the service user? Which outcomes should be considered: intermediate or short-term measures; mortality; morbidity and treatment complications; rates of relapse; late morbidity and readmission; return to work, physical and social functioning and other measures such as quality of life; general health status?

10 Questions relating to case identification and assessment tools and methods do not involve
11 an intervention designed to treat a particular condition and therefore the PICO framework
12 was not used. Rather, the questions were designed to pick up key issues specifically relevant
13 to clinical utility, for example their accuracy, reliability, safety and acceptability to the service
14 user.

15 In some situations, review questions related to issues of service delivery are occasionally
16 specified in the remit from the Department of Health. In these cases, appropriate review
17 questions were developed to be clear and concise.

18 For each topic, addressed by one or more review questions, a review protocol was drafted by
19 the technical team using a standardised template (based on the PROSPERO database of
20 systematic reviews in health), review and agreed by the committee (all protocols are included
21 in Appendix F).

22 To help facilitate the literature review, a note was made of the best study design type to
23 answer each question. There are five main types of review question of relevance to NICE
24 guidelines. These are listed in Table 4. For each type of question, the best primary study
25 design varies, where 'best' is interpreted as 'least likely to give misleading answers to the
26 question'. For questions about the effectiveness of interventions, where randomised
27 controlled trials (RCTs) were not available, the review of other types of evidence was
28 pursued only if there was reason to believe that it would help the committee to formulate a
29 recommendation.

30 However, in all cases, a well-conducted systematic review (of the appropriate type of study)
31 is likely to always yield a better answer than a single study.

1 **Table 4: Best study design to answer each type of question**

Type of question	Best primary study design
Effectiveness or impact of an intervention	RCT; other studies that may be considered in the absence of RCTs are prospective and retrospective cohort studies
Diagnostic accuracy	Comparing the information against a valid gold standard in a cohort or case-control study
Prognostic reviews	Prospective cohort studies or case-control
Prevalence of disease, rare side-effects	Prospective cohort, registry, cross-sectional study, case-control
Experience of care	Qualitative research (for example, grounded theory, ethnographic research)

2 (a) RCT = randomised controlled trial.

3 3.11 Clinical review methods

4 The aim of the clinical literature review was to systematically identify and synthesise relevant
5 evidence from the literature in order to answer the specific review questions developed by
6 the Committee. Thus, clinical practice recommendations are evidence-based, where
7 possible, and, if evidence is not available, either formal or informal consensus methods are
8 used to try and reach general agreement between committee members and the need for
9 future research is specified.

10 3.12 The search process

11 3.12.1 Scoping searches

12 A broad preliminary search of the literature was undertaken in January 2015 to obtain an
13 overview of the issues likely to be covered by the scope and to help define key areas. The
14 searches were restricted to clinical guidelines, Health Technology Assessment (HTA)
15 reports, key systematic reviews and RCTs. A list of databases and websites searched can be
16 found in Appendix H.

17 3.12.1.1 Systematic literature searches

18 After the scope was finalised, a systematic search strategy was developed to locate as much
19 relevant evidence as possible. The balance between sensitivity (the power to identify all
20 studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the
21 results) was carefully considered and a decision made to utilise a broad approach to
22 searching to maximise retrieval of evidence to all parts of the guideline. Searches were
23 restricted to certain study designs if specified in the review protocol and conducted in the
24 following databases:

- 25 • Cochrane Database of Abstracts of Reviews of Effects
- 26 • Cochrane Database of Systematic Reviews
- 27 • Cochrane Central Register of Controlled Trials Excerpta Medica Database (Embase)
- 28 • HTA database (technology assessments)
- 29 • Medical Literature Analysis and Retrieval System Online (MEDLINE)/MEDLINE In-
30 Process
- 31 • Psychological Information Database (PsycINFO)

32 The search strategies were initially developed for MEDLINE before being translated for use
33 in other databases/interfaces. Strategies were built up through a number of trial searches
34 and discussions of the results of the searches with the review team and committee to ensure

1 that all possible relevant search terms were covered. In order to assure comprehensive
2 coverage, search terms for mental health and learning disabilities were kept purposely broad
3 to help counter dissimilarities in database indexing practices and thesaurus terms and
4 imprecise reporting of study populations by authors in the titles and abstracts of records. The
5 search terms for each search are set out in full in Appendix H.

6 3.12.1.2 Reference Management

7 Citations from each search were downloaded into reference management software and
8 duplicates removed. Records were then screened against the eligibility criteria of the reviews
9 before being appraised for methodological quality (see below). The unfiltered search results
10 were saved and retained for future potential re-analysis to help keep the process both
11 replicable and transparent.

12 3.12.1.3 Search filters

13 To aid retrieval of relevant and sound studies, filters were used to limit a number of searches
14 to systematic reviews, RCTs and observational. The search filters for systematic reviews and
15 RCTs are adaptations of validated filters designed by the Health Information Research Unit
16 (HIRU) at McMaster University. The search filter for observational studies is an in-house
17 development. The filters have been recorded and can be found in Appendix H.

18 3.12.2 Date and language restrictions

19 Systematic database searches were initially conducted in May 2015 up to the most recent
20 searchable date. Search updates were generated on a six monthly basis, with the final re-
21 runs carried out in July 2016 ahead of the guideline consultation. After this point, studies
22 were only included if they were judged by the committee to be exceptional (for example, if
23 the evidence was likely to change a recommendation).

24 Although no language restrictions were applied at the searching stage, foreign language
25 papers were not requested or reviewed, unless they were of particular importance to a
26 review question.

27 Date restrictions were not applied, except for searches of systematic reviews which were
28 limited to research published from 2001. The search for systematic reviews was restricted to
29 the last 15 years as older reviews were thought to be less useful.

30 3.12.2.1 Other search methods

31 Other search methods involved: (a) scanning the reference lists of all eligible publications
32 (systematic reviews, stakeholder evidence and included studies) for more published reports
33 and citations of unpublished research; (b) sending lists of studies meeting the inclusion
34 criteria to subject experts (identified through searches and the committee) and asking them
35 to check the lists for completeness and to provide information of any published or
36 unpublished research for consideration (see Appendix E); (c) checking the tables of contents
37 of key journals for studies that might have been missed by the database and reference list
38 searches; (d) tracking key papers in the Science Citation Index (prospectively) over time for
39 further useful references; (e) conducting searches in ClinicalTrials.gov for unpublished trial
40 reports; (f) contacting included study authors for unpublished or incomplete datasets.
41 Searches conducted for existing NICE guidelines were updated where necessary. Other
42 relevant guidelines were assessed for quality using the AGREE (Appraisal of Guidelines for
43 Research and Evaluation Instrument) instrument (AGREE Collaboration, 2003). The
44 evidence base underlying high-quality existing guidelines was utilised and updated as
45 appropriate.

1 Full details of the search strategies and filters used for the systematic review of clinical
2 evidence are provided in Appendix H.

3 3.12.2.2 Study selection and assessment of methodological quality

4 All primary-level studies included after the first scan of citations were acquired in full and re-
5 evaluated for eligibility at the time they were being entered into the study information
6 database. Eligible systematic reviews and primary-level studies were critically appraised for
7 methodological quality (risk of bias) using a checklist (NICE, 2012a) for templates. However,
8 some checklists that were recommended in the 2014 manual update (NICE, 2014) were
9 used (for example, for qualitative studies, for systematic reviews [Assessing the
10 Methodological Quality of Systematic Reviews, AMSTAR, checklist] and for cross-sectional
11 and cohort studies [the Newcastle Ottawa checklist for observational studies was used
12 (Wells) for the epidemiological review on incidence and prevalence).

13 The Quality Assessment of Diagnostic Accuracy Studies – Revised (QUADAS-II) (Whiting et
14 al., 2011) was used for evaluating risk of bias and indirectness of diagnostic and assessment
15 tool studies.

16 For some review questions, it was necessary to prioritise the evidence with respect to the UK
17 context (that is, external validity). To make this process explicit, the committee took into
18 account the following factors when assessing the evidence:

- 19 • participant factors (for example, gender, age and ethnicity)
- 20 • provider factors (for example, model fidelity, the conditions under which the intervention
21 was performed and the availability of experienced staff to undertake the procedure)
- 22 • cultural factors (for example, differences in standard care and differences in the welfare
23 system).

24 It was the responsibility of the committee to decide which prioritisation factors were relevant
25 to each review question in light of the UK context.

26 3.12.2.3 Double-sifting

27 Titles and abstracts of identified studies were screened by two reviewers against inclusion
28 criteria specified in the protocols, until a good inter-rater reliability was observed (percentage
29 agreement $\geq 90\%$ or Kappa statistics, $K > 0.60$). Any disagreements between raters were
30 resolved through discussion. Initially 10% of references were double-screened. If inter-rater
31 agreement was good then the remaining references were screened by one reviewer.

32 Once full versions of the selected studies were acquired for assessment, full studies were
33 usually checked independently by two reviewers, with any differences being resolved. For
34 some review questions a random sample of papers was checked for inclusion. Any studies
35 that failed to meet the inclusion criteria at this stage were excluded.

36 3.12.2.4 Unpublished evidence

37 Stakeholders were invited to submit any relevant unpublished data using the call for
38 evidence process set out in NICE (2014). The committee used a number of criteria when
39 deciding whether or not to accept unpublished data. First, the evidence must have been
40 accompanied by a trial report containing sufficient detail to properly assess risk of bias.
41 Second, the evidence must have been submitted with the understanding that data from the
42 study and a summary of the study's characteristics would be published in the full guideline.
43 Therefore, in most circumstances the committee did not accept evidence submitted 'in
44 confidence'. However, the committee recognised that unpublished evidence submitted by
45 investigators might later be retracted by those investigators if the inclusion of such data
46 would jeopardise publication of their research.

1 3.12.3 Data extraction

2 3.12.3.1 Quantitative analysis

3 Study characteristics, aspects of methodological quality and outcome data were extracted
4 from all eligible studies, using Review Manager Version 5.3.5 (Cochrane Collaboration,
5 2014) and an Excel-based form.

6 In most circumstances, for a given outcome (continuous and dichotomous), where more than
7 50% of the number randomised to any group were missing or incomplete, the study results
8 were excluded from the analysis (except for the outcome 'leaving the study early', in which
9 case, the denominator was the number randomised). Where there were limited data for a
10 particular review, the 50% rule was not applied. In these circumstances the evidence was
11 downgraded.

12 Where possible, outcome data from an intention-to-treat analysis (that is, a 'once-
13 randomised-always-analyse' basis) were used. Where intention-to-treat had not been used
14 or there were missing data, the effect size for dichotomous outcomes were recalculated
15 using worse-case scenarios for positive outcome and vice versa (for example, it was
16 assumed that the person whose data was missing did not achieve remission). Results
17 reported at 12 months follow up (after the end of treatment) or as close as possible to 12
18 months were extracted. However, this was not always possible and outcomes up to 5 years
19 after treatment were sometimes reported.

20 All continuous outcomes were presented as a standardised mean difference (SMD) instead
21 of a mean difference (MD). The final scores in each group were the preferred outcome for
22 extraction. If final or change scores (from the baseline) were not reported, for example the
23 study reported an F-value, p-value or t-value, the standard mean difference (SMD) was
24 estimated if possible using a statistical calculator.

25 SMDs are typically used when different tools are used to measure the same outcome, for
26 example if depression is measured using either the Becks Depression Inventory or the
27 Hospital Anxiety and Depression Scale. However, in this guideline SMDs were also used to
28 present the results of continuous outcomes when the same tool was used, for example
29 eating psychopathology using the Eating Disorder Examination (EDE). The main reason for
30 this is that the committee are apt at making decisions based on SMDs using the
31 recommended interpretation of Cohen's effect size (d=0.2 small effect, d=0.5 moderate
32 effect, d=0.7 large effect).

33 An outcome that had an SMD of ≥ 0.2 was considered clinically significant (or clinically
34 important) and trends were discussed if the 95% confidence interval just crossed the line of
35 no effect. This apparently low number of an SMD ≥ 0.2 was used as the threshold because of
36 the small number of studies available and even small improvements on a scale that
37 measures eating behaviour or mental health were considered clinically important for the
38 person with an eating disorder.

39 The SMD results could have been converted back to MDs, however, no clinical consensus
40 was made on what constitutes a minimally important difference (MID) and no published MIDs
41 were found for body weight or for the various eating disorder scales reported. Granted, there
42 are methods available for estimating whether an MD is clinically important and there are
43 published MIDs for various depression scales, however, the committee acknowledged there
44 are limitations with both approaches (SMD and MD) and in order to make decisions across
45 many comparisons, SMDs was the preferred approach.

46 For dichotomous outcomes, clinical significance was considered anything that was +/- $\geq 10\%$
47 difference. Trends were discussed if the difference was +/- $\geq 10\%$ but just crossed the line of
48 no effect.

1 Where the committee agreed that treatment effects were of sufficient magnitude to be
2 clinically important they were described as 'favourable results' or being 'more effective' in the
3 Linking Evidence to Recommendations (LETR) tables. Conversely, if the outcome favoured
4 the control arm, the treatment was described as being 'less favourable' or 'less effective'. If
5 an outcome showed an effect size that was clinically important but just crossed the line of no
6 effect, it was considered clinically important with some uncertainty.

7 When calculating sensitivity and specificity for the case identification and assessment tools
8 reviews using the diagnostic test accuracy data (i.e. data about the true and false positives
9 and negatives yielded by the relevant test) a continuity correction of 0.5 was added to the
10 numerator and denominator in the cases where the denominator was equal to zero.

11 Where necessary, standard errors were calculated from confidence intervals (CIs) or p value
12 according to standard formulae; see the Cochrane Reviewers' Handbook 5.1.0 (Higgins and
13 Green, 2011). Data were summarised using the generic inverse variance method using
14 Review Manager.

15 Data from studies included in existing systematic reviews were extracted independently by
16 one reviewer and cross-checked with the existing dataset. Where possible, two independent
17 reviewers extracted data from new studies. Where double data extraction was not possible,
18 data extracted by one reviewer was checked by the second reviewer. Disagreements were
19 resolved through discussion. Where consensus could not be reached, a third reviewer or
20 committee members resolved the disagreement. Masked assessment (that is, blind to the
21 journal from which the article comes, the authors, the institution and the magnitude of the
22 effect) was not used since it is unclear that doing so reduces bias (Berlin, 2001; Jadad et al.,
23 1996).

24 The analyses performed for existing systematic reviews incorporated into the guideline were
25 not amended unless the committee considered that additional important aspects needed to
26 be taken into consideration. For example, this could include stratifying data, conducting
27 additional analyses, or using different results from the primary studies in a given analysis.
28 Otherwise, the analyses were not amended.

29 **3.12.4 Evidence synthesis**

30 The method used to synthesise evidence depended on the review question and availability
31 and type of evidence (see Appendix F for full details). Briefly, for questions about the
32 psychometric properties of instruments, reliability, validity and clinical utility were synthesised
33 narratively based on accepted criteria. For questions about test accuracy, bivariate test
34 accuracy meta-analysis was conducted when there were data from four or more studies to
35 calculate summary estimates of sensitivity and specificity for the relevant tool and threshold
36 (if applicable). In the case where there was data from less than four studies, a narrative
37 synthesis was presented. For questions about the effectiveness of interventions, standard
38 meta-analysis was used where appropriate, otherwise narrative methods were used with
39 clinical advice from the Committee. In the absence of high-quality research, formal and
40 informal consensus processes were used.

41 **3.12.5 Grading the quality of evidence**

42 For questions about the effectiveness of interventions and the organisation and delivery of
43 care, the GRADE approach was used to assess the quality of evidence for each outcome
44 (Guyatt et al., 2011). The technical team produced GRADE evidence profiles (see below)
45 using the GRADEpro guideline development tool, following advice set out in the GRADE
46 handbook (Schünemann et al., 2013). All staff doing GRADE ratings were trained, and
47 calibration exercises were used to improve reliability (Mustafa et al., 2013).

1 The analyses performed for existing systematic reviews incorporated into the guideline were
2 not amended unless the committee considered that additional important aspects needed to
3 be taken into consideration. For example, this could include stratifying data, conducting
4 additional analyses, or using different results from the primary studies in a given analysis.
5 Otherwise, the analyses were not amended.

6 For questions about what factors should be considered when admitting someone for
7 compulsory treatment, a quality appraisal checklist of studies reporting correlations and
8 associations was used. It is based on the appraisal step of the 'Graphical appraisal tool for
9 epidemiological studies GATE' (Jackson et al., 2006). This checklist enables a reviewer to
10 appraise a study's internal and external validity after addressing the following key aspects of
11 study design: characteristics of study participants; definition of independent variables;
12 outcomes assessed and methods of analyses. An estimate of the overall quality was based
13 on the average answer given to each of the checklists and given either very low, low,
14 moderate or high quality.

15 Heterogeneity was explored if the I² test was greater than 50%. As described in the
16 protocols, a sensitivity analysis was first conducted if see if studies that carried a high risk of
17 bias explained the heterogeneity. If removing studies with a high risk of bias did not explain
18 the results, then a subgroup analysis was conducted exploring the role duration of illness,
19 severity of illness and presence of comorbidities. The full results of this are explained in the
20 appendices and any subgroup analysis is shown in GRADE and explained in the LETR.

21 For observational studies included in any of the reviews, where randomised control trial
22 evidence was not available, they were appraised using a quality appraisal checklist provided
23 in the NICE manual 2012 (NICE, 2012b). This checklist assesses the study design, data
24 collection, trustworthiness of the investigators, and the rigour of the analysis.

25 For questions about tools for case-identification and assessment of eating disorders (see
26 Appendix M), a modified GRADE approach was used to produce an overall quality rating for
27 the evidence according to the GRADE criteria of risk of bias, inconsistency, indirectness and
28 imprecision. The default quality of evidence for cohort and cross-sectional studies was set as
29 high quality; case-control studies were set as low quality since they overestimate the
30 accuracy of tests due to spectrum bias (Kohn et al., 2013). The QUADAS-2 checklist was
31 used to evaluate risk of bias and indirectness (Bossuyt et al., 2013). Whilst the QUADAS-2
32 framework does not provide an overall quality index for each study, such a rating was
33 deemed important to assist the committee in interpreting the data on tools to augment
34 assessment of mental health problems. We therefore adopted the terminology used within
35 GRADE (high, moderate, low or very low quality evidence) (Schunemann et al., 2008;
36 Bossuyt et al., 2013). The approach taken to evaluating inconsistency and imprecision was
37 discussed and agreed with the committee: inconsistency was evaluated either by visual
38 inspection of the Summary Receiving Operating Characteristic (SROC) plot (where a meta-
39 analysis was possible) or by inspection of the sensitivity and specificity forest plots (based on
40 the primary measure of sensitivity or specificity, as appropriate), using the point estimates
41 and confidence intervals of the identified studies. In the latter case, the evidence was
42 downgraded by one increment if the individual studies varied across two areas (for example,
43 50–90% and 91–100%) and by two increments if the individual studies varied across three
44 areas (for example, 0–50%, 51–90% and 91–100%). When a meta-analysis was possible,
45 imprecision was evaluated by visual inspection of the confidence region on the SROC plot. In
46 this case, particular attention when evaluating imprecision was given to whether the
47 confidence region crossed the diagonal (which would indicate that the test was no better than
48 chance at identifying or diagnosing the relevant condition). When there were less than four
49 studies, imprecision was assessed according to the following criteria: a range of 0–20% of
50 differences in point estimates of sensitivity (for the review on case identification) or specificity
51 (for the review on assessment tools) was considered not imprecise, 21–40% serious
52 imprecision and >40% very serious imprecision.

1 The QUADAS-2 checklist uses signalling questions to evaluate the risk of bias across the
2 four domains of patient selection (three questions), index test (two questions), reference
3 standard (two questions) and the flow and timing (four questions) of the study; indirectness
4 ('applicability concerns') is evaluated according to the first three domains by a single
5 question. Each question can be answered as 'yes', 'no' or 'unclear'. Using the answers to the
6 signalling questions, each domain is then evaluated for risk of bias and indirectness as 'Low',
7 'High' or 'Unclear'. The quality of evidence for risk of bias and indirectness was then
8 downgraded by one increment (e.g. 'serious risk of bias') given the presence of one 'High' or
9 'Unclear' rating in a domain, and downgraded by two increments given the presence of more
10 than two such ratings (e.g. 'very serious risk of bias').

11 Overall quality of evidence, taking into account risk of bias, indirectness, inconsistency and
12 imprecision, was then assessed using the GRADE terminology ('high', 'moderate', 'low' and
13 'very low'), with the quality rating downgraded by one increment given the presence of a
14 'serious' (e.g. 'serious imprecision') and by two increments given the presence of a 'very
15 serious'. Thus a cohort study (which starts as high quality) that was evaluated as having
16 serious risk of bias and very serious imprecision would be rated overall as very low quality
17 evidence.

18 3.12.5.1 Evidence profiles

19 A GRADE evidence profile was used to summarise both the quality of the evidence and the
20 results of the evidence synthesis for each 'critical' and 'important' outcome (see Table 5 for
21 completed evidence profiles). The GRADE approach is based on a sequential assessment of
22 the quality of evidence, followed by judgment about the balance between desirable and
23 undesirable effects, and subsequent decision about the strength of a recommendation.

24 Within the GRADE approach to grading the quality of evidence, the following is used as a
25 starting point:

- 26 • RCTs without important limitations provide high-quality evidence
- 27 • observational studies without special strengths or important limitations provide very low-
28 quality evidence.

29 For each outcome, quality may be reduced depending on five factors: limitations,
30 inconsistency, indirectness, imprecision and publication bias. For the purposes of the
31 guideline, each factor was evaluated using criteria provided in Table 6.

32 For observational studies without any reasons for down-grading, the quality may be up-
33 graded if there is a large effect, all plausible confounding would reduce the demonstrated
34 effect (or increase the effect if no effect was observed), or there is evidence of a dose-
35 response gradient (details would be provided under the 'other' column).

36 Each evidence profile includes a summary of findings: number of participants included in
37 each group, an estimate of the magnitude of the effect, and the overall quality of the
38 evidence for each outcome. Under the GRADE approach, the overall quality for each
39 outcome is categorised into one of four groups (high, moderate, low, very low).

40

41

1 Table 5: Example of a GRADE evidence profile

Quality assessment							No. of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intervention	Control group	Relative (95% CI)	Absolute		
Outcome 1 (measured with: any valid method; better indicated by lower values)												
2	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Serious1	None	47	43	-	SMD 0.20 lower (0.61 lower to 0.21 higher)	⊕⊕⊕⊖ MODERATE	CRITICAL
Outcome 2 (measured with: any valid rating scale; better indicated by lower values)												
4	Randomised trials	Serious2	No serious inconsistency	No serious indirectness	Serious1	None	109	112	-	SMD 0.42 lower (0.69 to 0.16 lower)	⊕⊕⊖⊖ LOW	CRITICAL
Outcome 3 (measured with: any valid rating scale; better indicated by lower values)												
26	Randomised trials	No serious risk of bias	Serious ³	No serious indirectness	No serious imprecision	None	521/5597 (9.3%)	798/3339 (23.9%)	RR 0.43 (0.36 to 0.51)	136 fewer per 1000 (from 117 fewer to 153 fewer)	⊕⊕⊕⊖ MODERATE	CRITICAL
Outcome 4 (measured with: any valid rating scale; better indicated by lower values)												
5	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	No serious imprecision	None	503	485	-	SMD 0.34 lower (0.67 to 0.01 lower)	⊕⊕⊕⊕ HIGH	CRITICAL
Note.												

¹ OIS (for dichotomous outcomes, OIS = 300 events; for continuous outcomes, OIS = 400 participants) not met.

² Risk of bias across domains was generally high or unclear.

³ There is evidence of moderate heterogeneity of study effect sizes.

CI = confidence interval; OIS = optimal information size; RR = risk ratio; SMD = standardised mean difference.

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Table 6: Factors that decrease quality of evidence

Factor	Description	Criteria
Limitations	Methodological quality/ risk of bias.	Serious risks across most studies (that reported a particular outcome). The evaluation of risk of bias was made for each study using NICE methodology checklists (see Section 3.5.1).
Inconsistency	Unexplained heterogeneity of results.	Moderate or greater heterogeneity (using the methods suggested by GRADE1)
Indirectness	How closely the outcome measures, interventions and participants match those of interest.	If the comparison was indirect, or if the available evidence was substantially different from the population, intervention, comparator, or an outcome specified in the protocol for the question being addressed by the Committee.
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of the effect.	<ul style="list-style-type: none"> the 95% confidence interval around the pooled or best estimate of effect included both (a) no effect and (b) appreciable benefit or appreciable harm (using default minimally important differences, MIDs). If a dichotomous outcome, the MIDs were 0.75 and 1.25, if a continuous outcome and SMD is reported the MIDs were -0.5 and 0.5. If no MIDs were detected, the outcome was then checked to see if it met the optimal information size (OIS). for dichotomous outcomes, OIS = 300 events; for continuous outcomes OIS = 400 participants
Publication bias	Systematic underestimate or an overestimate of the underlying beneficial or harmful effect due to the selective publication of studies.	Evidence of selective publication. This may be detected during the search for evidence, or through statistical analysis of the available evidence.

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Notes: An i^2 of 50% was used as the cut-off to downgrade for inconsistency. If heterogeneity was found, subgroup analysis was performed using the pre-specified subgroups in the protocol (see Appendix F); if subgroup analysis did not explain the heterogeneity, a random-effects model was used and the outcome was downgraded. Abbreviations: GRADE = Grading of Recommendations Assessment, Development and Evaluation; NICE = National Institute for Health and Care Excellence; OIS = optimal information size.

1 **3.12.6 Presenting evidence to the Guideline Committee**

2 Study characteristics tables and, where appropriate, forest plots generated with Review
3 Manager Version 5.3 and GRADE summary of findings tables (see Table 8) were presented
4 to the Committee.

5 Where meta-analysis was not appropriate and/ or possible, the reported results from each
6 primary-level study were reported in the study characteristics table and presented to the
7 Committee. The range of effect estimates were included in the GRADE profile and, where
8 appropriate, described narratively.

9 **3.12.6.1 Summary of findings tables**

10 Summary of findings tables generated from GRADEpro were used to summarise the
11 evidence for each outcome and the quality of that evidence (Table 6). The tables provide
12 anticipated comparative risks for dichotomous outcomes, which are especially useful when
13 the baseline risk varies for different groups within the population.

14 Control group risks were not presented for SMDs as decisions on the clinical importance was
15 based on the effect sizes independently of/ regardless of the control risk. This would
16 obviously not be the case for MDs.

1 **Table 7: Example of a GRADE summary of findings table**

Outcomes	No of Participants (studies) Follow-up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with intervention (95% CI)
Global impression: 1. no improvement – short term	102 (1 study)	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision	RR 0.89 (0.69 to 1.16)	725 per 1000	80 fewer per 1000 (from 225 fewer to 116 more)
Behaviour: 1. average change score Adaptive Behaviour Scale – medium term	101 (1 study)	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		The mean behaviour score was 1	0.60 SDs lower (1 to 0.21 lower)
Adverse effects: 1. extrapyramidal symptoms – medium term	243 (2 studies)	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision	RR 0.34 (0.05 to 2.1)	33 per 1000	21 fewer per 1000 (from 31 fewer to 36 more)

Note.

The basis for the assumed risk was the median control group risk across studies. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

¹ Generally unclear risk of bias and funded by manufacturer.

² OIS (for dichotomous outcomes, OIS = 300 events; for continuous outcomes, OIS = 400 participants) not met.

CI = confidence interval; GRADE = Grading of Recommendations Assessment, Development and Evaluation; OIS = optimal information size; RR = risk ratio; SD = standard deviation.

2

3 3.12.7 Evidence statements

4 Evidence statements provide a narrative of the results presented either in GRADE tables or
5 other summary of evidence tables. For each outcome they describe what contributed to the
6 overall result including the number of studies, the number of participants, the quality of the
7 evidence, the direction of the effect and any uncertainty in the result. Subheading were used
8 to describe the intervention and comparison and if the result was found at the end of
9 treatment or long-term follow-up. The evidence statements were used by the guideline
10 committee to formulate and prioritise recommendations.

11 3.12.8 Extrapolation

12 When answering review questions, if there was no direct evidence from a primary dataset,
13 based on the initial search for evidence, data was extrapolated from another data set as
14 indirect evidence. In this situation, the following principles were used to determine when to
15 extrapolate:

- 16 • a primary dataset is absent, of particularly high risk of bias or is judged to be not relevant
17 to the review question under consideration, and

- 1 • a review question is deemed by the committee to be important, such that in the absence
2 of direct evidence, other data sources should be considered, and
3 • non-primary data source(s) is in the view of the committee available, which may inform the
4 review question.

5 When the decision to extrapolate was made, the following principles were used to inform the
6 choice of the non-primary dataset:

- 7 • the populations (usually in relation to the specified diagnosis or problem which
8 characterises the population) under consideration share some common characteristic but
9 differ in other ways, such as age, gender or in the nature of the disorder (for example, a
10 common behavioural problem; acute versus chronic presentations of the same disorder),
11 and
12 • the interventions under consideration in the view of the committee have one or more of
13 the following characteristics:
14 ○ share a common mode of action (for example, the pharmacodynamics of drug; a
15 common psychological model of change – operant conditioning)
16 ○ be feasible to deliver in both populations (for example, in terms of the required skills or
17 the demands of the health care system)
18 ○ share common side effects/harms in both populations, and
19 • the context or comparator involved in the evaluation of the different datasets shares some
20 common elements which support extrapolation, and
21 • the outcomes involved in the evaluation of the different datasets shares some common
22 elements which support extrapolation (for example, improved mood or a reduction in
23 behaviour that challenges).

24 When the choice of the non-primary dataset was made, the following principles were used to
25 guide the application of extrapolation:

- 26 • the committee should first consider the need for extrapolation through a review of the
27 relevant primary dataset and be guided in these decisions by the principles for the use of
28 extrapolation
29 • in all areas of extrapolation datasets should be assessed against the principles for
30 determining the choice of datasets. In general the criteria in the four principles set out
31 above for determining the choice should be met
32 • in deciding on the use of extrapolation, the committee will have to determine if the
33 extrapolation can be held to be reasonable, including ensuring that:
34 ○ the reasoning behind the decision can be justified by the clinical need for a
35 recommendation to be made
36 ○ the absence of other more direct evidence and by the relevance of the potential dataset
37 to the review question can be established
38 ○ the reasoning and the method adopted is clearly set out in the relevant section of the
39 guideline.
40 ○ If any data was extrapolated to help answer a review question, the results were
41 downgraded in GRADE for indirectness.

42 **3.12.9 Method used to answer a review question in the absence of appropriately** 43 **designed, high-quality research**

44 In the absence of appropriately designed, high-quality research (including indirect evidence
45 where it would be appropriate to use extrapolation) an informal consensus was adopted.

1 3.12.9.1 Informal method of consensus

2 The informal consensus process involved a group discussion of what is known about the
3 issues. The views of the committee were synthesised narratively by a member of the review
4 team and circulated after the meeting. Feedback was used to revise the text, which was then
5 included in the appropriate evidence review chapter.

6 3.13 Health economics methods

7 The aim of the health economics was to contribute to the guideline's development by
8 providing evidence on the cost effectiveness of interventions and services covered in this
9 guideline. This was achieved by a systematic literature review of existing economic evidence
10 in all areas covered in the guideline.

11 Economic modelling was planned to be undertaken in areas with likely major resource
12 implications, where the current extent of uncertainty over cost effectiveness was significant
13 and economic analysis was expected to reduce this uncertainty, in accordance with the NICE
14 manual (NICE, 2014). Prioritisation of areas for economic modelling was a joint decision
15 between the Health Economist and the Committee. The rationale for prioritising review
16 questions for economic modelling was set out in an economic plan agreed between NICE,
17 the Committee, the Health Economist and the other members of the technical team. The
18 following economic questions were selected as key issues to be addressed by economic
19 modelling:

- 20 • Cost effectiveness of psychological therapies for adults with bulimia nervosa
- 21 • Cost effectiveness of psychological individual therapies for adults with binge eating
22 disorder
- 23 • Cost effectiveness of psychological group therapies for adults with binge eating disorder

24 In addition, literature on the health-related quality of life (HRQoL) of people covered by this
25 guideline was systematically searched to identify studies reporting appropriate utility scores
26 that could be utilised in a cost-utility analysis.

27 In areas where modelling was not possible, the committee took into consideration resource
28 implications and anticipated the cost effectiveness of interventions and services for people
29 with eating disorders when making recommendations.

30 The methods adopted in the systematic literature review of economic evidence are described
31 in the remainder of this section.

32 3.13.1 Search strategy for economic evidence

33 3.13.1.1 Scoping searches

34 A broad preliminary search of the literature was undertaken in January 2015 to obtain an
35 overview of the issues likely to be covered by the scope and help define key areas. Searches
36 were restricted to economic studies and HTA reports and conducted in the following
37 databases:

- 38 • Embase
- 39 • MEDLINE/MEDLINE In-Process
- 40 • HTA database (technology assessments)
- 41 • NHS Economic Evaluation Database (NHS EED).

42 Any relevant economic evidence arising from the clinical scoping searches was also made
43 available to the health economist during the same period.

1 3.13.1.2 Systematic literature searches

2 After the scope was finalised, a systematic search strategy was developed to locate all the
3 relevant evidence. The balance between sensitivity (the power to identify all studies on a
4 particular topic) and specificity (the ability to exclude irrelevant studies from the results) was
5 carefully considered and a decision made to utilise a broad approach to searching to
6 maximise retrieval of evidence to all parts of the guideline. Searches were restricted to
7 economic studies and health technology assessment reports and conducted in the following
8 databases:

- 9 • Embase
- 10 • HTA database (technology assessments)
- 11 • MEDLINE/MEDLINE In-Process
- 12 • NHS EED
- 13 • PsycINFO.

14 Any relevant economic evidence arising from the clinical searches was also made available
15 to the health economist during the same period.

16 The search strategies were initially developed for MEDLINE before being translated for use
17 in other databases/interfaces. Strategies were built up through a number of trial searches
18 and discussions of the results of the searches with the review team and committee to ensure
19 that all possible relevant search terms were covered. In order to assure comprehensive
20 coverage, search terms for the guideline topic were kept purposely broad to help counter
21 dissimilarities in database indexing practices and thesaurus terms and imprecise reporting of
22 study interventions by authors in the titles and abstracts of records.

23 For standard mainstream bibliographic databases (Embase, MEDLINE and PsycINFO)
24 search terms for the guideline topic combined with a search filter for health economic
25 studies. For searches generated in topic-specific databases (HTA, NHS EED) search terms
26 for the guideline topic were used without a filter. The sensitivity of this approach was aimed
27 at minimising the risk of overlooking relevant publications, due to potential weaknesses
28 resulting from more focused search strategies. The search terms are set out in full in
29 Appendix F.

30 3.13.1.3 Reference Management

31 Citations from each search were downloaded into reference management software and
32 duplicates removed. Records were then screened against the inclusion criteria of the reviews
33 before being quality appraised. The unfiltered search results were saved and retained for
34 future potential re-analysis to help keep the process both replicable and transparent.

35 3.13.1.4 Search filters

36 The search filter for health economics is an adaptation of a pre-tested strategy designed by
37 CRD (2007). The search filter is designed to retrieve records of economic evidence
38 (including full and partial economic evaluations) from the vast amount of literature indexed to
39 major medical databases such as MEDLINE. The filter, which comprises a combination of
40 controlled vocabulary and free-text retrieval methods, maximises sensitivity (or recall) to
41 ensure that as many potentially relevant records as possible are retrieved from a search. A
42 full description of the filter is provided in Appendix F.

43 3.13.1.5 Date and language restrictions

44 Systematic database searches were initially conducted in May 2015 up to the most recent
45 searchable date. Search updates were generated on a six monthly basis, with the final re-
46 runs carried out in July 2016. After this point, studies were included only if they were judged

1 by the committee to be exceptional (for example, the evidence was likely to change a
2 recommendation).

3 Although no language restrictions were applied at the searching stage, foreign language
4 papers were not requested or reviewed, unless they were of particular importance to an area
5 under review. All the searches were restricted to research published from 2000 onwards in
6 order to obtain data relevant to current healthcare settings and costs.

7 **3.13.1.6 Other search methods**

8 Other search methods involved scanning the reference lists of all eligible publications
9 (systematic reviews, stakeholder evidence and included studies from the economic and
10 clinical reviews) to identify further studies for consideration.

11 Full details of the search strategies and filter used for the systematic review of health
12 economic evidence are provided in Appendix I.

13 **3.13.2 Inclusion criteria for economic studies**

14 The following inclusion criteria were applied to select studies identified by the economic
15 searches for further consideration:

- 16 1. Only studies from Organisation for Economic Co-operation and Development countries
17 were included, as the aim of the review was to identify economic information transferable
18 to the UK context.
- 19 2. Only studies published from 2000 onwards were included in the review. This date
20 restriction was imposed so that retrieved economic evidence was relevant to current
21 healthcare settings and costs.
- 22 3. Selection criteria based on types of clinical conditions and service users as well as
23 interventions assessed were identical to the clinical literature review.
- 24 4. Studies were included provided that sufficient details regarding methods and results were
25 available to enable the methodological quality of the study to be assessed and provided
26 that the study's data and results were extractable. Poster presentations of abstracts were
27 excluded.
- 28 5. Full economic evaluations that compared two or more relevant options and considered
29 both costs and consequences as well as costing analyses that compared only costs
30 between two or more interventions were included in the review. Non-comparative studies
31 were not considered in the review.
- 32 6. Economic studies were included if they used clinical effectiveness data from a clinical trial,
33 a prospective or retrospective cohort study, or from a literature review. Studies with
34 clinical effectiveness based on author's assumptions only were excluded.

35 **3.13.3 Applicability and quality criteria for economic studies**

36 All economic papers eligible for inclusion were appraised for their applicability and quality
37 using the methodology checklist for economic evaluations recommended in the NICE
38 Guidelines Manual (NICE, 2014). All studies that fully or partially met the applicability and
39 quality criteria described in the methodology checklist were considered during the guideline
40 development process. The completed methodology checklists for all economic evaluations
41 considered in the guideline are provided in Appendix R.

42 **3.13.4 Presentation of economic evidence**

43 The economic evidence considered in the guideline is provided in the respective evidence
44 chapters, following presentation of the relevant clinical evidence. The references to included
45 studies and the respective evidence tables with the study characteristics and results are

1 provided in Appendix S. Characteristics and results of all economic studies considered
2 during the guideline development process are summarised in economic evidence profiles
3 provided in Appendix T. The full guideline includes only a brief summary of de-novo
4 economic modelling undertaken. The detailed write up of de-novo economic models
5 including the methods and full results are presented in the Appendix X.

6 **3.13.5 Results of the systematic search of economic literature**

7 The titles of all studies identified by the systematic search of the literature were screened for
8 their relevance to the topic (that is, economic issues and information on HRQoL). References
9 that were clearly not relevant were excluded first. The abstracts of all potentially relevant
10 studies (17 references) were then assessed against the inclusion criteria for economic
11 evaluations by the health economist. Full texts of the studies potentially meeting the inclusion
12 criteria (including those for which eligibility was not clear from the abstract) were obtained.
13 Studies that did not meet the inclusion criteria, were duplicates, were secondary publications
14 of one study, or had been updated in more recent publications were subsequently excluded.
15 All economic evaluations eligible for inclusion (13 studies in 14 publications) were then
16 appraised for their applicability and quality using the methodology checklist for economic
17 evaluations. Finally, those studies that fully or partially met the applicability and quality
18 criteria set by NICE were considered at formulation of the guideline recommendations. Flow
19 chart of studies for economic literature review is presented in the Appendix M. Excluded
20 economic studies list is presented in the Appendix J.

21 **3.14 From evidence to recommendations**

22 Once the clinical and health economic evidence was summarised, the committee drafted the
23 recommendations. In making recommendations, the committee took into account the trade-
24 off between the benefits and harms of the intervention/instrument, as well as other important
25 factors, such as the relative value of different outcomes reported in the evidence, quality of
26 the evidence, trade-off between net health benefits and resource use, values and experience
27 of the committee and society, current clinical practice, the requirements to prevent
28 discrimination and to promote equality and the committee's awareness of practical issues.

29 Finally, to show clearly how the committee moved from the evidence to the
30 recommendations, each chapter (or sub-section) has a section called 'recommendations and
31 link to evidence'. Underpinning this section is the concept of the 'strength' of a
32 recommendation. Some recommendations are 'strong' in that the committee believes that
33 the vast majority of healthcare professionals and service users would choose a particular
34 intervention if they considered the evidence in the same way that the committee has. This is
35 generally the case if the benefits clearly outweigh the harms for most people and the
36 intervention is likely to be cost effective. However, there is often a closer balance between
37 benefits and harms and some service users would not choose an intervention whereas
38 others would. This may happen, for example, if some service users are particularly averse to
39 some side effect and others are not. In these circumstances the recommendation is generally
40 weaker, although it may be possible to make stronger recommendations about specific
41 groups of service users. The strength of each recommendation is reflected in the wording of
42 the recommendation, rather than by using ratings, labels or symbols. For example a
43 recommendation will use the words "consider" or "offer" a type of treatment, reflecting a
44 weaker versus a stronger recommendation respectively.

45 Where the committee identified areas of uncertainty or where robust evidence was lacking,
46 they developed research recommendations. Those that were identified as 'high priority' were
47 developed further in the NICE version of the guideline and presented in Appendix G.

1 **3.15 Stakeholder contributions**

2 Professionals, service users and companies have contributed to and commented on the
3 guideline at key stages in its development. Stakeholders for this guideline include:

- 4 • service user and carer stakeholders: national service user and carer organisations that
5 represent the interests of people whose care will be covered by the guideline
- 6 • local service user and carer organisations: but only if there is no relevant national
7 organisation
- 8 • professional stakeholders' national organisations: that represent the healthcare
9 professionals who provide the services described in the guideline
- 10 • commercial stakeholders: companies that manufacture drugs or devices used in treatment
11 of the condition covered by the guideline and whose interests may be significantly affected
12 by the guideline
- 13 • providers and commissioners of health services in England
- 14 • statutory organisations: including the Department of Health
- 15 • Government, NHS Quality Improvement Scotland, the Care Quality Commission and the
16 National Patient Safety Agency
- 17 • research organisations: that have carried out nationally recognised research in the area.

18 NICE clinical guidelines are produced for the NHS in England, so a 'national' organisation is
19 defined as 1 that represents England, or has a commercial interest in England.

20 Stakeholders have been involved in the guideline's development at the following points:

- 21 • commenting on the initial scope of the guideline and attending a scoping workshop held
22 by NICE
- 23 • commenting on the draft of the guideline

24 **3.16 Validation of the guideline**

25 This guidance is subject to a six week public consultation and feedback as part of the quality
26 assurance and peer review of the document. All comments received from registered
27 stakeholders are responded to in turn and posted on the NICE website when the pre-
28 publication check of the full guideline occurs.

29 **3.17 Disclaimer**

30 Healthcare providers need to use clinical judgement, knowledge and expertise when
31 deciding whether it is appropriate to apply guidelines. The recommendations cited here are a
32 guide and may not be appropriate for use in all situations. The decision to adopt any of the
33 recommendations cited here must be made by practitioners in light of individual patient
34 circumstances, the wishes of the patient, clinical expertise and resources.

35 The National Guideline Alliance (NGA) disclaims any responsibility for damages arising out
36 of the use or non-use of these guidelines and the literature used in support of these
37 guidelines.

4 Identification and management of eating disorders

4.1 Introduction

The early signs of an eating disorder (ED) can be behavioural, psychological or physical. Common ED behaviours include extreme dieting and cutting out specific food groups, avoiding meal times and compulsive exercise. Psychological signs may include increased preoccupation with eating, weight and body shape, distorted body image and the adoption of strict food-related rules. Common physical signs include rapid or frequent weight change, tiredness, low energy and poor concentration. In some cases, vomiting can cause damage to teeth.

Key groups for screening and possible identification of an ED include those who are underweight compared with age norms, those who are disproportionately concerned about their weight, are dieting when underweight, women with menstrual disturbances, those with unexplained gastrointestinal symptoms and those who present with the physical signs of malnutrition or repeated vomiting. EDs are also more common in those with other mental health problems and those with type 1 diabetes and poor treatment adherence should also be screened. In children, poor growth or a sudden change in eating habits can be indicators of an ED.

Individuals with an ED may present in a range of settings in the NHS including primary care and secondary services such as gastroenterology, reproductive medicine and general mental health services. Because of the emphasis on physical appearance including weight and body shape in some sub-groups, they can be more vulnerable to developing an ED (for example, ballet dancers and fashion models).

Whilst some people can talk openly about their ED, others might be unaware that they have an ED or find it too difficult to disclose. People with EDs often feel ashamed of their symptoms and many are ambivalent about seeking treatment. It is therefore important to take a supportive, non-judgemental stance when talking with someone about whether they might have an ED.

Clinical change and the level of risk in mental and physical health should be monitored throughout treatment. Changes in ED symptoms (including behaviours, cognitions and physical symptoms) should be monitored weekly during treatment. This provides important information about the progress and likely effectiveness of any intervention. It is commonly done using brief self-report measures that should be regularly discussed with patients. In some cases physical and/or mental health risk may increase – for example, continued weight loss in anorexia nervosa. This is why it is important to monitor levels of risk, so that treatment can be reviewed and changed as required.

4.2 Case identification of eating disorders

4.2.1 Review question: What are the utility, validity and reliability of the instruments, tools and methods used for case identification in eating disorders?

The review protocol summary, including the review question and the eligibility criteria used for this section of the guideline, can be found in Table 8 **Error! Reference source not found.** Further information about the search strategy can be found in Appendix I; the full review protocols can be found in Appendix F.

1 This review considers the utility of instruments used to identify cases of eating disorders in
 2 people who are suspected of having an eating disorder. Randomised control trials, cohort
 3 and cross-sectional studies that assessed the accuracy of the DAWBA-eating disorders
 4 section, ESP or SCOFF in identifying whether an eating disorder (or specific category
 5 thereof) is present as indicated by a full diagnostic interview were searched for. Studies were
 6 categorised according to whether they were used to identify cases of any eating disorder or a
 7 specific type of eating disorder.

8 **Table 8: Clinical review protocol summary**

Component	Description
Review question(s)	What are the utility, validity and reliability of the instruments, tools and methods used for case identification in eating disorders?
Population	Children, young people and adults with: <ul style="list-style-type: none"> a suspected eating disorder (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years.
Instruments, tools and methods	The following will be investigated: <ul style="list-style-type: none"> SCOFF (Sick-Control-One-Fat-Food) questionnaire DAWBA (self-assessment and parent/clinician component diagnostic and comorbidities) ESP (compared with SCOFF)
Reference tool	Reference tool (full diagnostic test for both clinical samples and population) <ul style="list-style-type: none"> DSM ICD-10
Critical outcomes	<ul style="list-style-type: none"> Sensitivity (Se): the proportion of true positives of all cases diagnosed in the population Specificity (Sp): the proportion of true negatives of all cases not-diagnosed in the population Positive predictive value Negative predictive value Likelihood values
Important outcomes	VALIDITY <ul style="list-style-type: none"> Concurrent validity, convergent validity, construct validity, content validity, predictive and discriminant validity RELIABILITY <ul style="list-style-type: none"> Inter-rater reliability. Intra-rater reliability, test re-test reliability, , internal consistency
Study design	<ul style="list-style-type: none"> RCTs Cohort Cross-sectional

9 **4.2.2 Clinical evidence**

10 No RCTs that satisfied the eligibility criteria were identified. Due to the paucity of evidence, it
 11 was decided to include case-control studies. Accordingly, 10 studies (seven cohort or cross-
 12 sectional studies; three case-control studies) met the eligibility criteria and were included in
 13 the review (Aoun et al., 2015; Baudet et al., 2013; Garcia-Campayo et al., 2005; House et al.,

1 2008; Liu et al., 2015; Luck et al., 2002; Morgan et al., 1999; Moya et al., 2005; Siervo et al.,
2 2005). The majority of participants were adult females. Since case-control studies are likely
3 to overestimate the accuracy of a test, data from such studies are presented separately from
4 those of cohort and cross-sectional studies. For an overview of included studies see Table 9.

5 **4.2.2.1 Development and Well-Being Assessment (DAWBA) – Eating Disorders Section**

6 Two studies (n=231) on DAWBA, which is intended for use with children and young people,
7 were included in the review (House 2008, Moya 2005). The vast majority of the participants
8 were young females (there were only four young males in the total sample). The cohort study
9 (n=57) examined the online version of DAWBA in a secondary care setting and used a
10 clinical assessment and EDE or C-EDE (as appropriate) as the reference tool (House 2008).
11 The case-control study (n=174) examined the interview version of DAWBA and used two
12 groups of participants from a primary/secondary care setting (an eating disorders group and
13 a non-eating disorders clinical control group) and a community control group (Moya 2005).
14 There were not a sufficient number of studies to allow a meta-analysis of the diagnostic test
15 accuracy data.

16 The quality of the evidence is presented for each study in the clinical evidence profiles below
17 in Table 10, Table 11 and Table 12. See also the study selection flow chart in Appendix K,
18 sensitivity and specificity forest plots in Appendix M, study evidence tables in Appendix L and
19 exclusion list in Appendix J.

20 **4.2.2.2 Eating Disorders Screen for Primary Care (ESP)**

21 No relevant studies for the ESP in clinical samples or those at risk of an eating disorder were
22 found. See also the study selection flow chart in Appendix K and exclusion list in Appendix J.

23 **4.2.2.3 Sick-Control-One-Fat-Food (SCOFF)**

24 For SCOFF, which is for use in adults, 1 cohort study (n=143), five cross-sectional studies
25 (n=2513) and two case-control studies (n=438) were included in this review (Aoun 2015,
26 Baudet 2013, Garcia 2011, Garcia-Campayo 2005, Liu 2015, Luck 2002, Morgan 1999,
27 Siervo 2005).

28 All of the participants were adult females with the exception of one study, that assessed the
29 accuracy of SCOFF in adult males and females (Liu 2015). Three of the cohort and cross-
30 sectional studies were conducted in a primary care setting (Baudet 2013, Garcia-Campayo
31 2005, Luck 2002) whilst the remaining studies were conducted in secondary care settings
32 (Aoun 2015, Liu 2015, Siervo 2005). In the two case-control studies, one study compared an
33 eating disorder group with a healthy control group (Garcia 2011), whilst the other study
34 compared a secondary care group with a group confirmed as not having an eating disorder
35 (Morgan 1999).

36 There were sufficient cohort and cross-sectional studies to conduct a meta-analysis of the
37 SCOFF at thresholds of 2 and 3 for the case identification of any eating disorder. (Note that
38 the case-controls studies were not included in this analysis). Since the majority of the
39 identified studies reported the critical outcomes of sensitivity and specificity for several
40 thresholds it was not possible to estimate a Summary ROC curve. However the available
41 data from six studies (n=2513) permitted the estimation of a summary sensitivity and
42 specificity at each of the two thresholds (Aoun 2015, Baudet 2013, Garcia-Campayo 2005,
43 Liu 2015, Luck 2002, Siervo 2005). The quality of evidence for the meta-analysis of SCOFF,
44 that included data for both male and female participants, for the case identification of any
45 eating disorder is presented in Table 14, Table 15 and Table 16, whilst the quality of
46 evidence for the relevant case-control studies are presented in Table 19. To enable a
47 comparison of the data for the SCOFF tool at different threshold, the consequences of using
48 SCOFF in terms of the number of false positives and false negatives the test would yield,

1 and the related likelihood ratios, were calculated given a one-year prevalence per 100,000 of
2 0.5%, 1% and 5% (see Table 17).

3 The one cross-sectional study (n=1541) that included both male and female participants,
4 conducted in an outpatient psychiatric clinic (Liu 2015), examined whether there were gender
5 differences in the optimal SCOFF threshold to identify eating disorder cases. The quality of
6 evidence for SCOFF in male participants is presented in Table 18.

7

8

Table 9: Study information for review of case identification of eating disorders in people with suspected eating disorders

Study ID	Country	Index Test	Version	Reference Tool	Type of study: sample	Sample N	Age (years)	Female (%)	Eating disorder tested for
House 2008	UK	DAWBA	Online	Multidisciplinary team clinical Interview, DSM-IV	Cohort: secondary care	57	15.7 (1.5)	93	Any eating disorder Anorexia nervosa Bulimia nervosa EDNOS
Moya 2005	Brazil	DAWBA	Interview	Open Clinical Interview, DSM-IV/ICD-10	Case-control: (I) eating disorder (II) clinical controls (III) community controls	174	15.3 (2.2)	100	Any eating disorder Anorexia nervosa Bulimia nervosa EDNOS
Aoun 2015	Lebanon	SCOFF	Written	Arabic MINI, DSM-IV	Cross-sectional: primary care	123	Range 15-55	100	Any eating disorder
Baudet 2013	France	SCOFF	Written	DSM-IV-TR French MINI/EDE-Q	Cohort: primary care	143	32.9 (9.2)	100	Any eating disorder
Garcia 2011	France	SCOFF	Written	French MINI, DSM-IV	Case-control: (I) eating disorder (II) healthy controls	226	22.1 Range 18-35	100	Any eating disorder Anorexia nervosa Bulimia nervosa
Garcia-Campayo 2005	Spain	SCOFF	Written	Spanish SCAN	Cross-sectional: primary care	203	29.2 (7.9) Range 14-55	100	Any eating disorder Anorexia nervosa Bulimia nervosa EDNOS
Liu 2015	Taiwan	SCOFF	Written	Mandarin Chinese SCID-I Patient, DSM-IV-TR	Cross-sectional: secondary care	1541	30.5 (7.8)	61	Any eating disorder
Luck 2002	UK	SCOFF	Interview	CDI, DSM-IV	Cross-sectional: primary care	341	Range 18-50	100	Any eating disorder
Morgan 1999	UK	SCOFF	Interview	CDI, DSM-IV	Case-control: (I) secondary care (II) No eating disorder	212	Range 18-40	100	Any eating disorder Anorexia nervosa Bulimia nervosa

Study ID	Country	Index Test	Version	Reference Tool	Type of study: sample	Sample N	Age (years)	Female (%)	Eating disorder tested for
Siervo 2005	Italy	SCOFF	Written	CDI, DSM-IV	Cross-sectional: secondary care	162	Range 16-35	100	Any eating disorder

Abbreviations: CDI, Clinical Diagnostic Interview; DAWBA, Development & Well-Being Assessment; EDE-Q, Eating Disorder Examination-Questionnaire; EDNOS, Eating Disorder Not Otherwise Specified; MINI, Mini-International Neuropsychiatric Interview; SCAN, Schedules for Clinical Assessment in Neuropsychiatry; SCID-I, Structured Clinical Interview for Axis I disorders, DSM-IV; SCOFF, Sick-Control-One-Fat-Food

Table 10: Clinical evidence profile for cohort and cross-sectional studies on the Development and Well-Being Assessment-eating disorders section – Online

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
DAWBA-eating disorder section (Online version)									
DAWBA for any eating disorder	1	57	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.94 (0.84, 0.99)	0.33 (0.04, 0.78)	MODERATE
DAWBA for anorexia nervosa	1	57	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.9 (0.73, 0.98)	0.93 (0.76, 0.99)	LOW
DAWBA for EDNOS	1	57	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Very serious imprecision ^d	0.67 (0.43, 0.85)	0.83 (0.67, 0.94)	VERY LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making; (a) Risk of bias was assessed using the QUADAS-2 checklist, (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability, (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 11: Clinical evidence profile for case-control studies on the Development and Well-Being Assessment-eating disorders section – Interview

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
DAWBA-eating disorder section (Interview version)									

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
DAWBA for any eating disorder	1	174	Very serious risk of bias ^a	Not applicable ^b	Very serious indirectness ^c	No serious imprecision ^d	1.0 (0.93, 1.0)	0.94 (0.88, 0.97)	VERY LOW
DAWBA for anorexia nervosa	1	174	Very serious risk of bias ^a	Not applicable ^b	Very serious indirectness ^c	No serious imprecision ^d	1.0 (0.93, 1.00)	1.0 (0.97, 1.00)	VERY LOW
DAWBA for bulimia nervosa	1	174	Very serious risk of bias ^a	Not applicable ^b	Very serious indirectness ^c	No serious imprecision ^d	0.94 (0.83, 0.99)	0.96 (0.91, 0.99)	VERY LOW
DAWBA for EDNOS	1	174	Very serious risk of bias ^a	Not applicable ^b	Very serious indirectness ^c	Serious imprecision ^d	0.71 (0.56, 0.83)	0.95 (0.9, 0.98)	VERY LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making; (a) Risk of bias was assessed using the QUADAS-2 checklist, (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability, (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 12: Summary table of QUADAS-2 results for risk of bias and indirectness for DAWBA

Study ID	RISK OF BIAS				INDIRECTNESS		
	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD	FLOW AND TIMING	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD
House 2008	☺	☹	☺	☺	☺	☺	☺
Moya 2005	☹	☺	☺	☹	☹	☺	☹
Key ☺=Low Risk ☹=High Risk							

Table 13: Graphical representation of QUADAS-2 results for risk of bias and applicability concerns for DAWBA

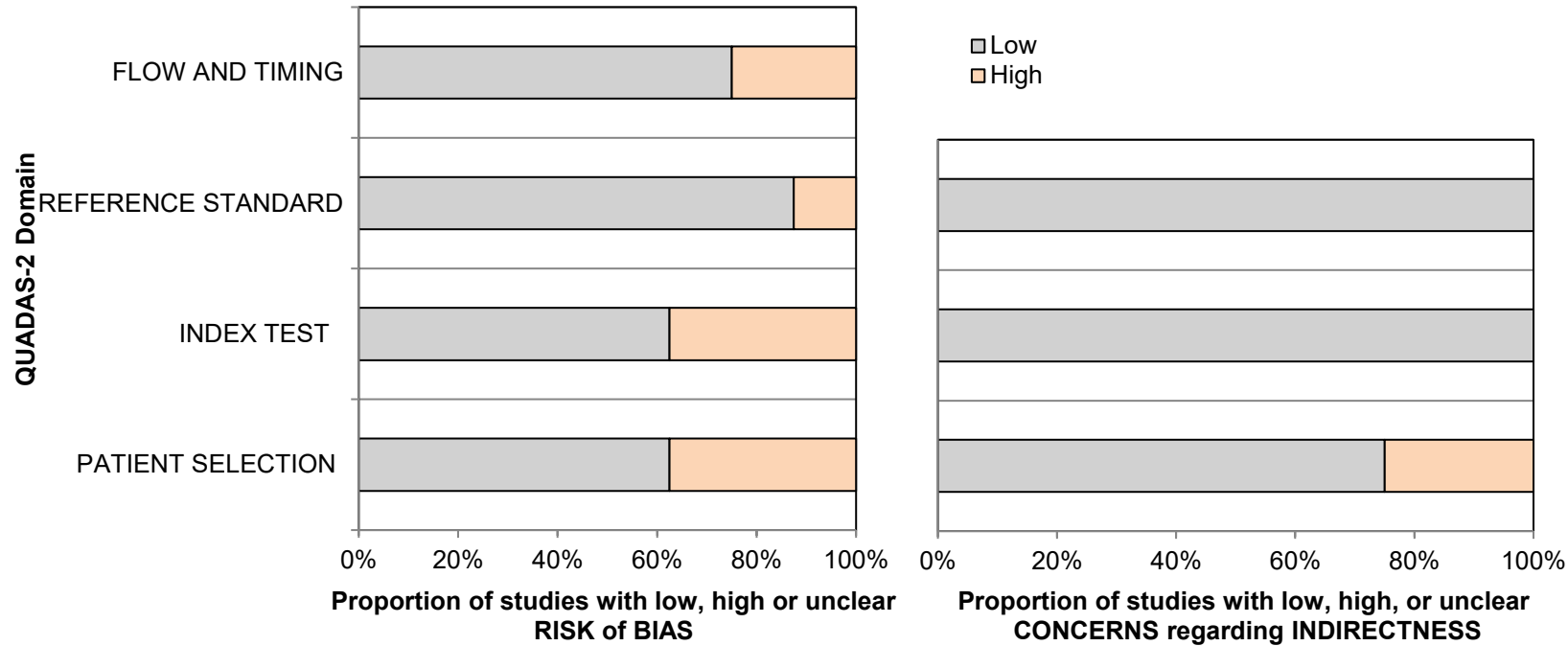


Table 14: Clinical evidence profile for cohort and cross-sectional studies of SCOFF for case identification of any eating disorder in adults

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for any eating disorder									
SCOFF at threshold ≥ 2	6	2513	No serious risk of bias ^a	Serious inconsistency ^b	No serious indirectness ^c	No serious imprecision ^d	Pooled 0.9 (0.81, 0.95)	Pooled 0.76 (0.56, 0.89)	MODERATE
SCOFF at threshold ≥ 3	6	2513	No serious risk of bias ^a	Very serious inconsistency ^b	No serious indirectness ^c	Serious imprecision ^d	Pooled 0.6	Pooled 0.93	VERY LOW

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
							(0.46, 0.73)	(0.82, 0.98)	

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist, for more details; (b) Inconsistency was assessed by visual inspection of the summary Receiving Operating Characteristic (sROC) plots across studies, using the point estimates and confidence intervals. (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability, (d) Judgement of precision was based on visual inspection of the confidence region in the diagnostic meta-analysis.

Table 15: Summary table of QUADAS-2 results for risk of bias and indirectness for cohort and cross-sectional studies on SCOFF

Study ID	RISK OF BIAS				INDIRECTNESS		
	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD	FLOW AND TIMING	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD
Aoun 2015	☺	☺	☺	☺	☺	☺	☺
Baudet 2013	☺	☺	☺	☺	☺	☺	☺
Garcia 2011	☹	☺	☺	☹	☹	☺	☺
Garcia-Campayo 2005	☺	☹	☺	☺	☺	☺	☺
Liu 2015	☺	☺	☺	☺	☺	☺	☺
Luck 2002	☺	☺	☺	☺	☺	☺	☺
Morgan 1999	☹	☹	☺	☹	☹	☺	☺
Siervo 2005	☹	☹	☹	☺	☺	☺	☺

Key
☺=Low Risk
☹=High Risk

Table 16: Graphical representation of QUADAS-2 results for risk of bias and indirectness for cohort and cross-sectional studies on SCOFF

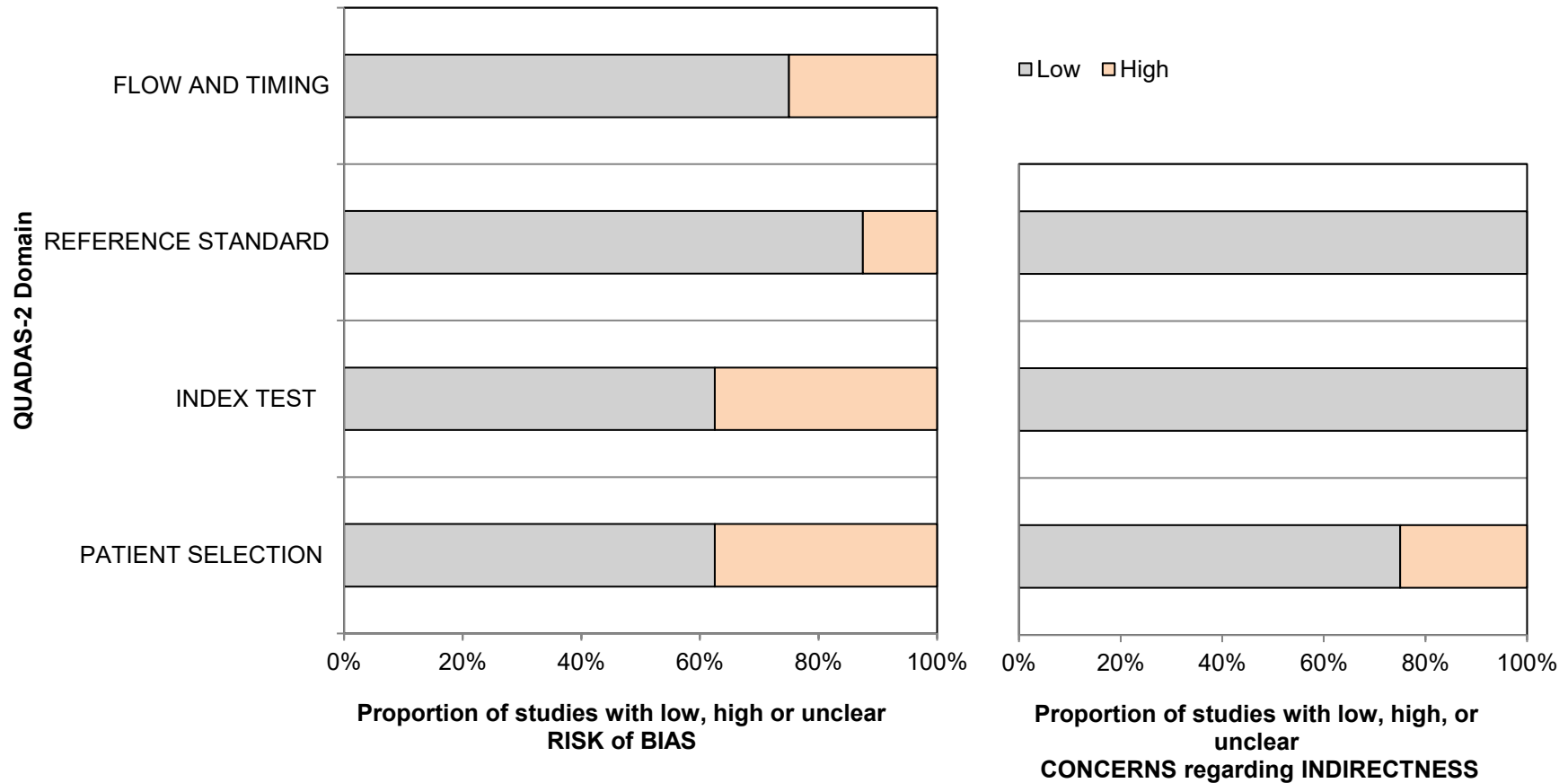


Table 17: Consequences of key findings on SCOFF for case identification of any eating disorder

	One-year prevalence per 100,000		
	0.5% prevalence	1% prevalence	5% prevalence
	SCOFF Threshold	SCOFF Threshold	SCOFF Threshold

Consequences	One-year prevalence per 100,000					
	≥2	≥3	≥2	≥3	≥2	≥3
Positive likelihood ratio	5.29	19.9	4.74	17.33	4.96	17.5
Negative likelihood ratio	0.38	0.21	0.12	0.31	0.07	0.31
False positive per 1000	189	40	188	40	180	38
False negative per 1000	0	1	1	3	3	15

Note: the number of false positives and false negatives per 1000 were calculated using the pooled sensitivity and specificity results from the meta-analysis of the cohort and cross-sectional data only. A positive likelihood ratio indicates how much more likely a person with a disease tests positive compared with a person without the disease, whilst a negative likelihood ratio indicates how less likely a person with a disease tests negative compared with a person without the disease. Likelihood ratios of <0.1 or >10 are typically interpreted as indicating that the relevant test is clinically very useful, 0.1-0.2 or 5-10 as moderately useful and 0.2-1 or 1-5 as not particularly useful.

Table 18: Clinical evidence profile for cohort and cross-sectional studies of SCOFF for case identification of any eating disorder in male adults

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for any eating disorder									
SCOFF at threshold ≥2	1								
Liu 2015		605	No serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.86 (0.70, 0.96)	0.74 (0.70, 0.78)	MODERATE
SCOFF at threshold ≥3	1								
Liu 2015		605	No serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.66 (0.48, 0.81)	0.91 (0.88, 0.93)	MODERATE

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist, (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability, (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 19: Clinical evidence profile for case-control studies of SCOFF for case identification of any eating disorder in adult females

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for any eating disorder									
SCOFF at threshold ≥ 2	2	438							
Garcia 2011		226	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	No serious imprecision ^d	0.94 (0.88, 0.97)	0.94 (0.88, 0.97)	VERY LOW
Morgan 1999		212	Very serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	No serious imprecision ^d	1.00 (0.97, 1.00)	0.88 (0.79, 0.93)	VERY LOW
SCOFF at threshold ≥ 3	2	438							
Garcia 2011		226	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	No serious imprecision ^d	0.66 (0.57, 0.75)	1.00 (0.97, 1.00)	VERY LOW
Morgan 1999		212	Very serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	No serious imprecision ^d	0.99 (0.95, 1.00)	0.96 (0.90, 0.99)	VERY LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist; (b) Inconsistency was assessed by inspection of the sensitivity and specificity forest plots (based on the primary measure), using the point estimates and confidence intervals. The evidence was downgraded by 1 increment if the individual studies varied across 2 areas (for example, 50–90% and 90–100%) and by 2 increments if the individual studies varied across 3 areas (for example, 0–50%, 50–90% and 90–100%); (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 20: Summary table of QUADAS-2 results for risk of bias and indirectness for case control studies on SCOFF

Study	RISK OF BIAS				INDIRECTNESS		
	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD	FLOW AND TIMING	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD
Garcia 2011	⊖	☺	☺	⊖	⊖	☺	☺
Morgan 1999	⊖	⊖	☺	⊖	⊖	☺	☺

Key
☺=Low Risk
⊖=High Risk

Table 21: Clinical evidence profile for cohort and cross-sectional studies of SCOFF for case identification of anorexia nervosa in adult females

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for anorexia nervosa									
SCOFF at threshold ≥ 2	1								
Garcia-Campayo 2005		195	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.93 (0.77, 0.99)	0.94 (0.90, 0.97)	LOW
SCOFF at threshold ≥ 3	1								
Garcia-Campayo 2005		195	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.9 (0.73, 0.98)	1.00 (0.98, 1.00)	LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist; (b) Inconsistency not applicable due to only one study. S; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 22: Clinical evidence profile for case-control studies of SCOFF for case identification of anorexia nervosa in adult females

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for anorexia nervosa									
SCOFF at threshold ≥ 2	2	438							
Garcia 2011		226	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	No serious imprecision ^e	0.96 (0.87, 0.99)	0.93 (0.82, 0.99)	VERY LOW
Morgan 1999		212	Very serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	No serious imprecision ^e	1.00 (0.95, 1.00)	0.88 (0.81, 0.92)	VERY LOW
SCOFF at threshold ≥ 3	1								
Garcia 2011		226	Serious risk of bias ^a	Not applicable ^c	Serious indirectness ^d	Serious imprecision ^e	0.66 (0.53, 0.77)	1.00 (0.98, 1.00)	VERY LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist. (b) Inconsistency was assessed by inspection of the sensitivity and specificity forest plots (based on the primary measure), using the point estimates and confidence intervals. The evidence was downgraded by 1 increment if the individual studies varied across 2 areas (for example, 50–90% and

90–100%) and by 2 increments if the individual studies varied across 3 areas (for example, 0–50%, 50–90% and 90–100%); (c) Inconsistency not applicable due to only one study; (d) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. (e) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 23: Clinical evidence profile for cohort and cross-sectional studies of SCOFF for case identification of bulimia nervosa in adult females

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for bulimia nervosa									
SCOFF at threshold ≥ 2	1								
Garcia-Campayo 2005		195	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.98 (0.89, 1.00)	0.94 (0.89, 0.97)	MODERATE
SCOFF at threshold ≥ 3	1								
Garcia-Campayo 2005		195	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.73 (0.58, 0.85)	1.00 (0.98, 1.00)	LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist. (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for sensitivity for decision-making.

Table 24: Clinical evidence profile for case-control studies of SCOFF for case identification of bulimia nervosa in adult females

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for bulimia nervosa									
SCOFF at threshold ≥ 2	2	438							
Garcia 2011		226	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	No serious imprecision ^e	0.93 (0.82, 0.99)	0.94 (0.89, 0.97)	VERY LOW
Morgan 1999		212	Very serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^d	No serious imprecision ^e	1.00 (0.93, 1.00)	0.87 (0.81, 0.92)	VERY LOW
SCOFF at threshold ≥ 3	1								

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
Garcia 2011		226	Serious risk of bias ^a	Not applicable ^c	Serious indirectness ^d	Serious imprecision ^e	0.67 (0.51, 0.8)	1.00 (0.98, 1.00)	VERY LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist. (b) Inconsistency was assessed by inspection of the sensitivity and specificity forest plots (based on the primary measure), using the point estimates and confidence intervals. The evidence was downgraded by 1 increment if the individual studies varied across 2 areas (for example, 50–90% and 90–100%) and by 2 increments if the individual studies varied across 3 areas (for example, 0–50%, 50–90% and 90–100%); (c) Inconsistency not applicable due to only one study; (d) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. (e) Due to an insufficient number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for decision-making.

Table 25: Clinical evidence profile for cohort and cross-sectional studies of SCOFF for case identification of EDNOS in adult females

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SCOFF for EDNOS									
SCOFF at threshold ≥ 2	1								
Garcia-Campayo 2005		195	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	1.00 (0.94, 1.00)	0.95 (0.90, 0.98)	MODERATE
SCOFF at threshold ≥ 3	1								
Garcia-Campayo 2005		195	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.24 (0.13, 0.37)	1.00 (0.98, 1.00)	LOW

Notes: The assessment of the evidence quality was conducted with emphasis on test sensitivity as this was the primary measure discussed in decision-making. (a) Risk of bias was assessed using the QUADAS-2 checklist. (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. (d) Due to an insufficient number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure for decision-making.

1

2 **4.2.3 Economic Evidence**

3 No economic evidence on the tools for identification of eating disorders was identified by the
4 systematic search of the economic literature undertaken for this guideline. Details on the
5 methods used for the systematic search of the economic literature are described in Chapter
6 3.

7 **4.2.4 Clinical evidence statements**

8 **4.2.4.1 DAWBA**

9 The overall quality of evidence from the one identified cohort study on the use of the eating
10 disorders section of DAWBA-online (n=57) to identify eating disorder cases in children and
11 young people, aged 5 to 16 years old, suspected of having an eating disorder ranged from
12 moderate for any eating disorder, to low for anorexia nervosa and very low for EDNOS. The
13 quality of evidence for all three cases was downgraded due to concerns over risk of bias and
14 concerns over imprecision in the case identification of anorexia nervosa and EDNOS.

15 The reported sensitivity was 0.94 for any eating disorder, 0.9 for anorexia nervosa and 0.67
16 for EDNOS; the related 95% CIs range were relatively consistent (i.e. narrow) and ranged
17 from 0.84 to 0.99 for any eating disorder, 0.73 to 0.98 for anorexia nervosa, and from 0.43 to
18 0.85 for EDNOS. By contrast, the reported specificity of DAWBA-online was 0.33 for any
19 eating disorder, 0.93 for anorexia nervosa and 0.83 for EDNOS; the related 95% CIs were
20 much wider, ranging from 0.04 to 0.78 for any eating disorder, 0.76 to 0.99 for anorexia
21 nervosa, and from 0.67 to 0.94 for EDNOS.

22 The quality of evidence from the one identified case control study on the eating disorders
23 section of DAWBA-interview (n=174) was very low for the case identification of any eating
24 disorder, anorexia nervosa, bulimia nervosa and EDNOS. The quality was affected by
25 concerns over risk of bias, indirectness and/or imprecision. As expected, the estimated
26 sensitivity and specificity of the eating disorders section of DAWBA-interview yielded by the
27 case control studies was higher than that of the online version. The reported sensitivity for
28 this study was 1.0 for any eating disorder and anorexia nervosa, and 0.71 for EDNOS; the
29 related 95% CI ranged from 0.93 to 1.00 for any eating disorder and anorexia nervosa, and
30 from 0.56 to 0.83 for EDNOS. The reported sensitivity of DAWBA-interview in identifying
31 cases of bulimia nervosa was 0.94, with the 95% CI ranging from 0.83 to 0.99. Similarly, the
32 reported specificity of the case control study on DAWBA-interview was higher than that
33 reported by the cohort study on DAWBA-online. The reported specificity for this study was
34 0.94 for any eating disorder, 1.00 for anorexia nervosa and 0.95 for EDNOS; the related 95%
35 CIs ranged from 0.88 to 0.97 for any eating disorder, 0.97 to 1.00 for anorexia nervosa, and
36 from 0.9 to 0.98 for EDNOS. The reported specificity of DAWBA-interview in identifying
37 cases of bulimia nervosa ranged from 0.91 to 0.99, with the 95% CI ranging from 0.91 to
38 0.99.

39 **4.2.4.2 SCOFF**

40 **Any eating disorder**

41 The overall quality of evidence from the six identified cohort and cross-sectional studies
42 (n=2513) included in the meta-analysis was moderate for SCOFF at a threshold of 2 or more,
43 but very low for SCOFF at a threshold of 3 or more. The quality of evidence for the use of
44 SCOFF in adult populations suspected of having an eating disorder was downgraded due to
45 concerns about inconsistency and/or imprecision.

1 The estimation of a summary sensitivity and specificity for SCOFF at a threshold of 2 yielded
2 a pooled sensitivity of 0.90 with a 95% CI from 0.81 to 0.95 and a pooled specificity of 0.76
3 with a 95% CI from 0.56 to 0.89. The estimation of a summary sensitivity and specificity for
4 SCOFF at a threshold of 3 yielded a pooled sensitivity of 0.6 with a 95% CI from 0.46 to 0.73
5 and a pooled specificity of 0.93 with a 95% CI from 0.82 to 0.98. Whilst the number of false
6 positives per 1000 at the one-year prevalence rates per 100,000 of 0.5%, 1% and 5% were
7 much higher for the SCOFF at a threshold of 2 compared to a threshold of 3, the number of
8 false negatives was lower.

9 The quality of evidence from the one study that examined the use of SCOFF in male
10 populations suspected of having an eating disorder was moderate (n=605) due to concerns
11 about imprecision. In male participants at a SCOFF threshold of 2, the one identified study
12 yielded a sensitivity of 0.86 with a 95% CI from 0.7 to 0.96 and a specificity of 0.74 with a
13 95% CI from 0.7 to 0.78. At a threshold of 3, the sensitivity of SCOFF was 0.66 with a 95%
14 CI from 0.48 to 0.81, whilst the specificity was 0.91 with a 95% CI from 0.88 to 0.93.

15 The quality of evidence from the two identified case-control studies (n=438) that examined
16 the use of SCOFF in populations with suspected eating disorders was very low due to
17 concerns over risk of bias and indirectness. The reported sensitivity for SCOFF at a
18 threshold of 2 or more ranged from 0.94 to 1.00 with the related 95% CIs ranging from 0.88
19 to 1.00. The reported specificity of SCOFF at a threshold of 3 or more ranged from 0.66 to
20 0.99 with the related 95% CIs ranging from 0.57 to 1.00, whilst the specificity ranged from
21 0.90 to 1.00 with the related 95% CIs also ranging from 0.90 to 1.00.

22 Overall, the evidence suggests that SCOFF is generally a more useful case identification tool
23 when used with a threshold of 2 compared with a threshold of 3 at identifying any eating
24 disorder.

25 **Anorexia nervosa**

26 The quality of evidence from the one cross-sectional study (n=195) that examined the use of
27 SCOFF to identify cases of anorexia nervosa in adult female populations suspected of
28 having an eating disorder was low for both thresholds examined due to concerns over risk of
29 bias and imprecision. The reported sensitivity for SCOFF at a threshold of 2 in this study was
30 0.93 with 95% CI ranging from 0.77 to 0.99, whilst the specificity was 0.94 with the related
31 95% CI ranging from 0.90 to 0.97. The sensitivity for SCOFF at a threshold of 3 in this study
32 was slightly lower at 0.9 with 95% CI ranging from 0.73 to 0.98, whilst the specificity was
33 1.00 with the 95% CI ranging from 0.98 to 1.00.

34 The quality of evidence from the two case control studies (n=438) that examined the use of
35 SCOFF at a threshold of 2 or more to identify cases of anorexia nervosa in adult female
36 populations was very low due to concerns over risk of bias and indirectness. The reported
37 sensitivity for SCOFF at a threshold of 2 or more ranged from 0.96 to 1.00 with the related
38 95% CIs ranging from 0.87 to 1.00, whilst the specificity ranged from 0.88 to 0.93 with the
39 related 95% CIs ranging from 0.81 to 1.00.

40 The quality of the one case control study (n=226) that examined the use of SCOFF at a
41 threshold of 3 to identify cases of anorexia nervosa in adult female populations suspected of
42 having an eating disorder was also very low due to concerns over risk of bias, indirectness
43 and imprecision. The reported sensitivity was 0.66 (with 95% CI ranging from 0.53 to 0.77),
44 whilst the specificity was 1.00 (with 95% CI ranging from 0.98 to 1.00).

45 **Bulimia nervosa**

46 The quality of evidence from the one cross-sectional study (n=195) that examined the use of
47 SCOFF to identify cases of bulimia nervosa in adult female populations suspected of having
48 an eating disorder was moderate for a threshold of 2 or more and low for a threshold of 3 or
49 more, due to concerns over risk of bias and/or imprecision. The reported sensitivity for

1 SCOFF at a threshold of 2 was 0.98 (with 95% CI ranging from 0.89 to 1.00), whilst the
2 specificity was 0.94 (with 95% CI ranging from 0.89 to 0.97). At a threshold of 3, the reported
3 sensitivity was 0.73 (with 95% CI ranging from 0.58 to 0.85), whilst the specificity was 1.00
4 (with 95% CI ranging from 0.98 to 1.00).

5 The quality of evidence from the two case control studies (n=438) that examined the use of
6 SCOFF at a threshold of 2 or more to identify cases of bulimia nervosa in adult female
7 populations was very low due to concerns over risk of bias and indirectness. The reported
8 sensitivity for SCOFF at a threshold of 2 or more ranged from 0.93 to 1.00 with the related
9 95% CIs ranging from 0.82 to 1.00, whilst the specificity ranged from 0.87 to 0.94 with the
10 related 95% CIs ranging from 0.81 to 0.97.

11 The quality of the one case control study (n=226) that examined the use of SCOFF at a
12 threshold of 3 to identify cases of bulimia nervosa in adult female populations suspected of
13 having an eating disorder was again very low due to concerns over risk of bias, indirectness
14 and imprecision. The reported sensitivity was 0.67 (with 95% CI ranging from 0.51 to 0.80),
15 whilst the specificity was 1.00 (with 95% CI ranging from 0.98 to 1.00).

16 EDNOS

17 The quality of evidence from the one cross-sectional study (n=195) that examined the use of
18 SCOFF to identify cases of EDNOS in adult female populations suspected of having an
19 eating disorder was moderate for a threshold of 2 or more and low for a threshold of 3 or
20 more, due to concerns over risk of bias and/or imprecision. The reported sensitivity for
21 SCOFF at a threshold of 2 was 1.00 (with 95% CI ranging from 0.94 to 1.00), whilst the
22 specificity was 0.95 (with 95% CI ranging from 0.90 to 0.98). At a threshold of 3, the reported
23 sensitivity was no better than chance at 0.24 (with 95% CI ranging from 0.13 to 0.37), whilst
24 the specificity was 1.00 (with 95% CI ranging from 0.98 to 1.00).

25 4.2.5 Economic Evidence statements

26 No economic evidence on the tools for the identification of eating disorders was available.

27 4.2.6 Recommendations and link to evidence

28 Initial assessments in primary and secondary mental health care

<ol style="list-style-type: none">1. Be aware that eating disorders present in a range of settings, including:<ul style="list-style-type: none">• primary and secondary health care (including acute hospitals)• social care• education• work. 2. Although eating disorders can develop at any age, be aware that the risk in young men and women is highest between 13 and 17 years of age. 3. Do not use screening tools (for example, SCOFF) as the sole method to determine whether or not people have an eating disorder.
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<p>Relative value of different outcomes</p>	<p>For the review on the validity of tools that may be used for case-identification, the committee considered the critical outcomes were sensitivity, specificity, positive predictive value, and negative predictive value and likelihood ratio values. Other outcomes were considered important but studies were not included if they did not measure any of the critical outcomes. Important outcomes included numerous validity and reliability measures.</p> <p>The critical outcome of sensitivity was used as the primary measure for decision making given the need to minimise false negatives when seeking to identify eating disorder cases in people with a suspected eating disorder. That is, such a test needs to minimise the number of false negatives so that the test is more inclusive and ensures more people who are likely to have an eating disorder go on to receive the full diagnostic test (e.g. at the secondary care stage).</p> <p>Studies were excluded if they investigated how well the tool was at screening the general population for eating disorders because this would not be considered a good use of resources in an NHS setting. Instead, the usefulness of a case-identification tool in a clinical setting, such as when a person with a suspected eating disorder visits a general practitioner, was considered.</p> <p>The outcomes of positive and negative predictive value, and positive and negative likelihood ratios were presented although not considered by the committee (with the exception of the latter relating to the results of the meta-analysis of SCOFF for any eating disorder).</p>
<p>Trade-off between clinical benefits and harms</p>	<p>The review on what tests were effective at identifying people with an eating disorder (case identification) showed that the Development and Well-Being Assessment (online or interview) may be a better case identification tool in interview format than online for young people with any eating disorder, anorexia nervosa, bulimia nervosa or OSFED. Overall, there was a similar number of false negatives for case identification of any eating disorder, anorexia nervosa, bulimia nervosa and EDNOS. However, the online version produced a higher number of false positives compared with the full interview. This in turn would result in a high number of young people needing to undergo a full diagnostic test, leading to a waste in resources and an increase in costs.</p> <p>Another tool where evidence was found was SCOFF (Sick-Control-One-Fat-Food). The review compared how well this tool identifies adults with a suspected eating disorder with different cut-off scores used. Overall, the evidence suggests that when a threshold of two or more is used, it is better at identifying the presence of an eating disorder (both generally and for the specific disorders of anorexia, bulimia and EDNOS) in populations who are suspected to have such and in minimising the number of false negatives. When a cut-off score greater than three is used, the number of false negatives increases as the prevalence of eating disorders increases in the population. However, a cut-off score greater than two leads to a higher number of false positives compared to a cut-off score greater than three. This would both waste secondary care resources and increase the associated costs of assessment.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>There was no evidence on the cost effectiveness of identification tools in people with eating disorders. The committee discussed the time it takes to administer such tools (for example, DAWBA can take up to 50 min and SCOFF only few minutes) and the consequence associated with eating disorders. The committee considered very limited clinical evidence and noted that that even though there are various tools available there is no convincing evidence that any of these tools are effective on their own in the identification of eating disorders. Based on the administration time SCOFF would be the preferred option. However, given the range in quality of the clinical evidence (which was mostly very low quality and conflicting) and the relatively low prevalence of eating disorders (especially anorexia nervosa) – both</p>

	<p>in the general population and in those people presenting in a primary care setting - the committee felt that even if the sensitivity of the reviewed case identification tools were higher, their utilisation would not be an efficient use of resources. As a result, the committee refrained from recommending any case identification tool, and noted that such tools should not be used as a sole method to determine whether people have an eating disorder.</p>
<p>Quality of evidence</p>	<p>The overall quality of evidence of the case-identification studies was assessed using a modified GRADE approach that used the QUADAS-2 checklist to evaluate the risk of bias and indirectness. The quality of evidence ranged from moderate quality to very low quality. Outcomes were downgraded for: i) risk of bias, ii) indirectness, iii) imprecision, and iv) inconsistency (if applicable). The evidence from case-control studies started at low quality because of the risk of spectrum bias. As expected, these studies generally yielded higher estimates of the sensitivity of the relevant tools compared with the identified cohort and cross-sectional studies.</p> <p>Few studies were identified for the case-identification review (only two for the Development and Well-Being Assessment), so an overall point estimate of specificity and sensitivity could not be estimated. Also, no evidence was found on the ESP test that met the criteria of the protocol.</p> <p>The sensitivity of the interview and online versions of DAWBA yielded similar estimates for any eating disorder, anorexia nervosa and EDNOS, however, it was limited to one cohort study conducted in a UK secondary care setting and one case-control study conducted in Brazil. There was also substantial variability in its estimated specificity.</p> <p>There was substantially more evidence for the performance of SCOFF for any eating disorder, but only one cross-sectional study conducted in a Spanish primary care setting and two case-control studies that examined its performance in identifying cases of particular eating disorders. Whilst the quality of evidence for SCOFF at a cut-off score greater than two was moderate, the pooled estimate of its sensitivity was only 0.9. That is, if 100 people with an eating disorder were to take the test, only 90 of them would test positive.</p> <p>Any variability in the estimated sensitivity and specificity across the studies may have been due to a difference in the prevalence of the disease in the populations used. More generally, if there is a low prevalence in the population used, then there will be more people in whom the condition is barely present and fewer people in whom the condition is clearly present. As such, sensitivity may be lower (detecting true positives) because it will be more difficult to detect people with the target conditions. Conversely, if there is a higher disease prevalence, for example a sample from tertiary care or a case control study, there may be fewer participants with limited forms of the disease and more with the clear manifested forms. In such cases, it will be easier to clearly detect those with the condition and sensitivity will be higher. Indeed, the estimated sensitivity of SCOFF for both cut-off scores in the studies conducted in primary care were generally lower than for those conducted in secondary care.</p> <p>There are a number of other reasons that may explain test variability, including how similar the symptoms appear in a pool of participants. The more similar the underlying conditions appear in people, the more false positives are likely to be found. When underlying conditions appear very much alike, the target condition may also be recognised as a comorbidity, which may result in more false negatives. This could lead to a lower sensitivity and specificity in a study population that has been selected for case identification compared with the general population. Other reasons for variability across studies include reader expectation (what the person diagnosing typically sees), and study design such as case-controls versus a spectrum of participants that reflects what the clinician would</p>

	typically see in practice. In the case of SCOFF, the estimated sensitivity in the case control studies was, as expected, generally higher than that in the cohort and cross-sectional studies.
Other considerations	<p>The committee discussed whether to recommend any of the case-identification tools. They agreed that, although SCOFF was relatively good at identifying true cases and minimising false negatives and could be integrated into the early stages of identifying people with an eating disorder, it would be better for clinicians to use their judgment rather than one of the tools considered in this review. This was mostly due to the low prevalence of eating disorders, the variable likelihood ratios associated with the SCOFF for any eating disorder, and the wide range in the number of false negatives and positives that it would yield for the various types of eating disorders. The committee agreed that when a person with a suspected eating disorder presents for evaluation, there are better ways of determining whether s/he has an eating disorder (e.g. using a full diagnostic test such as the EDE). The Committee decided that no research recommendation was required.</p> <p>The tools investigated in this review were by no means a comprehensive list of all the tools available for case-identification or for a full-diagnosis. The committee were asked to provide a list of the most common and relevant tools that could be investigated in the time available for this review.</p> <p>It is important to note that results from the studies will vary depending on the population used to assess the tools. This is because sensitivity and specificity may vary with the prevalence of the disease. For this reason, clinicians are advised to base their decisions on studies that most closely match their own clinical situation. Although the committee discussed whether further guidance should be given, they concluded that clinical expertise is sufficient for identifying eating disorder cases.</p> <p>Although the committee was not able to make specific recommendations for the use of any tools to support case identification of eating disorders, they were aware of problems in the under-identification of eating disorders, particularly in non-specialist healthcare settings. The committee therefore drew on their knowledge of current service utilisation and existing epidemiological data, and used informal consensus methods to generate two recommendations. First, in order to increase awareness that eating disorders may present in range of settings the committee decided to develop a recommendation highlighting that eating disorders may present in a variety of settings, including physical healthcare, social care, work and educational settings. Second, in order to improve recognition the committee decided to develop a recommendation highlighting the fact that, although an eating disorder can develop at any age, the risk of onset of eating disorders is greatest between ages 13 and 17 years for young men and women.</p>

1

2 **4.3 Assessment and monitoring of eating disorders**

3 **4.3.1 Review question: What is the validity and reliability of the instruments, tools** 4 **and methods used to assess and monitor eating disorders?**

5 The review protocol summary, including the review question and the eligibility criteria used
 6 for this section of the guideline, can be found in Table 26. Further information about the
 7 search strategy can be found in Appendix H; the full review protocols can be found in
 8 Appendix F.

9 Randomised control trials, cohort and cross-sectional studies were sought that assessed the
 10 accuracy of the Anorexia Nervosa Inventory for Self-rating, Bulimic Investigatory test
 11 Edinburgh, ED-15, Eating Attitudes Test, Eating Disorders Assessment for DSM 5, the

1 Eating Disorders Examination-Questionnaire, Eating Disorder Inventory, the Structured
 2 Inventory for Anorexic and Bulimic Eating Disorders-Interview, Structured Inventory for
 3 Anorexic and Bulimic Eating Disorders-self-rating and the Short Evaluation for Eating
 4 Disorders in people already identified (e.g. in primary care) as having either an eating
 5 disorder or an early onset eating disorder, as defined by the DSM, ICD-10 or the semi-
 6 structured 'gold standard' EDE interview or the structured SCID-I-P were searched for. The
 7 studies were categorised according to the specific type of eating disorder assessed.

8 **Table 26: Clinical review protocol summary**

Component	Description
Review question(s)	What is the validity and reliability of the instruments, tools and methods used to assess and monitor eating disorders?
Population	Children, young people and adults with: <ul style="list-style-type: none"> • early onset of eating disorders, e.g. people with body shape dissatisfaction • clinical samples (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> • children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years Exclude: <ul style="list-style-type: none"> • People with disordered eating because of a physical health problem or another primary mental health problem of which a disorder of eating is a symptom (for example, depression). • People with feeding disorders, such as pica or avoidant restrictive food intake disorders (for example, food avoidance emotional disorder or picky/selective eating). • People with obesity without an eating disorder. • People from the general population where the tool would be used for screening.
Instruments, tools and methods	<ul style="list-style-type: none"> • The following will be investigated as a tool to use after a suspected index case has been raised: • EAT (Eating Attitudes Test; including different versions: EAT-40, EAT-26, ChEAT etc.). • EDI (Eating Disorder Inventory; distinguish between different versions) • BITE (Bulimic Investigatory Test, Edinburgh) • EDE-Q (Eating Disorder Examination-Questionnaire; distinguish between different versions) • SEED • ED-15 • The Structured Inventory for Anorexic and Bulimic Eating Disorders: available as a structured clinical interview for experts (SIAB-EX) and as a self-rated questionnaire (SIAB-S) • Munich ED-Quest (Munich Eating Disorder Questionnaire) • ANIS (Anorexia Nervosa Inventory for Self-rating) • EDA-5 (The Eating Disorder Assessment for DSM-5; for feeding or eating disorders or related conditions according to the DSM-5 criteria)
Reference	Gold standard, relevant ED definition as reported in: <ul style="list-style-type: none"> • DSM • ICD-10

Component	Description
	<ul style="list-style-type: none"> EDE –Interview SCID (1)
Critical outcomes	<ul style="list-style-type: none"> Sensitivity (Se): the proportion of true positives of all cases diagnosed in the population Specificity (Sp): the proportion of true negatives of all cases not-diagnosed in the population Positive predictive value Negative predictive value Likelihood values
Important outcomes	VALIDITY <ul style="list-style-type: none"> Concurrent validity, convergent validity, construct validity, content validity, predictive and discriminant validity RELIABILITY <ul style="list-style-type: none"> Inter-rater reliability. Intra-rater reliability, test re-test reliability, , internal consistency
Study design	<ul style="list-style-type: none"> RCTs Cohort Cross-sectional

1

2 4.3.2 Clinical evidence

3 Due to the numerous studies that reported important outcomes only and the paucity of
 4 studies reporting critical outcomes on the aforementioned assessment tools, it was decided
 5 to include only studies that reported sensitivity and specificity (or reported data from which
 6 these could be derived) and moreover to include case-control studies. No RCTs that satisfied
 7 the eligibility criteria for this review were found. 15 cohort, cross sectional or case-control
 8 studies were identified (seven cohort or cross sectional studies, eight case-control studies),
 9 the majority of which were in adult females (Allen et al., 2011; Alvarez-Rayon et al., 2004;
 10 Berg et al., 2012; Fichter and Quadflieg, 2000; Fichter and Quadflieg, 2001; Fichter et al.,
 11 2015; Henderson and Freeman, 1987; Rivas et al., 2010; Ro et al., 2015; Sysko et al., 2015;
 12 Thurfjell et al., 2003; Vander Wal et al., 2011; Waller, 1992). Only 1 study was found that
 13 evaluated an assessment tool specifically designed for use in children and young people
 14 (Thurfjell 2003). No studies that reported the critical outcomes of sensitivity and specificity
 15 were found for the ANIS, ED-15 and SEED assessment tools. An overview of the included
 16 studies can be found in Table 27, whilst an overview of risk of bias and indirectness can be
 17 found in Table 28. See also the study selection flow chart in Appendix K, sensitivity and
 18 specificity forest plots in Appendix M, study evidence tables in Appendix L and exclusion list
 19 in Appendix J.

20 For the majority of assessment tools, only one or two studies were found that met the
 21 eligibility criteria. Whilst four studies were found for the EDE-Q, only two of these were cohort
 22 or cross-sectional studies. Since case-control studies overestimate the accuracy of a test, a
 23 meta-analysis was not conducted on the EDE-Q and data from such studies are presented
 24 separately from those of cohort and cross-sectional studies. In the case that a study reported
 25 data for more than one threshold for a given assessment tool, the data from the threshold
 26 recommended by the study was used. To enable visual comparisons between tests for any
 27 eating disorder or a specific type of disorder, the sensitivity and specificity of the assessment
 28 tools were plotted on a ROC curve.

1 **4.3.2.1 Any eating disorder**

2 **Children and young people**

3 One case-control study (n=2274) was identified (Thurfjell 2003) that examined an
4 assessment tool specifically designed for children and young people. The majority of
5 participants in this study were female. The quality of evidence is presented in Table 28 and
6 Table 29. See also the study selection flow chart in Appendix K, sensitivity and specificity
7 forest plots in Appendix M, study evidence tables in Appendix L and exclusion list in
8 Appendix J.

9 **Children, young people and adults**

10 One cohort study (n=212) (Allen 2011) using the EDE-Q, which was conducted in a tertiary
11 care setting, and three case-control studies using the EAT-40 (n=556) (Alvarez-Rayon 2004),
12 EAT-26 (n=172) (Rivas 2010) and EDE-Q (n=2465) (Ro 2015) were identified. The majority
13 of participants in the cohort study, and all the participants in the case-control studies, were
14 female. The quality of evidence is presented in Table 30 and Table 31. See also the study
15 selection flow chart in Appendix K, sensitivity and specificity forest plots in Appendix M, study
16 evidence tables in Appendix L and exclusion list in Appendix J.

17 **4.3.2.2 Anorexia nervosa**

18 Six cohort and cross-sectional studies using the EDE-Q for DSM-IV (n=429) (Allen 2001,
19 Berg 2012), EDE-Q for DSM 5 (n=217) (Berg 2012), Munich ED-Quest (n=195) (Fichter
20 2015), SIAB-EX (n=80) (Fichter 2001), EDA-5 (n=66) (Sysko 2015) and EDA-5 App (n=71)
21 (Sysko 2015) and 3 case-control studies using the EAT-40 (n= 556) (Alvarez-Rayon 2004),
22 EDE-Q (n= 2465) (Ro 2015) and BITE (n=81) (Waller 1992), were identified. The majority of
23 cohort and cross-sectional studies were conducted in tertiary care settings, whilst the
24 majority of participants were female. One case-control study that examined the BITE
25 assessment tool, which was originally designed to assess binge eating, evaluated its utility in
26 assessing the restricting and binge-purge subtypes of anorexia nervosa (Waller 1992).

27 The quality of evidence is presented in Table 32 and Table 33. See also the study selection
28 flow chart in Appendix K, sensitivity and specificity forest plots in Appendix M, study evidence
29 tables in Appendix L and exclusion list in Appendix J.

30 **4.3.2.3 Bulimia nervosa**

31 Six cohort and cross-sectional studies using the EDE-Q for DSM-IV (n=429 (Allen 2001, Berg
32 2012), EDE-Q for DSM 5 (n=217) (Berg 2012), Munich ED-Quest (n=195) (Fichter 2015),
33 SIAB-EX (n=80) (Fichter 2001), EDA-5 (n=66) (Sysko 2015) and EDA-5 App (n=71) (Sysko
34 2015) and 3 case-control studies using the EAT-40 (n= 556) (Alvarez-Rayon 2004), EDE-Q
35 (n= 2465) (Ro 2015) and BITE (n=81) (Waller 1992), were identified. The majority of cohort
36 and cross-sectional studies were conducted in tertiary care settings, whilst the majority of
37 participants were female. One case-control study that examined the BITE assessment tool,
38 which was originally designed to assess binge eating, evaluated its utility in assessing
39 bulimia nervosa with and without a history of anorexia nervosa (Waller 1992).

40 The quality of evidence is presented in Table 34 and Table 35. See also the study selection
41 flow chart in Appendix K, sensitivity and specificity forest plots in Appendix M, study evidence
42 tables in Appendix L and exclusion list in Appendix J.

43 **4.3.2.4 Anorexia and bulimia nervosa**

44 Two cohort studies using the SIAB-EX (n=377) (Fichter 2000) and SIAB-S (n=80) (Fichter
45 2001) and 1 case-control study using the EAT-40 (n=556) (Alvarez-Rayon 2004) were

1 identified. Both cohort studies were conducted in a secondary care setting and were in both
2 adult males and females. The quality of evidence is presented in Table 36 and Table 37. See
3 also the study selection flow chart in Appendix K, sensitivity and specificity forest plots in
4 Appendix M, study evidence tables in Appendix L and exclusion list in Appendix J.

5 **4.3.2.5 Binge eating disorder**

6 Three cohort and cross-sectional studies using EDA-5 (n=66) (Sysko 2015), EDA-5 App
7 (n=71) (Sysko et al., 2015) (Sysko 2015) and EDE-Q (n=217) (Berg 2012) and 3 case-control
8 studies using BITE (n=119) (Henderson 1987) and EDE-Q (n=41) (Vander Wal 2011) were
9 identified. All three cohort and cross-sectional studies were conducted in a tertiary care
10 setting and the majority of participants were female.

11 The quality of evidence is presented in Table 38 and Table 39. See also the study selection
12 flow chart in Appendix K, sensitivity and specificity forest plots in Appendix M, study evidence
13 tables in Appendix L and exclusion list in Appendix J.

14 **4.3.2.6 EDNOS**

15 Four cohort or cross-sectional studies using the EDA-5 (n=66) (Sysko 2015), EDA-5 App
16 (n=71) (Sysko 2015) and EDE-Q (n=429) (Allen 2001, Berg 2012) and 2 case-control studies
17 using the EAT-40 (n=556) (Alvarez-Rayon 2004) and EDE-Q for DSM-IV (n=2465) (Ro 2015)
18 were identified. All four cohort and cross-sectional studies were conducted in a tertiary care
19 setting and the majority of participants were female.

20 The quality of evidence is presented in Table 40 and Table 41. See also the study selection
21 flow chart in Appendix K, sensitivity and specificity forest plots in Appendix M, study evidence
22 tables in Appendix L and exclusion list in Appendix J.

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1 Table 27: Study information for review on assessment tools of eating disorders in early onset or clinical populations

Study ID	Country	Assessment tool	ED Reference definition	Sample	Sample N	Age (years)	Female (%)	Eating Disorder assessed
Henderson 1987 Study 1	UK	BITE	DSM-III	Case-control: (I) Binge eaters=15 (II) Controls=40	55	24.2 (5.5)	76	BED
Henderson 1987 Study 2	UK	BITE	DSM-III	Case-control: (I) BN=32 (II) Controls=32	64	25.1 (5.7)	100	BED
Waller 1992	UK	BITE	Interview, DSM-III-R	Case-control: (I) ED outpatients=81 (II) Controls=27	81	25.7 (7.6)	100	AN-R, AN-BP, BN with history of AN, BN without history of AN
Rivas 2010 Study 2	Spain	EAT-26	Spanish Q-EDD, DSM-IV	Case-control: (I) ED outpatients=86 (II) Controls=79	172	18.6 (4.4) Range 12-35	100	Any ED
Alvarez-Rayon 2004	Mexico	EAT-40	DSM-IV	Case-control: (I) ED outpatients=276 (ii) Controls=280	556	19.4 (3.9)	100	Any ED AN, BN, AN or BN, EDNOS
Sysko 2015 Study 1	USA	EDA-5	EDE, Version 16, DSM-IV	Cross sectional: individuals seeking or receiving treatment for ED at tertiary care centre	66	30.9 (11) Range 14-58	89	AN, BN, BED EDNOS or OSFED/US FED
Sysko 2015 Study 2	USA	EDA-5 App	Clinician interview, DSM 5	Cohort: receiving treatment for ED, tertiary care	71	32.7 (11.9) Range 18-65	94	AN, BN, BED EDNOS or OSFED/US FED

Study ID	Country	Assessment tool	ED Reference definition	Sample	Sample N	Age (years)	Female (%)	Eating Disorder assessed
Allen 2011	Australia	EDE-Q	EDE, DSM-IV	Cohort: ED outpatients, tertiary care	212	26.18 (9.21) Range 16-72	99	Any ED AN, BN, EDNOS
Berg 2012	USA	EDE-Q	EDE, DSM-IV	Cross-sectional: ED outpatients, tertiary care	217	19.6 (9.6) Range 9-61	90	AN, BN, BED, EDNOS
Ro 2015	Norway	EDE-Q	Clinical diagnosis, ICD-10 transformed to DSM-IV	Case-control: (I) ED in- and out- patients=620 (II) Controls=1845	2465	30.7 (10.3) Range 16-66	100	Any ED AN, BN, EDNOS
Vander Wal 2011	USA	EDE-Q	Diagnostic items EDE, Version 12, DSM-IV	Case-control: Overweight or obese individuals with BED (n=15) and without BED (n=26)	41	52.0 (12.1)	71	BED
Thurfjell 2003	Sweden	EDI-C	Semi-structured interview adapted for young people, DSM-IV	Case-control: (I) ED patients from special ED unit=201 (II) Controls=2073	2274	15.7 (1.6)	100	Any ED
Fichter 2015 Sample 6	Germany	Munich ED-Quest	SIAB-EX, DSM 5	Cross-sectional: ED inpatients, tertiary care	195	21.7 (8.7)	100	AN, BN
Fichter 2000	Germany	SIAB-EX	EDE, DSM-IV	Cohort: ED inpatients, secondary care	377	29.1 (9.3)	97	AN or BN
Fichter 2001	Germany	SIAB-S	SIAB-EX	Cohort: ED inpatients, secondary care	80	28.8 (9.5)	96	AN, BN, AN or BN

- 1 Abbreviations: AN, anorexia nervosa; BN, bulimia nervosa; EDNOS eating disorder not otherwise specified; ED, eating disorder; EDE-Q, Eating Disorder Examination; EDI, Eating Disorder Inventory; BITE, Bulimic Investigatory Test, Edinburgh; DSM, diagnostic statistical manual of mental disorders; SIAB EX The Structured Inventory for Anorexic and Bulimic Eating Disorders: available as a structured clinical interview for experts; SIAB S The Structured Inventory for Anorexic and Bulimic Eating Disorders as a self-rated questionnaire; ANIS, Anorexia Nervosa Inventory for Self-rating; EDA-5, The Eating Disorder Assessment for DSM 5

1 **Table 28: Summary table of QUADAS-2 results for risk of bias and indirectness for studies on assessmental tools of eating disorders**

Study	RISK OF BIAS				INDIRECTNESS		
	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD	FLOW AND TIMING	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD
BITE							
Henderson 1987 Study 1	⊖	⊖	⊕	⊕	⊕	⊖	⊕
Henderson 1987 Study 2	⊖	⊖	⊕	⊕	⊕	⊖	⊕
Waller 1992	⊖	⊖	⊖	⊕	⊕	⊖	⊕
EAT-26							
Rivas 2010 Study 2	⊖	⊖	⊖	⊕	⊕	⊖	⊕
EAT-40							
Alvarez-Rayon 2004	⊖	⊖	⊕	⊖	⊕	⊖	⊕
EDA-5							
Sysko 2015 Study 1	⊕	⊖	⊕	⊕	⊕	⊕	⊕
EDA-5 App							
Sysko 2015 Study 2	⊕	⊖	⊖	⊕	⊕	⊕	⊕
EDE-Q							
Allen 2011	⊕	⊕	⊖	⊕	⊕	⊕	⊕
Berg 2012	⊕	⊖	⊖	⊖	⊕	⊕	⊕
Ro 2015	⊖	⊖	⊕	⊖	⊕	⊖	⊕
Vander Wal 2011	⊖	⊖	⊕	⊖	⊖	⊕	⊕
EDI-C							
Thurfjell 2003	⊖	⊖	⊖	⊖	⊕	⊖	⊕
Munich ED-Quest							

Study	RISK OF BIAS				INDIRECTNESS		
	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD	FLOW AND TIMING	PATIENT SELECTION	INDEX TEST	REFERENCE STANDARD
Fichter 2015 Sample 6	⊖	⊖	⊖	☺	☺	☺	☺
SIAB-EX							
Fichter 2000	⊖	☺	☺	☺	☺	☺	☺
SIAB-S							
Fichter 2001 Study 2	☺	⊖	☺	☺	☺	☺	☺
Key ☺=Low Risk ⊖=High Risk							

1 **Table 29: Clinical evidence profile for case-control studies on assessment tools for eating disorders in children and young people**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDI-C	1								
Thurfjell 2003		2274	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.74 (0.67, 0.79)	0.77 (0.75, 0.79)	VERY LOW

2 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
3 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
4 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
5 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
6 decision-making.

1 **Table 30: Clinical evidence profile for cohort and cross-sectional studies on assessment tools for eating disorders in children, young**
 2 **people and adults**

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDE-Q for DSM-IV	1									
Allen 2001		Cohort	232	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Not applicable ^d	0.64 (0.57, 0.7)	1.00 ^d	LOW ^d

3 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 4 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 5 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) there were no false positives and no true negatives in the sample. A continuity correction
 6 was applied to allow calculation of specificity. The related confidence interval, and therefore imprecision, was not estimable. The overall quality of the evidence was therefore
 7 downgraded by one in this case.

8 **Table 31: Clinical evidence profile for case-control studies on assessment tools for eating disorders in children, young people and**
 9 **adults**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EAT-26	1								
Rivas 2010		172	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.6 (0.48, 0.71)	0.95 (0.88, 0.99)	VERY LOW
EAT-40 ≥ 26	1								
Alvarez-Rayon 2004		556	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.83 (0.78, 0.87)	0.91 (0.87, 0.94)	VERY LOW
EDE-Q for DSM-IV ≥ 2.5	1								
Ro 2015		2465	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.86 (0.83, 0.89)	0.86 (0.84, 0.88)	VERY LOW

10 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 11 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 12 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
 13 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
 14 decision-making.

1 **Table 32: Clinical evidence profile for cohort and cross-sectional studies on assessment tools for anorexia nervosa in children,**
 2 **young people and adults**

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDA-5	1									
Sysko 2015 Study 1		Cross-sectional	66	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	1.0 (0.85, 1.0)	0.83 (0.69, 0.93)	LOW
EDA-5 App	1									
Sysko 2015 Study 2		Cohort	71	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.83 (0.59, 0.96)	1.0 (0.93, 1.0)	LOW
EDE-Q for DSM-IV	2		429							
Allen 2001		Cohort	212	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness ^c	No serious imprecision ^d	0.71 (0.54, 0.85)	0.97 (0.93, 0.99)	MODERATE
Berg 2012		Cross-sectional	217	Very serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness ^c	No serious imprecision ^d	0.73 (0.39, 0.94)	0.99 (0.96, 1.0)	LOW
EDE-Q for DSM 5	1									
Berg 2013		Cross-sectional	217	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.73 (0.45, 0.92)	0.99 (0.96, 1.0)	LOW
Munich ED-Quest	1									
Fichter 2015		Cross-sectional	195	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.93 (0.89, 0.99)	0.98 (0.93, 1.0)	LOW
SIAB-EX	1									

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
Fichter 2001		Cohort	80	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.67 (0.38, 0.88)	0.92 (0.83, 0.97)	MODERATE

1 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
2 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency was assessed by inspection of the sensitivity and specificity forest plots (based
3 on the primary measure), using the point estimates and confidence intervals. The evidence was downgraded by 1 increment if the individual studies varied across 2 areas (for
4 example, 50–90% and 91–100%) and by 2 increments if the individual studies varied across 3 areas (for example, 0–50%, 51–90% and 91–100%). Inconsistency not
5 applicable if only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small
6 number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious
7 imprecision. Imprecision was assessed on the primary measure of specificity for decision-making.

8 **Table 33: Clinical evidence profile for case-control studies for anorexia nervosa in children, young people and adults**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
BITE for AN-R	1								
Waller 1992		81	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	1.0 (0.72, 1.00)	1.00 (0.95, 1.0)	VERY LOW
BITE for AN-BP	1								
Waller 1992		81	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.40 (0.12, 0.74)	1.0 (0.95, 1.0)	VERY LOW
EAT-40 ≥ 28	1								
Alvarez-Rayon 2004		556	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.85 (0.72, 0.93)	0.93 (0.90, 0.95)	VERY LOW
EDE-Q for DSM-IV ≥ 2.09	1								
Ro 2015		2465	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.8 (0.73, 0.86)	0.8 (0.78, 0.82)	VERY LOW

9 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
10 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
11 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of

1 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
 2 decision-making.

3 **Table 34: Clinical evidence profile for cohort and cross-sectional studies on assessment tools for bulimia nervosa in children, young**
 4 **people and adults**

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDA-5	1									
Sysko 2015 Study 1		Cross-sectional	66	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.71 (0.44, 0.9)	0.96 (0.85, 0.99)	MODERATE
EDA-5 App	1									
Sysko 2015 Study 2		Cohort	71	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.96 (0.8, 1.0)	0.98 (0.88, 1.0)	LOW
EDE-Q for DSM-IV	2									
Allen 2001		Cohort	212	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness ^c	No serious imprecision ^d	0.53 (0.42, 0.63)	0.88 (0.81, 0.94)	MODERATE
Berg 2012		Cross-sectional	217	Very serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness ^c	No serious imprecision ^d	0.74 (0.58, 0.87)	0.91 (0.86, 0.95)	LOW
EDE-Q for DSM 5	1									
Berg 2012		Cross-sectional	217	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.73 (0.58, 0.85)	0.94 (0.89, 0.97)	LOW
Munich ED-Quest	1									
Fichter 2015		Cross-sectional	195	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.73 (0.57, 0.85)	0.97 (0.93, 0.99)	LOW

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SIAB-EX	1									
Fichter 2001		Cohort	80	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.63 (0.44, 0.79)	0.79 (0.65, 0.9)	MODERATE

1 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
2 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency was assessed by inspection of the sensitivity and specificity forest plots (based
3 on the primary measure), using the point estimates and confidence intervals. The evidence was downgraded by 1 increment if the individual studies varied across 2 areas (for
4 example, 50–90% and 90–100%) and by 2 increments if the individual studies varied across 3 areas (for example, 0–50%, 51–90% and 91–100%). Inconsistency not
5 applicable if only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small
6 number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious
7 imprecision. Imprecision was assessed on the primary measure of specificity for decision-making.

8 **Table 35: Clinical evidence profile for case-control studies on assessment tools for bulimia nervosa in children, young people and**
9 **adults**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
BITE for BN with history of AN	1								
Waller 1992		81	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.83 (0.61, 0.95)	1.0 (0.94, 1.0)	VERY LOW
BITE for BN without history of AN	1								
Waller 1992		81	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.9 (0.55, 1.0)	1.0 (0.95, 1.0)	VERY LOW
EAT-40 ≥ 28	1								
Alvarez-Rayon 2004		556	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.87 (0.79, 0.93)	0.93 (0.90, 0.95)	VERY LOW
EDE-Q for DSM-IV ≥ 2.62	1								
Ro 2015		2465	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.87	0.87	VERY LOW

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
							(0.82, 0.91)	(0.86, 0.88)	

1 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 2 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 3 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
 4 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision.

5 **Table 36: Clinical evidence profile for cohort and cross-sectional studies on assessment tools for anorexia or bulimia nervosa in**
 6 **children, young people and adults**

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
SIAB-EX	1									
Fichter 2001		Cohort	80	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.68 (0.53, 0.81)	0.79 (0.61, 0.91)	LOW
SIAB-S	1									
Fichter 2000		Cohort	377	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.7 (0.64, 0.75)	0.8 (0.7, 0.87)	MODERATE

7 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 8 was assessed using the QUADAS-2 checklist. See Table 28 for more details (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 9 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
 10 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
 11 decision-making.

12 **Table 37: Clinical evidence profile for case-control studies on assessment tools for anorexia and bulimia nervosa in children, young**
 13 **people and adults**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EAT-40 ≥ 28	1								

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
Alvarez-Rayon 2004		556	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.86 (0.79, 0.91)	0.94 (0.91, 0.96)	VERY LOW

1 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 2 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 3 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
 4 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
 5 decision-making.

6 **Table 38: Clinical evidence profile for cohort and cross-sectional studies on assessment tools for binge eating disorder in children,**
 7 **young people and adults**

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDA-5	1									
Sysko 2015 Study 1		Cross-sectional	66	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	1.0 (0.48, 1.0)	0.98 (0.91, 1.0)	MODERATE
EDA-5 App	1									
Sysko 2015 Study 2		Cohort	71	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.86 (0.57, 0.98)	0.96 (0.88, 1.0)	LOW
EDE-Q for DSM-IV	1									
Berg 2012		Cross-sectional	217	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.28 (0.1, 0.53)	0.97 (0.94, 0.99)	LOW

8 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 9 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 10 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
 11 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
 12 decision-making.

1 **Table 39: Clinical evidence profile for case-control studies on assessment tools for binge eating disorder in children, young people**
2 **and adults**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
BITE	2	119							
Henderson 1987 (Study 1)		55	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	No serious imprecision ^d	1.0 (0.89, 1.0)	1.0 (0.89, 1.0)	VERY LOW
Henderson 1987 (Study 2)		64	Serious risk of bias ^a	No serious inconsistency ^b	Serious indirectness ^c	No serious imprecision ^d	0.93 (0.68, 1.0)	0.95 (0.83, 0.99)	VERY LOW
EDE-Q for DSM-IV ≥ 3.2-3.3	1								
Vander Wal 2011		41	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	Serious imprecision ^d	0.73 (0.45, 0.92)	0.81 (0.61, 0.93)	VERY LOW

3 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
4 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
5 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
6 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
7 decision-making.

8 **Table 40: Clinical evidence profile for cohort and cross-sectional studies on assessment tools for EDNOS in children, young people**
9 **and adults**

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDA-5	1									
Sysko 2015 Study 1		Cross-sectional	66	Serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.65 (0.38, 0.86)	0.96 (0.85, 0.99)	MODERATE
EDA-5 App	1									
Sysko 2015 Study 2		Cohort	71	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	Serious imprecision ^d	0.73 (0.39, 0.94)	0.9 (0.79, 0.96)	VERY LOW

Index test	Number of studies	Type of study	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EDE-Q for DSM-IV	2		439							
Allen 2001		Cohort	212	Serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness ^c	No serious imprecision ^d	0.72 (0.61, 0.81)	0.63 (0.54, 0.71)	MODERATE
Berg 2012		Cross-sectional	217	Very serious risk of bias ^a	No serious inconsistency ^b	No serious indirectness ^c	Serious imprecision ^d	0.84 (0.77, 0.9)	0.71 (0.6, 0.81)	VERY LOW
EDE-Q for DSM 5	1									
Berg 2012		Cross-sectional	217	Very serious risk of bias ^a	Not applicable ^b	No serious indirectness ^c	No serious imprecision ^d	0.82 (0.74, 0.88)	0.76 (0.67, 0.84)	LOW

1 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency was assessed by inspection of the sensitivity and specificity forest plots (based on the primary measure), using the point estimates and confidence intervals. The evidence was downgraded by 1 increment if the individual studies varied across 2 areas (for example, 50–90% and 91–100%) and by 2 increments if the individual studies varied across 3 areas (for example, 0–50%, 51–90% and 91–100%). Inconsistency not applicable if only one study; (c) Indirectness was assessed using the QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for decision-making.

8 **Table 41: Clinical evidence profile for case-control studies on assessment tools for EDNOS in children, young people and adults**

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
EAT-40 ≥ 22	1								
Alvarez-Rayon 2004		556	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.83 (0.75, 0.89)	0.82 (0.78, 0.86)	VERY LOW
EDE-Q for DSM-IV ≥ 2.63	1								

Index test	Number of studies	n	Risk of bias	Inconsistency	Indirectness	Imprecision	Sensitivity (95% CI)	Specificity (95% CI)	Quality
Ro 2015		2465	Very serious risk of bias ^a	Not applicable ^b	Serious indirectness ^c	No serious imprecision ^d	0.88 (0.83, 0.92)	0.88 (0.87, 0.89)	VERY LOW

- 1 Notes: The assessment of the evidence quality was conducted with emphasis on test specificity as this was the primary measure discussed in decision-making; (a) Risk of bias
 2 was assessed using the QUADAS-2 checklist. See Table 28 for more details; (b) Inconsistency not applicable due to only one study; (c) Indirectness was assessed using the
 3 QUADAS-2 checklist items referring to applicability. See Table 28 for more details; (d) Due to the small number of studies, a range of 0–20% of differences in point estimates of
 4 sensitivity was considered not imprecise, 21–40% serious imprecisions, and >40% very serious imprecision. Imprecision was assessed on the primary measure of specificity for
 5 decision-making.

1 **4.3.3 Economic evidence**

2 No economic evidence on the tools for the assessment and monitoring of eating disorders
3 was identified by the systematic search of the economic literature undertaken for this
4 guideline. Details on the methods used for the systematic search of the economic literature
5 are described in Chapter 3.

6 **4.3.4 Clinical evidence statements**

7 **4.3.4.1 Any eating disorder**

8 The quality of evidence from the one case control study (n=2274) that examined the use of
9 an assessment tool (the EDI-C) in children and young people with eating disorders was very
10 low due to concerns over risk of bias and indirectness. The reported specificity was 0.77
11 (with 95% CI ranging from 0.75 to 0.79), whilst the sensitivity was 0.74 (with 95% CI ranging
12 from 0.67 to 0.79).

13 The quality of evidence from the one cohort study (n=212) that examined the use of the EDE-
14 Q in an eating disorder population (i.e. children, young people and adults) was low due to
15 concerns about risk of bias. The reported specificity was 1.00 (the 95% CI was not
16 estimable) whilst the sensitivity was 0.64 (with 95% CI ranging from 0.57 to 0.70).

17 The quality of evidence from the three case control studies that examined the use of an
18 assessment tool in an eating disorder population (i.e. children, young people and adults) was
19 very low due to concerns about risk of bias and indirectness. The assessment tools
20 examined were EAT-26 (n=172), EAT-40 at a threshold of 26 or more (n=556) and EDE-Q
21 for DSM-IV at a threshold of 2.5 or more (n=2465). The specificity of the tools were relatively
22 similar: the EAT-26 had the highest specificity of 0.95 (with 95% CI ranging from 0.88 to
23 0.99), followed by the EAT-40 with a specificity of 0.91 (with 95% CI ranging from 0.87 to
24 0.94) and the EDE-Q for DSM-IV with a specificity of 0.86 (with 95% CI ranging from 0.84 to
25 0.88). By contrast, the sensitivity of the tools were wider: the EDE-Q had the highest
26 sensitivity of 0.86 (with 95% CI ranging from 0.83 to 0.89), followed by the EAT-40 with a
27 sensitivity of 0.83 (with 95% CI ranging from 0.78 to 0.87) and the EAT-26 with a specificity
28 of 0.6 (with 95% CI ranging from 0.48 to 0.71).

29 **4.3.4.2 Anorexia nervosa**

30 The quality of evidence from the six cohort or cross-sectional studies examining assessment
31 tools for anorexia nervosa in populations with an eating disorder ranged from moderate to
32 low due to concerns about risk of bias. The evaluated assessment tools included the
33 interview version of EDA-5 (n=66), the electronic application version of EDA-5 (n=71), EDE-
34 Q for DSM-IV (n=429), EDE-Q for DSM 5 (n=217), Munich ED-Quest (n=195) and SIAB-EX
35 (n=80). The reported specificity of these tools was relatively high and the related 95% CIs
36 were also relatively narrow: the EDA-5 App had the highest specificity of 1.00 (with 95% CI
37 ranging from 0.93 to 1.00), followed by the EDE-Q (specificity ranging from 0.97 to 0.99, with
38 95% CI ranging from 0.93 to 1.00 for DSM-IV, and specificity of 0.99 with 95% CI ranging
39 from 0.96 to 1.00 for EDE-Q for DSM 5) and Munich ED-Quest (specificity=0.98 with 95% CI
40 ranging from 0.93 to 1.00), the SIAB-EX (specificity= 0.92 with 95% CI ranging from 0.83 to
41 0.97) and the interview version of the EDA-5 (specificity=0.83 with 95% CI ranging from 0.69
42 to 0.93). However, the reported sensitivity of the tools was more variable and the 95% CIs
43 were relatively wide: the interview version of the EDA-5 had the highest sensitivity of 1.00
44 (with 95% CI ranging from 0.85 to 1.00), followed by Munich ED-Quest (sensitivity=0.93 with
45 95% CI ranging from 0.89 to 0.99), EDA-5 App (sensitivity=0.83 with 95% CI ranging from
46 0.59 to 0.96), EDE-Q (sensitivity ranging from 0.71 to 0.73 with 95% CI ranging from 0.39 to

1 0.94 for DSM-IV; sensitivity=0.73 with 95% CI ranging from 0.45 to 0.92 for DSM 5) and
2 SIAB-EX (sensitivity=0.67 with 95% CI ranging from 0.38 to 0.88).

3 The quality of evidence for the three identified case control studies was very low due to
4 concerns over risk of bias and indirectness. The EAT-40 at a threshold of 28 had the highest
5 specificity of 0.93 (with 95% CI ranging from 0.90 to 0.95) for the assessment of anorexia
6 nervosa, followed by the EDE-Q at a threshold of 2.09 (specificity=0.8 with 95% CI ranging
7 from 0.78 to 0.82). The EAT-40 at a threshold of 28 had the highest sensitivity of 0.85 (with
8 95% CI ranging from 0.72 to 0.93), followed by the EDE-Q at a threshold of 2.09
9 (sensitivity=0.8 with 95% CI ranging from 0.73 to 0.86).

10 The specificity of the BITE for both restricting and binge-purge subtypes of anorexia nervosa
11 was 1.00 and the 95% CIs ranged from 0.95 to 1.0 for both subtypes. However, whilst the
12 sensitivity of BITE for the restricting subtype was 1.0 (with 95% CI ranging from 0.72 to 1.00),
13 the sensitivity for the binge-purge subtype was much lower at 0.4 (with 95% CI ranging from
14 0.12 to 0.74).

15 4.3.4.3 Bulimia nervosa

16 The quality of evidence from the six cohort and cross-sectional studies examining
17 assessment tools for bulimia nervosa in eating disordered populations ranged from moderate
18 to low due to concerns about risk of bias. The evaluated assessment tools included the
19 interview version of EDA-5 (n=66), the electronic application version of EDA-5 (n=71), EDE-
20 Q for DSM-IV (n=429), EDE-Q for DSM 5 (n=217), Munich ED-Quest (n=195) and SIAB-EX
21 (n=80). The reported specificity of these tools was relatively high and the related 95% CIs
22 were also relatively narrow: the EDA-5 App had the highest specificity of 0.98 (with 95% CI
23 ranging from 0.88 to 1.00), followed by Munich ED-Quest (specificity=0.97 with 95% CI
24 ranging from 0.93 to 0.99), the interview version of EDA-5 (specificity=0.96 with 95% CI
25 ranging from 0.85 to 0.99), EDE-Q (specificity ranging from 0.88 to 0.91 with 95% CI ranging
26 from 0.81 to 0.95 for DSM-IV; specificity=0.94 with 95% CI ranging from 0.89 to 0.97 for DSM
27 5) and SIAB-EX (specificity=0.79 with 95% CI ranging from 0.65 to 0.90). The reported
28 sensitivity of these tools and their related 95% CIs was much more wide-ranging, with the
29 EDA-5 App also having the highest sensitivity of 0.96 (with 95% CI ranging from 0.80 to
30 1.00), followed by the Munich ED-Quest (sensitivity=0.73 with 95% CI ranging from 0.57 to
31 0.85) and EDE-Q (sensitivity ranging from 0.53 to 0.74 with 95% CI ranging from 0.42 to 0.87
32 for DSM-IV; sensitivity=0.73 with 95% CI ranging from 0.58 to 0.85 for DSM 5), EDA-5
33 (sensitivity=0.71 with 95% CI ranging from 0.44 to 0.90) and SIAB-EX (sensitivity=0.63 with
34 95% CI ranging from 0.44 to 0.79).

35 The quality of evidence for the three identified case control studies was very low due to
36 concerns over risk of bias and indirectness. The EAT-40 at a threshold of 28 had the highest
37 specificity of 0.93 (with 95% CI ranging from 0.90 to 0.95) for the assessment of bulimia
38 nervosa, followed by the EDE-Q at a threshold of 2.62 (specificity=0.87 with 95% CI ranging
39 from 0.86 to 0.88). The EAT-40 at a threshold of 28 also had the highest sensitivity of 0.85
40 (with 95% CI ranging from 0.72 to 0.93), followed by the EDE-Q at a threshold of 2.62
41 (sensitivity=0.87 with 95% CI ranging from 0.82 to 0.91).

42 The specificity of the BITE for the assessment of people with bulimia nervosa with and
43 without a history of anorexia nervosa was 1.0 with the related 95% CI ranging from 0.94 to
44 1.0 for the former, and from 0.95 to 1.0 for the latter. The sensitivity of BITE to bulimia
45 nervosa with and without a history of anorexia nervosa was also similar at 0.83 (95% CI from
46 0.61 to 0.95) and 0.9 (95% CI from 0.55 to 1.0) respectively.

47 4.3.4.4 Anorexia or bulimia nervosa

48 The quality of evidence for the two cohort studies that examined an assessment tool for
49 either anorexia or bulimia nervosa in eating disordered populations was moderate to low due

1 to concerns over risk of bias and/or imprecision. The assessment tools evaluated were the
2 SIAB-EX (n=80) and SIAB-S (n=377). The SIAB-S had the highest specificity of these two
3 studies (0.8, 95% CI ranging from 0.7 to 0.87) closely followed by the SIAB-EX (0.79, 95% CI
4 ranging from 0.61 to 0.91). Similarly, the SIAB-S had the highest sensitivity (0.7, 95% CI
5 ranging from 0.64 to 0.75), again closely followed by the SIAB-EX (0.68, 95% CI ranging
6 from 0.51 to 0.81).

7 The quality of evidence for the one case control study that examined an assessment tool for
8 the evaluation of anorexia or bulimia nervosa was very low due to concerns over risk of bias
9 and indirectness. The specificity and sensitivity of the case control study on EAT-40 at a
10 threshold of 28 or more (n=556) was 0.94 (with 95% CI ranging from 0.91 to 0.96) and 0.86
11 (with 95% CI ranging from 0.79 to 0.91), respectively.

12 4.3.4.5 Binge eating disorder

13 The quality of evidence from the three cohort or cross-sectional studies that examined
14 assessment tools for binge eating disorder in eating disordered populations ranged from
15 moderate to low. The tools evaluated were the interview (n=66) and electronic application
16 versions (n=71) of the EDA-5 and the EDE-Q for DSM-IV (n=217). The interview version of
17 the EDA-5 had the highest specificity (0.98, 95% CI ranging from 0.91 to 1.00), followed by
18 EDE-Q for DSM-IV (0.97, 95% CI ranging from 0.94 to 0.99) and the electronic application
19 version of EDA-5 (0.96, 95% CI ranging from 0.88 to 1.00). The reported sensitivity of these
20 studies was much more wide ranging, with the EDA-5 having a high sensitivity (1.0, 95% CI
21 ranging from 0.48 to 1.00), followed by the EDA-5 App (0.86, 95% CI ranging from 0.57 to
22 0.98). The EDE-Q for DSM-IV had a very low sensitivity of 0.28 (95% CI ranging from 0.1 to
23 0.53).

24 The quality of evidence for the three case control studies was very low. The reported
25 specificity of the three case control studies were from 0.93 to 1.0 for BITE (with 95% CI
26 ranging from 0.83 to 1.0) and 0.73 (95% CI ranging from 0.61 to 0.93) for EDE-Q for DSM-IV
27 at a threshold of between 3.3 and 3.33. The reported sensitivity for these studies was from
28 0.93 to 1.00 for the BITE (95% CIs ranging from 0.68 to 1.0) and 0.73 for EDE-Q for DSM-IV
29 (95% CI ranging from 0.45 to 0.92).

30 4.3.4.6 EDNOS

31 Very low to moderate quality evidence from five cohort or cross-sectional studies (n= 793)
32 showed the EDA-5 interview has the highest specificity (0.96) for assessing EDNOS in
33 clinical or early onset populations compared with EDE-5 App, EDE-Q for DSM-IV or DSM 5.

34 Very low to moderate quality evidence from five cohort or cross-sectional studies (n= 793)
35 showed other assessment tools (EDE-5 App, EDE-Q for DSM-IV or DSM 5) were neither
36 specific nor accurate.

37 Very low quality evidence from two case-control studies (n= 3021) showed EAT-40 at a
38 threshold of 22, and EDE-Q for DSM-IV at a threshold of 2.63 were not particularly accurate.

39 The quality of evidence for the five cohort or cross-sectional studies that examined an
40 assessment tool for EDNOS in eating disordered populations ranged from moderate to very
41 low due to concerns over risk of bias and/or imprecision. The tools evaluated included the
42 interview (n=66) and electronic application (n=71) versions of EDA-5 and the EDE-Q for
43 DSM-IV (n=439) and DSM 5 (n=217). The tool with the highest reported specificity of 0.96
44 was the EDA-5 (95% CI ranging from 0.85 to 0.99), followed by EDA-5 App (0.9, 95% CI
45 ranging from 0.79 to 0.96), EDE-Q for DSM 5 (0.76, 95% CI ranging from 0.67 to 0.84) and
46 EDE-Q for DSM-IV (specificity ranging from 0.63 to 0.71, with 95% CI ranging from 0.54 to
47 0.81). The reported sensitivity of these studies was more wide ranging: the EDE-Q for DSM-
48 IV had a reported sensitivity of 0.72 and 0.84 (with 95% CI ranging from 0.61 to 0.9), whilst
49 the EDE-Q for DSM 5 had a sensitivity of 0.82 (95% CI ranging from 0.74 to 0.88). The EDA-

1 5 App had a sensitivity of 0.73 (95% CI ranging from 0.39 to 0.94), whilst the EDA-5 had a
2 sensitivity of 0.65 (95% CI ranging from 0.38 to 0.86). (Note that since both the EDA-5 and
3 EDA-5 App are intended for use with DSM 5, it can be used to assess Other Specified
4 Feeding and Eating Disorders [OSDED] and Unspecified Eating and Feeding Disorder
5 [USFED] in addition to the DSM-IV category of EDNOS.)

6 The quality of evidence for the two case control studies was very low due to concerns over
7 risk of bias and indirectness. The reported specificity of the EAT-40 at a threshold of 22 or
8 more was 0.82 (95% CI ranging from 0.78 to 0.86), whilst its sensitivity was 0.83 (95% CI
9 ranging from 0.75 to 0.89). The specificity of the EDE-Q for DSM-IV at a threshold of 2.63 or
10 more was 0.88 (95% CI ranging from 0.87 to 0.89), whilst its sensitivity was 0.88 (95% CI
11 ranging from 0.83 to 0.92).

12 **4.3.5 Economic evidence statements**

13 No economic evidence on the tools for the assessment and monitoring of eating disorders
14 was available.

15 **4.3.6 Recommendations and link to evidence**

16

4. People with eating disorders should be assessed and receive treatment at the earliest opportunity.

5. Early treatment is particularly important for those with or at risk of severe emaciation and such patients should be prioritised for treatment.

6. When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply:

- an unusually low or high BMI or body weight for their age
- rapid weight loss
- dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
- family members or carers report a change in eating behaviour
- social withdrawal, particularly from situations that involve food
- other mental health problems
- a disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)
- problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
- menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- physical signs of:

	<ul style="list-style-type: none"> o malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor o compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise • abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition • unexplained electrolyte imbalance or hypoglycaemia • atypical dental wear (such as erosion) • whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling). <p>7. Be aware that, in addition to the points in recommendation 4, children and young people with an eating disorder may also present with faltering growth (for example, a low weight or height for their age) or delayed puberty.</p> <p>8. Do not use single measures such as BMI or duration of illness to determine whether to offer treatment for an eating disorder.</p> <p>9. Professionals in primary and secondary mental health or acute settings should assess the following in people with a suspected eating disorder:</p> <ul style="list-style-type: none"> • their physical health, including checking for any physical effects of malnutrition or compensatory behaviours such as vomiting • the presence of mental health problems commonly associated with eating disorders, including depression, anxiety, self-harm and obsessive compulsive disorder • the possibility of alcohol or substance misuse. • the need for emergency care in people whose physical health is compromised or who have a suicide risk.
<p>Relative value of different outcomes</p>	<p>For the review on the utility and validity of tools that may be used for assessment and/or monitoring of eating disorders, the committee considered the critical outcomes were sensitivity, specificity, positive predictive value, and negative predictive value and likelihood ratio values. Other outcomes were considered important but studies were not included if they did not measure any of the critical outcomes. Important outcomes included numerous validity and reliability measures.</p> <p>The critical outcome of specificity was used as the primary measure for decision making given the need to minimise false positives when seeking to identify eating disorder cases in people with an eating disorder or in people who are in the early stages of developing one. That is, such a test needs to minimise the number of false positives so that the test is more exclusive and ensures people who do not have an eating disorder are not given unnecessary treatment (e.g. at the secondary care stage).</p> <p>The committee evaluated the performance of the relevant tests on the critical outcomes of sensitivity and specificity (and the related number of false positives</p>

	<p>and negatives) and decided that identification of eating disorders should be on the basis of clinical judgment via a full diagnostic 'gold standard' interview. Since such an interview is by definition valid and reliable in the UK, further analysis of the important outcomes for the relevant tools was not deemed necessary.</p> <p>The outcomes of positive and negative predictive value, and positive and negative likelihood ratios were presented although not considered by the committee. No review was conducted on where healthcare professionals may expect to find people with an eating disorder, or what they should consider when conducting an initial assessment including any safeguarding concerns.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>For the review on what tools are effective at assessing those with an eating disorder, the critical outcome is specificity. Evidence was found on a number of tests including Eating Disorder Examination-Questionnaire, Munich-ED, the 40-item Eating Attitudes Test, Structured Expert Interview for Anorexic and Bulimic Syndromes and Structured Inventory for Anorexic and Bulimic Syndromes self-report, EDE-Q, EDA-5 (interview and electronic application) and Bulimic Investigatory Test, Edinburgh.</p> <p>To assess whether people have anorexia nervosa, the best tests appear to be EDA-5 App, EDE-Q (for both DSM-IV and DSM-5), and Munich-ED, which all had a specificity greater than 97%. To assess whether people have bulimia nervosa, the best tests appear to be EDA-5 App, Munich ED-Quest and EDA-5, which all had a specificity greater than 95%. To assess whether people have binge eating disorder, the best tests appear to be EDA-5, EDE-Q for DSM-IV and EDA-5 App, which all had a specificity over 95%. For OSFED, the best test appears to be EDA-5, which had a specificity over 95%. Overall, the EDA-5 appears to be most versatile for assessing anorexia nervosa, bulimia nervosa and OSFED in adults.</p> <p>Despite the relatively high specificity of the above tests, and given the low number of studies on each assessment tool and wide range in quality of evidence, the committee expressed the view that the risk of false positives (and hence inappropriate treatment) due to the use of these assessment tools outweighed the potential benefits, especially given that a full clinical diagnostic 'gold standard' interview, which by definition has 100% specificity, would be required.</p> <p>In lieu of any recommendation to use a particular assessment tool, the committee based their recommendations above on their clinical experience and current practice.</p> <p>The committee were unable to find any high quality evidence to support the use of any particular measure where the benefits of its use outweighed the potential harms to patients given the limited utility of the measures.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>There was no evidence on the cost effectiveness of methods for the assessment and monitoring of eating disorders. The committee expressed the view that, in principle, if assessment and monitoring were to lead to the timely identification, and appropriate treatment, of an eating disorder then the additional costs associated with undertaking such assessment and monitoring would likely be outweighed by both the longer term improvements in health outcomes and the potential future cost savings to the healthcare system, given that delays in treatment exacerbate symptoms. Furthermore, providing timely assessment and monitoring may prevent the need of expensive secondary care. Whilst the committee agreed this in principle, they were of the opinion that in practice, there was little point in taking the time to administer the reviewed assessment tools when a full clinical diagnostic interview (such as the 'gold standard' EDE) would in any case be required.</p>
<p>Quality of evidence</p>	<p>The overall quality of evidence of the diagnostic studies was assessed using a modified GRADE approach that used the QUADAS-2 checklist to evaluate risk of</p>

	<p>bias and indirectness. The quality of evidence of the included studies ranged from moderate to very low quality. Outcomes were downgraded if: i) there was risk of bias, ii) for indirectness, iii) imprecision, and iv) inconsistency (if applicable). All case-control studies started at low quality because of the risk of spectrum bias. As expected, the case control studies generally yielded higher estimates of the sensitivity of the relevant tools compared to the cohort and cross-sectional studies. When reviewing the quality of evidence for assessment tools, the critical outcome is specificity. That is, considering how well the test is at reducing the number of false positives, so that people who do not have an eating disorder do not undergo unnecessary treatment. Few studies were identified that measured the effectiveness of a tool in different eating disorders, so interpretation of the data was based on few studies with small number of participants. Studies that used a case-control study design were highlighted to the committee as being at a high risk of bias given that it does not reflect a real-life situation and there is a greater chance of true positive and true negatives.</p>
<p>Other considerations</p>	<p>The Committee discussed the relevance of using an alternative tool to DSM-IV for assessing whether a person has an eating disorder. Although the EDE-Q is probably the most commonly used assessment tool, the committee agreed that none of the reviewed tools should be used on their own. As the committee were unable to find any high quality evidence to support a recommendation about assessment or routine monitoring, they drew on their expert knowledge and experience and used informal consensus to develop a number of recommendations on the structure and content of initial assessment. The committee agreed on a list of criteria that they considered to be the most important to use when assessing a person for the presence of an eating disorder, including (though not limited to) an unusually low or high BMI, social withdrawal from situations that involve food, a disproportionate concern about weight or shape, and atypical dental wear. The committee considered faltering growth or delayed puberty to be a particular problem in children and young people because of the substantial impact an eating disorder can have on their growth.</p> <p>They also wanted to emphasise that when deciding whether someone should be offered treatment, neither BMI nor severity of illness should be the sole determining factor and therefore made a recommendation to this effect. The committee provided circumstances where body weight or body mass index (BMI) has been inappropriately used to decide if treatment should be offered (for example, when a person with an eating disorder had a BMI that was considered too low to be offered binge eating disorder treatment). They also discussed the possibility that duration of illness has been misused as an indicator that the person is unlikely to respond to treatment. The committee therefore agreed that single measures should not be used to decide whether or not to offer treatment and that it should be based on a comprehensive psychological and physical assessment.</p> <p>Finally, the committee was aware that a number of physical and mental health issues are often comorbid with, and can complicate treatment of, an eating disorder. They thus made the recommendation that physical and mental health, alcohol or substance misuse, and the need for emergency care be assessed when assessing for an eating disorder so that a comprehensive treatment plan can be developed.</p>

5 Coordinating care of eating disorders

5.1 Introduction

The coordination of care for those experiencing an eating disorder and for their families/ carers, varies widely across the country depending on a number of factors, including where the individual lives, allocated clinical commissioning/ specialised commission funding in that area, differences in thresholds (i.e. some services are restricted due to BMI criteria), variation in specialist skills and overarching inconsistencies across care pathways.

Coordination of care generally commences at the point of the individual accessing a service. This may be via a self-referral to the GP (not always for the initial eating disorder itself but for an associated problem) or primary care team. This is a crucial point for the coordination of care and access to an appropriate onward referral relies on the GP having received adequate training in the field of eating disorders. GPs are also under increasing time pressures, which can lead to the individual not sharing the extent of the problem. However, there are now a number of GPs across the country who have extensive expertise in working with such eating disorders. Appropriate referral also depends on the availability of specialist secondary care services, the provision of which varies greatly around the UK, with some regions having fully integrated primary to tertiary stepped services and other regions having a complete lack of eating disorder specialist support.

In some circumstances, involvement may start via another point of contact. This may include schools, dentists, pharmacies, sports clubs, and paediatricians. A parent/ carer may be the one who initiates an appointment with a professional as it is not uncommon for the individual experiencing the eating disorder to be lacking insight or ambivalent about accessing help.

Well established care pathways take into consideration the issue of consent and the ethical issues arising from eating disorders. Care coordination starts with initial assessment of the patient and assessment of risk, with referral being made to the relevant specialist service if available, ideally resulting in an agreed plan of care implemented.

Good practice emphasises a seamless approach from initial referral to treatment with targets met around waiting times. Historically, this has been due to lengthy wait list controls. New initiatives regarding standardising access and waiting times and narrowing the gap around inconsistencies that result due to geographical disparities continue to be addressed nationally and are being highlighted for children and young people with eating disorders in particular, via the *Access and Waiting Time Standard for Children and Young People with an Eating Disorder*, Commissioning Guidance published in August 2015, in collaboration with NHS England and the National Collaboration Centre for Mental Health (NHS England 2015).

Care provided to children, adults, their families and carers should be delivered by professionals experienced in the evidence based management and treatment of eating disorders.

One of the issues that often results in barriers to the coordination of care is poor communication between teams. The individual may be receiving support from a number of services, however if these are not in regular communication with each other, this often results in gaps in the provision of care. Engagement of the individual may also present as a barrier in the coordination of care and can require time and sensitivity from the professional in building up a therapeutic relationship with the service user.

The transition period from child to adult services can also lead to barriers in the continuity of care coordination and relies on effective transition protocols being delivered. A few areas are now served by community eating disorder teams for people across the age spectrum however these are rare.

1 5.1.1 Co-ordinating care

2 The co-ordination of care for patients with eating disorders varies across the country,
3 depending on local commissioning arrangements and service design. Where specialist
4 eating disorder services exist, a 'case manager' or care co-ordinator within the service
5 commonly oversees the co-ordination and delivery of treatment. Case managers are
6 responsible for ensuring that the package of care being delivered is appropriate for the
7 individual's needs and for liaison with relevant professionals and agencies. Whilst for many
8 this may involve the delivery of psychological therapies, for those with more severe eating
9 difficulties it may include co-ordinating funding and access to either a specialist day or in-
10 patient unit. Alongside discussing and agreeing an appropriate package of care, case
11 managers are responsible for communicating the agreed treatment plan with all those
12 involved in an individual's care. In many parts of the country this is done using the Care
13 Programme Approach (CPA) and is likely to include a combination of CPA meetings and
14 regular written updates to all relevant professionals, as well as to patients themselves. Whilst
15 many specialist services will include medical monitoring as part of care, in some cases this
16 responsibility will be held by the GP, a paediatrician or other physician. In these situations,
17 excellent communication and clear guidance from the specialist team is needed, ideally using
18 a shared care agreement and results of blood tests and other investigations fed back to the
19 specialist team on a regular basis to inform further care planning. Such agreements need to
20 specify who is responsible for taking action when results are abnormal or deteriorating and
21 incorporate a shared understanding of the 'concern' and 'alert' ranges for blood results,
22 physical observations, weight etc.

23 Care coordination may also include other health care professionals as required, such as
24 gastroenterologists or diabetes specialists. The co-ordination of care for those who have an
25 eating disorder as part of a broader psychiatric presentation, which may include depression,
26 personality difficulties including emotionally unstable personality disorder, significant
27 suicidality or substance misuse, is often overseen by a care-co-ordinator based in a local
28 Community Mental Health Team (CMHT) or generic Child and Young people Mental Health
29 Service (CAMHS), although this may change in response to new recommendations
30 (NCCMH, 2015). This type of care co-ordination may involve integrating treatments from a
31 number of services (e.g. CAMHS, general psychiatry, drug and alcohol teams). This way of
32 working can enable 'joined-up' treatment packages to be drawn together that address the
33 patient's broad ranging needs, thus reducing the possibility of individuals being 'bounced'
34 between services. However, multiple professionals being involved in an individual's care can
35 lead to differences in clinical opinion and tensions between teams as to what constitutes the
36 most appropriate care package, so effective communication and supervision are particularly
37 important.

38 Most referrals to specialist services are made directly from primary care or by self-referral, in
39 some areas they are made via the local CMHT or CAMHS. This can result in a two-step
40 process, introducing barriers to treatment and delaying diagnosis and access to care. In
41 England, the recently introduced *Access and Waiting Times Standards for Young People
42 with an Eating Disorder* are intended to reduce duration of untreated illness by removing
43 these barriers through direct access (NHS England 2015). Recent innovations in adult care
44 have involved rolling the secondary care team out into the community with triage,
45 assessment and therapy all being delivered in a primary care setting.

46 5.1.2 Transition of care

47 There are a number of reasons why patients might need to transition. They include transition
48 between child and young people and adult services, between inpatient and outpatient where
49 these are separate (typical for young people), between different geographical areas
50 (common in the student population) or between different types of treatment, including back to
51 primary care at the end of specialist treatment.

1 Most transitions between specialist CAMHS and adult services will follow a transition protocol
2 which is likely to recommend a six month transitional period. During this time a therapist from
3 the adult service will join meetings in CAMHS and get to know the patient and their family.
4 This gives an opportunity for individuals to talk about any anxieties they might have about
5 moving into adult services, as well as time to plan an appropriate on-going package of care.
6 This transitional time can be difficult for parents as, once in adult services, their children are
7 likely to have more say in relation to their treatment and whether they want to continue to
8 share information about their care with their parents.

9 Another difficult time of transition relates to those moving between geographically separate
10 specialist services. Whilst the ideal process would include a handover CPA with both the
11 existing and new care teams, in reality local service procedures often hinder a smooth
12 transition. This can be particularly difficult for students who may split their time between
13 home and university. In these cases best practice might include services working together,
14 although in reality there are often difficulties related to temporary registration with different
15 GPs and services declining to get involved with patients whose addresses are out of their
16 catchment area. This can lead to disjointed and disrupted treatment. Handover from
17 specialist 'home' teams to university GP practices can aid the transition of care significantly.

18 Transitions also occur between types of care, most notably between in-patient and out-
19 patient treatments. In some cases moving to day-care can provide a supportive 'step-down'
20 to community care, which can reduce the risk of relapse and help patients to adjust to life
21 outside of a hospital environment. This is important given that the risk of relapse is high
22 following an episode of in-patient care.

23 As there are a limited number of beds in England, patients may be admitted to units
24 geographically distant from home and from their community specialist or general services. As
25 well as being challenging for people with an eating disorder and their families to manage, this
26 disconnect between inpatient and outpatient or community care can result in increased
27 lengths of inpatient stay because of the need to re-establish therapeutic working
28 relationships and, in the case of young people in particular, re-empower parents and carers
29 to their caring role. A role of case managers is to oversee this process. It is important that the
30 regular CPA reviews for these patients include home teams, to plan support during periods of
31 home leave as well as at discharge.

32 Some patients will be treated in general hospitals and may then be transferred to a specialist
33 eating disorder bed. The transition point must be agreed jointly by the clinical teams, so that
34 patients are adequately medically stabilised at the point of transfer. The MARSIPAN and
35 Junior MARSIPAN reports (Royal College of Psychiatry, 2012; Royal College of Psychiatry,
36 2014) emphasise the importance of collaboratively developed protocols to facilitate shared
37 care and admission and discharge processes and cite examples of poor outcome (including
38 death) when these are not in place.

39 5.2 Coordinating care

40 5.2.1 Review question: Do different ways of coordinating care produce 41 benefits/harms for people with eating disorders? Does the setting (inpatient, 42 outpatient or other specific setting) and different ways of coordinating, 43 transitioning and integrating care for treating eating disorders produce 44 benefits/harms in people with eating disorders?

45 The review protocol summary in Table 42 incorporated two review questions since the
46 interventions overlapped and could be described as either a way of coordinating care or the
47 setting in which treatment should be provided. Further information about the search strategy
48 can be found in Appendix H and the full review protocols can be found in Appendix F.

1

Table 42: Clinical review protocol summary

Component	Description
Review question(s)	<p>Do different ways of coordinating care produce benefits/harms for people with eating disorders?</p> <p>Does the setting (inpatient, outpatient or other specific setting) and different ways of coordinating, transitioning and integrating care for treating eating disorders produce benefits/harms in people with eating disorders?</p>
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) and a common comorbidity (e.g. diabetes, hypothyroidism). Strata: children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<ul style="list-style-type: none"> Case management (named person coordinates patient) vs. none Specialist vs. non specialist Inpatient vs. outpatient Mental health vs. paediatric (physical health) practitioner Teams vs. individual practitioners Stepped care Compulsory vs. voluntary treatment
Comparison	<ul style="list-style-type: none"> Note the comparison listed against the intervention.
Critical outcomes	<ul style="list-style-type: none"> Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> All-cause mortality Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) Family functioning General psychopathology (including mood/depression/anxiety) General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) Quality of life Relapse Resource use Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs Observational studies: including prospective or retrospective cohort studies, (if no RCTs)

1 **5.2.2 Clinical evidence**

2 **5.2.2.1 Specialist vs. non-specialist care and inpatient versus outpatient treatment**

3 10 RCTs (N=748) met the eligibility criteria for the two review questions, and mostly included
4 people with anorexia nervosa and bulimia nervosa (Crisp et al., 1991; Gowers et al., 1994;
5 Durand and King, 2003; Gowers et al., 2007; Herpertz-Dahlmann et al., 2014; Jager et al.,
6 1996; Kong, 2005; Madden et al., 2014; Zeeck et al., 2009a; Zeeck et al., 2009).

7 19 observational studies (n=2883) fulfilled the criteria for this review. The studies included
8 people with anorexia nervosa and bulimia nervosa and some with any eating disorder
9 (Arcelus et al., 2008; Birchall et al., 2002; Carmen et al., 2007; Tulloch et al., 2008; Goddard
10 et al., 2013; Golan and Heyman, 2005; Hogdahl, 2013; House et al., 2012; Hughes et al.,
11 2014; Kawai et al., 2015; Kells et al., 2012; Meguerditchian et al., 2010; Milos et al., 2004;
12 Olmsted et al., 2002; Tantillo et al., 2009; Vandereycken and Vansteenkiste, 2009; Waller et
13 al., 2016; Zeeck et al., 2004; Zeeck et al., 2011). An overview of the trials included in the
14 analysis can be found in Table 43 and Table 44. See also the study selection flow chart in
15 Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and exclusion
16 list in Appendix J.

17 **5.2.2.2 Stepped care interventions for anorexia nervosa**

18 One RCT (n=45) met the eligibility criteria for the two review questions, that was on young
19 people with anorexia nervosa (Lock, 2015). The trial examined the effect of adding three
20 sessions of intensive family coaching to participants who failed to gain more than 2.3 kg after
21 four sessions of family-based treatment. An overview of the trials included in the analysis can
22 be found in Table 43. See also the study selection flow chart in Appendix K, forest plots in
23 Appendix M, study evidence tables in Appendix L and exclusion list in Appendix J.

24 **5.2.2.3 Stepped care interventions for bulimia nervosa**

25 Three RCTs (n=461) met the eligibility criteria for this review, that were all in adults (Davis et
26 al., 1999; Mitchell et al., 2011; Crow et al., 2013; Treasure et al., 1996). An overview of the
27 trials included in the analysis can be found in Table 46. Further information about both
28 included and excluded studies can be found in Appendix J.

29 One study (n=58; Davis 1999) compared group psychoeducation then CBT-ED or wait list
30 control. The study examined the effect of following six 90 min sessions of group
31 psychoeducation over six weeks with either 16 weeks of CBT-ED (12 or 20 sessions
32 depending on binge/purge frequency) or wait list control.

33 One study (n=110; Treasure 1996) compared self-help then CBT-ED versus CBT-ED. The
34 study compared the effect of following eight weeks of self-help followed by eight weeks of
35 CBT-ED (if the participants had experienced a binge or purge episode in the past 28 days)
36 with 16 weekly sessions of CBT-ED.

37 One study (n=293; Mitchell 2011/Crow 2013) compared guided self-help followed by an
38 antidepressant and CBT-ED versus CBT-ED then fluoxetine. The study participants were
39 moved to the subsequent treatment if at the end of each treatment they had experienced a
40 binge or purge episode in the past 28 days.

41 Summary of findings for stepped care intervention for bulimia nervosa can be found in Table
42 67, Table 68 and Table 69. See also the study selection flow chart in Appendix K, forest plots
43 in Appendix M, study evidence tables in Appendix L and exclusion list in Appendix J.

1 **5.2.2.4 Stepped care for binge eating disorder**

2 No studies were found that examined a stepped care intervention for people with binge
3 eating disorder.

4 **5.2.2.5 Stepped care for EDNOS**

5 No studies were found that examined a stepped care intervention for people with EDNOS.

6

7

1 **Table 43: Study information on the RCTs included in the analysis of coordinating care and treating settings for people with an eating**
2 **disorder.**

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
Crisp 1991/ Gowers 1994 UK	AN 100% female	23.2 (4.9) years	40.8 (6.1) kg	90	Duration of illness 41.0 (30.17) months 33.4 (25.9) months 27.5 (25.8) months 53.5 (52.9) months	Inpatient. Weight restoration to the mean matched-population weight at the age of onset of anorexia, including individual therapy, family therapy, group therapy, dietary counselling and occupational therapy. Followed by 12 sessions of out-patient psychotherapy sessions	Outpatient individual CBT-E and family psychotherapy + dietary counselling. Outpatient group therapy + dietary counselling No further treatment	12 months (unclear duration of therapy) 2 year FU
Durand 2003 UK	BN 100% female	24.5 (5.2) years	Not reported	68	5.9 (3.9) years 7.7 (4.6) years	Specialist Clinic Treatment A consultant psychiatrist managed each clinic. Other staff included psychiatrists, psychologists, nurse specialists, and dietitians. Each clinic offered similar forms of therapy, including a CBT and interpersonal psychotherapy.	General practice self-help CBT-ED. Received a copy of Bulimia Nervosa: a guide to recovery and advised to work through it while keeping in regular contact with their GP.	9 months
Gowers 2007/ Gowers 2010 UK	AN 100% female	14.9 years	Weight below 85% of expected based on age and height	170	Mean length of illness 13 months	General community CAMHS a multidisciplinary, family-based approach with variable dietetic, individual supportive therapy and paediatric liaison	Specialist out-patient. It comprised an initial motivational interview, individual CBT plus parental feedback, parental counselling with dietary therapy. multi-modal feedback In patient (CBT + FT) The treatment was not manualised, but services all used a multidisciplinary psychiatric approach with the aim of normalising eating,	6 months 1 year FU (only data available)

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
							restoring healthy weight and facilitating psychological (cognitive) change. Each participant received both individual supportive or cognitive therapies and family therapy	
Herpertz-Dahlmann 2014 Germany	AN 100% female	15.2 (1.5) years	15.1 (1.2) BMI	172	Duration of illness: 53.7 (39.6) weeks 42.4 (33.1) weeks	Continued inpatient care	Day patient treatment. At week 3 after inpatient All patients were provided with the same outpatient treatment programme. Typical day patient treatment in Germany offers a structured eating disorder programme from 0800 h to 1630 h on weekdays	12 months after admission (follow up),
Jager 1996 Germany	BN 100% female	23.8 (17-35) years	20.7 (16.6-29.3) BMI	61	Duration of illness: 4.7 (0.6 to 23) years	In patient therapy. Group therapy psychoanalytical group sessions integrated, structured groups which are presented with a problem-oriented task or topic. Treatment focuses on comorbidity with low self-esteem and interpersonal problems.	Outpatient treatment focuses on interrelationships. This form of therapy follows the Milan family therapy model.	1 year
Kong 2005 South Korea	AN: 32%: BN: 41%; EDNOS 25% 100% female	27.0 (7.2) years	21.5 (5.7) BMI	50	Duration of illness: 4.2 (1.8) years 3.4 (1.1) years	Modified day treatment Includes CBT, FT, includes meals supervised, group sessions, body image therapy, community meetings and exercise and nutrition education, cooking classes, dance and art therapy,	Traditional outpatient IPT, CBT and pharmacotherapy in an individual format. The treatment with traditional outpatient programme was continued after the study finished.	10.7 (3.8) weeks

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
						sexuality groups and weekend planning group		
Madden 2014 Australia	AN 95% female	14.9 (1.5) years	Not reported	82	Duration of illness: 7.4 (5.4) months	Hospitalization for medical stabilisation followed by FT out-patient if they had no markers of medical instability for 72 h after nasogastric feeds were ceased	Weight restoration Participants in the WR arm continued in hospital on supported meals without nasogastric feeding once they had no markers of medical instability for 72 hours, until they reached 90% ideal body weight before discharge to out-patient FBT.	In hospital 36.9 (17.1) days + 12 months FT
Zeeck & Maier 2009/ Zeeck & Weber 2009 Germany	BN 100% female	24.0 (7.6) years	21.5 (2.2) BMI	55	Duration of illness: 7 years (6.5) or 10.5 years (7.6)	Inpatient clinic program includes CBT and integrates a treatment contract, meal plans; 1 or 2 sessions with the family. Meals are supervised Inpatients are allowed to leave for the weekends during the last weeks of treatment.	Day clinic (treatment as usual). The day clinic and inpatient program comprise the same treatment components	12 weeks. Mean treatment duration: 86.7 days (23.6) 1 year FU

- 1 Abbreviations: AN – anorexia nervosa; BN – bulimia nervosa; EDNOS – eating disorder not otherwise specified; BMI – body mass index; CBT- cognitive behavioural therapy;
2 FT – family therapy; FBT- family-based treatment; FU – follow up; GP – general practice; h – hours.

3 **Table 44: Study information on the observational studies included in the analysis of coordinating care and treatment settings for**
4 **people with an eating disorder.**

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
Arcelus 2008 UK	AN, BN, EDNOS, BED NR: number	206	Not reported	19.7 (10.7 to 43.1)	Age of onset of illness: 14.0 (1.8) years.	Patients who had previous involvement at CAMHS as out-patients and referred to a specialist Adult Eating Disorders Service (AEDS)	Adults referred to a specialist Adult Eating Disorders Service (AEDS)	4 years

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
	of females					Previous treatment with CAMHS due to their ED (less than 5 years ago).	Specialist eating disorders service. Outpatient service after referral from primary care.	
Birchall 2002 UK	Severe AN NR: number of females	27	15.0 (1.9) years	Not reported	Not reported	Day programme Open 10.00 a.m. until 5.15 p.m. 5 days a week and has a maximum capacity of 10 places. The ethos is to provide whatever help patients who struggle towards weight restoration and recovery, and transitions between out-patient, day patient and in-patient treatment are designed to be as seamless as possible. The day programme is not a facility for patients 'stuck' with anorexia	Early programme (inpatient) Before the day programme was opened, the treatment of anorexia nervosa was dichotomous. In-patient treatment is intensive, lengthy and costly, but provides round-the-clock care	Not reported. Data available: 6 mo FU for BMI and 1.5-1.8 years FU for readmission
Carmen 2007 UK	Any ED 100% females	138	Not reported	Not reported	After first appointment with general practitioner	Opt-in letter. Outpatient The opt-in form was attached and they were invited to return it within 4 weeks from the date of the letter.	No opt-in letter. Outpatient	Not reported
Goddard 2013 UK	AN. 95% females	166	26.5 (8.9) years	14.0 (1.7)	Length of illness 8.2 (8.3) years Length of illness 2.0 (1.7) years	Inpatient care Patients were considered discharged when they ceased to receive intensive treatment for their eating disorder (that is, inpatient treatment or day patient treatment ≥ 4 days a week).	Day patient care (no details)	17.8 (10.4) weeks 29.0 (11.9)
Golan 2005 Israel	AN (49%) and BN (51%)	123	AN 20.6 (4.1) years	AN 16.2 (1.7) BN 21.4 (1.6) BMI	Duration of illness AN: 5.1 (3.4) years	Extensive Outpatient Program Psychotherapy and nutrition counselling in addition to a variety of outreach services delivered by clinical mentors	Limited Outpatient program. Psychotherapy and nutrition counselling	1-5 hours /weeks

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
	100% females		BN 22.1 (3.9) years		BN 6.0 (3.6) years			
Hogdahl 2013 Sweden	BN, BED or EDNOS-BN 96% females	79	27.9 (7.5) years	24.0 (4.6)	Duration of illness: 11.3 (8.0) years	Guided self-help It contains facts about eating disorders, and a six-step self-help program with detailed instructions, assignments and checklists. Patient and therapist decide on a day of the week when the therapist answers the patient's messages.	Day patient psychodynamic intensive group treatment with group and individual therapy, meals, body knowledge, and art therapy.	16 weeks
House 2012 UK	AN 58%; BN:25% ; EDNOS 17% 97% females	345	15.1 years	Mean weight for height 82.8%		Specialist eating disorders service. Outpatient service they first came face-to-face with after referral from primary care. A specialist service was defined as a minimum of a multidisciplinary team, a team with the expertise to deliver recommended treatments (assessment of physical risk and psychological therapies including family therapy); and the resources to offer routine outpatient treatment.	Specialist CAMHS or Specialist NHS eating disorder service. Assessment and treatment. (May have patients referred for treatment from non-specialist CAMHS). Non-specialist CAMHS. Assessment and at least initial treatment but ultimately transferred for specialist CAMHS for treatment.	12 months
Hughes 2014 Australia	AN NR: number of females	161	Not reported	Not reported	Point of diagnosis	New model of care. Family therapy as first line. For patients diagnosed with AN or EDNOS-AN type. FBT is an outpatient intervention in which a mental health clinician helps parents become actively involved in supporting weight gain and normalizing eating patterns for their child.	Old model of care. Mostly inpatient Inpatient admissions were routinely used in response to medical instability, failure of outpatient management. Mental health input was generally sought during inpatient admissions; however, there were	Not reported

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
							inconsistencies in outpatient mental health care from community mental health services (e.g., individual, group, or family therapies).	
Kawai 2015 Japan	AN. 97% females	249	22.5 (8.6)	14.0 (1.8)	Duration 7.3 (7.4) years Duration 4.5 (5.4) years	Urgent hospitalisation. Patients hospitalized with disturbances of consciousness and/or difficulty walking on the day of consultation.	Planned inpatient admission. Patients hospitalized for AN up to one year after the day of consultation. For patients whose BMI was not expected to increase and/or eating behaviour abnormality was not expected to improve, inpatient treatment with CBT-ED was offered.	Not reported
Kells 2012 USA	AN NR number of females	52	15.9 (2.5)	15.9 (2.5)	Not reported	Meal supervision Goal of inpatient treatment was weight gain goal of 0.2 kg/day Group includes all patients receiving at least one supervised meal during course of admission. Meal supervision in hospitalized patients modifies the Maudsley method by using clinical staff, rather than parents, as active and supportive observers during meal time.	No meal supervision Patients who were not supervised at meal times during their IP stay.	Not reported
Meguerditchian 2010 France	AN 100% females	143	26.0 years	15.1 (12-20)	Disease duration: 4.1	Hospitalization was prescribed only for life-threatening medical conditions due to severe	Ambulatory care. Outpatient Initial outpatient treatment was based on a weight	4.8 year FU

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
					(0.16 to 29) years	malnutrition, patient incapacity to reach weight objectives patient request, or marked suicidal ideation. Discharge weight was negotiated with each patient	contract (progressive return to normal BMI), and consisted of somatic and nutritional assessment, nutritional education by the dietitian, monthly medical follow up by a physician specialized in nutrition, and weekly psychotherapy sessions of mixed cognitive-behavioural and analytical types.	(duration of care 13.4 (1-68) months)
Milos 2004 Switzerland	AN (29.7%), BN (56.8%), EDNOS (13.5%) 100% females	222	26.8 (6.6) years	AN 15.2 (1.5) BN-21 (5.4) EDNOS/BN 22.2 (5.4).	Not reported	Inpatient. Participants who had spent at least 1 day as an inpatient (in a psychiatric or psychotherapeutic inpatient unit or day hospital or in a somatic hospital) during that period were classified as inpatients.	No history of inpatient experience. All other participants were classified as not currently receiving inpatient treatment.	Not reported
Olmsted 2002 Canada	AN and BN 100% females	581	25.4 (6.6)	21.3 (5.1)	Not reported	5 day programme Intensive group therapy, nutritional rehabilitation, and pharmacotherapy when indicated. The program is predominantly cognitive-behavioural in orientation with some interpersonal and experiential components. Psychopharmacologic interventions include antidepressants and selective serotonin reuptake inhibitors.	4 day programme The intensity, goals, and modality of treatment did not change at this time. Rather, the aim was to be more efficient with less time.	8 hours a day. 8.6 weeks
Tantillo 2009 USA	AN (40%), BN	35	22.1 (5.5)	20.4 (3.5)	Duration of illness: 6.1 (6.6) years	Combined treatment group Partial Hospitalization and Supported Housing, Sage House.	Partial Hospitalization. Inpatient	Unclear

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
	(20%), EDNOS (40%) 100% females					The overall aim of supported housing is to help integrate individuals into the community and allow them to lead fulfilling and satisfying lives outside a hospital or institutional setting. In addition to a safe living environment, the individual residing in supported housing may receive individual counselling or case management to improve problem-solving and daily living skills, support groups, meals, and transportation to appointments/events in the community.	Eating Disorders Partial Hospitalization programs are intensive multidisciplinary treatment venues in which patients spend 7–12 hours per day and receive at least two supervised meals and one snack. The majority time is spent in group and individual therapy, nutritional counselling, psychopharmacological evaluation medication monitoring, and case management. Patients and family members receive family and multifamily therapy, and parenting group is often available for parents of young people and young adults.	
Tulloch 2008 UK (COSI-CAPS)	AN NR: number of females	107	12-18 years	15.3 (2.2)	Inpatient care	Specialist eating disorder inpatient ward	General ward (non-specialist)	140 days
Vandereycken 2009 Belgium	AN (53%), BN (32%) EDNOS (15%)	174	21 (15 to 45) years	14.8 (7.9)	Duration of illness 4.2 years	New strategy. Inpatient the patient is proposed to come at least for an introductory week: a minimum commitment of 5 days (Monday to Friday) with the explicit promise that she will be free to leave the hospital even if her family would prefer her to	Old strategy. Inpatient The staff took all decisions concerning further treatment, including the choice of the treatment group and the duration of	6 months

Study ID	Eating Disorder	N	Age mean (SD)	BMI	Stage of illness	Intervention	Comparison	Duration
	Not reporter number of females					stay. However, if her medical condition were at serious risk, she would be transferred to the internal medicine department of a general hospital nearby	treatment. Both staff and family used various ways to convince patients to stay in the treatment, including medical arguments and psychological pressure with direct or indirect guilt-inducing messages. If patients ran away or refused to return, the family was supposed to bring them back to the hospital.	
Waller 2016 USA	AN NR number of females	29	14.5 (2.1)	74.1 % ABW	Duration of illness 12.4 (13.8) months	Continuum Care Program To make available additional levels of intensive care such as partial hospitalisation, day treatment, and especially intensive outpatient treatment so that inpatient can be used more selectively.	Historical exclusive inpatient Patients admitted exclusively inpatient treatment of AN	3 year FU
Zeeck 2004/Zeeck 2011 Germany	Severe BN 100% females	36	27.1 (6.8) years	23.9 (3.7)	Duration of illness 9.4 (7.8) years	Outpatient Monday to Friday from 08.00 to 16.00 hours. Patients stay for 3 months The nurses provide weekly sessions with a strong symptom orientation including cooking sessions. The initial focus is on symptomatology shifting later more and more to a focus on underlying conflicts or personality deficits. Main elements of treatment are a multidisciplinary team approach and treatment in a 'therapeutic community'.	Inpatient The inpatient treatment is comparable to the day clinic treatment in all treatment components other than that patients stay overnight, have their own room and nurses whom they can meet in the evenings and at weekends.	3-4 months

- 1 Abbreviations: AN – anorexia nervosa; BN – bulimia nervosa; ABW- average body weight; CAMHS – child and adolescent mental health services; EDNOS – eating disorder not otherwise specified; FU – follow up;
2

1 **Table 45: Study information on the RCT included in the analysis of stepped care in young people with anorexia nervosa.**

Study ID	N Randomized	Female (%)	Sample	Intervention	Duration of Intervention	Comparison(s)	Duration of Comparison
Lock 2015	45*	92	AN excluding amenorrhea criterion	Family-based treatment (15 sessions) (+ 3 sessions of Intensive Parental Coaching if weight gain <4.8 lb)	6 months (+ 3 sessions IPC in-between FBT Session 4 and FBT Session 5)	Family-based treatment (15 sessions)	6 months

2 Notes: Participants initially randomised into two groups, one that received family-based treatment only (n=10), and one that received family-based treatment with the possibility of also receiving intensive family coaching if weight gain was less than 2.3 kg after 4 sessions of therapy (n=35). Data only included for participants in latter group.

4 Abbreviations: AN – anorexia nervosa; IFT – intensive family coaching; DSM- IV – Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; lb- pounds; < less than.

5 **Table 46: Study information of the RCTs included in the review of stepped care interventions people with bulimia nervosa.**

Study ID	N Randomized	Female (%)	Sample	Intervention	Age at onset	Duration of illness (years)	Course of Intervention	Comparison(s)	Age at onset	Duration of illness (years)	Course of Comparison	Follow up
Davis 1999	58	100	BN	Group psychoeducation → CBT-ED (12 or 20 sessions)*	Not reported	7.6 (5.4) a	Week 1-6 → Week 7-22	Group psychoeducation → Wait list control	Not reported	7.6 (5.4)	Week 1-6 → Week 7-22	Not reported
Mitchell 2011/ Crow 2013	293	Not reported	BN-P or BN-NP	Guided self-help manual for BN → Fluoxetine (20, 40, 60 mg)** → CBT-ED (20 sessions)***	Not reported	Not reported	Week 1-18 → Week 10-70 → Week 18-44	CBT-ED (20 sessions) → Fluoxetine (20, 40, 60 mg)**	Not reported	Not reported	Week 1-18 → Week 5-70	Not reported
Treasure 1996	110	Not reported	BN or atypical BN	Self-help manual for BN → CBT-ED	17.5 (4.8)	8.0 (5.0)	8 weeks → 8 weeks	CBT-ED (16 sessions)	17 (4.4)	9.1 (6.5)	Week 1-16	18 months

Study ID	N Randomized	Female (%)	Sample	Intervention	Age at onset	Duration of illness (years)	Course of Intervention	Comparison(s)	Age at onset	Duration of illness (years)	Course of Comparison	Follow up
				(8 sessions)***								

- 1 Notes: a, Whole sample; *20 sessions if ≥4 binge or purge episodes past 28 days. 12 sessions if ≤3 binge or purge episodes past 28 days. **, Patients assigned to treatment if they were predicted to be non-responders and consented to treatment; ***, Patients offered treatment if they had not achieved abstinence (no binge nor purge episodes in past 28 days). Arrow indicates the following treatment patients were stepped up to. Abbreviations: BN-NP, Bulimia nervosa non purging subtype; BN-P, Bulimia nervosa purging subtype; CBT- ED, cognitive behavioural therapy with an eating disorder focus.

5 Randomised control trials for coordinating care and treatment settings for people with an eating disorder

6 Table 13: Summary table of findings for inpatient care versus another setting (other) for people with anorexia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Inpatient vs. Other (AN) (95% CI)
BMI Adults - Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI adults - inpatient vs. day clinic in the intervention groups was 0.04 standard deviations higher (0.56 lower to 0.64 higher)
Binge eating - Adults - Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating - adults - inpatient vs. day clinic in the intervention groups was 0.45 standard deviations lower (1.05 lower to 0.16 higher)
Vomiting- Adults - Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting- adults - inpatient vs. day clinic in the intervention groups was 0.39 standard deviations lower (0.99 lower to 0.21 higher)

EDI-2 Bulimia - Adults- Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi-2 bulimia - adults- inpatient vs. day clinic in the intervention groups was 0.12 standard deviations higher (0.48 lower to 0.72 higher)
Change in Global MR - In-patient vs. Outpatient Individual + FT_Adults	50 (1 study)	⊕⊕⊕⊕ VERY LOW1,2 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in global mr - in-patient vs. outpatient individual + ft_adults in the intervention groups was 0.14 standard deviations lower (0.70 lower to 0.43 higher)
Change in Global MR - In-patient vs. Outpatient Group Adults	50 (1 study)	⊕⊕⊕⊕ VERY LOW1,2 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in global mr - in-patient vs. outpatient group adults in the intervention groups was 0.06 standard deviations higher (0.5 lower to 0.63 higher)
Change in Global MR - In-patient vs. WLC Adults	50 (1 study)	⊕⊕⊕⊕ VERY LOW1,2 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in global mr - in-patient vs. wlc adults in the intervention groups was 0.03 standard deviations higher (0.54 lower to 0.60 higher)
Change in MR: Menstruation - In-patient vs. Outpatient Individual + FT	50 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: menstruation - in-patient vs. outpatient individual + ft in the intervention groups was 0.02 standard deviations lower (0.59 lower to 0.55 higher)
Change in MR: Menstruation - In-patient vs. Outpatient Group	50 (1 study)	⊕⊕⊕⊕ VERY LOW1,2 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: menstruation - in-patient vs. outpatient group in the intervention groups was 0.16 standard deviations lower (0.72 lower to 0.41 higher)
Change in MR: Menstruation - In-patient vs. WLC	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculabl e for	The mean change in mr: menstruation - in-patient vs. wlc in the intervention groups was 0.02 standard deviations higher (0.55 lower to 0.58 higher)

				SMD values	
Change in MR: Nutrition - In-patient vs. Outpatient Individual + FT	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: nutrition - in-patient vs. outpatient individual + ft in the intervention groups was 0.06 standard deviations lower (0.63 lower to 0.51 higher)
Change in MR: Nutrition - In-patient vs. Outpatient Group	50 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: nutrition - in-patient vs. outpatient group in the intervention groups was 0.2 standard deviations lower (0.77 lower to 0.36 higher)
Change in MR: Nutrition - In-patient vs. WLC	50 (1 study)	⊕⊕⊕⊕ LOW ^{1,4} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: nutrition - in-patient vs. wlc in the intervention groups was 0.33 standard deviations higher (0.24 lower to 0.90 higher)
Change MR: Mental State - In-patient vs. Outpatient Individual + FT	50 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change mr: mental state - in-patient vs. outpatient individual + ft in the intervention groups was 0.29 standard deviations lower (0.86 lower to 0.28 higher)
Change MR: Mental State - In-patient vs. Outpatient Group	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change mr: mental state - in-patient vs. outpatient group in the intervention groups was 0.07 standard deviations higher (0.50 lower to 0.64 higher)
Change MR: Mental State - In-patient vs. WLC	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change mr: mental state - in-patient vs. wlc in the intervention groups was 0.12 standard deviations lower (0.69 lower to 0.45 higher)
Change in MR: Sexual adjustment - In-patient vs. Outpatient Individual + FT	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of		Not calculabl	The mean change in mr: sexual adjustment - in-patient vs. outpatient individual + ft in the intervention groups was

		bias, imprecision		e for SMD values	0.11 standard deviations higher (0.65 lower to 0.87 higher)
Change in MR: Sexual adjustment - In-patient vs. Outpatient Group	50 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: sexual adjustment - in-patient vs. outpatient group in the intervention groups was 0.07 standard deviations lower (0.83 lower to 0.69 higher)
Change in MR: Sexual adjustment - In-patient vs. WLC	50 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: sexual adjustment - in-patient vs. wlc in the intervention groups was 0.05 standard deviations lower (0.81 lower to 0.71 higher)
Change in MR: Social economic adjustment - In-patient vs. Outpatient Individual + FT	50 (1 study)	⊕⊕⊖⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: social economic adjustment - in-patient vs. outpatient individual + ft in the intervention groups was 0.31 standard deviations lower (0.88 lower to 0.26 higher)
Change in MR: Social economic adjustment - In-patient vs. Outpatient Group	50 (1 study)	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: social economic adjustment - in-patient vs. outpatient group in the intervention groups was 0 standard deviations higher (0.57 lower to 0.57 higher)
Change in MR: Social economic adjustment - In-patient vs. WLC	50 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean change in mr: social economic adjustment - in-patient vs. wlc in the intervention groups was 0.13 standard deviations higher (0.43 lower to 0.70 higher)
Global Severity Index - _Adults - Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊖⊖ LOW ^{1,4} due to risk of bias, imprecision		Not calculabl e for SMD values	The mean global severity index - _adults - inpatient vs. day clinic in the intervention groups was 0.41 standard deviations higher (0.19 lower to 1.02 higher)

Remission - _Adults - Inpatient vs. Day Clinic_ITT	55 (1 study)	⊕⊕⊕⊕ LOW1,6 due to risk of bias, imprecision	RR 1.81 (0.6 to 5.5)	143 per 1000	116 more per 1000 (from 57 fewer to 643 more)
BMI- _Adults FU - Inpatient vs. Specialist Outpatient	76 (1 study)	⊕⊕⊕⊕ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi- _adults fu - inpatient vs. specialist outpatient in the intervention groups was 0.00 standard deviations higher (0.47 lower to 0.47 higher)
BMI- Adultss FU - Inpatient vs. General Outpatient	74 (1 study)	⊕⊕⊕⊕ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi- adults fu - inpatient vs. general outpatient in the intervention groups was 0.25 standard deviations lower (0.73 lower to 0.23 higher)
BMI-Young people FU - Inpatient vs. Day patient	161 (1 study)	⊕⊕⊕⊕ LOW5,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi-young people fu - inpatient vs. day patient in the intervention groups was 0.09 standard deviations lower (0.4 lower to 0.22 higher)
Binge eating - _Adults FU - Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊕⊕ LOW4,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating - _adults fu - inpatient vs. day clinic in the intervention groups was 0.36 standard deviations higher (0.24 lower to 0.97 higher)
Vomiting - _Adults FU - Inpatient vs. Day Clinic	44 (1 study)	⊕⊕⊕⊕ LOW3,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting - _adults fu - inpatient vs. day clinic in the intervention groups was 0.31 standard deviations lower (0.91 lower to 0.28 higher)
Menstruation regular - Young people FU	156 (1 study)	⊕⊕⊕⊕ VERY LOW6,9 due to risk of bias, imprecision	RR 0.81 (0.41 to 1.6)	198 per 1000	38 fewer per 1000 (from 117 fewer to 119 more)

EDI Total - _Adults FU - Inpatient vs. Specialist Outpatient	85 (1 study)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi total - _adults fu - inpatient vs. specialist outpatient in the intervention groups was 0.28 standard deviations lower (0.7 lower to 0.15 higher)
EDI Total - _Adults FU - Inpatient vs. General Outpatient	83 (1 study)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi total - _adults fu - inpatient vs. general outpatient in the intervention groups was 0.46 standard deviations lower (0.9 to 0.02 lower)
EDI Total - Young people FU - Inpatient vs. Day Patient	143 (1 study)	⊕⊕⊖⊖ LOW5,9 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi total - young people fu - inpatient vs. day patient in the intervention groups was 0.11 standard deviations higher (0.22 lower to 0.43 higher)
EDI-2 Bulimia - Young people FU - Inpatient vs. Day Clinic	43 (1 study)	⊕⊕⊖⊖ LOW4,10 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi-2 bulimia - young people fu - inpatient vs. day clinic in the intervention groups was 0.58 standard deviations higher (0.03 lower to 1.19 higher)
MR: Total Outcome - FU - Inpatient vs. Specialist Outpatient	103 (1 study)	⊕⊕⊖⊖ LOW5,8 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean mr: total outcome - fu - inpatient vs. specialist outpatient in the intervention groups was 0.04 standard deviations lower (0.43 lower to 0.35 higher)
MR: Total Outcome - FU - Inpatient vs. General Outpatient	104 (1 study)	⊕⊕⊖⊖ LOW5,8 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean mr: total outcome - fu - inpatient vs. general outpatient in the intervention groups was 0 standard deviations higher (0.38 lower to 0.38 higher)
Global severity index - Young people FU - Inpatient vs. Day Patient	141 (1 study)	⊕⊕⊖⊖ LOW5,9 due to risk of bias, imprecision		Not calculabl e for	The mean global severity index - young people fu - inpatient vs. day patient in the intervention groups was 0.20 standard deviations higher (0.13 lower to 0.53 higher)

				SMD values	
Global severity index - Adults FU - Inpatient vs. Day Patient (Copy)	43 (1 study)	⊕⊕⊕⊕ LOW5,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean global severity index - adults fu - inpatient vs. day patient (copy) in the intervention groups was 0.21 standard deviations higher (0.39 lower to 0.81 higher)
Serious adverse events - Young people FU	161 (1 study)	⊕⊕⊕⊕ VERY LOW6,9 due to risk of bias, imprecision	RR 1.31 (0.5 to 3.44)	81 per 1000	25 more per 1000 (from 41 fewer to 199 more)
Remission - Young people FU - Inpatient vs. Day patient_ITT (Copy)	172 (1 study)	⊕⊕⊕⊕ LOW9,11 due to risk of bias, imprecision	RR 0.91 (0.73 to 1.14)	671 per 1000	60 fewer per 1000 (from 181 fewer to 94 more)
Readmissions/Relapse for ED - Young people FU - Inpatient vs. Day patient	161 (1 study)	⊕⊕⊕⊕ LOW9,12 due to risk of bias, imprecision	RR 1.68 (0.89 to 3.16)	151 per 1000	103 more per 1000 (from 17 fewer to 327 more)
Remission_Adults FU - Inpatient vs. Specialist Outpatient_ITT	113 (1 study)	⊕⊕⊕⊕ LOW8,12 due to risk of bias, imprecision	RR 1.41 (0.77 to 2.57)	236 per 1000	121 more per 1000 (from 57 fewer to 473 more)
Remission - Adults FU - Inpatient vs.General Outpatient_ITT	113 (1 study)	⊕⊕⊕⊕ VERY LOW6,8 due to risk of bias, imprecision	RR 0.92 (0.55 to 1.52)	364 per 1000	55 fewer per 1000 (from 200 fewer to 229 more)
Remission - Adults FU - Inpatient vs. Day patient_ITT	55 (1 study)	⊕⊕⊕⊕ LOW10,11 due to risk of bias, imprecision	RR 0.52 (0.14 to 1.87)	214 per 1000	103 fewer per 1000 (from 184 fewer to 186 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: intention to treat; FU: follow up

1 Unclear how randomisation sequence was generated or if allocation concealment was conducted. Participants and investigators were not blind. It was unclear if assessor was blind. High dropout rates were detected in one arm >20%

2 95% CI crossed 2 MIDs (-0.5 and 0.5)

3 95% CI crossed 1 MID (-0.5)

4 95% CI crossed 1 MID (0.5)

5 For a continuous outcome, there were fewer than 400 participants.

6 95% CI crossed 2 MIDs (0.75 and 1.25)

7 In Gowers 2007, it was unclear how randomisation sequence was generated or if allocation concealment was conducted. It was unclear if participants, investigators were blind. Assessor were blind. High dropout rates were detected in one arm >20% In Herpertz-Dahlmann 2014 performed adequate randomisation and allocation concealment. Patients and investigators were not blind and assessors were only blind at baseline.

8 In Gowers 2007, it was unclear how randomisation sequence was generated or if allocation concealment was conducted. It was unclear if participants, investigators were blind. Assessor were blind. High dropout rates were detected in one arm >20%

9 In Herpertz-Dahlmann 2014 performed adequate randomisation and allocation concealment. Patients and investigators were not blind and assessors were only blind at baseline.

10 In Zeek 2009/2008b, it was unclear if adequate randomisation sequence was generated or if allocation concealment was performed. Participants and investigators were not blind but assessors were.

11 For a dichotomous outcome, there are fewer than 300 events.

12 95% CI crossed 1 MID (1.25)

1 Table 47: Summary table of findings for specialised outpatient care versus general outpatient care for people with anorexia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General outpatient (AN)	Risk difference with Specialist outpatient (95% CI)
BMI FU	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.29 standard deviations lower (0.69 lower to 0.11 higher)
EDI Total FU	82 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total fu in the intervention groups was 0.17 standard deviations lower (0.6 lower to 0.26 higher)

MR: Total Outcome FU	103 (1 study)	⊕⊕⊕⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean mr: total outcome fu in the intervention groups was 0.04 standard deviations higher (0.35 lower to 0.43 higher)
Subsequent admission to hospital FU	110 (1 study)	⊕⊕⊕⊖ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 1.13 (0.63 to 2.03)	273 per 1000	35 more per 1000 (from 101 fewer to 281 more)
Remission FU_ITT	110 (1 study)	⊕⊕⊕⊖ LOW ^{1,5} due to risk of bias, imprecision	RR 0.65 (0.36 to 1.17)	364 per 1000	127 fewer per 1000 (from 233 fewer to 62 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up; MR: Morgan Russell

1 It is unclear how the randomisation sequence was generated and if allocation concealment was performed. It is unclear if participants and investigators were blind, however, the assessors were masked. High dropouts were reported >20%.

2 95% CI crossed 1 MID (-0.5)

3 For a continuous outcome, there were fewer than 400 participants.

4 95% CI crossed 2 MIDs (0.75 and 1.25)

5 95% CI crossed 1 MID (0.75)

1 **Table 48: Summary table of findings for inpatient care with group psychotherapy versus family therapy (FT) outpatient care for people**
2 **with bulimia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with FT Outpatient (BN)	Risk difference with Inpatient Group (95% CI)
Binges FU	71 (1 study)	⊕⊕⊕⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean binges fu in the intervention groups was 0.06 standard deviations lower (0.53 lower to 0.41 higher)
Self-induced vomiting FU	71 (1 study)	⊕⊕⊕⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean self-induced vomiting fu in the intervention groups was 0.11 standard deviations lower (0.57 lower to 0.36 higher)

Depression FU	71 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.14 standard deviations higher (0.33 lower to 0.61 higher)
Bulimic severity score FU	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic severity score fu in the intervention groups was 0.07 standard deviations lower (0.55 lower to 0.42 higher)
Remission FU_ITT	71 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 0.79 (0.43 to 1.43)	436 per 1000	92 fewer per 1000 (from 248 fewer to 187 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 The study was only partially randomised, only 52% were assigned randomly. The investigators decided some patients needed to be allocated due to their clinical condition. It was unclear if either the participants, investigators and assessors were blind. High dropouts were detected in one arm >20%

2 95% CI crossed 1 MID (-0.5)

3 95% CI crossed 1 MID (0.5)

4 95% CI crossed 2 MIDs (0.75 and 1.25)

1 **Table 49: Summary table of findings for modified day treatment compared to traditional outpatient for any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with traditional outpatient (ANY ED)	Risk difference with modified day treatment (95% CI)
BMI	43 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.57 standard deviations higher (0.12 to 1.02 higher)
Binge eating episodes	43 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating episodes in the intervention groups was 0.93 standard deviations lower (1.57 to 0.3 lower)
Purging episodes	43 (1 study)	⊕⊕⊕⊕ LOW ^{1,3}		Not calculable for SMD values	The mean purging episodes in the intervention groups was

		due to risk of bias, imprecision			1.21 standard deviations lower (1.87 to 0.56 lower)
Depression	43 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.83 standard deviations lower (1.45 to 0.2 lower)
EDI-2 Total score	43 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 total score in the intervention groups was 1.42 standard deviations lower (2.09 to 0.74 lower)
EDI-2 Drive for thinness	43 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 drive for thinness in the intervention groups was 1.88 standard deviations lower (2.61 to 1.15 lower)
EDI-2 Bulimia	43 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 bulimia in the intervention groups was 1.52 standard deviations lower (2.21 to 0.83 lower)
EDI-2 Body dissatisfaction	43 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 body dissatisfaction in the intervention groups was 1.2 standard deviations lower (1.86 to 0.55 lower)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 It was unclear if allocation concealment was performed. It was also unclear if either the participants, investigators and assessors were blind.					
2 95% CI crossed 1 MID (0.5)					
3 95% CI crossed 1 MID (-0.5)					
4 For a continuous outcome, there were fewer than 400 participants.					

1 **Table 50: Summary table of findings for inpatient weight stabilisation (short) compared with weight restoration (long) for any eating disorder**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with weight restoration (longer) (AN)	Risk difference with Inpatient weight stabilisation (short) (95% CI)

Remission Young people_ITT	82 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.11 (0.5 to 2.45)	220 per 1000	24 more per 1000 (from 110 fewer to 318 more)
Change EDE Global score Young people FU	69 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change ede global score young people fu in the intervention groups was 0.12 standard deviations lower (0.59 lower to 0.36 higher)
Hospital readmission Young people FU	78 (1 study)	⊕⊖⊖⊖ VERY LOW1,4 due to risk of bias, imprecision	RR 0.95 (0.53 to 1.72)	368 per 1000	18 fewer per 1000 (from 173 fewer to 265 more)
Remission Young people FU_ITT	82 (1 study)	⊕⊖⊖⊖ VERY LOW1,4 due to risk of bias, imprecision	RR 0.92 (0.48 to 1.78)	317 per 1000	25 fewer per 1000 (from 165 fewer to 247 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Randomisation was adequate however it was unclear if allocation concealment was performed. Participants and investigators were not blind, however, the assessor was blind to treatment allocation.

2 95% CI crossed 1 MID (1.25)

3 95% CI crossed 1 MID (-0.5)

4 95% CI crossed 2 MIDs (0.75 and 1.25)

5.2.2.61 Observational studies for coordinating care and the best setting for treating eating disorders (quality starts at very low)

2 Table 51: Summary of findings table for inpatient care versus day patient care for people with anorexia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with day patient - Adult - AN	Risk difference with Inpatient (95% CI)
Binge eating	152 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 0.41 (0.26 to 0.64)	667 per 1000	393 fewer per 1000 (from 240 fewer to 493 fewer)

Laxative use	152 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.66 (0.16 to 2.66)	133 per 1000	45 fewer per 1000 (from 112 fewer to 221 more)
Self-induced vomiting	152 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.57 (0.26 to 1.26)	333 per 1000	143 fewer per 1000 (from 247 fewer to 87 more)
Excessive Exercise	152 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.64 (0.35 to 1.17)	467 per 1000	168 fewer per 1000 (from 303 fewer to 79 more)
EDE- Total	152 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- total in the intervention groups was 0.25 standard deviations lower (0.79 lower to 0.28 higher)
BMI	179 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.55 standard deviations lower (0.99 to 0.1 lower)
Quality of life	152 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.08 standard deviations lower (0.62 lower to 0.45 higher)
BMI FU	27 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.35 standard deviations lower (1.11 lower to 0.42 higher)
Readmission FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 2 (0.45 to 8.94)	167 per 1000	167 more per 1000 (from 92 fewer to 1000 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

¹ The day patients were heavier/had a higher BMI than inpatients at baseline and slightly lower duration of illness. The authors did not adjust for potential confounders. Length of stay was longer for inpatients vs. day patient. Investigators and participants were not blinded.

2 For a dichotomous outcome, there are fewer than 300 events.

3 For a continuous outcome, there were fewer than 400 participants

1 **Table 52: Summary of findings table for inpatient care versus ambulatory care for people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with ambulatory care AN	Risk difference with Inpatient (95% CI)
BMI FU	143 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.13 standard deviations lower (0.48 lower to 0.22 higher)
Hospitalisation in last 6 months FU	143 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 2.67 (1.5 to 4.77)	155 per 1000	258 more per 1000 (from 77 more to 583 more)
Remission_ITT_FU	143 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 0.82 (0.37 to 1.82)	186 per 1000	33 fewer per 1000 (from 117 fewer to 152 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Patient in hospital had a lower BMI versus ambulatory care. Pure restrictive forms were overrepresented in the inpatient group. Prevalence of history of suicide attempts in the last 24 months was also higher. This group underwent longer treatment (on average of 1.5 years) than the ambulatory group. Finally, a larger percentage of patients were still followed by specialists in nutrition and/or psychiatry at the time of the survey. Neither patients nor investigators were blind.

2 For a continuous outcome, there were fewer than 400 participants

3 For a dichotomous outcome, there are fewer than 300 events

2 **Table 53: Summary of findings table for partial hospitalisation (PH) and support versus partial hospitalisation for people with anorexia nervosa**

3

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with PH AN	Risk difference with Partial Hospitalisation + Support (95% CI)

Difference in Weight Gain	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in weight gain in the intervention groups was 1.02 standard deviations higher (0.13 to 1.91 higher)
Difference in BMI	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in BMI in the intervention groups was 0.4 standard deviations higher (0.26 lower to 1.06 higher)
Difference in Purging	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in purging in the intervention groups was 0.57 standard deviations higher (0.38 lower to 1.52 higher)
Difference in EDI-2 Total Risk	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in edi-2 total risk in the intervention groups was 0.92 standard deviations higher (0.12 to 1.72 higher)
Difference in EDI-2 Drive for thinness	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in edi-2 drive for thinness in the intervention groups was 0.68 standard deviations higher (0.12 lower to 1.48 higher)
Difference in EDI-2 Body dissatisfaction	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in edi-2 body dissatisfaction in the intervention groups was 0.51 standard deviations higher (0.31 lower to 1.33 higher)
Difference in EDI-2 Bulimia	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in edi-2 bulimia in the intervention groups was 1.31 standard deviations higher (0.51 to 2.11 higher)
Difference EDEQ: Restraint	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference edeq: restraint in the intervention groups was 0.39 standard deviations higher (0.38 lower to 1.16 higher)
Difference EDEQ: Eating concern	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference edeq: eating concern in the intervention groups was 0.33 standard deviations higher (0.44 lower to 1.1 higher)

Difference EDEQ: Shape concern	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference edeq: shape concern in the intervention groups was 0.33 standard deviations higher (0.47 lower to 1.13 higher)
Difference EDEQ: Weight concern	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean difference edeq: weight concern in the intervention groups was 0.83 standard deviations higher (0.03 to 1.63 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval;

1 Patients were not matched at baseline. Those who needed supported housing to potentially ensure successful outcome, were initially encouraged to receive Sage House service. However, the investigators attempted to address this by controlling for age, duration of eating disorder, and EDPHP length of stay

2 For a continuous outcome, there were fewer than 400 participants.

1 Table 54: Summary of findings table for family therapy compared with inpatient care for people with anorexia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Inpatient AN	Risk difference with Family therapy (95% CI)
Readmission	171 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.56 (0.36 to 0.87)	546 per 1000	240 fewer per 1000 (from 71 fewer to 350 fewer)
Readmission > 3 times	90 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.6 (0.2 to 1.77)	185 per 1000	74 fewer per 1000 (from 148 fewer to 143 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Likely to be a similar population seeking ED assessment. After 2008 patients were then allocated to FT compared with those historically who were not. However, no baseline data was provided. No adjustments were made to account for covariates. Neither participants nor investigators were blind.

2 For a dichotomous outcome, there were fewer than 300 events.

1 **Table 55: Summary of findings table for day patient care versus inpatient care for people with bulimia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Inpatient BN	Risk difference with Day patient (95% CI)
EDI - Drive for thinness	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 0.22 standard deviations lower (0.87 lower to 0.44 higher)
EDI - Body dissatisfaction	33 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was 0.32 standard deviations higher (0.37 lower to 1.01 higher)
EDI - Bulimia	33 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 0.13 standard deviations higher (0.56 lower to 0.82 higher)
SCL -90R Global Severity Index	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean scl -90r global severity index in the intervention groups was 0.26 standard deviations lower (0.94 lower to 0.42 higher)
Depression	34 (1 study)	⊕⊕⊕⊕ VERY LOW ¹ due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.27 standard deviations lower (0.94 lower to 0.41 higher)
Remission_ITT	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 0.83 (0.31 to 2.24)	333 per 1000	57 fewer per 1000 (from 230 fewer to 413 more)
EDI - Bulimia FU	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia fu in the intervention groups was 0.41 standard deviations lower (1.07 lower to 0.25 higher)
EDI - Drive for thinness FU	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness fu in the intervention groups was 0.49 standard deviations lower (1.15 lower to 0.18 higher)

SCL -90R Global Severity Index FU	36 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean scl -90r global severity index fu in the intervention groups was 0.35 standard deviations lower (1.01 lower to 0.3 higher)
Depression FU	36 (1 study)	⊕⊕⊕⊖ VERY LOW1 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.35 standard deviations lower (1.01 lower to 0.3 higher)
Binge eating FU	36 (1 study)	⊕⊕⊕⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.23 standard deviations lower (0.88 lower to 0.43 higher)
Vomiting Severity FU	36 (1 study)	⊕⊕⊕⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting severity fu in the intervention groups was 0.21 standard deviations higher (0.45 lower to 0.86 higher)
Remission FU_ITT	36 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	RR 5 (1.27 to 19.68)	111 per 1000	444 more per 1000 (from 30 more to 1000 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 The day patient group were heavier in weight and the inpatient group had more general psychopathology in the SCL-90-R scale. That is inpatients were more severely ill. Differences were also detected for depression, and interpersonal sensitivity. The authors did not adjusted for these differences. Neither the participants nor investigators were blind to treatment. There was an unclear duration of follow up.

2 For a continuous outcome, there are fewer than 400 participants.

3 For a dichotomous outcome, there are fewer than 300 events.

1 Table 56: Summary of findings table for 5 days versus 4 day care for people with anorexia nervosa and bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with 4 days_AN_BN	Risk difference with 5 days (95% CI)
Bingeing	369 (1 study)	⊕⊕⊕⊖ VERY LOW1,2		Not calculable for SMD values	The mean bingeing in the intervention groups was

		due to risk of bias, imprecision			0.37 standard deviations lower (0.59 to 0.14 lower)
Vomiting	359 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.21 standard deviations lower (0.43 lower to 0.02 higher)
BMI	153 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.37 standard deviations lower (0.69 to 0.04 lower)
EDI - Drive for thinness	461 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 0.64 standard deviations lower (0.85 to 0.42 lower)
EDI - Bulimia	461 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 0.49 standard deviations lower (0.71 to 0.28 lower)
EDI - Body dissatisfaction	461 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was 0.55 standard deviations lower (0.77 to 0.33 lower)
Depression	408 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.73 standard deviations lower (0.95 to 0.5 lower)
Remission_ITT	756 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 3.31 (2.29 to 4.78)	101 per 1000	233 more per 1000 (from 130 more to 381 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

¹ Patients in 5-day were older, lighter, had more binges, vomiting, had lower depression and self-esteem problems, EDI was also better. Pre-treatment scores were used as covariates. Neither patients nor participants were blind.

² 95% CI crossed 1 MID (-0.5)

3 For a continuous outcome, there were fewer than 400 participants.

4 For a dichotomous outcome, there were fewer than 300 events.

1 **Table 57: Summary of findings table for inpatient CAMHS versus outpatient CAMHS for people with any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Outpatient CAMHS ANY ED	Risk difference with Inpatient CAMHS (95% CI)
BMI FU	57 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.17 standard deviations lower (0.69 lower to 0.36 higher)
EDI Bulimia FU	57 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia fu in the intervention groups was 0.4 standard deviations higher (0.14 lower to 0.93 higher)
EDI Body dissatisfaction FU	57 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction fu in the intervention groups was 0.05 standard deviations lower (0.57 lower to 0.48 higher)
EDI Drive for thinness FU	57 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu in the intervention groups was 0.19 standard deviations lower (0.71 lower to 0.34 higher)
SCL-90 Global Severity Index FU	57 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean scl-90 global severity index fu in the intervention groups was 0.22 standard deviations lower (0.75 lower to 0.31 higher)
Rosenberg Self Esteem FU	57 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean Rosenberg self-esteem fu in the intervention groups was 3.1 standard deviations higher (2.31 to 3.89 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; FU: follow up

¹ There were significant differences between the groups for maturity, age of onset and Self-Esteem score at baseline. Patients treated as in-patients had significantly higher scores in the RSES and MF subscale comparing to the other two groups. The difference in the age of onset was statistically significant between patients treated as

outpatients and those not treated by CAMHS. The authors did not adjust for any confounders. CAMHS patients were likely to have gotten treatment for a longer period compared with those who entered AMHS. Neither participants nor investigators were blind to treatment.

2 For a continuous outcome, there were fewer than 400 participants.

1 **Table 58: Summary of findings table for guided self-help (SH) versus day patient care for people bulimia nervosa or EDNOS**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Day Patient BN or EDNOS	Risk difference with Guided SH (95% CI)
EDE-Q Total	66 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q total in the intervention groups was 0.15 standard deviations higher (0.34 lower to 0.63 higher)
Objective binge eating	66 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean objective binge eating in the intervention groups was 0.43 standard deviations higher (0.06 lower to 0.92 higher)
Vomiting	65 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.24 standard deviations higher (0.25 lower to 0.73 higher)
Excessive Exercise	66 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean excessive exercise in the intervention groups was 0.22 standard deviations lower (0.71 lower to 0.26 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; FU: follow up

1 The patients were well matched at baseline for illness duration and severity (based on BMI). However, the ED diagnosis was different: CBT_GSH had higher number of BED and EDNOS-BN. The authors did not adjust for confounders. Neither participants nor investigators were not blinded.

2 For a continuous outcome, there were fewer than 400 participants.

1 **Table 59: Summary of findings table for extensive program (community outreach combined with limited) compared with a limited**
2 **program (psychotherapy and nutritional counselling) for people with any eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Limited Program ANY ED	Risk difference with Extensive Program (95% CI)
Remission	123 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.39 (0.21 to 0.73)	537 per 1000	328 fewer per 1000 (from 145 fewer to 424 fewer)
Remission - AN	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.41 (0.18 to 0.91)	455 per 1000	268 fewer per 1000 (from 41 fewer to 373 fewer)
Remission - BN	63 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.38 (0.16 to 0.95)	578 per 1000	358 fewer per 1000 (from 29 fewer to 485 fewer)
Remission FU	123 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.5 (0.35 to 0.72)	761 per 1000	381 fewer per 1000 (from 213 fewer to 495 fewer)
Remission FU - AN	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.42 (0.26 to 0.68)	818 per 1000	475 fewer per 1000 (from 262 fewer to 605 fewer)
Remission FU - BN	63 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.61 (0.35 to 1.05)	733 per 1000	286 fewer per 1000 (from 477 fewer to 37 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

¹ Patients were allocated depending on their physical status, symptom severity, comorbidity, and occupational functioning. Patients who did not respond to limited treatment or who needed structured eating and had no regular occupation were assigned to intensive treatment. Patients assigned to intensive treatment had a higher rate

of comorbidity, a longer duration of illness, more previous treatments, lower scores in social and occupational adjustment than those offered limited treatment. The authors did not adjust for confounders. Neither participants nor investigators were blinded.

2 For a dichotomous outcome, there were fewer than 300 events.

1 **Table 60: Summary of findings table for history of inpatient care compared with no history of inpatient care for people with any eating disorder.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with No history ANY ED	Risk difference with History of Inpatient (95% CI)
EDI- Drive for thinness	222 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- drive for thinness in the intervention groups was 0.02 standard deviations higher (0.28 lower to 0.31 higher)
EDI- Bulimia	222 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- bulimia in the intervention groups was 0.07 standard deviations higher (0.22 lower to 0.36 higher)
EDI-Body dissatisfaction	222 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-body dissatisfaction in the intervention groups was 0.18 standard deviations lower (0.48 lower to 0.11 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval;

1 It is not clear what the differences in severity were between those who had (historically) received inpatient vs not. No adjustments were made for confounders. Neither participants nor investigators were blinded.

2 For a continuous outcome, there were fewer than 300 events.

3 **Table 61: Summary of findings table for specialist (Sp) compared to non-specialist (Non-Sp) assessment for people with any eating disorder.**
4

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with non-specialist assessment and treatment (ANY ED)	Risk difference with Specialist (95% CI)

Admitted to inpatient treatment - Sp to Sp vs. NonSp to Non Sp	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.81 (0.24 to 2.68)	188 per 1000	36 fewer per 1000 (from 142 fewer to 315 more)
Admitted to inpatient treatment - Sp to Sp vs. NonSp to Sp	68 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.38 (0.15 to 0.92)	400 per 1000	248 fewer per 1000 (from 32 fewer to 340 fewer)
Admitted to inpatient treatment - Non Sp to Non Sp vs. Non Sp to Sp	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.47 (0.14 to 1.55)	400 per 1000	212 fewer per 1000 (from 344 fewer to 220 more)
Continuity of care - Sp to Sp vs. NonSp to Sp	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.11 (0.81 to 1.51)	750 per 1000	83 more per 1000 (from 142 fewer to 382 more)
Continuity of care - Sp to Sp vs. NonSp to NonSp	68 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 2.08 (1.1 to 3.9)	400 per 1000	432 more per 1000 (from 40 more to 1000 more)
Continuity of care - Non Sp to Sp vs. Non Sp to Sp	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.88 (0.95 to 3.71)	400 per 1000	352 more per 1000 (from 20 fewer to 1000 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up; OR: Odds ratio; Sp- Specialist; Non Sp – non-specialist

¹ Comparisons between PCT groups revealed no statistically significant differences in age, gender, ethnicity, weight for height percentage at assessment, or referrals. Thus no adjustments were needed. But unclear how they estimated predicted referrals and no data was provided on success rates. Neither participants nor investigators were blind.

² For a dichotomous outcome, there were fewer than 300 events.

1 **Table 62: Summary of findings table for inpatient treatment versus variation of day, inpatient and outpatient care for people with any eating disorder**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Variation (Day, Hospital, OutP) - AN	Risk difference with Inpatient (95% CI)
Body Weight (ABW)	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean body weight (abw) in the intervention groups was 0.75 standard deviations lower (1.51 lower to 0.01 higher)

3 **Table 63: Summary of findings table for prior opt-in versus post opt-in for people with any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Post opt-in ANY ED	Risk difference with Prior opt-in (95% CI)
% attended their first appointment	138 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.1 (1.02 to 1.18)	618 per 1000	62 more per 1000 (from 12 more to 111 more)
Overall attrition rates	138 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.80 (0.77 to 4.25)	103 per 1000	82 more per 1000 (from 24 fewer to 335 more)
Did not attend	138 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 3.2 (1.04 to 8.18)	44 per 1000	97 more per 1000 (from 2 more to 317 more)
No cancellations	138 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.97 (0.93 to 1.02)	0 per 1000	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 No demographic data so unable to know if there were any differences pre and post opt-in intervention.

2 For a dichotomous outcome, there were fewer than 300 events.

1 **Table 64: Summary of findings table for meal supervision versus no meal supervision for people with any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with No meal supervision	Risk difference with Meal Supervision (95% CI)
Length of Hospital Stay	51 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean length of hospital stay in the intervention groups was 0.51 standard deviations higher (0.13 lower to 1.15 higher)
Weight gain	47 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean weight gain in the intervention groups was 0.33 standard deviations higher (0.33 lower to 0.99 higher)
Bradycardia (HR <45 BPM) % days in treatment	50 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean bradycardia (hr <45 bpm) % days in treatment in the intervention groups was 0.62 standard deviations lower (1.28 lower to 0.04 higher)

2 **Table 65: Summary of findings table for eating disorder specialist ward versus general ward for people with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with General ward	Risk difference with Eating disorder unit (95% CI)
BMI	110 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI in the intervention groups was 1.29 standard deviations higher (0.87 to 1.72 higher)
Length of time in hospital	110 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean length of time in hospital in the intervention groups was 0.02 standard deviations higher (0.37 lower to 0.40 higher)
Morgan Russell Score	110 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision	Not calculable for SMD values	The mean Morgan Russell score in the intervention groups was 0.68 standard deviations higher (0.28 to 1.07 higher)
General health	110 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,3}	Not calculable for SMD values	The mean general health in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with General ward	Risk difference with Eating disorder unit (95% CI)
		due to risk of bias, imprecision		0.19 standard deviations higher (0.19 lower to 0.57 higher)
Children's global assessment	110 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	Not calculable for SMD values	The mean children's global assessment in the intervention groups was 0.15 standard deviations lower (0.54 lower to 0.23 higher)

1 Anorexia nervosa stepped care

2 Table 66: Summary table of findings for family-based treatment (FBT) then intensive family coaching versus family-based treatment
3 for young people with anorexia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with FBT	Risk difference with FBT->IPC (95% CI)
Recovered from AN (>=95% EBW)	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision	RR 1.12 (0.6 to 2.07)	522 per 1000	63 more per 1000 (from 209 fewer to 558 more)
BMI	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.28 standard deviations higher (0.42 lower to 0.98 higher)
% Expected Body Weight	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean % expected body weight in the intervention groups was 0.22 standard deviations higher (0.48 lower to 0.92 higher)
EDE Global	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4}		Not calculable for	The mean ede global in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with FBT	Risk difference with FBT->IPC (95% CI)
		due to risk of bias, indirectness, imprecision		SMD values	0.92 standard deviations higher (0.18 to 1.65 higher)
Depression BDI	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.59 standard deviations higher (0.12 lower to 1.3 higher)
Yale-Brown-Cornell Eating Disorder Scale	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean Yale-Brown-Cornell eating disorder scale in the intervention groups was 0.71 standard deviations higher (0.01 lower to 1.43 higher)
Service user experience Helping Relationship Questionnaire	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean service user experience in the intervention groups was 0.86 standard deviations lower (1.59 to 0.13 lower)
Number of Sessions attended	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean number of sessions attended in the intervention groups was 0.92 standard deviations higher (0.18 to 1.65 higher)
Suitability of therapy - child Therapy Suitability and Patient Expectancy	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean suitability of therapy - child in the intervention groups was 0.38 standard deviations lower (1.09 lower to 0.32 higher)
Child's expectations about therapy Therapy Suitability and Patient Expectancy	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for	The mean child's expectations about therapy in the intervention groups was 0.45 standard deviations lower (1.16 lower to 0.26 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with FBT	Risk difference with FBT->IPC (95% CI)
				SMD values	
Suitability of therapy - Mother Therapy Suitability and Patient Expectancy	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean suitability of therapy - mother in the intervention groups was 0.64 standard deviations higher (0.08 lower to 1.35 higher)
Mother's expectations about therapy Therapy Suitability and Patient Expectancy	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean mother's expectations about therapy in the intervention groups was 0.54 standard deviations higher (0.17 lower to 1.25 higher)
Suitability of therapy - Father Therapy Suitability and Patient Expectancy	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean suitability of therapy - father in the intervention groups was 0 standard deviations higher (0.7 lower to 0.7 higher)
Father's expectations about therapy Therapy Suitability and Patient Expectancy	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean father's expectations about therapy in the intervention groups was 0.27 standard deviations lower (0.97 lower to 0.43 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p> <p>1 Lock & Le Grange 2015: High risk of selection and performance bias.</p> <p>2 Participants initially randomized into FBT only and FBT/IPC groups. Participants in FBT/IPC group subsequently divided into IPC (those <2.3 kg weight gain by week 4 of FBT) and No IPC groups (those >2.3 kg weight gain by week 4 of FBT). Data only for FBT+IPC vs FBT+No IPC groups.</p> <p>3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).</p> <p>4 CI crosses either 0.75 or 1.25 (Risk ratio), or either 0.5 or -0.5 (SMD).</p>					

1 **Bulimia nervosa stepped care**

2 **Table 67: Summary table of findings for group psychoeducation then either CBT-ED or wait list control (WLC) in adults with bulimia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group Psychoeducation->WLC	Risk difference with Group Psychoeducation->CBT-ED (95% CI)
Not in Remission	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	RR 0.67 (0.48 to 0.95)	842 per 1000	278 fewer per 1000 (from 42 fewer to 438 fewer)
Not in Remission from Binge eating	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	RR 0.62 (0.41 to 0.92)	789 per 1000	300 fewer per 1000 (from 63 fewer to 466 fewer)
Not in Remission from Purging	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	RR 0.58 (0.38 to 0.89)	789 per 1000	332 fewer per 1000 (from 87 fewer to 489 fewer)
Binge Frequency EDE 28 days	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.54 standard deviations lower (1.11 lower to 0.02 higher)
Purge Frequency EDE 28 days	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean purge frequency in the intervention groups was 0.7 standard deviations lower (1.27 to 0.13 lower)
EDE Global	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.08 standard deviations lower (0.63 lower to 0.48 higher)
Depression BDI	56 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.17 standard deviations lower (0.72 lower to 0.39 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group Psychoeducation->WLC	Risk difference with Group Psychoeducation->CBT-ED (95% CI)
General Psychopathology Brief Symptom Inventory	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.21 standard deviations lower (0.76 lower to 0.35 higher)
General Functioning SAS	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean social adjustment in the intervention groups was 0.3 standard deviations lower (0.86 lower to 0.25 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Davis 1999: unclear randomization method and allocation concealment. No participant blinding, unclear investigator and assessor blinding. Unclear whether baseline characteristics similar.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio).					

1 **Table 68: Summary table of findings for self-help manual then CBT-ED versus CBT-ED at end of treatment and follow up in adults with bulimia nervosa.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-ED	Risk difference with Self-Help Manual for BN -> CBT-ED (95% CI)
Remission Abstinence from binge eating, purging or other weight control behaviour in past month (or if not available: BITE Symptom score<=11 and BITE Severity score=0)	86 (1 study) 18 months	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 1.01 (0.53 to 1.93)	300 per 1000	3 more per 1000 (from 141 fewer to 279 more)
Remission 18-mo FU Abstinence from binge eating, purging or other weight control behaviour in past month (or if not available: BITE Symptom score<=11 and BITE Severity score=0)	64 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 0.97 (0.54 to 1.76)	412 per 1000	12 fewer per 1000 (from 189 fewer to 313 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-ED	Risk difference with Self-Help Manual for BN -> CBT-ED (95% CI)
<p>1 Treasure 1996: inadequate randomization method and allocation concealment; No participant blinding, unclear investigator and assessor blinding; dropout rate of CBT-ED group >20%.</p> <p>2 CI crosses both 0.75 and 1.25.</p>					

1 **Table 69: Summary table of findings for guided self-help CBT-ED then antidepressant then CBT-ED versus CBT-ED then antidepressant (AD) in adults with bulimia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-BN->AD	Risk difference with GSH CBT->AD->CBT-BN (95% CI)
Remission	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4} due to risk of bias, inconsistency, indirectness, imprecision	RR 0.94 (0.67 to 1.33)	313 per 1000	19 fewer per 1000 (from 103 fewer to 103 more)
EDE Global	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
EDE Restraint	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
EDE Shape Concerns	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
EDE Weight Concerns	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable	Not calculable for SMD values

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-BN->AD	Risk difference with GSH CBT->AD->CBT-BN (95% CI)
				for SMD values	
EDE Eating Concerns	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
Yale-Brown-Cornell ED Scale - Preoccupation	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
Yale-Brown-Cornell ED Scale - Ritual	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
Depression BDI	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
Quality of Life Quality of Well Being Scale	293 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	Not calculable for SMD values
<p><i>The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</i></p> <p>1 Mitchell 2011/Crow 2013: Unclear allocation concealment. No participant nor investigator blinding. Dropout rates of both groups>20%, no details provided for reasons.</p> <p>2 I2>50%.</p> <p>3 Randomization was to different treatments. No randomisation to next level of stepped care.</p> <p>4 CI crosses both 0.75 and 1.25 (Risk Ratio).</p> <p>5 <400 participants.</p>					

1 5.2.3 Economic evidence

2 5.2.3.1 Coordination of care and treatment setting

3 The systematic search of the economic literature undertaken for the guideline identified:

- 4 • One UK study on the cost effectiveness of inpatient psychiatric treatment versus specialist
5 outpatient treatment and general outpatient treatment in young people with anorexia
6 nervosa (Byford et al., 2007); follow up data in (Gowers et al., 2010);
- 7 • One German study on the cost effectiveness of day treatment in young people with
8 anorexia nervosa(Herpertz-Dahlmann et al., 2014);
- 9 • One US study on the cost effectiveness of partial day hospital care in adults with anorexia
10 nervosaor sub-threshold anorexia nervosaor bulimia nervosa or sub-threshold bulimia
11 nervosa (Williamson et al., 2001);
- 12 • One US study assessing the cost effectiveness of an adequate care model (inpatient care,
13 partial hospital care, psychotherapy and medication management) in people with anorexia
14 nervosa(Crow and Nyman, 2004);
- 15 • One Australian study on the cost effectiveness of a best practice model (early
16 intervention, a range of care from GPs, self-help, intensive outpatient and residential care,
17 inpatient care, stepped care approach) in people with anorexia nervosa, bulimia nervosa,
18 BED or EDNOS (Deloitte Access Economics, 2012).

19 References to included studies and evidence tables for all economic evaluations included in
20 the systematic literature review are provided in Appendix P. Completed methodology
21 checklists of the studies are provided in Appendix O. Economic evidence profiles of studies
22 considered during guideline development (that is, studies that fully or partly met the
23 applicability and quality criteria) are presented in Appendix Q.

24 Byford and colleagues (Byford et al., 2007) evaluated the cost effectiveness of an inpatient
25 psychiatric treatment compared with specialist outpatient treatment and also with general
26 outpatient treatment in young people aged between 11-17 years with anorexia nervosa in the
27 UK. The economic evaluation was undertaken alongside an RCT (Byford 2007) (N=167 at
28 baseline, N=160 at two years for the effectiveness data). Byford and colleagues report
29 results over two years, whereas the publication by Gowers and colleagues (2010a) is based
30 on the same RCT but reports cost over three to five years. Inpatient psychiatric treatment
31 was provided within generic children's or young people psychiatric inpatient unit. It lasted six
32 weeks and comprised a multidisciplinary psychiatric approach with the aim of normalising
33 eating, restoring healthy weight and facilitating psychological (cognitive) change. Each
34 participant received both individual supportive or cognitive therapies and family therapy.
35 Specialist outpatient treatment comprised motivational interview, individual CBT plus parental
36 feedback (12 sessions), parental counselling with the individual (minimum of four sessions,
37 increasing to eight for younger people), dietary therapy (four sessions, with parental
38 involvement as required), multi-modal feedback (weight, self-report and clinician-rated
39 questionnaire) and monitoring (four sessions). The treatment was designed to last six
40 months. General outpatient treatment adopted a multidisciplinary, family-based approach,
41 with variable dietetic, individual supportive therapy and paediatric (medical) liaison. The
42 analysis was conducted from a public sector perspective (health, social care and education).
43 The study considered a range of costs including secondary health services (inpatient and
44 outpatient visits, day care attendances, A&E visits), community health and social service
45 contacts (GP, practice nurse, dietitian, district nurse, health visitor, community paediatrician,
46 community psychiatric nurse, clinical psychologist, counsellor, family therapist, dentist,
47 school doctor, school nurse, social worker, eating disorders association, family therapy,
48 foster care), education (state day school, independent day school, independent boarding
49 school, hospital school, home tuition, school counsellor, education welfare officer). The
50 resource use estimates were based on the RCT (N=135 at 2 years, N=71 3-5 years). The

1 unit costs were obtained from national sources. The measure of outcome for the economic
2 analysis was the improvement measured on MRAOS scale. The time horizon of the analysis
3 was five years. Results were reported at two years and then during three to five years. Costs
4 beyond year one were discounted at 3.5%.

5 The specialist outpatient treatment resulted in higher MRAOS scores at two years follow up
6 when compared with the other two treatment options. The scores were 8.3 (SD 2.6), 8.4 (SD
7 2.4) and 8.3 (SD 2.6) for inpatient treatment, specialist outpatient treatment and general
8 outpatient treatment, respectively. The difference between inpatient and specialist outpatient
9 treatment was not significant. There was no difference between inpatient and general
10 outpatient treatment. Outcomes at five years were not reported.

11 The mean total cost per participant at two years follow up was £34,531 (SD £52,439) for
12 inpatient treatment, £26,738 (SD £46,809) specialist outpatient treatment and £40,794 (SD
13 £63,652) for the general outpatient treatment (in likely 2003/04 prices). The difference
14 between inpatient treatment and specialist outpatient treatment was £7,793 (specialist
15 outpatient treatment had lower cost) and the difference between inpatient treatment and
16 general outpatient treatment was £6,262 (inpatient treatment had lower cost). However, none
17 of the cost differences was statistically significant.

18 The mean total cost per participant during three to five years of follow up was £15,304 (SD
19 £69,083) for the inpatient treatment, £15,636 (SD £46,545) for the specialist outpatient
20 treatment and £15,203 (SD £61,275) for the general outpatient treatment. None of the cost
21 differences was statistically significant.

22 Based on the above, at two years follow up specialist outpatient treatment dominated both
23 inpatient and general outpatient treatment. At a WTP of £0 per additional point of
24 improvement on MRAOS scale, the probability that specialist outpatient treatment is cost
25 effective is 78%, the probability that inpatient treatment is cost effective is 16% and the
26 probability that general outpatient treatment is cost effective is only 6%.

27 The findings were robust to changes in the discount rate and assumptions underlying
28 analyses of missing data; also the exclusion of education costs had no impact of the
29 conclusions.

30 The analysis was judged by the committee to be directly applicable to the NICE decision-
31 making context. Even though the authors did not attempt to estimate QALYs this was not a
32 problem in terms of interpretation of findings since the specialist outpatient treatment was
33 found to be dominant at two years follow up. Overall, this was a well conducted study and
34 was judged by the committee to have only minor methodological limitations.

35 Herpertz-Dahlmann and colleagues (Herpertz-Dahlmann, 2013) evaluated the cost
36 effectiveness of a day treatment programme (following a short inpatient treatment) compared
37 with continued inpatient treatment (following a short inpatient treatment) in young people
38 females (11-18 years) with anorexia nervosa in Germany. The economic analysis was
39 conducted alongside an RCT (Herpetz-Dahlmann 2014) (N=172).

40 The analysis was conducted from the health care provider perspective. The study considered
41 a range of costs including psychiatrist visits, psychologist visits, admissions (including re-
42 admissions) and outpatient visits. The resource use estimates were based on the RCT. The
43 unit costs were obtained from hospital tariffs.

44 The measure of outcome for the economic analysis was the improvement in BMI (between
45 the time of admission and follow up). The time horizon of the analysis was 12 months.

46 Day treatment resulted in a greater improvement in BMI when compared with the continued
47 inpatient treatment (3.2 versus 2.7 points, a difference of 0.46 points; $p < 0.0001$). The mean
48 total cost per participant at the 12 month follow up was €31,114 (SD €16,246) and €39,481
49 (SD €16,174) for day treatment and inpatient treatment, respectively; a difference of €8,367

1 (in favour of day treatment) in likely 2013 Euros, $p = 0.002$. Based on the above, day
2 treatment was the dominant option (that is, it resulted in better outcomes and lower costs).

3 The analysis was judged by the committee to be partially applicable to the NICE decision-
4 making context, as it has been conducted in Germany. The authors did not attempt to
5 estimate quality adjusted life years (QALYs). However, this was not a problem in terms of the
6 interpretation of the findings, since day treatment was the dominant option. This was a well
7 conducted study and was judged by the committee to have only minor methodological
8 limitations.

9 Williamson and colleagues (Williamson et al., 2001) attempted to assess the cost
10 effectiveness of partial day hospital compared with inpatient care in people with anorexia
11 nervosa, sub-threshold anorexia nervosa or bulimia nevosa and sub-threshold bulimia
12 nevosa in the US. People assigned to inpatient or partial day treatment attended the same
13 psychological treatment programme. Inpatients stayed on an adult or young people unit.
14 People receiving day hospital care lived at home or stayed in local hotels. The programme
15 included supervised meals and group therapy, including special groups for body image,
16 behaviour management, CBT, meal planning, nutrition education, activity therapy and
17 exercise. Also, most people were prescribed psychotropic medication. The economic
18 analysis was based on an observational cohort study (N=51). The analysis was conducted
19 from a health care provider perspective. The study considered only costs associated with
20 treatment and admissions. The clinical effectiveness data and resource use estimates were
21 based on observational cohort study. Unit costs were obtained from local sources (hospital
22 financial records). The measure of outcome for the economic analysis was improvement as
23 measured by BMI and MAEDS. However, the authors did not report the effectiveness data
24 for each arm of the study. The authors only reported that in both groups there was a
25 significant improvement in BMI and on all MAEDS subscales at the end of treatment and 12
26 month follow up, $p < 0.007$. So, in effect, this was a cost analysis.

27 The total mean cost per participant at 12 month follow up was \$12,740 (SD \$16,414) and
28 \$22,385 (SD \$18,024) for partial day hospital and inpatient care, respectively; a difference of
29 \$9,645 (in favour of partial day hospital), $p < 0.02$ (in likely 2000 US dollars).

30 The analysis was judged by the committee to be partially applicable to the NICE decision-
31 making context, as it has been conducted in the US. This study was judged by the committee
32 to have potentially serious methodological limitations, including the study design (small
33 observational cohort study), lack of consideration of wider health care and social care costs
34 and the use of local unit costs.

35 Crow (2004) evaluated the cost effectiveness of an adequate care model compared with SC
36 in people with anorexia nervosa in the US. This was a modelling study. Adequate care was
37 defined as 45 days of inpatient hospital treatment, 20 days of partial hospital, 50 sessions of
38 psychotherapy (50 min per each session), medication management (20 sessions) and
39 fluoxetine (60 mg per day) for two years. SC was defined as seven days of inpatient hospital
40 treatment, 15 days of partial hospital, 25 sessions of psychotherapy (50 min per each
41 session), medication management (20 sessions) and fluoxetine (60 mg per day) for two
42 years.

43 The analysis was conducted from a health care payer perspective. The study considered a
44 range of costs including inpatient treatment, partial hospitalisation, psychotherapy, outpatient
45 visits, medication and medication management. The resource use estimates were based on
46 charge data. Unit costs were obtained from local sources. The measure of outcome for the
47 economic analysis was the number of life years saved (LYS). The time horizon of the
48 analysis was life time.

49 The adequate care model resulted in 2.75 additional life years saved. The mean life time
50 costs per person were \$119,200 and \$36,200 for the adequate care model and SC,

1 respectively; a difference of \$83,000 (in likely 2003 US dollars). Based on the above, the
2 ICER of adequate care was \$30,180 per additional LYS.

3 The analysis was judged by the committee to be partially applicable to the NICE decision-
4 making context, as it has been conducted in the US. The authors did not attempt to estimate
5 quality adjusted life years (QALYs) which made it difficult to interpret the cost-effectiveness
6 results and to compare the findings with other studies. This study was judged by the
7 committee to have potentially serious methodological limitations, including the assumptions
8 about mortality rates and treatment efficacy that were based on authors' opinion, no
9 consideration of wider health care costs, use of local unit costs and lack of sensitivity
10 analyses.

11 Deloitte Access Economics (2012) evaluated the cost effectiveness and cost benefit of a best
12 practice model when compared with treatment as usual (TAU) in people with anorexia
13 nervosa, bulimia nervosa, BED and EDNOS in Australia. This was a modelling study with
14 effectiveness data derived from a systematic review of RCTs, other published sources and
15 authors' assumptions. The best practice model focused on early intervention, a range of
16 delivery options from general practitioners and online self-help, through intensive outpatient
17 and residential programmes, to full inpatient hospitalisation; a stepped care approach,
18 realising that people might need to progress both up and down (sometimes repeatedly)
19 through delivery levels; and long-term follow up, to prevent relapse. TAU was defined as
20 patchy services (largely untreated eating disorders), no specialist eating disorder inpatient
21 services, no continuity in care and sub-optimal treatment dose. The analysis was conducted
22 from a societal perspective. The study considered a range of costs including treatment
23 provision and other health care costs, productivity, employment and welfare. The resource
24 use estimates were from published sources. The source of unit costs was unclear. The
25 measure of outcome for the economic analysis was disability adjusted life years (DALYs) and
26 monetised DALYs. DALYs were converted into a dollar figure using an estimate of the value
27 of a statistical life year (VSLY). The VSLY is an estimate of the value society places on an
28 anonymous life year. The time horizon of the analysis was 10 years. A discount rate of 7%
29 was applied to costs and monetised DALYs.

30 The best practice model resulted in fewer DALYs per participant (0.96 versus 2.25,
31 respectively; a difference of 1.29 DALYs in favour of the best practice model. The monetised
32 DALYs were equal to \$161,346 and \$353,647 (in likely 2013 AU dollars) with the best
33 practice model and TAU, respectively; the net savings associated with the best practice
34 model were \$192,301 per participant. The best practice model also resulted in a reduction in
35 the mean total costs over 10 years (\$72,699 versus \$130,390 for the best practice model and
36 TAU, respectively; a difference of \$57,690 in favour of the best practice model). Based on
37 the above, the best practice model was found to be dominant (that is, it led to cost reductions
38 and also fewer DALYs). When using monetised DALYs the savings amounted to \$250,261
39 per participant over 10 years.

40 The analysis was judged by the committee to be partially applicable to the NICE decision-
41 making context, as it has been conducted in Australia. This study was judged by the
42 committee to have potentially serious methodological limitations, including some of the
43 clinical input parameters and resource use inputs were based on the authors' assumptions;
44 the unclear source of unit cost data, discount rate of 7% for costs and outcomes and lack of
45 sensitivity analyses.

46 5.2.3.2 Stepped care

47 The systematic search of the economic literature undertaken for the guideline identified:

- 48 • 1 US study and 1 Finnish study on the cost effectiveness of stepped care models in adults
49 with bulimia nervosa (Crow et al., 2013; Pohjolainen et al., 2010).

1 References to included studies and evidence tables for all economic evaluations included in
2 the systematic literature review are provided in Appendix P. Completed methodology
3 checklists of the studies are provided in Appendix O. Economic evidence profiles of studies
4 considered during guideline development (that is, studies that fully or partly met the
5 applicability and quality criteria) are presented in Appendix Q.

6 Crow (2013) evaluated the cost effectiveness of a stepped care model compared with high
7 intensity CBT treatment augmented as indicated with fluoxetine in adult women with purging
8 or non-purging bulimia nervosa alongside an RCT (Mitchell 2011) (N=293) conducted in the
9 US. The stepped care model involved a stepped series of interventions moving from less
10 intensive and less expensive to more intensive and expensive interventions. Interventions
11 included CBT, self-help, admissions, outpatient care and medication management.

12 The analysis was conducted from a health care provider perspective. The study considered a
13 range of costs including CBT, self-help, medication, physician visits, emergency room,
14 hospitalisation, individual therapy, group therapy and medication. The resource use
15 estimates were based on the RCT (N=293). The unit costs were obtained from national
16 sources (Medicare rates) and where necessary supplemented with other published sources.
17 The measure of outcome for the economic analysis was the proportion of participants
18 abstinent at 12 month follow up. The time horizon of the analysis was 12 months.

19 The stepped care model resulted in a greater proportion of participants abstinent at 12 month
20 follow up (26% versus 18% for the stepped care model and high intensity CBT, respectively;
21 a difference of 8%). The mean total costs per participant over 12 months were \$3,158 for the
22 stepped care model and \$3,657 for a high intensity CBT, a difference of \$499 (in favour of
23 the stepped care model) in 2005 US dollars. Based on the above, the stepped care model
24 was dominant (that is, it led to cost savings and also a greater proportion of participants
25 abstinent at the 12 month follow up). Bootstrapping indicated that the stepped care model
26 was both less expensive and more effective than high intensity CBT in 81% of the
27 replications.

28 The results were robust to changing the assumptions pertaining to the unit cost estimates
29 (that is, instead of using Medicare rates, actual fees charged were used).

30 The analysis was judged by the committee to be partially applicable to the NICE decision-
31 making context, as it has been conducted in the US. The authors did not attempt to estimate
32 quality adjusted life years (QALYs). However, this was not a problem in terms of the
33 interpretation of findings since the stepped care model was found to be dominant. Overall,
34 this was a well conducted study and was judged by the committee to have only minor
35 methodological limitations.

36 Pohjolainen and colleagues (2010) evaluated the cost utility of a stepped care model
37 compared with 'no treatment' in adult females with BN in Finland. This was a modelling study
38 with the effectiveness data derived from an observational cohort study (N=72), published
39 studies and authors' assumptions. The stepped care model was defined as psychoeducation
40 that included elements of CBT, followed by group CBT (8 sessions) and then individual CBT
41 (20 sessions), and followed by day hospital or inpatient treatment. Participants also received
42 psychopharmacological treatment if needed, individual nutritional counselling and social skills
43 training. The analysis was conducted from a health care payer perspective. The study
44 considered only the costs associated with the intervention provision including admissions,
45 outpatient visits, laboratory testing and radiology. The resource use estimates were from the
46 observational cohort study. The unit costs were obtained from local sources. The measure of
47 outcome for the economic analysis was the QALY with HRQoL weights derived using the
48 15D generic instrument with valuations provided by the general Finnish population. The time
49 horizon of the analysis was 10 years. However, the costs and outcomes were measured only
50 over six months. It was assumed by the authors that there was no difference in the costs
51 between the groups over the study period between six months and 10 years. Also, it was
52 assumed in the base case analysis that in untreated people their HRQoL improves linearly in

1 10 years to the same level as the treated people had after six months of treatment. For those
2 treated, the authors assumed that the HRQoL gain by six months would persist until 10
3 years. Discounting was undertaken only in the sensitivity analysis using either 3% or 5% for
4 outcomes.

5 The stepped care model resulted in 0.241 QALYs gained at the 10 year follow up. The
6 incremental undiscounted cost of stepped care model at six month follow up was €3,972 (SD
7 €5,518) per participant (in likely 2010 Euros). Based on the above, the mean undiscounted
8 cost per QALY gained for stepped care model was €16,481 when compared with no
9 treatment.

10 Deterministic sensitivity analyses indicated that the cost per QALY associated with the best
11 practice model was €19,663 per QALY and €17,812 per QALY when using the discount rate
12 for QALYs of 5% and 3%, respectively. Using the upper and lower 95% confidence intervals
13 for incremental QALYs of 0.339 and 0.113 resulted in an ICER of €11,717 and €35,150 per
14 QALY, respectively. Using upper and lower 95% confidence interval for the incremental costs
15 of €5,269 and €4,702 resulted in an ICER of €21,863 and €19,510 per QALY. Using upper
16 95% confidence interval for the incremental costs and lower 95% confidence interval for
17 incremental QALYs resulted in and ICER of €46,628 per QALY.

18 In the base case analysis, it was assumed that in untreated people the HRQoL improved
19 linearly over 10 years to the same level as in the treated people after 6 months of treatment.
20 In the best case scenario it was assumed that in people receiving 'no treatment' HRQoL did
21 not improve at all. This best case scenario resulted in an ICER of €1,455 per QALY.
22 Similarly, using the best case scenario, but discounting QALYs gained at 5% resulted in an
23 ICER of €4,428 per QALY.

24 The analysis was judged by the committee to be partially applicable to the NICE decision-
25 making context, as it was conducted in Finland. The authors estimated QALYs; however, the
26 HRQoL weights were derived using the 15D generic instrument with the valuations being
27 obtained from a general Finnish population. This study was judged by the committee to have
28 potentially serious methodological limitations, including the study design that provided the
29 efficacy data (small observational cohort study), the consideration of intervention costs only,
30 the various assumptions regarding future costs and benefits in both arms of the model and
31 the use of local unit costs.

32 **5.2.4 Clinical evidence statements**

33 **5.2.4.1 RCT evidence for coordination of care and treatment setting**

34 **Inpatient care versus day clinics for adults with anorexia nervosa at end of treatment**

35 Low quality evidence from one RCT (n=43) showed no difference in the effect of inpatient
36 care on BMI, vomiting, binge eating, EDI-bulimia, global severity index and remission
37 compared with day clinics.

38 **Inpatient care versus day clinic for adults with anorexia nervosa at follow up**

39 Low quality evidence from one RCT (n=37) showed no difference in the effect of inpatient
40 care on binge eating, vomiting, EDI-total, global severity index and remission, compared with
41 day clinic.

42 **Inpatient care versus outpatient individual and family therapy for adults with anorexia 43 nervosa at end of treatment**

44 Low quality evidence from one RCT (n=50) showed no difference in the effect of inpatient
45 care on change in the following Morgan-Russell scores: global, menstruation, nutrition,

1 mental state, sexual adjustment, social economic adjustment, compared with outpatient
2 individual and family therapy.

3 **Inpatient care versus outpatient group therapy for adults with anorexia nervosa at end**
4 **of treatment**

5 Low quality evidence from one RCT (n=50) showed no difference in the effect of inpatient
6 care on change in the following Morgan-Russell scores: global menstruation, nutrition,
7 mental state, sexual adjustment, social economic adjustment, compared with outpatient
8 group therapy.

9 **Inpatient care versus wait list control for adults with anorexia nervosa at end of**
10 **treatment**

11 Low quality evidence from one RCT (n=50) showed no difference in the effect of inpatient
12 care on change in the following Morgan-Russell scores: global menstruation, nutrition,
13 mental state, sexual adjustment, social economic adjustment, compared with wait list control.

14 **Inpatient care versus specialist outpatient care (CBT-ED) for adults with anorexia**
15 **nervosa at follow up**

16 Low quality evidence from one RCT (n=104) showed no difference in the effect of inpatient
17 care on BMI, EDI-total, Morgan-Russell total score and remission compared with specialist
18 outpatient.

19 **Inpatient care versus general outpatient care for adults with anorexia nervosa at**
20 **follow up**

21 Low quality evidence from one RCT (n=100) showed no difference in the effect of inpatient
22 care on BMI, EDI-total, Morgan-Russell total score and remission compared with general
23 outpatient care.

24 **Inpatient care versus day clinic for young people with anorexia nervosa at follow up**

25 Low quality evidence from one RCT (n=143 to 172) showed no difference in the effect of
26 inpatient care on BMI, EDI-total, global severity index, remission, relapse, menstrual function
27 and adverse events compared with day clinic

28 Low quality evidence from one RCT (n=143 to 172) showed inpatient care is less effective on
29 EDI-bulimia compared with day clinic, but there was some uncertainty.

30 **Specialist outpatient (CBT-ED) versus general outpatient care for adults with anorexia**
31 **nervosa at follow up**

32 Very low to low quality evidence from one RCT (n=98 to 110) showed no difference in the
33 effect of specialist outpatient on BMI, EDI-total, Morgan-Russell total, remission and
34 readmission to hospital compared with general outpatient care.

35 **Inpatient group versus outpatient (family therapy) for adults with bulimia nervosa at**
36 **follow up**

37 Very low quality evidence from one RCT (n=71) showed no difference in the effect of
38 inpatient group therapy on binges, vomiting, depression, bulimic severity score and remission
39 compared with outpatient care

1 **Specialist outpatient versus GP outpatient for adults with bulimia nervosa at the end**
2 **of treatment**

3 Very low quality evidence from one RCT (n=68) showed no difference in the effect of
4 specialist outpatient treatment on binges, vomiting, EDE global or subscales, bulimic
5 investigatory test, depression or work, leisure, family life questionnaire compared with GP
6 outpatient care.

7 **Modified day treatment versus traditional outpatient for adults with any eating**
8 **disorder at end of treatment**

9 Low quality evidence from one RCT (n=43) showed modified day treatment is more effective
10 on binges, vomiting, purging, depression, EDI-total score, EDI-drive for thinness, EDI-
11 bulimia, EDI-body dissatisfaction compared with outpatient care.

12 Low quality evidence from one RCT (n=43) showed BMI increased in the modified day
13 treatment compared with outpatient care but it is unclear if this is favourable outcome in this
14 population.

15 **Inpatient weight stabilisation versus inpatient weight restoration (long) for young**
16 **people with any eating disorder at end of treatment**

17 Low quality evidence from one RCT (n=69 to 82) showed no difference in inpatient weight
18 stabilisation on remission and change in EDE-global score compared with weight restoration.

19 **Inpatient weight stabilisation versus inpatient weight restoration (long) for young**
20 **people with any eating disorder at follow up**

21 Very low quality evidence from one RCT (n=78 to 82) showed no difference in inpatient
22 weight stabilisation on remission and change in EDE-global score compared with weight
23 restoration.

24 **5.2.4.2 Observational evidence for coordination of care and treatment setting**

25 **Inpatient care versus day patient care for adults with anorexia nervosa at end of**
26 **treatment**

27 Very low quality evidence from one observational study (n=152) showed no difference in
28 inpatient care on binge eating, laxative use, vomiting, excessive exercise, EDE-total, quality
29 of life compared with day patient care.

30 Very low quality evidence from one study (n=152) showed inpatient care is less effective on
31 BMI compared with day patient care.

32 **Inpatient care versus outpatient care for adults with anorexia nervosa at follow up**

33 Very low quality evidence from one observational study (n=143) showed no difference in
34 inpatient care on BMI, hospitalisation and remission compared with outpatient ambulatory
35 care.

36 **Partial hospitalisation and support versus partial hospitalisation for adults with**
37 **anorexia nervosa at end of treatment**

38 Very low quality evidence from one observational study (n=35) showed partial hospitalisation
39 and support is more effective on weight gain, change in EDI-total, EDI-bulimia and EDE-
40 weight concern compared with partial hospitalisation.

1 Very low quality evidence from one observational study (n=35) showed no difference in
2 partial hospitalisation and support on BMI, purging, EDI-drive for thinness, EDI-body
3 dissatisfaction, EDE-restraint, EDE-eating concern and EDE-shape concern compared with
4 partial hospitalisation.

5 **Family therapy versus inpatient care for adults with anorexia nervosa at end of**
6 **treatment**

7 Very low quality evidence from one observational study (n=171) showed family therapy is
8 more effective on remission and readmission compared with inpatient care.

9 **Day patient versus inpatient care for adults with bulimia nervosa at end of treatment**

10 Very low quality evidence from one observational study (n=33 to 36) showed no difference in
11 the effect of day patient care on EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction,
12 global severity index, depression and remission compared with inpatient care.

13 **Day patient versus inpatient care for adults with bulimia nervosa at follow up**

14 Very low to low quality evidence from one observational study (n=33 to 36) showed no
15 difference in the effect of day patient care on EDI-bulimia, EDI-drive for thinness, EDI-body
16 dissatisfaction, global severity index and depression compared with inpatient care.

17 Low quality evidence from one observational study (n= 36) showed day patient care is more
18 effective on remission compared with inpatient care.

19 **Five day inpatient care versus four day inpatient care for adults with bulimia nervosa**
20 **or anorexia nervosa end of treatment**

21 Low quality evidence from one observational study (n= 153 to 756) showed 5-day inpatient
22 care is more effective on binge eating, BMI, EDI-drive for thinness, EDI-bulimia, EDI-body
23 dissatisfaction, depression and remission compared with 4 day inpatient care.

24 Low quality evidence from one observational study (n= 153 to 756) showed 5 day inpatient
25 care is more effective on vomiting compared with 4-day inpatient care, but there was some
26 uncertainty.

27 **Inpatient CAMHS versus outpatient care for adults with any eating disorder at follow**
28 **up**

29 Very low quality evidence from one observational study (n=57) showed no difference in the
30 effect of inpatient care on BMI, EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction
31 and global severity index compared with outpatient care.

32 Very low quality evidence from one observational study (n=57) showed inpatient care is more
33 effective on self-esteem compared with outpatient care.

34 **Guided self-help versus day patient care for adults with bulimia nervosa and EDNOS**
35 **at end of treatment**

36 Very low quality evidence from one observational study (n=57) showed no difference in the
37 effect of guided self-help on EDE-total, binge eating, vomiting, excessive exercise compared
38 with day patient care.

1 **Extensive programme versus limited programme for adults with anorexia nervosa at**
2 **end of treatment**

3 Very low quality evidence from one observational study (n=60) showed extensive
4 programmes is less effective on remission compared with a limited programme.

5 **Extensive programme versus limited programme for adults with bulimia nervosa at**
6 **end of treatment**

7 Very low quality evidence from one observational study (n=63) showed extensive
8 programmes is less effective on remission compared with a limited programme.

9 **Extensive programme (community outreach combined with limited programme)**
10 **versus limited programme (psychotherapy and nutritional counselling) for adults with**
11 **anorexia nervosa at follow up**

12 Very low quality evidence from one observational study (n=60) showed extensive
13 programmes is less effective on remission compared with a limited programme.

14 **Extensive programme (community outreach combined with limited programme)**
15 **versus limited programme (psychotherapy and nutritional counselling) for adults with**
16 **bulimia nervosa at end of treatment**

17 Very low quality evidence from one observational study (n=63) showed no difference in the
18 effect of extensive programmes on remission compared with a limited programme.

19 **History of inpatient care versus no history for adults with any eating disorder at end of**
20 **treatment**

21 Very low quality evidence from one observational study (n=222) showed no difference in the
22 effect of treatment in those who had a history of inpatient care on EDI-drive for thinness, EDI-
23 body dissatisfaction, EDI-bulimia compared those with no history.

24 **Specialist care versus non-specialist care for adults with any eating disorder at end of**
25 **treatment**

26 Very low quality evidence from one observational study (n=69) showed no difference in the
27 number who were admitted to inpatient treatment if the patient went via specialist
28 assessment to specialist treatment compared with non-specialist assessment to non-
29 specialist treatment.

30 Very low quality evidence from one observational study (n=31) showed no difference in the
31 number who were admitted to inpatient treatment if the patient went via non-specialist
32 assessment to non-specialist treatment compared with non-specialist assessment to
33 specialist treatment.

34 Very low quality evidence from one observational study (n=68) showed a lower number
35 admitted to inpatient treatment if the patient went via specialist assessment to specialist
36 treatment compared with non-specialist assessment to specialist treatment.

37 Very low quality evidence from one observational study (n=69) showed no difference in the
38 continuity of care if the patient went via specialist assessment to specialist treatment
39 compared with non-specialist assessment to specialist treatment.

40 Very low quality evidence from one observational study (n=69) showed no difference in the
41 continuity of care if the patient went via non-specialist assessment to non-specialist
42 treatment compared with non-specialist assessment to specialist treatment.

1 Very low quality evidence from one observational study (n=69) showed better continuity of
2 care if the patient went via specialist assessment to specialist treatment compared with non-
3 specialist assessment to specialist treatment.

4 **Inpatient care versus variation in care (day, hospital, outpatient) for adults with**
5 **anorexia nervosa at end of treatment**

6 Very low quality evidence from one observational study (n=29) showed inpatient care is less
7 effective on body weight compared with any other type of care, but there was some
8 uncertainty.

9 **Prior to opt-in versus post opt-in in adults with any eating disorder at end of treatment**

10 Very low quality evidence from one observational study (n=138) showed opt-in is less
11 effective on attendance to the first appointment compared with no opt-in.

12 Very low quality evidence from one observational study (n=138) showed opt-in is more
13 effective on reducing the number who do not attend compared with no opt-in.

14 Very low quality evidence from one observational study (n=138) showed no difference in the
15 effect of opt-in on overall attrition rates compared with no opt-in.

16 Very low quality evidence from one observational study (n=138) showed no difference in the
17 effect of opt-in on cancellations rates compared with no opt-in.

18 **Meal supervision versus no supervision in adults with any eating disorder at end of**
19 **treatment**

20 Very low quality evidence from one observational study (n=47 to 51) showed no difference in
21 the effect of meal supervision on length of hospital stay and weight gain compared with no
22 meal supervision.

23 Very low quality evidence from one observational study (n=47 to 51) showed meal
24 supervision is more effective on incidence of bradycardia compared with no meal supervision
25 but there was some uncertainty.

26 **Eating disorder ward versus general ward for adults with anorexia nervosa at end of**
27 **treatment**

28 Very low quality evidence from one observational study (n=110) showed an eating disorder
29 ward is more effective on BMI and Morgan-Russell score compared with a general ward.

30 Very low quality evidence from one observational study (n=110) showed no difference in the
31 effect of an eating disorder ward on time in hospital, general health and children's global
32 assessment compared with a general ward.

33 **5.2.4.3 Stepped care for anorexia nervosa**

34 **Intensive family coaching with family-based treatment versus family-based treatment**
35 **for anorexia nervosa**

36 Very low quality evidence from one RCT (n=35) showed no difference in the effect of adding
37 intensive family coaching to family-based treatment on recovery, BMI, % expected body
38 weight, depression, the family's (child, mother and father) expectations about therapy and
39 the child and father's perceptions about the suitability of therapy compared with family-based
40 treatment only.

1 Very low quality evidence from one RCT (n=35) showed that adding intensive family
2 coaching to family-based treatment may be more effective on YBC-EDS scores and the
3 mother's perceptions about the suitability of therapy compared with family-based treatment,
4 although there was some uncertainty.

5 Very low quality evidence from one RCT (n=35) showed that adding intensive family
6 coaching to family-based treatment is less effective on EDE-global, service user experience
7 and number of therapy sessions attended compared with family-based treatment.

8 **5.2.4.4 Stepped care for bulimia nervosa**

9 **Group psychoeducation then CBT-ED or wait list control in adults with bulimia** 10 **nervosa**

11 Low quality evidence from one RCT (n=56) showed that group psychoeducation followed by
12 CBT-ED was more effective on the number of people not in remission, not in remission from
13 binge eating and not in remission from purging and purge frequency compared with group
14 psychoeducation followed by wait list control.

15 Low quality evidence from one RCT (n=56) showed that group psychoeducation followed by
16 CBT-ED may be more effective on binge frequency compared with group psychoeducation
17 followed by wait list control, although there was some uncertainty.

18 Low quality evidence from one RCT (n=56) showed no difference in the effect of group
19 psychoeducation followed by CBT-ED on EDE-global, general psychopathology, depression
20 and general functioning, compared with group psychoeducation followed by wait list control.

21 **Self-help for BN then CBT-ED versus CBT-ED at end of treatment in adults with** 22 **bulimia nervosa**

23 Very low quality evidence from one RCT (n=86) showed no difference in the effect of a self-
24 help manual for bulimia nervosa followed by CBT-ED on remission compared with CBT-ED
25 only.

26 **Self-help for BN then CBT-ED versus CBT-ED at follow up in adults with bulimia** 27 **nervosa**

28 Very low quality evidence from one RCT (n=64) showed no difference in the effect of a self-
29 help manual for bulimia nervosa followed by CBT-ED on remission compared with CBT-ED
30 only.

31 **Guided self-help for BN then antidepressant then CBT-ED versus CBT-ED then** 32 **antidepressant in adults with bulimia nervosa**

33 Very low quality evidence from one RCT (n=293) showed no difference in the effect of guided
34 self-help for BN then antidepressant then CBT-ED on remission, EDE-global, EDE-dietary
35 restraint, EDE-shape concerns, EDE-weight concerns, EDE-eating concerns, YBC-EDS-
36 preoccupation, YBC-EDS-ritual, depression and quality of life compared with CBT-ED
37 followed by antidepressant.

38 **5.2.4.5 Binge eating disorders**

39 No clinical evidence on stepped care was found on binge eating disorder.

40 **5.2.4.6 Eating disorders not otherwise specified**

41 No clinical evidence on stepped care was found on EDNOS.

1 **5.2.5 Economic evidence statements**

2 **5.2.5.1 Coordination of care**

3 There was limited UK evidence (N=167) showing that specialist outpatient care was
4 dominated (that is, it was more effective and resulted in lower costs) when compared with
5 both inpatient and general outpatient care in young people with anorexia nervosa. This
6 evidence came from a directly applicable study that was characterised by minor
7 methodological limitations.

8 There was evidence from one German study (N=172) showing that day treatment when
9 compared with inpatient care was dominant in people with anorexia nervosa. This evidence
10 came from a partially applicable study that was characterised by minor methodological
11 limitations.

12 There was evidence from one US study (N=51) showing that partial day hospital care was
13 cost saving when compared with inpatient care in people with anorexia nervosa or bulimia
14 nervosa (or sub-threshold anorexia nervosa or bulimia nervosa). This evidence came from a
15 partially applicable study that was characterised by potentially serious methodological
16 limitations.

17 There was evidence from one US modelling study showing that adequate care model
18 (inpatient care, partial hospital treatment, psychotherapy and medication treatment) when
19 compared with standard care was potentially cost effective in people with anorexia nervosa.
20 This evidence came from a partially applicable study that was characterised by potentially
21 serious methodological limitations.

22 There was evidence from one Australian modelling study showing that the best practice
23 model (early intervention, a range of care from GPs, self-help, intensive outpatient and
24 residential care, inpatient care and stepped care approach) when compared with treatment
25 as usual was dominant in people with anorexia nervosa, bulimia nervosa, BED and EDNOS.
26 This evidence came from a partially applicable study that was characterised by potentially
27 serious methodological limitations.

28 **5.2.5.2 Stepped care**

29 There was evidence from one US study (N=293) showing that stepped care model was
30 dominant when compared with high intensity CBT in people with bulimia nervosa. This
31 evidence came from a partially applicable study that was characterised by minor
32 methodological limitations.

33 There was evidence from one Finnish study (N=72) showing that stepped care model was
34 potentially cost effective in people with bulimia nervosa. This evidence came from a partially
35 applicable study that was characterised by potentially serious methodological limitations.

36 There was no economic evidence on the cost effectiveness of stepped care models for
37 people with anorexia nervosa, BED or EDNOS.

38 **5.2.6 Recommendations and link to evidence**

39 **Improving access to services**

10. Be aware that people with an eating disorder may:

- find it difficult or distressing to discuss it with healthcare professionals, staff and other service users
- be vulnerable to stigma and shame

	<ul style="list-style-type: none"> • need information and interventions tailored to their age and level of development. <p>11. Ensure that all people with an eating disorder and their parents or carers (as appropriate) have equal access to treatments (including through self-referral) for eating disorders, regardless of:</p> <ul style="list-style-type: none"> • age • gender or gender identity (including people who are transgender) • sexual orientation • socioeconomic status • religion, belief, culture, family origin or ethnicity • where they live and who they live with • any physical or other mental health problems or disabilities. <p>12. Healthcare professionals assessing people with an eating disorder (especially children and young people) should be alert throughout assessment and treatment to signs of bullying, teasing, abuse (emotional, physical and sexual) and neglect. For guidance on when to suspect child maltreatment, see the NICE guideline on child maltreatment.</p>
<p>Relative value of different outcomes</p>	<p>No formal review was conducted to address the barriers and facilitators for accessing treatment.</p> <p>For the review on the methods of improving access to and coordinating care the committee considered the critical outcomes were improved access to and uptake of services in particular for people from potentially disadvantaged groups. Other important outcomes included drop out from care and poor adherence with treatment</p>
<p>Trade-off between clinical benefits and harms</p>	<p>The committee agreed it was important to include general principles that healthcare professionals should incorporate when engaging people with an eating disorder in care. Moreover, the committee wanted to highlight how people with an eating disorder may feel vulnerable when accessing care and to ensure people of all backgrounds have equal access.</p> <p>The committee used their experience and knowledge of the issues to reach an informal consensus about these issues and develop the recommendations.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>The committee expressed the view that eating disorders cause a significant burden on individual with an eating disorder and their parents or carers and also healthcare system in terms of increased health and social care costs and reduced quality of life. Given that there are effective treatments for eating disorders the committee stressed the importance of improving and ensuring equal access to treatment. It was noted that, for example, in rural areas certain type of therapies may not be possible, such as group therapies. In such cases, access to other effective treatments such as self-help (computer programs that people can access from their homes) and individual therapies should be facilitated. The committee expressed the view that improving and facilitating equal access to treatments for eating disorders may incur additional resource use (for example, providing individual therapy versus group). However, if this results in timely treatment and management of eating disorders at an earlier stage, before individuals require</p>

	<p>more resource intensive management, then the additional costs associated with improving and facilitating access to treatments is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>No quality assessment was conducted in the absence of a formal review.</p>
Other considerations	<p>In the absence of a formal review, the committee generated the recommendations based on their clinical and service-user experience. Although they considered a wide-range of ways that having an eating disorder could interfere with the process of accessing and receiving treatment, the barriers should not be considered a comprehensive list or representative of all people with an eating disorder who may not access treatment.</p> <p>For people with an eating disorder, accessing care may be anxiety provoking and will involve discussing, possibly for the first time, a number of issues that they may find humiliating or embarrassing. Mood and anxiety symptoms are very common, in addition to low self-esteem and low confidence. For people with anorexia nervosa, weight loss is experienced as a positive achievement and therefore, they may often deny the seriousness of their condition. Many will only access treatment when they reach crisis point.</p> <p>Typically, individuals will be persuaded to seek treatment by concerned family members, teaching staff or general practitioners with whom they consult about physical consequences. In some cases, they will seek treatment in their own right if they begin to see the damaging effects of the disorder. Children and young people rarely seek treatment independently and are often brought to treatment by parents or carers.</p> <p>The committee also highlighted that it was vitally important that healthcare professionals consider the developmental level of the person with the eating disorder, in addition to their physical age, when providing information, conducting assessments and delivering treatment as there is a danger that age be used as a reason to deny or stop treatment.</p> <p>For these reasons, the committee agreed that it was important that healthcare professionals are aware of the difficulties that people with an eating disorder may have when they seek help, that they understand the person may feel vulnerable and shame regarding their condition, and that they take the age and development level of the person into account.</p> <p>In addition, they emphasised that healthcare professionals should be attuned to safeguarding issues and look out for signs of bullying, teasing, abuse and neglect (especially in children and young people) when assessing people and treating the eating disorder as there may be instances where the eating disorder has developed in response to these factors.</p> <p>For children and young people who need protection, healthcare professionals should be skilled and trained in safeguarding, which is defined as:</p> <ul style="list-style-type: none"> • protecting children and young people from maltreatment • preventing impairment of children's and young people's health and development • ensuring children and young people grow up in circumstances consistent with the provision of safe and effective care • taking action to ensure all children and young people have the best outcomes. <p>Healthcare professionals should ensure safeguarding of these individuals and refer to the NICE guideline (CG89) on child maltreatment when appropriate.</p>

A focus of all NICE guidelines is to ensure there is equal access to services and treatment. Therefore, the committee agreed it was important to highlight groups that may feel marginalised or reluctant to seek treatment. Such groups may include, though are not limited to: transgender individuals, individuals who have a particular religion or belief, children who are looked after in foster care, people with another mental health or physical health problem.

The committee also highlighted the reluctance of men to seek treatment or be considered at risk of an eating disorder by health professionals. They also mentioned people who are transgender may be prone to eating disorders because of the desire to fit the image of a new gender. Thus, they may be particularly vulnerable to eating disorders and should have equal access to care and treatment.

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Communication, information, and support

	<p>13. When assessing a person with a suspected eating disorder, find out what they and their family members or carers (as appropriate) know about eating disorders and address any misconceptions.</p> <p>14. Offer people with an eating disorder and their family members or carers (as appropriate) education and information on:</p> <ul style="list-style-type: none"> • the nature and risks of the eating disorder and how it is likely to affect them • the treatments available and their likely benefits and limitations. <p>15. When communicating with people with an eating disorder and their family members or carers (as appropriate):</p> <ul style="list-style-type: none"> • be sensitive when discussing a person’s weight and appearance • be aware that family members or carers may feel guilty and responsible for the eating disorder • show empathy, compassion and respect • provide information in a format suitable for them, and check they understand it. <p>16. Ensure that people with an eating disorder and their parents or carers (as appropriate) understand the purpose of any meetings and the reasons for sharing information about their care with others.</p> <p>Support for people with an eating disorder</p> <p>17. Assess the impact of the home, education, work and wider social environment (including the internet and social media) on each person’s eating disorder. Address their emotional, education, employment and social needs throughout treatment.</p> <p>18. If appropriate, encourage family members, carers, teachers, and peers of children and young people to support them during their treatment.</p>
<p>Relative value of different outcomes</p>	<p>No formal review was conducted to address the barriers and facilitators for accessing treatment.</p> <p>Here the critical outcomes are improved knowledge about, engagement in care and satisfaction with care.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>The committee agreed it was important for the guideline to include general principles that healthcare professionals should follow when treating and managing people with an eating disorder.</p>

Trade-off between net health benefits and resource use	The committee expressed the view that offering people with eating disorders and their family members or carer's education, information and support is an integral part of most eating disorder-specific psychological interventions and providing such supplementary advice would have only modest resource implications, if any, which are justifiable as these principles and factors are deemed essential in ensuring the success of treatment.
Quality of evidence	No quality assessment was conducted in the absence of a formal review.
Other considerations	<p>The committee used their knowledge and experience and informal consensus to generate a series of recommendations. They agreed that effective communication with the person and their family is a major part of ensuring their experience is positive. Healthcare professionals should first establish what they know and take the opportunity to correct any misconceptions they may have.</p> <p>Once existing knowledge has been established, the healthcare professional should then offer the person with the eating disorder and their family or carers information on the nature and risks of their eating disorder and how it may affect them. They should also describe the available treatments and their likely benefits and limitations. Information about risks are also pertinent given the physical health problems typically associated with having an eating disorder, such as cardiac problems and delayed growth</p> <p>Communicating with children and young people with an eating disorder and their parents or carers was regarded by the committee as particularly challenging. The committee drew upon the recommendations from the NICE guideline CG136 <i>Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services</i> and was mindful that healthcare professionals should take into account the child or young person's developmental level, emotional maturity and cognitive capacity.</p> <p>Given the importance of the role of parents or carers in the treatment of children and young people with eating disorders, especially anorexia nervosa, the committee also agreed it was important for them to understand the purpose of any meetings and the reasons for sharing information about the care with other professionals.</p> <p>The committee agreed that it is important to make sure that the person with the eating disorder has support when they are undergoing treatment, which can contribute to them having a positive experience. They agreed that it was important that the impact of the person's living circumstances and relationships (including the role of the internet and social media) be assessed. In some cases, a long-term focus on eating and dieting can lead to social withdrawal and a compromise in time engaged in leisure activities, daily living and productivity in employment or education.</p> <p>Thus, healthcare professionals should assess how much support is available and encourage this support network to help where possible during treatment. This network may extend beyond immediate family to, for example, peers, work colleagues and teachers. The committee were aware of some observational studies that suggest informal, supportive, social relationships outside of treatment and a supportive relationship with a partner can be important in the recovery process for people with an eating disorder.</p> <p>The committee stressed that people (especially children and young people) may experience a wide range of social and emotional difficulties that may lead to developing an eating disorder. Moreover, the resilience of a person to cope with adversity or stress is affected by their own characteristics, as well as the support</p>

	<p>they receive from others, the environment they live and learn in and their opportunities for positive engagement and success. The committee therefore considered it important that healthcare professionals:</p> <ul style="list-style-type: none"> • think about how the home, education, work and wider social environment (including the internet and social media) affects a person’s eating disorder and the treatment he or she may be having. • that the emotional, education and social needs of people are not neglected during their treatment • that a planned and supportive environment is at the heart of supporting people throughout their treatment <p>The committee agreed in the absence of evidence on how to treat children with an eating disorder that health care professionals should follow the recommendations for young people with the same eating disorder. Children make up a relatively small proportion of the total number of people with eating disorders, however, they agreed that the treatments for young people should work equally well.</p>
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Consent and confidentiality

	<p>19. When working with people with an eating disorder and their family members or carers (as appropriate):</p> <ul style="list-style-type: none"> • hold discussions in places where confidentiality, privacy and dignity can be respected • explain the limits of confidentiality (that is, which professionals and services have access to information about their care and when this may be shared with others). <p>20. When seeking consent for assessments or treatments for children or young people under 16, respect Gillick competence if they consent and do not want their family members or carers involved.</p>
Relative value of different outcomes	No review was conducted on the concerns of children and young people surrounding confidentiality.
Trade-off between clinical benefits and harms	<p>No evidence was reviewed to develop recommendations surrounding confidentiality when treating children and young people with eating disorder. The committee agreed that it was important that a recommendation was made on consent and confidentiality.</p> <p>The committee used their experience and knowledge to support informal consensus to develop a recommendation.</p>
Trade-off between net health benefits and resource use	The recommendations relate to the principles of care and factors that directly impact on the treatment outcomes for children and young people with an eating disorder. The committee expressed the view that these recommendations may have modest resource implications), which are justifiable as these principles and factors are deemed essential in ensuring the success of treatment.
Quality of evidence	No quality assessment was conducted in the absence of a formal review.

Other considerations	<p>The committee discussed how the family or carers of a person with an eating disorder are often involved in the treatment of the eating disorder, especially when the person is a child or young person. For this reason they generated recommendations that would ensure discussions are held where confidentiality, privacy and dignity can be respected.</p> <p>The committee highlighted that consultation between those with an eating disorder and healthcare professionals should respect generic rules of confidentiality that should only be breached if the person with an eating disorder or others are at significant risk, and that a breach of confidentiality is likely to reduce that risk. They also discussed how the person with an eating disorder should be informed of any breach of that confidentiality.</p> <p>Some young people may be mature enough to make informed decisions about their own care and might therefore want to discuss and negotiate the extent to which their parents are involved. In such cases, the committee wanted to remind healthcare professionals to consider whether the child or young person satisfies 'Gillick competence'.</p>
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Training and competencies

	<p>21. Professionals who assess and treat people with an eating disorder should be competent to do this for the age groups they care for.</p> <p>22. Health, social care and education professionals working with people with an eating disorder should be trained and skilled in:</p> <ul style="list-style-type: none"> • negotiating and working with family members and carers • managing issues around information sharing and confidentiality • safeguarding • working with multidisciplinary teams. <p>23. Base the content, structure and duration of psychological treatments on relevant manuals that focus on eating disorders.</p> <p>24. Professionals who provide treatments for eating disorders should:</p> <ul style="list-style-type: none"> • receive appropriate clinical supervision • use standardised outcome measures, for example the Eating Disorder Examination Questionnaire (EDE-Q) • monitor their competence (for example by using recordings of sessions, and external audit and scrutiny) • monitor treatment adherence in people who use their service.
Relative value of	No review was conducted on what the training and competencies should be of healthcare professionals who manage and deliver care for those with an eating disorder.

different outcomes	
Trade-off between clinical benefits and harms	No evidence was formally reviewed to develop recommendations on the training and competencies healthcare professionals should have when managing and delivering care for those with an eating disorder people since this question was outside of the scope. However, the committee drew on their expert knowledge and experience and used informal consensus to develop a recommendation was needed to ensure a high standard of care is delivered and to increase the likelihood of people recovering from an eating disorder.
Trade-off between net health benefits and resource use	The committee expressed the view that training and competency monitoring should be routinely undertaken in professionals working with children and young people and that offering it in line with the outlined principles would not incur significant extra resource implications. The committee expressed the view that the cost of providing training and monitoring/supervision of professional is relatively small, taking into account that it has the potential to significantly change the behaviour of professionals in meaningful and positive ways (for example, reduced harm, improved staff ability to recognise eating disorders through better sharing of information, better ability to communicate with the family and carers and the potential to reduce their burden) and make their overall interactions more efficient when dealing with people with eating disorders, parents, carers and other professionals and as a result lead to timely and appropriate care, improved health outcomes and the overall cost savings to the healthcare system. The committee expressed the view that supervision and monitoring of professionals is essential in ensuring that staff are competent in how to deal with people who have eating disorders.
Quality of evidence	No quality assessment was conducted in the absence of a formal review.
Other considerations	<p>The committee discussed how the involvement of parents and carers in the treatment of eating disorders can be complex. For this reason, staff should receive training in the skills needed to negotiate with parents and carers in managing issues relating to information sharing and confidentiality.</p> <p>Two examples of where it is essential that healthcare professionals communicate and cooperate effectively with each other are when a person with an eating disorder needs safeguarding or when they are being treated for a comorbidity. Thus, the committee agreed that it was important that they are trained to work with multidisciplinary teams. The committee were of the view that professionals who assess and manage people with eating disorders must be competent in delivering interventions to the age group for which they provide care.</p> <p>As in all areas of mental and physical health, the healthcare professional should receive appropriate clinical supervision in order to ensure that interventions are delivered competently. The committee had concerns that therapists not adhere to manualised forms of therapy, the committee agreed it is important that healthcare professionals monitor their own adherence to the treatment throughout its duration and that the following methods could be used: recordings, external audits and general scrutiny.</p> <p>A number of people with an eating disorder will not adhere to treatment at some point during its course. This prolongs time to recovery and increases healthcare costs.</p> <p>NHS England (2015) discusses how raising the awareness of professionals in primary care, education and other services will improve early identification of people either at risk of developing or currently experiencing an eating disorder.</p>

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Coordination of care, referral, care settings and planning, and discharge

Coordination of care

25. Take particular care to ensure services are well coordinated when:

- a young person moves from children's to adult services (see the NICE guideline on transition from children's to adults' services)
- more than one service is involved (such as inpatient and outpatient services, child and family services, or when a comorbidity is being treated by a separate service)
- people need care in different places at different times of the year (for example, university students).

Referral

26. If an eating disorder is suspected after an initial assessment, refer immediately to a community-based, age-appropriate eating disorder service for further assessment or treatment.

Inpatient and day care treatment

27. Admit people with an eating disorder whose physical health is severely compromised to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding, if these cannot be done in an outpatient setting.

28. Do not use an absolute weight or BMI threshold when deciding whether to admit people with an eating disorder to day patient or inpatient care.

29. When deciding whether day patient or inpatient care is most appropriate, take the following into account:

- the person's BMI or weight, and whether these can be safely managed in a day patient service or whether the rate of weight loss (for example more than 1 kg a week) means they need inpatient care
- whether inpatient care is needed to actively monitor medical risk parameters such as blood tests, physical observations and ECG (for example bradycardia below 40 beats per minute or a prolonged QT interval) that have values or rates of change in the concern or alert ranges: refer to Box 1 in Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN), or Guidance 1 and 2 in junior MARSIPAN
- the person's current physical health and whether this is significantly declining
- whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient.

30. When reviewing the need for inpatient care as part of an integrated treatment programme for a person with an eating disorder:

- do not use inpatient care solely to provide psychological treatment for eating disorders do not discharge people solely because they have reached a healthy weight.

31. For people with an eating disorder and acute mental health risk (such as significant suicide risk), consider psychiatric crisis care or psychiatric inpatient care.

32. Children, young people and adults with an eating disorder who are admitted to day patient or inpatient care should be cared for in age-appropriate facilities (for example, paediatric wards or adolescent mental health services). These should be near to their home, and have the capacity to provide appropriate educational activities during extended admissions.

33. When a person is admitted to inpatient care for medical stabilisation, specialist eating disorder or liaison psychiatry services should:

- keep in contact with the inpatient team to advise on care and management, both during the admission and when planning discharge
- keep the person's family members or carers involved
- consider starting or continuing psychological treatments for the eating disorder.

34. Inpatient or day patient services should collaborate with other teams (including the community team) and the person's family members or carers (as appropriate), to help with treatment and transition.

Care planning and discharge from inpatient care

35. Develop a care plan for each person with an eating disorder who is admitted to inpatient care. The care plan should:

- give clear objectives and outcomes for the admission
- be developed in collaboration with the person, their family members or carers (as appropriate), and the community-based eating disorder service
- set out how they will be discharged, how they will move back to community-based care, and what this care should be.

36. Whether or not the person is medically stable, within 1 month of admission, review with them, their parents or carers (as appropriate) and the referring team, whether inpatient care should be continued or stepped down to a less intensive setting.

	<p>37. As part of the review:</p> <ul style="list-style-type: none"> • assess whether enough progress has been made towards the objectives agreed at admission • agree a schedule for further reviews, with reviews happening at least monthly take into account the risk that people with an eating disorder can become institutionalised by a long admission, and that a lack of change in their condition could indicate that inpatient treatment is harmful • consider seeking an independent second opinion if healthcare professionals have different views about the benefit of continued inpatient care..
<p>Relative value of different outcomes</p>	<p>Coordination of care</p> <p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of different treatment settings or coordinating care for children, young people and adults with an eating disorder. For those with anorexia nervosa, body weight or BMI and remission are of greatest concern. For bulimia nervosa, binge eating and remission are the most critical outcomes. Service user experience is also a critical outcome.</p> <p>For any eating disorder, other outcomes that are important but considered rare events, or rarely measured in RCTs for eating disorders, include all-cause mortality, adverse events, quality of life, resource use and relapse.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance, but are clearly important, include improved uptake and reduced attrition from services, general psychopathology, general functioning and family functioning.</p> <p>Inpatient and day-patient treatment</p> <p>No review was conducted to consider what the optimal discharge plan should be if a person is admitted for inpatient care. The committee discussed the importance and relevance of various outcomes when considering discharge from hospital. For all disorders these include readmission and relapse. For those with anorexia nervosa, body weight or BMI and remission are of greatest concern. For bulimia nervosa, binge eating and remission are the most critical outcomes. Service user experience would also be a critical outcome.</p> <p>For any eating disorder, other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. Other outcomes of concern for people with an eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning and family functioning.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>Coordination of care, referral, and inpatient and day-patient treatment</p> <p>Randomised control trials</p> <p>Anorexia nervosa:</p> <p>A number of RCTs were identified that compared the effect of care within in different settings on weight and remission in young people and adults with anorexia nervosa.</p>

Comparing an inpatient versus a day clinic setting for adults, no difference in BMI was found at the end of treatment or in remission rates at the end of treatment or at one year follow up. All other outcomes were similar between the two settings. They included: binge eating, vomiting, EDI-bulimia and global severity index. No data was available for BMI at follow up, or at either time point for family functioning, service user experience, all-cause mortality quality of life, resource use, or general psychopathology.

Inpatient treatment compared with an outpatient psychotherapy group that included the delivery of individual and family therapy in adults with anorexia nervosa showed no difference on Morgan–Russell global or subscale scores at the end of treatment. No data was available for the critical outcomes of BMI and remission, or any other important outcomes at the end of treatment or follow up including general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use and general psychopathology.

No differences were found on these same outcomes when inpatient treatment was compared with outpatient group therapy or a wait list control group.

In young people, follow-up data 12 months after admission were available for those who had treatment in an inpatient setting compared to a day clinic setting. The results showed that at follow up, inpatient care was equally effective as a day clinic on remission and BMI, EDI-total, EDI-bulimia and scores on the global severity index. However, relapse or readmission rates were higher in the inpatient group compared with the day clinic group. No data were reported at the end of treatment and no follow up data were available for family functioning, service user experience, all-cause mortality, quality of life, resource use, or general psychopathology.

A study on young people with anorexia nervosa in the UK showed no difference at one year follow up in remission or BMI in those who attended an inpatient setting compared with those who attended a specialised outpatient clinic (offering CBT-ED). EDE-total and Morgan–Russell scores were also similar at follow up. No data was reported at the end of treatment and no follow up data was available for general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use, or general psychopathology.

Similar results were found in the same study when comparing inpatients with those randomised to a general outpatient treatment (community child and young people mental health service [CAMHS]). At one-year follow up, no difference was found in remission rates and BMI. EDI-total favoured the inpatient arm but no difference was found in the Morgan–Russell score. No data was reported at the end of treatment and no follow up data was available for general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use, or general psychopathology.

When comparing the two outpatient interventions described above (specialised outpatient treatment versus general CAMHS treatment), no difference was found in any of the outcomes at follow up, including BMI, remission, EDI-total, Morgan–Russell score and readmission to hospital. No data was reported at the end of treatment and no follow up data was available for general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use, or general psychopathology.

Bulimia nervosa:

One RCT was identified in adults with bulimia nervosa and showed at 12- to 14-months' follow up that there was no difference in remission or binge eating between those who had inpatient group psychoanalytical therapy compared with

those who received outpatient family therapy. Other outcomes were also similar, including vomiting, depression and bulimic severity score. No data was available at the end of treatment and no outcomes were reported for general functioning, family functioning, service user experience, all-cause mortality, quality of life or resource use.

Evidence from one study on adults with bulimia nervosa showed no difference at the end of treatment in the effect of specialist outpatient treatment on binges, vomiting, EDE global or subscales, bulimic investigatory test, depression or work/leisure/family life questionnaire compared with GP outpatient care. No data were available on remission, general functioning, family functioning, service user experience, all-cause mortality or resource use.

Any eating disorder:

One study randomised participants to a modified day clinic and compared the outcome with those who attended traditional outpatient therapy. At the end of treatment, the results favoured the day clinic. Binge eating episodes, purging episodes, depression, EDE-total, EDI-2-drive for thinness, EDI-2-bulimia, EDI-2-body dissatisfaction were all in favour of the day clinic, except for BMI. No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life or resource use.

One study compared different durations and aims of inpatient treatment. In one arm the aim was for medical stabilisation (mean 22 days), whilst in the other it was for weight restoration (mean 38 days). The outcomes were similar. Remission, hospital readmission and change in EDE-global score were the same at the end of treatment. Remission was also similar at long-term follow up. No data was available for family functioning, service user experience, all-cause mortality, quality of life, resource use, general functioning or general psychopathology.

Observational studies

Anorexia nervosa:

A cohort study comparing outcomes of adults with anorexia nervosa who were in inpatient care with day patient care showed that day patient care was favourable for improving BMI. Results regarding binge eating favoured inpatient care, but otherwise all other outcomes were similar, including laxative use, vomiting, excessive exercise and quality of life. At follow up, no differences were found between BMI (after 6 months) and readmission rates (after 1.7 years). No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

Another cohort study compared the outcomes of people with anorexia nervosa who were admitted to a general admissions unit with those who admitted to an eating disorder unit. At the time of discharge, there was a similar improvement in symptoms using the Morgan–Russell score and Children’s Global Assessment Scale (CGAS). However, although those in the specialist unit achieved a higher BMI, they had a longer hospital stay. No data was available for remission, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

With a mean follow up of 4.8 years, another inpatient versus outpatient cohort study in adults showed that remission and BMI were similar. However, hospitalisation rates were higher in the group treated in an inpatient setting. No data was available for general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

Inpatient care also showed less favourable results in adults compared with family therapy, with higher overall readmission rates but no difference for those readmitted more than three times. No data was available for body weight, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

When comparing inpatient care with a community-based treatments (including day clinic and outpatient care) in young people with anorexia nervosa the findings favoured community-based treatment with greater gains in body weight. No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One study in adults compared day hospitalisation and support (community housing with counselling and case management) with day hospitalisation alone. The findings favoured the group that had additional support with improvements in weight gain, EDI-2-total, EDI-2-bulimia and EDE-weight concern. No other differences were found in other EDI-2- or EDE-subscases, BMI or purging. No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

Bulimia nervosa:

One study compared day patient care with inpatient care in adults with bulimia nervosa and showed no difference between the groups on remission, global severity score, depression and EDI-subscases. However, at 3-year follow up, remission favoured the day patient group, while there was no difference on binge eating, vomiting, depression, and scores on the global severity index, EDI-bulimia and EDI-drive for thinness. They. No data was available for family functioning, service user experience, all-cause mortality, quality of life or resource use.

An inpatient study with a mix of people with bulimia nervosa and anorexia nervosa compared a five-day versus a four-day hospital programme and showed all outcomes favoured the five-day treatment. The outcomes included remission, binge eating, BMI, depression, EDI-bulimia, EDI-drive for thinness and EDI-body dissatisfaction. Vomiting also appeared to favour the five-day treatment, although there was some uncertainty. No data was available for general functioning, family functioning, service user experience, all-cause mortality, quality of life or resource use.

Any eating disorder:

Comparing an inpatient with outpatient CAMHS programme for those with any eating disorder showed no difference in most outcomes at follow up including BMI, EDI-bulimia, EDI-body dissatisfaction, EDI-drive for thinness, and global severity. Self-esteem scores were higher in the inpatient group. No data was available for remission, family functioning, service user experience, all-cause mortality, quality of life or resource use.

A day-hospital programme compared with guided self-help showed bingeing improved more in the former group, while other outcomes (including EDE-total, vomiting and excessive exercise) were similar between the groups. No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One study that compared an extensive programme (that included an additional community out-reach programme) with a limited programme (that included combined psychotherapy with nutritional counselling) improved remission rates in adults with anorexia nervosa and bulimia nervosa at the end of treatment and at

follow up. No data was available for body weight, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One study compared the long-term (unclear duration) outcomes of patients who had a history of inpatient care compared with those who had no history and found no difference in scores for EDI-drive for thinness, EDI-body dissatisfaction and EDI-bulimia. No critical outcomes were reported. No data was available for remission, body weight, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One study compared the outcomes in young people with any eating disorder who had progressed through different pathways of care in the UK. Those who were referred and treated in an eating disorder-specialised CAMHS or other eating disorder service ('Specialist' in GRADE) had better outcomes compared with those who were either referred and treated in a non-eating disorder specialised CAMHS service or referred to a non-eating disorder specialist CAMHS ('Non-specialist' in GRADE) and treated at a specialist eating disorder setting. No data was available for remission, body weight, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

Compared with those who stayed in a non-specialised setting, the group treated in a specialised eating disorder unit had better continuity of care and were more likely to receive care from a specialist. However, there was no difference in the number of people admitted to hospital. Compared with those who ultimately received specialised care, the group who received specialised care continuously showed lower rates of admission to hospital but no difference in continuity of care. No data was available for remission, body weight, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One study investigated the effectiveness of an opt-in intervention on attendance to first appointments, which require the patient to respond in some way to the offer of an appointment. Those who do not respond are ineligible to attend. The results showed that, after the opt-in programme was introduced, it was less effective on ensuring people attended their first appointment. However, although the number of people who failed to attend a first appointment was reduced, more people were actually seen. No data was available for remission, body weight, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One study compared inpatient care with a variety of other care settings (including day, hospital and outpatient) and showed inpatient care may be less effective on body weight compared with any other type of care. No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

One inpatient study compared the effectiveness of meal supervision compared with no such supervision in adults with any eating disorder. Whilst the length of hospital stay and weight gain was no different between the groups, the number of adults experiencing bradycardia was less in the meal supervised group. No data was available for remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or general psychopathology.

	<p>Overall, the evidence in both young people and adults with anorexia nervosa, bulimia nervosa and any eating disorder clearly showed that inpatient care does not result in better outcomes than for those treated as outpatients.</p> <p>Care planning and discharge from inpatient care</p> <p>No evidence was formally reviewed to develop recommendations on care planning and what the appropriate discharge plan from inpatient care should be for a person with an eating disorder who has been admitted to hospital since this question is outside the scope. However, the committee agreed that a recommendation is needed to ensure people are not kept in hospital longer than they should be and are discharged only when appropriate.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>Coordinated care</p> <p>Generally, the committee considered that coordinated approach to the management of eating disorders may have resource implications in terms of the extra time required to facilitate such approach to care. However, the committee expressed the view that if such service structures lead to prompt identification of needs and this results in subsequent treatment and management of an eating disorder (and potentially of any comorbidities) at an earlier stage, before individuals require more resource intensive management, then the additional costs associated with facilitating a coordinated approach is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p> <p>Inpatient and day patient treatment</p> <p>The existing economic evidence on the cost effectiveness of inpatient and day patient care is very sparse. The existing UK study indicated that at two years follow up specialist outpatient treatment dominated both inpatient and general outpatient treatment. Also, specialist outpatient treatment had a high probability of being cost effective. The existing limited evidence is characterised by minor methodological limitations.</p> <p>The cost per admitted individual to the adult specialist eating disorder service is £450.82 per day versus £182.91 and £185.58 per community contact and outpatient attendance, respectively (DoH, 2015). The committee considered clinical benefits and high costs associated with the inpatient care and expressed the view that inpatient treatment should only be used for medical stabilisation and initiation of refeeding and that it should not be used solely for the psychological treatment of eating disorders.</p> <p>The committee also took into account the psychological and financial burden associated with eating disorders both for people with eating disorders and for their families, as well as the benefits associated with the specialist eating disorder service. The committee considered the substantial costs associated with delayed diagnosis and management of unrecognised eating disorders and recognised that early diagnosis of eating disorders which is most likely to be facilitated by a specialist eating disorder service offers a benefit to the individuals who receive appropriate treatment, and may also result in a considerable reduction in healthcare resource use. Regarding assessment, the committee acknowledged that appropriate assessment of people with eating disorders enables them to receive suitable treatment according to their needs, thus ensuring efficient use of available healthcare resources.</p> <p>Care planning and discharge from inpatient care</p> <p>There was no evidence on the cost effectiveness of care plan arrangements for people with eating disorders. However, the committee expressed the view that if such care plans lead to the prevention of relapse and appropriate aftercare then the additional costs associated with facilitating such service structures are likely to</p>

	<p>be outweighed by the improvements in the health outcomes and potential future cost savings to the healthcare system. Also, providing comprehensive care plan and reviews may prevent the need of expensive secondary care.</p>
Quality of evidence	<p>In the absence of a formal review regarding care planning and discharge from inpatient care, no quality assessment was conducted. The evidence for the setting in which treatment occurs is discussed below.</p> <p>Randomised controlled trials</p> <p>The majority of the evidence was very low quality. The evidence was downgraded for imprecision and risk of bias for reasons such as unclear randomisation, lack of clarity on whether allocation concealment was performed and if either or all of the participants, investigators or assessors were blinded. High dropout rates were also detected, with more than 20% dropping out in each arm.</p> <p>The study sizes were mostly small (fewer than 400 participants or 300 events) and very few studies were available for each comparison, so imprecision was detected in a lot of outcomes. Remission was not always measured, and some studies did not provide data at the end of the treatment, only at follow up. Service user outcomes were not reported either, so the preference of participants was not an outcome that the committee could consider.</p> <p>Observational studies</p> <p>The quality of the evidence was all very low quality. In GRADE all observational studies start at very low quality and can only be scored up if the effect size is large, there is a dose-response and the possible effect of confounders have been taken into account. The majority of studies did not adjust the data for potential confounders, and in many cases the cohorts were not matched for factors such as severity of illness. In a lot of cases remission was not measured.</p> <p>The majority of the studies were from outside the UK, so applying the findings to the NHS is difficult and may be considered indirect evidence. For instance, one study in the USA looked at the benefit of adding community housing to people who were partially hospitalised. This is not something the NHS would recommend, even though it showed some benefit. When including studies from other countries, it is important to consider the different pathways of care, who pays for the treatment (insurance versus nationalised health service), the culture of inpatient admissions, the availability of beds and the costs of treatment.</p> <p>When considering the recommendations regarding referrals, the committee focused on a study that showed referral of young people to such services results in fewer people being admitted to inpatient care compared with people referred to a general CAMHS services. This study was very low quality because it was an observational study and no adjustments were made to the data. However, no statistically significant differences were found between the groups in age, gender, ethnicity or weight for height percentage at the assessment stage or when being referred. Nevertheless, this study was conducted in the UK so the findings and setting were considered pertinent to this guideline.</p>
Other considerations	<p>Referral to and delivery of care in a community-based eating disorder service</p> <p>The committee agreed that inpatient care does not result in better outcomes compared with those treated in outpatient or community settings, and that in some instances inpatient care may result in worse outcomes. . The committee wanted to be specific and offer more than just generic 'outpatient care' because there was evidence in the UK that showed specialist care results in better outcomes compared with those who are treated in non-specialist settings.</p> <p>Thus, it was recommended that people with an eating disorder be referred to, and treated in, an age-appropriate community-based specialist eating disorder service.</p>

The committee discussed the relevance of the term and decided to recommend that referral should occur 'immediately', as those referring individuals should not 'wait and see' if the symptoms progress.

No evidence for this review was found in children with an eating disorder. Nevertheless, the committee ensured that the recommendation was sufficiently clear by the qualification that people should be treated in an age-appropriate community-based eating disorder setting.

Coordination of care

The committee the transition from a young person to adult service, or between adult services.

The committee discussed how transfer of care is likely to require the establishment of new relationships and a shift in treatment approaches. Where clear transition protocols are not in place, with adequate preparation for transfer of care, recovery can be hampered. Based on their knowledge and experience the committee used informal consensus to agree that effective collaboration to manage the treatment of the eating disorder, coexisting mental health or physical health problems, and the physical consequences of severe eating disorders, is essential.

The committee agreed that it is critical for the interface between different care providers to be managed effectively. This should include good communication, clear lines of responsibility and ensuring a transition protocol is in place.

Inpatient and day patient treatment

The committee discussed the role, importance and effectiveness of inpatient care. A number of committee members agreed that inpatient care may be effective for some people with a severe eating disorder. For example, those who are unresponsive to outpatient care may need more intensive inpatient treatment. However, the evidence did not support such a recommendation. The RCT and observational evidence generally showed no difference in the outcomes in young people or adults with anorexia nervosa or bulimia nervosa who are treated as inpatients compared with outpatient treatment whether it be day patient or community based CBT-ED, group or family therapy. In some cases, remission rates may be lower if treated as an inpatient compared with a day clinic. Finally, the costs of inpatient treatment compared with an outpatient setting do not justify such a recommendation.

The committee agreed that the only time inpatient care should be used for with the treatment of an eating disorder is if their physical health is compromised and such treatment is needed for medical stabilisation and refeeding (and then, only if this cannot be achieved in an outpatient setting). They further agreed that it is important that if children and young people are admitted to inpatient care then it is to an age-appropriate facility that has the capacity to provide appropriate educational and related activities (especially if they are admitted for a number of weeks or more).

In the case of suicide risk or other acute mental health risks, the committee recommended what is considered appropriate treatment for anyone with a mental health problem, not just an eating disorder.

The committee agreed that it was important to list some of the most important factors to consider when deciding whether to use day-patient or in-patient care. They included outcomes that show: a BMI or body weight below a safe range; blood tests, physical observations or ECG results in the alert range; an overall ill health or rapid decline to ill health; and if the parents or carers cannot support the child or young person. The committee agreed that healthcare professionals should

	<p>refer to the risk parameters listed in the MARSIPAN and Junior MARSIPAN reports (Royal College of Psychiatrists 2012, 2014) for detailed guidance.</p> <p>Overall, the committee agreed that it was important to pay attention not just to a single measure but measures over time that may indicate a rapid decline. This will ensure a person gets help early before s/he slips into a critical state. The committee discussed how people admitted for inpatient care, especially those who are in such care for a number of weeks, should start or continue with psychological therapy if appropriate. However, they agreed that it should be offered in conjunction with the relevant physical health treatment and not as a sole treatment in hospital. It was noted by the committee that an overemphasis on weight and weight restoration can be unhelpful or harmful for adults receiving inpatient treatment (Button and Warren, 2001) and lead to increased risk of drop out from treatment. It was therefore agreed that reaching a healthy weight should not be used as the only criteria for discharge from inpatient care.</p> <p>Care planning and discharge from inpatient care</p> <p>The committee discussed how to best manage a person who has been admitted to inpatient care and ensure that it does not continue beyond the point where outpatient or day patient treatment could be safely reinstated. It was agreed that long-term admissions should be avoided.</p> <p>The committee agreed that a care plan should be developed in conjunction with the relevant community-based eating disorder service in collaboration with the person who is being admitted for inpatient treatment and their family or carers (if appropriate). Such a plan should include clear objectives and outcomes, and set out how the person with the eating disorder should be discharged, transferred to community-based care, and what such care should be.</p> <p>In order to ensure that people do not endure unnecessarily long and counter-productive admissions, the committee agreed that a review on the need for ongoing inpatient treatment should be conducted within the first month of admission regardless of whether the person is medically stable. The committee used their knowledge and experience to agree on a number of factors that should be considered when discharging a patient from hospital. They included: whether the person has made enough progress towards the goals agreed at admission; the risk that the person may become dependent on inpatient care and reluctant to be discharged; that inpatient treatment is not effective and that the person may be better managed in a community setting; and that services might seek an independent second opinion if there is disagreement as to the benefit of continued inpatient care.</p> <p>When discharged, they committee agreed that the person with the eating disorder should be stepped down to less intensive treatment such as a day clinic or return home to receive ongoing psychological treatment in a community based eating disorder service (as described in the recommendation).</p>
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Stepped care

	<p>No recommendation was made on stepped care. Instead a research recommendation was made.</p>
<p>Relative value of different outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of interventions for treating children, young people and adults with an eating disorder. For people with anorexia nervosa, body weight or BMI and remission are of greatest concern. For those with bulimia nervosa or binge eating disorder, binge eating and remission are of greatest concern.</p>

	No recommendation was made on stepped care. Instead a research recommendation was made.
	<p>Other outcomes that are important but are considered rare events or rarely measured in randomised controlled trials for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. Thus, they were extracted where possible, but did not factor strongly in the decision making.</p> <p>Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>Anorexia nervosa An RCT on stepped care in young people with anorexia nervosa showed if family therapy is stepped up to intensive parental coaching compared with continued family therapy, there was no difference at the end of treatment on remission, body weight and depression and may be less effective on EDE-global scores and service use experience. The study did not report data on the important outcomes of general functioning, all-cause mortality, relapse or quality of life.</p> <p>Bulimia nervosa An RCT on stepped care in adults with bulimia nervosa showed that group psychoeducation stepped-up to CBT-ED may lead to better remission rates compared with group psychoeducation and wait list control but no other outcomes favoured the stepped care approach as they all showed no difference between the two arms, including binge frequency and EDE-global. The study did not report data on the important outcomes of family functioning, resource use, service user experience, all-cause mortality or relapse.</p> <p>Another study showed self-help stepped up to CBT-ED compared with CBT-ED alone had a similar effect on remission at the end of treatment and at follow up in adults with bulimia nervosa. The study did not report data on the critical outcome of binge eating, nor the important outcomes of family functioning, resource use, service user experience, all-cause mortality or relapse.</p> <p>Guided self-help stepped up to an antidepressant followed by CBT-ED showed no difference on remission rates compared with CBT-ED alone in adults with bulimia nervosa. The study did not report data on the important outcomes of general functioning, family functioning, resource use, service user experience, all-cause mortality or relapse.</p> <p>No published stepped-care evidence was found in people with binge eating disorder or EDNOS.</p>
Trade-off between net health benefits and resource use	<p>There was evidence from two studies showing that stepped care may potentially be cost effective in people with BN. However, both studies were non-UK and were only partially applicable to the NICE decision making context. One study was characterised by minor methodological limitations and one by potentially serious methodological limitations. The committee considered the above evidence. However, they could not draw any firm conclusions from it. Given that the overall existing evidence was positive the committee noted that there is a need for future well-conducted UK studies comparing the effectiveness and cost effectiveness of such care arrangements for people with eating disorders.</p>
Quality of evidence	<p>The quality of the evidence on stepped care was mostly very low quality. The evidence was downgraded for imprecision and risk of bias for reasons such as unclear randomisation, it was unclear if allocation concealment was performed, if</p>

	No recommendation was made on stepped care. Instead a research recommendation was made.
	<p>either or all of the participants, investigators or assessors were blinded and high drop outs were detected >20%.</p> <p>Studies were included in the review if the higher level of care was the result of the participants' non-responsiveness to the previous intervention. However, in the study on people with anorexia nervosa, the non-responders were not randomised to a higher level of care (after failing to show a response to six months of family therapy). Therefore, at the end of treatment, the two arms of the study included two very different populations (one that showed a response early one versus those who did not). For this reason, the results are difficult to decipher and it is closer to an observational study.</p>
Other considerations	The committee agreed that the evidence was too limited to make a recommendation on stepped care and instead a research recommendation was generated that is relevant for all eating disorders to examine the effectiveness of stepped care for the psychological treatment of eating disorders for people of any age.

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1. Research recommendation: What is the effectiveness of stepped care for psychological treatment of eating disorders for people of any age?

Medication risk management

	<p>38. When prescribing medication for people with an eating disorder and comorbid mental or physical health conditions, take into account the impact malnutrition and compensatory behaviours can have on medication effectiveness and the risk of side effects.</p> <p>39. When prescribing for people with an eating disorder and a comorbidity, assess how the eating disorder will affect medication adherence (for example, for medication that can affect body weight).</p> <p>40. When prescribing for people with an eating disorder, take into account the risks of medication that can compromise physical health due to pre-existing medical complications.</p> <p>41. Offer ECG monitoring for people with an eating disorder who are taking medication that could compromise cardiac functioning (including medication that could cause electrolyte imbalance, bradycardia below 40 beats per minute, hypokalaemia, or a prolonged QT interval).</p>
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical, whilst for OSFED, remission and either binge eating or body weight/BMI (depending on the eating disorder they most closely resemble) are critical.</p> <p>The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.</p>

	<p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>No relevant published RCT or observational evidence was identified where they treated people with an eating disorder and a comorbid condition with medication.</p> <p>The committee used their experience and knowledge to generate a group discussion about the issues, and the recommendations were developed using an informal method of consensus.</p>
Trade-off between net health benefits and resource use	<p>There was no existing economic evidence on the costs and benefits associated with the medication risk management strategies. Medication risk management in line with the principles outlined in the recommendations may incur additional resources. However, the committee noted the importance of the appropriate use of the medication given that people with eating disorders have a high rate of comorbid health problems (such as cardiovascular problems, osteoporosis, kidney dysfunction, etc.) and this in turn may affect how medications work. Fragmented and inappropriate prescribing, sub-optimal dosing and poor adherence, affects health outcomes and overall healthcare costs (for example, sub-optimal dosing leads to poorer outcomes, which then increase healthcare utilisation and overall healthcare costs). Overall, the committee expressed the view that if medication risk management results in appropriate treatment, before individuals require more resource intensive care, then the additional costs associated with facilitating such service structures is expected to result in improved health outcomes (for example, prevention of liver or kidney damage) in the longer term and potential future cost savings to the healthcare system. Similarly, offering regular ECG tests for people with eating disorders who are taking medication that can compromise their cardiac functioning may incur additional resources. However, the committee expressed the view that the cost of ECG monitoring is very small relative to the costs associated with managing future cardiac problem (expensive secondary care and high cost surgical interventions).</p>
Quality of evidence	<p>In the absence of relevant published evidence no quality assessment was conducted.</p>
Other considerations	<p>Although medication is not being recommended for the sole treatment of any eating disorder, people with severe eating disorders have elevated rates of physical illnesses and psychiatric disorders. Thus, they may need medication, such as antidepressants or antipsychotics for the treatment of comorbid mental and as well as medication for physical health conditions.</p> <p>However, when medication is used to treat people with severe eating disorders, the side effects of the drugs (in particular, cardiac side effects) should be carefully considered because of the compromised cardiovascular function of many people with anorexia nervosa.</p> <p>Reported mortality rates of anorexia nervosa are highly variable and typically range from 5 to 20%. Case studies on people with anorexia nervosa who have died suddenly have shown prolonged QT intervals (the time between the start of the heart's electrical Q wave and the end of the T wave) in the electrocardiogram (ECGs) several days before death. Ventricular tachyarrhythmias have also been associated with prolonged QT intervals.</p>

The committee agreed that healthcare professionals should be aware of the risk of drugs that prolong the QT interval on the ECG; and the implications for the use of ECGs should be offered.

Other concerns surrounding prescribing medication for people with an eating disorder include how a compromised nutritional status can affect the mechanism of drug action, which is rarely considered in studies, and how antidepressants may be less effective if the person has low oestrogen levels and if tryptophan levels are altered.

Compensatory behaviours may also affect the effectiveness of medication. Malnutrition, vomiting, dehydration and over-hydration may influence pharmacokinetics (drug absorption and toxicity). For example, if someone vomits soon after taking medication, absorption is reduced. For this reason, the committee agreed that when prescribing medication it is important to consider how malnutrition and compensatory behaviours can affect the effectiveness of the medication, in addition to the side-effects as discussed above.

Medication adherence can also be a problem in people with anorexia nervosa given the concerns they may have with weight gain. This may increase the desire for additional control of eating and weight and shape. Thus, the committee agreed that it was important for the health professionals to be aware of which medications will affect medication adherence.

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Physical health assessment and monitoring of all eating disorders

42. Assess fluid and electrolyte balance in people with an eating disorder who are believed to be engaging in compensatory behaviours, such as vomiting, taking laxatives or diuretics, or water loading.

43. Assess whether ECG monitoring is needed in people with an eating disorder, based on the following risk factors:

- rapid weight loss
- excessive exercise
- severe purging behaviours, such as laxative or diuretic use or vomiting
- bradycardia
- hypotension
- excessive caffeine (including from energy drinks)
- prescribed or non-prescribed medications
- muscular weakness
- electrolyte imbalance
- previous abnormal heart rhythm.

Management for all eating disorders

44. Provide acute medical care (including emergency admission) for people with an eating disorder who have severe electrolyte

	<p>imbalance, severe malnutrition, severe dehydration or signs of incipient organ failure.</p> <p>45. For people with an eating disorder who need supplements to restore electrolyte balance, offer these orally unless the person has problems with gastrointestinal absorption or the electrolyte disturbance is severe.</p> <p>46. For people with an eating disorder and continued unexplained electrolyte imbalance, assess whether it could be caused by another condition.</p> <p>47. Encourage people with an eating disorder who are vomiting to:</p> <ul style="list-style-type: none"> • have regular dental and medical reviews • avoid brushing teeth immediately after vomiting • rinse with non-acid mouthwash after vomiting • avoid highly acidic foods and drinks. <p>48. Advise people with an eating disorder who are misusing laxatives or diuretics:</p> <ul style="list-style-type: none"> • that laxatives and diuretics do not reduce calorie absorption and so do not help with weight loss. • to gradually reduce and stop laxative or diuretic use. <p>49. Advise people with an eating disorder who are exercising excessively to stop doing so.</p> <p>50. For guidance on identifying, assessing and managing overweight and obesity, see the NICE guideline on obesity.</p>
<p>Relative value of different outcomes</p>	<p>For the review on how to manage, treat or reduce the short and long-term physical health conditions associated with eating disorders, the committee agreed that the critical outcomes will depend on the health condition under review.</p> <p>Other outcomes that are important include quality of life, weight or BMI, compensatory behaviours, side-effects, remission for eating disorders and the relevant physical disorders, and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>No relevant published RCT or observational evidence was identified on how to manage, treat or reduce the short and long-term physical health conditions associated with eating disorders.</p> <p>The committee used their experience and knowledge to generate a group discussion about the issues, and the recommendations were developed using an informal method of consensus.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>There was no existing economic evidence on the costs and benefits associated with health monitoring strategies of people with eating disorders. Health monitoring in line with the principles outlined in the recommendations may incur additional health care resources. However, the committee noted the importance of close health monitoring of people with eating disorders given that they have a very high rate of comorbid health problems (such as cardiovascular problems, osteoporosis, kidney dysfunction, etc.). The committee considered that the costs of ECG,</p>

	<p>electrolytes tests, etc., are low compared with the consequences of the potential health complications such as, kidney and liver damage and cardiovascular problems. Overall, if such careful monitoring leads to better identification of health needs and this results in timely and appropriate subsequent medical intervention for the underlying health problem at an earlier stage, before an individual requires more resource intensive management, then the additional costs associated with facilitating such health monitoring is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system. The committee noted that the aim of health monitoring should be prevention of the complications and not the treatment of accumulated problems that require very expensive multidisciplinary management.</p>
Quality of evidence	<p>In the absence of relevant published evidence no quality assessment was conducted.</p>
Other considerations	<p>The recommendations are based on the committee's knowledge and experience regarding good practice and the use of an informal consensus method.</p> <p>Fluid and electrolyte imbalance is detected in approximately 10% of those with bulimia nervosa. It is often the result of laxative and/or diuretics use, and can sometimes be detected with routine screening. For this reason, the committee recommended that fluid and electrolyte balance is assessed in those who are using such compensatory behaviours. They stressed that blood tests for electrolytes are often normal in people with eating disorders and that these can be falsely reassuring, especially before refeeding.</p> <p>Due to the risk of death due to cardiac complications in people with eating disorders (anorexia nervosa in particular), the committee agreed that health professionals should consider whether ECG monitoring is needed based on a number of risk factors including: rapid weight loss, excessive exercise, severe purging behaviours, bradycardia, hypotension, muscular weakening, electrolyte imbalance and previous abnormal heart rhythm.</p> <p>The committee discussed whether rapid weight loss could be defined as, for example, 1kg or more per week. However this figure was controversial and raises potential complications because individuals may already be very underweight. It was therefore decided to not be specific about how much weight loss was necessary for it to be 'rapid'. The committee also discussed the length of time over which ECG monitoring should occur. In both cases, they decided to leave the determination of these issues to the health professional.</p> <p>Due to the risk associated with vomiting such as 1) the erosion of tooth enamel, which has the potential to lead to destruction of the whole dentition, 2) tooth pain and 3) having unattractive teeth, which can affect self-esteem, the committee agreed that it was important to include recommendations about dental health by advising that people with an eating disorder have regular dental reviews, avoid brushing after vomiting, rinse with non-acidic mouthwash and avoid highly acidic foods and drinks.</p> <p>Due to the risks, discussed above, of laxative and diuretic misuse and the misconception associated with it, the committee recommended that people who are engaging in such behaviours be advised that laxatives and diuretics do not reduce calorie absorption and that they should gradually reduce and stop their use.</p> <p>Regarding excessive exercise, the committee agreed that it was important that it be stopped as this can have undue physical and psychological effects such as bone fractures, arthritis, depression, anxiety and, in women, amenorrhoea.</p>

The committee highlighted that it is important to note that people who have an eating disorder may not be as easy to engage with or have them comply with physical health monitoring so it is important clinicians are aware of this.

The committee also discussed the complexities of treating obesity in people with eating disorder. There is the possibility that treatments may be less, equally or more effective (for example bariatric surgery may be equally effective in people with binge eating disorders, but behavioural weight loss may be less effective). However, without reviewing moderators on the response to treatment, the committee could not be explicit on this issue and it was, in any case, out of the scope. It was decided to refer to NICE guidance CG189 *Obesity: identification, assessment and management*.

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Assessment and monitoring of physical health in anorexia nervosa

	<p>51. GPs should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder. The review should include:</p> <ul style="list-style-type: none"> • weight or BMI (adjusted for age if appropriate) • blood pressure • relevant blood tests • any problems with daily functioning • assessment of risk (related to both physical and mental health) • an ECG, for people with purging behaviours and/or significant weight changes • a discussion of treatment options. <p>52. Monitor growth and development in children and young people with anorexia nervosa who have not completed puberty (for example, not reached menarche or final height).</p>
Relative value of different outcomes	<p>For the review on how to manage, treat or reduce the short and long-term physical health conditions associated with eating disorders, the committee agreed that the critical outcomes will depend on the health condition under review. For treating delayed physical development or stunted growth, the committee agreed that the critical outcome is growth.</p> <p>Other outcomes that are important include quality of life, weight or BMI, compensatory behaviours, side-effects, resumption of menses, remission and service user experience.</p>
Trade-off between clinical benefits and harms	<p>No relevant published RCT or observational evidence was identified on how to manage, treat or reduce the short and long-term physical health conditions associated with eating disorders.</p> <p>The committee used their experience and knowledge to generate a group discussion about the issues, and the recommendations were developed using an informal method of consensus.</p>
Trade-off between net health	<p>There was no existing economic evidence on the costs and benefits associated with health monitoring strategies of people with anorexia nervosa. Health monitoring in line with the principles outlined in the recommendations may incur</p>

benefits and resource use	<p>additional health care resources. However, the committee noted the importance of close health monitoring of people with eating disorders and in particular people with anorexia nervosa given that they have a very high rate of comorbid health problems (such as cardiovascular problems, osteoporosis, kidney dysfunction, etc.). The committee expressed the view that most people with eating disorders die due to the cardio-metabolic risk and this is partially due to poor health monitoring. The committee considered that the costs of ECG, electrolytes tests, etc., are very low compared with the consequences of the potential health complications, such as, kidney and liver damage and cardiovascular problems. Overall, if such careful monitoring leads to better identification of health needs and this results in timely and appropriate subsequent medical intervention for the underlying health problem at an earlier stage, before individual requires more resource intensive management, then the additional costs associated with facilitating such health monitoring is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system. The committee noted that the aim of health monitoring should be prevention of the complications and not the treatment of accumulated problems that require very expensive multidisciplinary management.</p>
Quality of evidence	<p>In the absence of relevant published evidence no quality assessment was conducted.</p>
Other considerations	<p>The committee discussed how people with anorexia nervosa who are not currently receiving psychological treatment should be offered an annual review, at the very least, with a general practitioner. This is to ensure that either their long-term recovery is on track or that they are not relapsing. The committee listed parameters that should be taken into account in the review, including BMI or weight, blood pressure, relevant blood tests, impairment of daily functioning, assessment of physical and mental health risk, an ECG and possible treatment options if needed.</p> <p>The committee also agreed on the importance of monitoring growth and development in children and young people with anorexia nervosa who have not completed puberty as it can affect growth and they can be particularly vulnerable to injuries due to low bone mineral density (see discussion of this in Chapter 6).</p> <p>Due to the concerns surrounding delayed physical development and faltering growth, the committee agreed by informal consensus that growth and development should be monitored in children and young people with an eating disorder who have not completed puberty (for example, not reached menarche or final height). See also the LETRs on growth and development, and the treatment of low bone mineral density, in Chapter 6.7.</p> <p>The committee agreed that there is little evidence on which physical parameters, such as blood pressure and ECGs, are the most informative when managing risk in people with anorexia nervosa. Given that the majority of risk frameworks for assessing risk are based on consensus, they agreed that a research recommendation in this area was vitally important.</p>

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2 **2. Research recommendation: What physical parameters (for example, blood**
3 **pressure and ECGs) are most informative in the risk management of people with**
4 **anorexia nervosa?**

5 **Conception and pregnancy for women with eating disorders**

53. Provide advice and education to women with an eating disorder who plan to conceive, to increase the likelihood of conception

	<p>and to reduce the risk of miscarriage. This may include information on the importance of:</p> <ul style="list-style-type: none"> • maintaining good mental health and wellbeing • ensuring adequate nutrient intake and a healthy body weight • stopping behaviours such as binge eating, vomiting, laxatives and excessive exercise. <p>54. Nominate a dedicated professional (such as a GP or midwife) to monitor and support pregnant women with an eating disorder during pregnancy and in the post-natal period, because of:</p> <ul style="list-style-type: none"> • concerns they may have specifically about gaining weight • possible health risks to the mother and child. • the high risk of mental health problems in the perinatal period <p>55. For women who are pregnant or in the perinatal period and have an eating disorder:</p> <ul style="list-style-type: none"> • offer treatment for their eating disorder as covered in chapters 6-9. • provide monitoring and education during pregnancy as recommended in the NICE guideline on antenatal and postnatal mental health. <p>56. For guidance on providing advice to pregnant women about healthy eating and feeding their baby, see the NICE guideline on maternal and child nutrition.</p> <p>57. Consider more intensive prenatal care for pregnant women with current or remitted anorexia nervosa, to ensure adequate prenatal nutrition and fetal development.</p>
<p>Relative value of different outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing whether a treatment for eating disorders needs to be modified in pregnancy. In pregnancy, health risks to the mother and child were considered critical outcomes. The other critical outcomes depended on the eating disorder included in the study. Remission is of greatest concern for any eating disorder. For those with anorexia nervosa, body weight or BMI are of greatest concern. For bulimia nervosa and binge eating disorder, binge eating is a critical outcome.</p> <p>For any eating disorder, other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but are clearly important include, general psychopathology, general functioning, family functioning and service user experience.</p>
<p>Trade-off between clinical</p>	<p>No relevant published RCTs or observational studies were identified on whether treatment for eating disorders need to be modified if the person is pregnant.</p>

benefits and harms	The committee used their experience and knowledge to generate a group discussion about the issues, and the recommendations were developed using an informal method of consensus.
Trade-off between net health benefits and resource use	The committee considered that pregnancy can be extremely challenging time for women with eating disorders and providing advice and education to women who are thinking of conceiving is crucial. Also, pregnancy can trigger flare ups of an eating disorder and other severe problems. Thus the use of a prompt multidisciplinary approach to monitor and support women is particularly important. Providing advice and education, and the use of multidisciplinary approach may have resource implications in terms of the extra time required to facilitate these. However, the committee expressed the view that any problems and complications should be treated as soon as possible since the life of the baby is compromised if the mother's life is compromised. The committee expressed the view that if such service structures lead to timely and better identification of health needs and this results in appropriate subsequent treatment and management of underlying health problems and complications at an earlier stage, before women (and potentially the baby, for example complications associated with the small gestational age) require more resource intensive management, then the additional costs associated with facilitating such service structures are expected to result in improved health outcomes in the longer term (both for mother and the baby) and potential future cost savings to the healthcare system.
Quality of evidence	No quality assessment was conducted in the absence of relevant published evidence for this review.
Other considerations	<p>In the absence of relevant published evidence for this review the committee discussed how an eating disorder prior to or during pregnancy may be a cause of concern among women of reproductive age. A growing foetus requires adequate nutrition for normal development and growth and vital nutrients may not be available to the foetus in a woman who binge and subsequently purges, uses laxatives and/or diuretics, fasts and/or engages in excessive exercise before or during pregnancy.</p> <p>Some women with an eating disorder are overly concerned with body weight and body image. Weight gain and shape changes during pregnancy may thus not be well accepted and may increase the risk of the women engaging in compensatory behaviours during pregnancy. Given that pre-pregnancy weight and maternal weight gain during pregnancy are the best predictors of infant birth weight and birth outcome, it was recommended that healthcare professionals refer to NICE guideline PH11 <i>Maternal and child nutrition</i> for advice and guidance on healthy eating and feeding the baby</p> <p>A multidisciplinary team is critical for the care of person with an eating disorder who is pregnant because the aetiology is more complex than simply a preoccupation with body weight and body image. Open and active communication amongst the pregnant women and all the members of the team (such as the obstetrician, dietitian, psychologist, and psychiatrist) is vitally important. The committee agreed that providing monitoring and education during pregnancy and in the perinatal period was important and recommended that these should be provided in line with NICE guideline CG45 <i>Antenatal and postnatal mental health: Clinical management and service guidance</i>. For example, women with anorexia nervosa are at greater risk of premature offspring and those that are small for gestational age. There is evidence from case-series that women with anorexia nervosa also have difficulty feeding their children and that the child's growth can be abnormal. The committee therefore also agreed that it was important to recommend that pregnant women with anorexia nervosa may need more intensive prenatal care to ensure adequate prenatal nutrition and foetal development.</p>

6 Treatment and management of anorexia nervosa

6.1 Introduction

People with anorexia nervosa induce weight loss and maintain low body weight. In psychological terms, this is often described as related to an underlying 'fear of fat' and an altered body image, where individuals see themselves as overweight whilst beneath the normal weight range. Anorexia nervosa is more common in females than males, although there is recognition that its incidence in males has been persistently underestimated. The onset of anorexia nervosa is characteristically when the person is young but may also occur in children and adults. Anorexia Nervosa usually runs a sustained course and persists into adulthood for most people.

A number of behaviours are characteristically associated with inducing and maintaining low body weight. These include dietary restriction, excessive exercise and purging behaviours, for example, diuretic use or induced vomiting. Low body weight is an essential feature of anorexia nervosa and is frequently accompanied by other indicators of inadequate nutrition, including electrolyte imbalance, vitamin deficiency and secondary endocrine effects. Although the best known secondary endocrine effect is amenorrhoea in women, similar effects may be manifest such as a loss of sexual interest in men and by delayed or arrested pubertal development in both sexes. Therapeutic strategies in anorexia nervosa usually involve psychological approaches to beliefs and behaviour, with concurrent interventions to address the impact of low body weight and inadequate nutrition on people's general physical health

6.2 Psychological interventions

6.2.1 Review question: Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with eating disorders compared with any other intervention or controls?

The review protocol summary, including the review question and the eligibility criteria used for this section of the guideline, can be found in Table 70. Further information about the search strategy can be found in Appendix H; the full review protocols can be found in Appendix F.

This review considers all psychological interventions that may be delivered to children, young people and adults with an eating disorder with or without a pharmacological intervention. The interventions were categorised according to their mode of delivery, i.e. individual, group or self-help, the age of the participants and the type of eating disorder. In addition, the interventions were grouped according to their type of therapy and were compared to any other intervention or to wait list controls.

Table 70: Clinical review protocol summary

Component	Description
Review question(s)	Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with eating disorders compared with any other intervention or controls?

Component	Description
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). <p>Strata:</p> <ul style="list-style-type: none"> children (<12), young people (13-17 years), adults ≥18 years eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical eating disorder) mode of delivery (i. individual ii. family iii. group iv. self-help)
Intervention(s)	<p>Psychological intervention including:</p> <ul style="list-style-type: none"> Dialectical behaviour therapy (DBT) Counselling (Nutritional/Other) Integrative Cognitive-Affective Therapy for Binge Eating (ICAT) Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) Cognitive remediation therapy (CRT) Specialist supportive clinical management for anorexia nervosa (SSCM) Behavioural therapy (BT) CBT (General or ED specific) Dynamic (IPT, Psychodynamic General or ED specific) Guided Self Help w therapist guidance Pure self help E-therapies <p>Psychological in combination with any pharmacological intervention.</p>
Comparison	<ul style="list-style-type: none"> Wait list control Treatment as usual Another other intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> Remission (if symptoms were measured over a minimum 2 week period) Binge eating for bulimia nervosa and binge eating disorder; and weight/body mass index (adjusted for age) for anorexia nervosa
Important outcomes	<ul style="list-style-type: none"> Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) General psychopathology (including mood/depression/anxiety) General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) Family functioning Service user experience Quality of life All-cause mortality Relapse Adverse events Resource use
Study design	<ul style="list-style-type: none"> Systematic reviews RCTs

1 **6.2.2 Clinical evidence**

2 **6.2.2.1 Individual psychotherapy**

3 16 RCTs (n=1181) were identified as relevant studies that investigated the effects of
4 individual psychotherapy in people with anorexia nervosa, the majority of these were on
5 adults and two were follow up studies (Carter et al., 2011; Dalle Grave et al., 2013; Dare et
6 al., 2001; Eisler et al., 1997; Gowers et al., 2007; Hall and Crisp, 1987; Lock et al., 2010;
7 McIntosh et al., 2005; Pike et al., 2003; Robin et al., 1999; Russell et al., 1987; Schmidt et
8 al., 2012; Schmidt et al., 2015; Touyz et al., 2013; Treasure et al., 1995; Zipfel et al., 2014).
9 An overview of the trials included in the meta-analysis can be found in Table 71. Further
10 information about both included and excluded studies can be found in Appendix J.

11 Summary of findings can be found in Table 74. See also the study selection flow chart in
12 Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and exclusion
13 list in Appendix J.

14 **6.2.2.2 Group therapy**

15 No papers on group therapy in people with anorexia nervosa were identified.

16 **6.2.2.3 Self-help**

17 One RCT (n=221) on self-help was identified in people with anorexia nervosa (Fichter et al.,
18 2012). An overview of the trials included in the meta-analysis can be found in. Summary of
19 findings can be found in Table 73. See also the study selection flow chart in Appendix K,
20 forest plots in Appendix M, study evidence tables in Appendix L and exclusion list in
21 Appendix J.

22 **6.2.2.4 Family therapy**

23 Thirteen RCTs were found that were relevant for this review, the majority of which were in
24 children and young people (Agras et al., 2014; Dare et al., 2001; Eisler et al., 1997; Eisler et
25 al., 2000; Eisler et al., 2016; Geist et al., 2000; Godart et al., 2012; Herscovici et al., 2015; Le
26 Grange et al., 2016; Lock et al., 2005; Lock et al., 2006; Lock et al., 2010; Robin et al., 1999;
27 Russell et al., 1987; Whitney et al., 2012).

28 One of the 13 studies (n=60) (Godart 2012) compared family therapy (ED) and treatment as
29 usual with treatment as usual in young inpatients with anorexia nervosa. Summary of
30 findings can be found in Table 86.

31 Two of the 13 studies (n=73) (Geist 2000; Whitney 2012) compared family therapy versus
32 any other type of family-ED intervention in inpatients with anorexia nervosa. One study (Geist
33 2000) compared family therapy with family group psychoeducation in young people, whilst
34 one study (Whitney 2012) compared family therapy with a 3-day family day workshop
35 intervention. Summary of findings can be found in Table 87, Table 100 and Table 101.

36 One of the 13 studies (n=164) (Agras 2014) compared family therapy with general family
37 therapy in young people with anorexia nervosa. Summary of findings can be found in Table
38 88 and Table 89.

39 One of the 13 studies (n=169) (Eisler 2016) compared multi-family therapy with family
40 therapy in young people with anorexia nervosa. Summary of findings can be found in Table
41 90 and Table 91.

42 Four of the 13 studies (n=263) compared family therapy with any individual therapy in people
43 with anorexia nervosa. The comparison interventions included various forms of individual
44 therapy for young people such as individual supportive therapy and cognitive analytic

1 therapy. Three of these (n=179) were for anorexia nervosa in young people (Lock 2010;
2 Robin 1999; Russell 1987; Eisler 1997) and one study (n=84) was for adults (Dare 2001).
3 Summary of findings can be found in Table 92, Table 93 and Table 103.

4 Two of the 13 studies (n=147) (Eisler 2000; Le Grange 2016) compared family therapy with
5 an alternative family therapy in people with anorexia nervosa. Both studies compared family
6 therapy in which the patient and carer are seen together by the therapist with family therapy
7 in which they are seen separately. Summary of findings can be found in Table 94 and Table
8 95.

9 One of the 13 studies (n=86) (Lock 2005; Lock 2006) compared long-term family therapy (12
10 months) with short-term family therapy (6 months) in young people with anorexia nervosa.
11 Summary of findings can be found in Table 96 and Table 97.

12 One of the 13 studies (n=23) (Herscovici 2015) compared family therapy and family meal
13 with family therapy without family meal in young people with anorexia nervosa. Summary of
14 findings can be found in Table 98 and Table 99.

15 One of the 13 studies (n=30) (Hall 1987) compared a combined course of general family
16 therapy and individual psychodynamic therapy with nutritional counselling. Summary of
17 findings can be found in Table 102.

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1 **Table 71: Study information for trials included in the meta-analysis of individual psychotherapy versus any other intervention or wait**
2 **list controls in people with anorexia nervosa**

Study ID	Mean Age (SD) years	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison	Sessions N	Treatment Length	Long-term FU
Dare 2001	26.3 (6.7)	15.4 (1.6)	98%	Most will have had > 3 years	84	General psychodynamic psychotherapy x 2 (FPP; CAT)	Psychiatric Counselling Family therapy	30	1 year	NA
Dalle Grave 2013	23.4 (6.9)	14.3 (1.8)	78%	Require inpatient treatment.	80	CBT-ED.1	CBT-ED.2 (variation in content)	Unclear	20 weeks	12 months FU
Gowers 2007	14.9	15.5 (1.6)	NR	<1 year	170	Outpatient CBT-ED	Outpatient treatment as usual* Inpatient care	NR	6 weeks to 6 months	18 months FU
Hall 1987	19.6 (14 to 25)	Deviation from matched population mean weight 25%	100%	Mean duration of illness 29.7 months	30	Combined general FT and IPT	Nutritional counselling	12	12-24 weeks	6 months FU
Lock 2010	14.4 (1.6)	16.1 (1.1)	91%	Early most <3 years	121	AFT	Family therapy	32	12 months	12 months FU
McIntosh 2005/ Carter 2011	17-40	17.3 (1.1)	100%	Unclear	56	CBT-ED	IPT SSCM	20	20 weeks	6.7 year FU
Pike 2003	26.1 (6.2)	16.0 (2.1)	100%	1 year after hospitalisation	33	CBT-ED	Nutritional counselling	50	1 year	NA

Study ID	Mean Age (SD) years	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison	Sessions N	Treatment Length	Long-term FU
Robin 1999	14.9	15.86 (2.05)	100%	Developed AN less than one year	37	AFT	Family therapy	Variable	15.9 months	12 months FU
Russell 1987/Eisler 1997	15.3 (1.8)	65.9 (8.0)% of average body weight	91%	Post hospital. Duration of illness 1.2 (0.7) years	21	Supportive therapy	Family therapy	Variable	12 months	5 year FU
Schmidt 2012	25.5 (6.9)	16.3 (1.3)	91.20 %	Most > 3y Duration of illness 77.3 months (70.8)	72	MANTRA	SSCM	26	10.6 months	2 months FU
Schmidt 2015	26.7 (7.7)	16.6 (1.2)	98.6%	Most > 3y Duration of illness 8.3 (7.3) years	142	MANTRA	SSCM	20	20 weeks	6 months FU
Touyz 2013	34.6 (9.0)	16.3 (1.3)	100%	Chronic AN (least 7 years)	63	CBT-ED	SSCM	30	8 months	12 months FU
Treasure 1995	25.3 (7)	15.0 (1.0)	100%	Poor prognosis	30	SSCM	General psychodynamic psychotherapy	20	20 weeks	32 weeks FU
Zipfel 2014	28.0 (8.6)	16.57 (1.0)	100%	40-60% AN>6 years	242	CBT-ED	FPT Treatment as usual	40	10 months	12 months FU

- 1 Notes: *, treatment as usual was in an outpatient setting and included non-prescriptive family therapy with variable dietetic, individual supportive therapy and paediatric liaison.
2 Abbreviations: AFT – adolescent-focused psychotherapy; AN – anorexia nervosa; BT – behavioural therapy; CAT – cognitive analytic therapy; CBT-ED – cognitive behavioural therapy with an eating disorder focus; ED – eating disorder; ESM - emotional and social mind training; FPP – focal psychoanalytic psychotherapy; FPT, focal psychodynamic therapy; FU – follow up; ICAT – integrative cognitive affective therapy; IPT – interpersonal psychotherapy; N – number; NR – not reported; MANTRA – The Maudsley model of anorexia nervosa treatment for adults; SSCM – specialist supportive clinical management; WLC – wait list control; < - less than; > - greater than.

1 **Table 72: Study information for trials included in the meta-analysis of self-help versus any other intervention or wait list control for**
2 **people with anorexia nervosa.**

Study ID	Mean age years (SD)	Mean BMI, kg/m ² (SD)	Female (%)	Sample	N random-ised	Intervention	Comparison	Number of sessions	Treatment Length	Long-term FU
Fichter 2012	23.8 (6.5)	17.8 (1.4)	100%	Discharged from inpatient care	258	Internet guided self-help	Treatment as usual (dependent on patient)	9	9 months	9 months FU

3 Abbreviation: FU – follow up

4 **Table 73: Study information for trials included in the meta-analysis of family therapy versus any other intervention or wait list control**
5 **for people with anorexia nervosa.**

Study ID	Mean age years (SD)	Mean BMI, kg/m ² (SD)	Female (%)	Sample	N random-ised	Intervention	Comparison	Number of sessions	Treatment Length	Long-term FU
Agras 2014	15.3 (1.8)	Not reported	89	DSM-IV criteria for AN except for amenorrhea criterion	164	FBT-ED Duration of illness: 11.6 (9.8) months	SFT-ED Duration of illness: 15.4 (16.9) months.	16	9 months	12 months FU
Dare 2001	26.3 (6.7)	15.4 (1.6)	98	DSM-IV AN	84	FT-ED Duration of illness: 5.8 (4.9) years.	FPP Duration of illness: 6.7 (5.9) years. CAT Duration of illness: 6.7 (7.6) years Counselling Duration of illness: 6.1 (5) years	Mean 13.6 (8.6)	12 months	na

Study ID	Mean age years (SD)	Mean BMI, kg/m ² (SD)	Female (%)	Sample	N randomised	Intervention	Comparison	Number of sessions	Treatment Length	Long-term FU
Eisler 2000	15.5 (1.6)	NA	98	DSM-IV or ICD-10 criteria for AN	40	Conjoint FT-ED Duration of illness: 13 months (range 2-36 mo)	Separated FT-ED Duration of illness: 12 months (range 2-36 mo)	Mean 16.4 (8.9)	12 months	na
Eisler 2016	15.7 (1.6)	15.7 (1.2)	91	DSM-IV AN-R or EDNOS	169	FT-ED	Multi-FT-ED	FT-ED group, median =19 [IQR 12-27]; Multi-FT-ED, median =18.5 [IQR 11-24]	12 months	6 months FU
Geist 2000	14.6 (1.6)	na	100	Inpatients, DSM-IV except <90% IBW	25	FT-ED	Family Group PE	~64	4 months	na
Godart 2012	16.6 (1.6)	16.9 (1.1)	100	Inpatients, DSM-IV criteria for AN, ≤3 years since hospital admission for AN.	60	FT-ED and treatment as usual	Treatment as usual	FT: Mean 11.8 (5.7). Overall (consultations, FT, individual therapy) mean:	18 months	18 months FU

Study ID	Mean age years (SD)	Mean BMI, kg/m ² (SD)	Female (%)	Sample	N randomised	Intervention	Comparison	Number of sessions	Treatment Length	Long-term FU
								33.7 (24.6)		
Hall 1987	19.6 (13.5)	na	100	AN, <85% matched population mean weight + amenorrheic	30	Combined general FT and IPT Duration of illness: 29.7 months (range: 6-72 months)	Nutritional Duration of illness: 24.5 months (range: 6-72 months)	12	12-24 weeks	12 months FU
Herscovici 2015	17.1 (2.3)	Weight (kg)=42.9 (7.3)	96	GOSH operational definition of AN	23	FT-ED with family meal	FT-ED without family meal	Intervention: mean 18 (14-25) Comparison mean: 14 (range 10-19)	6 months	6 months FU
Lock 2005/ Lock 2006	15.2	17.3 (1.5)	90	DSM-IV AN, though some (i) were partially weight restored or (ii) had only missed one menstrual period	86	Long-term FT-ED Duration: 12 (9.9) months	Short-term FT-ED Duration: 11.3 (10.4) months	20	12 months	3 years FU
Lock 2010	14.4 (1.6)	16.1 (1.1)	91	Early most <3 years	121	FBT-AN	AFT	32	12 months	12 months FU

Study ID	Mean age years (SD)	Mean BMI, kg/m ² (SD)	Female (%)	Sample	N randomised	Intervention	Comparison	Number of sessions	Treatment Length	Long-term FU
Robin 1999	14.17	na	100	DSM-III-R criteria for AN. Developed AN≤1 year.	37	BFST	AFT	variable	variable, 12-18 months [Average 15.9 mo]	12 months FU
Russell 1987/ Eisler 1997	15.3 (1.8)	na	91	DSM-III criteria for AN. Just before discharge from ED unit. Illness for less than 3 years.	21	FT-ED	Supportive therapy	variable	12 months	5 years FU
Whitney 2012	na	13.3 (1.6)	98	Inpatient unit for AN. Duration of illness from <1 year, to >20 years (median 5-10 years)	48	Individual family work	Family day workshops	18 hours of treatment in 1-2 hr sessions (weekly or fortnightly) + 3 FU sessions	18 hours	36 months FU

1 Abbreviations: AFT, Adolescent-focussed psychotherapy; BFST, Behavioural Family Systems Therapy; CAT, Cognitive Analytic Therapy; DSM-IV, Diagnostic and Statistical
2 Manual of Mental Disorders, 4th edition; FBT-AN, Family-based Treatment for anorexia nervosa; FDW, Family Day Workshops; FPP, Focal Psychoanalytic Psychotherapy; FT-
3 ED, Family Therapy for eating disorders; IFW, Individual Family Work; IPT, Individual Psychodynamic Therapy; IT, Individual Therapy; PE, Psychoeducation; SFT-AN,
4 Systematic Family Therapy for anorexia nervosa; na, not applicable; TAU, treatment as usual.

5

6 Individual therapy

1 **Table 74: Summary of findings table for CBT-ED versus any other intervention at the end of treatment and at follow up (FU) in adults**
2 **and children and young people with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Another intervention	Risk difference with AN CBT-ED (95% CI)
Weight - Adults	298 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight - adults in the intervention groups was 0.17 standard deviations higher (0.07 lower to 0.42 higher)
EDE-Restraint - Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,4,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-restraint - adults in the intervention groups was 0.13 standard deviations lower (0.69 lower to 0.44 higher)
EDE-Eating concerns- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,3,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concerns- adults in the intervention groups was 0.31 standard deviations lower (0.87 lower to 0.25 higher)
EDE-Weight concerns- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concerns- adults in the intervention groups was 0.39 standard deviations higher (0.17 lower to 0.95 higher)
EDE-Shape concerns- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concerns- adults in the intervention groups was 0.09 standard deviations lower (0.65 lower to 0.46 higher)
EDI - Drive for thinness- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{5,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness- adults in the intervention groups was 0.07 standard deviations lower (0.63 lower to 0.48 higher)
EDI - Body dissatisfaction- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{5,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction- adults in the intervention groups was 0.2 standard deviations lower (0.76 lower to 0.35 higher)
EDI - Bulimia- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{5,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia- adults in the intervention groups was

					0.21 standard deviations lower (0.76 lower to 0.35 higher)
EDI Total - Adults	242 (1 study)	⊕⊕⊕⊕ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total - adults in the intervention groups was 0.08 standard deviations lower (0.35 lower to 0.19 higher)
General psychopathology- Adults	242 (1 study)	⊕⊕⊕⊕ VERY LOW5,8,9 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general psychopathology- adults in the intervention groups was 0.25 standard deviations lower (0.52 lower to 0.02 higher)
Depression Adults	56 (1 study)	⊕⊕⊕⊕ LOW5,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression adults in the intervention groups was 0.20 standard deviations lower (0.76 lower to 0.35 higher)
Relapse	33 (1 study)	⊕⊕⊕⊕ LOW11,12 due to risk of bias, imprecision	RR 0.42 (0.16 to 1.12)	533 per 1000	309 fewer per 1000 (from 448 fewer to 64 more)
Remission ITT- Adults	275 (2 studies)	⊕⊕⊕⊕ VERY LOW1,13,14,15 due to risk of bias, inconsistency, indirectness, imprecision	RR 1.78 (0.93 to 3.39)	102 per 1000	79 more per 1000 (from 7 fewer to 243 more)
BMI-Adolescents FU	98 (1 study)	⊕⊕⊕⊕ LOW5,16 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi-adolescents fu in the intervention groups was 0.29 standard deviations lower (0.69 lower to 0.11 higher)
BMI - Adults FU	285 (2 studies)	⊕⊕⊕⊕ VERY LOW1,2,13,15 due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean bmi - adults fu in the intervention groups was 0.05 standard deviations lower (0.29 lower to 0.2 higher)
EDE-Shape concerns - Adults FU	44 (1 study)	⊕⊕⊕⊕ LOW3,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concerns - adults fu in the intervention groups was 0.31 standard deviations lower (1.33 lower to 0.71 higher)

EDE-Eating concerns- Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW3,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concerns- adults fu in the intervention groups was 0.16 standard deviations lower (0.78 lower to 0.45 higher)
EDE-Restraint - Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW5,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-restraint - adults fu in the intervention groups was 0.36 standard deviations lower (0.97 lower to 0.26 higher)
EDE-Weight concerns - Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW6,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concerns - adults fu in the intervention groups was 0.02 standard deviations lower (0.63 lower to 0.59 higher)
EDI - Body dissatisfaction- Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW5,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction- adults fu in the intervention groups was 0.32 standard deviations lower (0.94 lower to 0.29 higher)
EDI - Bulimia - Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW6,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia - adults fu in the intervention groups was 0.43 standard deviations higher (0.19 lower to 1.06 higher)
EDI - Drive for thinness - Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW6,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness - adults fu in the intervention groups was 0.25 standard deviations higher (0.37 lower to 0.87 higher)
EDI Total Adults - FU	242 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,5 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi total adults - fu in the intervention groups was 0.07 standard deviations higher (0.19 lower to 0.34 higher)
EDI-Total Adolescents FU	82 (1 study)	⊕⊕⊕⊕ LOW5,16 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-total adolescents fu in the intervention groups was 0.17 standard deviations lower (0.6 lower to 0.27 higher)
Depression Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW6,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression adults fu in the intervention groups was 0.13 standard deviations lower (0.48 lower to 0.75 higher)

General Function Adults FU	43 (1 study)	⊕⊕⊕⊕ LOW5,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean general function adults fu in the intervention groups was 0.04 standard deviations lower (0.65 to 0.57 lower)
General psychopathology Adults FU	242 (1 study)	⊕⊕⊕⊕ VERY LOW3,8,9 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general psychopathology adults fu in the intervention groups was 0.03 standard deviations higher (0.24 lower to 0.3 higher)
Remission- Adolescents FU ITT	110 (1 study)	⊕⊕⊕⊕ LOW15,16 due to risk of bias, imprecision	RR 1.25 (0.53 to 2.93)	145 per 1000	36 more per 1000 (from 68 fewer to 281 more)
Remission -Adults FU ITT	242 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,13,18,19 due to risk of bias, inconsistency, indirectness, imprecision	RR 0.85 (0.51 to 1.43)	235 per 1000	35 fewer per 1000 (from 115 fewer to 101 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was performed. High drop outs >20% were reported. Only assessors were blind in all studies.

2 In Zipfhel, between baseline and end of treatment, the following had hospital study longer than 28 days for weight restoration: 5/ 80 (6%) focal psychodynamic, 8/80 (10%) CBT-ED and 9/82 (11%) TAU.

3 For a continuous outcome, there were fewer than 400 participants.

4 Heterogeneity present, I²>80%

5 95% CI crossed 1 MID (-0.5)

6 95% CI crossed 1 MID (0.5)

7 Unclear if allocation concealment was performed or how randomisation was conducted. Neither patients or investigators were blind, assessor was blind. High dropout >20% was reported.

8 Unclear if allocation concealment was performed. Participants were not blind, unclear if investigators were blind, Assessors were blind. High drop outs were detected >20%

9 High number of participants spent time in hospital: 23% Focal Psychodynamic therapy, 34% CBT, 41% TAU had periods of hospitalisation

10 Unclear how randomisation was performed or if allocation concealment was performed. High drop outs were reported >20% in most studies. Only assessors were blind.

11 Unclear how randomisation was performed or if allocation concealment was conducted. Unclear if assessors, participants or investigators were blind.

12 95% CI crossed 1 MID (0.75)

- 13 Heterogeneity, I² >50%
- 14 In Pike, participants were assigned to therapy within 1 week of successful completion of hospitalization. Different population to other studies.
- 15 For a dichotomous outcome, there were fewer than 300 events.
- 16 Unclear methods of randomisation. It was unclear if either participants, investigators or assessors were blind. High drop outs were reported >20%.
- 17 Unclear if allocation concealment was performed. Neither patients or investigators were blind, assessor was blind. High drop outs reported >20%...
- 18 95% CI crossed 2 MIDs (0.75 and 1.25)
- 19 Inconsistency was between 2 different comparisons from the same study that included 3-arms.

1 **Table 75: Summary of findings table for psychiatric counselling versus any other intervention at the end of treatment in adults with**
2 **anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with AN Psychiatric Counselling (95% CI)
Remission Adults	104 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.10 (0.95 to 1.28)	106 per 1000	11 more per 1000 (from 5 fewer to 30 more)
All-cause mortality Adults	84 (1 study)	⊕⊕⊖⊖ LOW1 due to risk of bias, imprecision	RR 1.01 (0.9 to 1.13)	16 per 1000	0 more per 1000 (from 2 fewer to 2 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how random sequence was generated or if sealed envelopes were opaque. Neither the investigators, assessors nor participants were blinded. High dropouts were reported >20%.

2 95% CI crossed 1 MID (1.25).

3 **Table 76: Summary of findings table for supportive therapy versus another intervention at the end of treatment and at follow up in**
4 **young people with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Another intervention Young people	Risk difference with AN Supportive therapy (95% CI)

Weight (percentile) Young people	21 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (percentile) young people in the intervention groups was 0.98 standard deviations lower (1.90 to 0.07 lower)
Did not achieve remission ITT Young people	21 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision	RR 2.27 (1.04 to 4.97)	600 per 1000	762 more per 1000 (from 24 more to 1000 more)
Weight (percentile) Young people FU	19 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (percentile) young people fu in the intervention groups was 0.57 standard deviations lower (1.50 lower to 0.35 higher)
Remission ITT- Young people FU	21 (3 studies)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision	See comment	400 per 1000	144 more per 1000 (from 184 fewer to 984 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Russel/Eisler. Unclear if allocation concealment was performed. High dropout rates >20% were reported. Assessors were blind, but it was unclear if participants were but investigators were not blind.

2 95% CI crossed 1 MID (-0.5) 3 95% CI crossed 1 MID (0.75)

1 **Table 77: Summary of findings table for (young people) adolescent-focused psychotherapy versus another intervention at the end of**
2 **treatment and at follow up in young people with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with AN Young people focused therapy (95% CI)
BMI Young people	139 (2 studies)	⊕⊕⊕⊕ LOW1,2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI young people in the intervention groups was 0.43 standard deviations lower (0.77 to 0.09 lower)

Remission ITT Young people	158 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, inconsistency, imprecision	RR 0.79 (0.61 to 1.01)	700 per 1000	147 fewer per 1000 (from 273 fewer to 7 more)
BMI Young people FU	129 (3 studies)	⊕⊕⊕⊕ LOW ^{1,2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI young people fu in the intervention groups was 0.18 standard deviations lower (0.53 lower to 0.16 higher)
Remission ITT- Young people FU	158 (3 studies)	⊕⊕⊕⊕ LOW ^{1,2,5} due to risk of bias, imprecision	See comment	588 per 1000	41 more per 1000 (from 100 fewer to 217 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Robin 1999. Unclear if allocation concealment was performed. It was unclear if either the participants, investigators or assessors were blind.					
2 Lock 2010. Unclear if allocation concealment was performed. Assessors were blind, but participants and investigators were not blind.					
3 95% CI crossed 1 MID (-0.5).					
4 95% CI crossed 1 MID (0.75).					
5 95% CI crossed 1 MID (1.25).					

1 **Table 78: Summary of findings table for general psychodynamic general therapy versus another intervention at the end of treatment**
2 **and follow up in adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Adults	Risk difference with AN Psychodynamic General (95% CI)
EDI Total - Adults	242 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi total - adults in the intervention groups was 0.02 standard deviations lower (0.29 lower to 0.24 higher)
All-cause mortality- Adults	84 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,5,6} due to risk of bias,	RR 1.05 (0.94 to 1.18)	49 per 1000	2 more per 1000 (from 3 fewer to 9 more)

		indirectness, imprecision			
General psychopathology- Adults	242 (1 study)	⊕⊕⊕⊕ VERY LOW1,7 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general psychopathology- adults in the intervention groups was 0.08 standard deviations higher (0.19 lower to 0.35 higher)
Remission_Adults_ITT	326 (2 studies)	⊕⊕⊕⊕ VERY LOW2,5,6,8 due to risk of bias, indirectness, imprecision	RR 1.73 (0.95 to 3.14)	89 per 1000	65 more per 1000 (from 4 fewer to 190 more)
Weight (BMI and kg)- Adult FU	293 (2 studies)	⊕⊕⊕⊕ VERY LOW2,3,5,8 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight (bmi and kg)- adult fu in the intervention groups was 0.09 standard deviations higher (0.14 lower to 0.33 higher)
EDE Bulimia- Adults FU	30 (1 study)	⊕⊕⊕⊕ VERY LOW8,9 due to risk of bias, imprecision	RR 0.76 (0.15 to 3.92)	188 per 1000	45 fewer per 1000 (from 159 fewer to 548 more)
EDI-Total- Adults FU	242 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi - total- adults fu in the intervention groups was 0.07 standard deviations lower (0.35 lower to 0.19 higher)
Morgan Russell ED- Adults FU	30 (1 study)	⊕⊕⊕⊕ LOW7,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean Morgan Russell ed- adults fu in the intervention groups was 0.32 standard deviations higher (0.4 lower to 1.04 higher)
General psychopathology - Adults FU	242 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general psychopathology - adults fu in the intervention groups was 0.00 standard deviations lower (0.27 lower to 0.27 higher)

Remission FU_ - Adults ITT	272 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,9,10} due to risk of bias, indirectness, imprecision	RR 2.00 (1.33 to 3.03)	174 per 1000	174 more per 1000 (from 57 more to 354 more)
<p><i>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</i></p> <p><i>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</i></p> <p><i>1 Unclear if allocation concealment was performed. Participants were not blind, it was unclear if investigators were, however, and assessors were blind to treatment allocation. High dropouts reported >20%.</i></p> <p><i>2 In Zipfel, between baseline and end of treatment, the following had hospital stay longer than 28 days for weight restoration: 5/ 80 (6%) focal psychodynamic, 8/80 (10%) CBT-ED and 9/82 (11%) TAU.</i></p> <p><i>3 For a continuous outcome, there were fewer than 400 participants.</i></p> <p><i>4 Unclear methods of randomisation and if allocation concealment was performed. High dropouts reported >20%. Unclear if either patient, investigator or assessor were blind.</i></p> <p><i>5 In Dare, a number of patients were hospitalised during the treatment: 104% Family therapy, 104% focal psychoanalytic psychotherapydynamic, 9% focal psychodynamic CAT, 26% treatment as usual – counselling.</i></p> <p><i>6 95% CI crossed 1 MID (1.25).</i></p> <p><i>7 95% CI crossed 1 MID (0.5).</i></p> <p><i>8 Unclear if allocation concealment was performed or if assessors were blind. High dropouts reported >20%.</i></p> <p><i>9 95% CI crossed 2 MIDs (0.75 and 1.25).</i></p> <p><i>10 Unclear if allocation concealment was performed or if participants, investigators or assessors were blind. High dropouts reported >20%.</i></p>					

1 **Table 79: Summary of findings table for interpersonal psychotherapy (IPT) versus any other intervention at the end of the treatment and follow up in adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with another intervention	Risk difference with AN IPT (95% CI)
BMI- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean bmi- adults in the intervention groups was 0.13 standard deviations lower (0.68 lower to 0.41 higher)
EDE-Restraint- Adults	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,3}	Not calculable for SMD values	The mean ede-restraint- adults in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with another intervention	Risk difference with AN IPT (95% CI)
		due to risk of bias, imprecision		0.99 standard deviations higher (0.41 to 1.57 higher)
EDE-Eating concerns- Adults	56 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-eating concerns- adults in the intervention groups was 0.49 standard deviations higher (0.06 lower to 1.04 higher)
EDE-Weight concerns- Adults	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-weight concerns- adults in the intervention groups was 0.2 standard deviations lower (0.75 lower to 0.34 higher)
EDE-Shape concerns- Adults	56 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-shape concerns- adults in the intervention groups was 0.25 standard deviations higher (0.29 lower to 0.8 higher)
General Function (GAF)- Adults	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean general function (gaf)- adults in the intervention groups was 0.5 standard deviations lower (1.06 lower to 0.05 higher)
Depression (Hamilton)- Adults	56 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression (Hamilton)- adults in the intervention groups was 0.4 standard deviations higher (0.15 lower to 0.95 higher)
EDI-Drive for thinness- Adults	48 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi - drive for thinness- adults in the intervention groups was 0.17 standard deviations lower (0.76 lower to 0.43 higher)
EDI-Bulimia- Adults	48 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi - bulimia- adults in the intervention groups was 0.36 standard deviations higher (0.24 lower to 0.96 higher)
EDI-Body dissatisfaction- Adults	48 (1 study)	⊕⊖⊖⊖ VERY LOW1,2,3	Not calculable for SMD values	The mean edi - body dissatisfaction- adults in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with another intervention	Risk difference with AN IPT (95% CI)
		due to risk of bias, imprecision		0.01 standard deviations higher (0.59 lower to 0.6 higher)
BMI - Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI - follow up- adults in the intervention groups was 0.10 standard deviations higher (0.54 lower to 0.75 higher)
EDE-Shape concerns Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-shape concerns follow up- adults in the intervention groups was 0.18 standard deviations higher (0.47 lower to 0.82 higher)
EDE-Eating concerns Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-eating concerns follow up- adults in the intervention groups was 0.17 standard deviations lower (0.81 lower to 0.47 higher)
EDE-Restraint Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-restraint follow up- adults in the intervention groups was 0.28 standard deviations lower (0.93 lower to 0.37 higher)
EDE-Weight concerns Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-weight concerns follow up- adults in the intervention groups was 0.1 standard deviations lower (0.74 lower to 0.54 higher)
EDI-Drive for thinness - FU- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi - drive for thinness - fu- adults in the intervention groups was 0.54 standard deviations lower (1.19 lower to 0.11 higher)
EDI-Bulimia - FU- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi - bulimia - fu- adults in the intervention groups was 0.21 standard deviations lower (0.85 lower to 0.44 higher)
EDI-Body dissatisfaction - FU- Adults	43 (1 study)	⊕⊕⊕⊕ LOW1,3	Not calculable for SMD values	The mean edi - body dissatisfaction - fu- adults in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with another intervention	Risk difference with AN IPT (95% CI)
		due to risk of bias, imprecision		0.14 standard deviations higher (0.5 lower to 0.78 higher)
Depression (Hamilton) Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision	Not calculable for SMD values	The mean depression (Hamilton) follow up- adults in the intervention groups was 0.08 standard deviations lower (0.72 lower to 0.56 higher)
General Function (GAF) Follow up- Adults	43 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision	Not calculable for SMD values	The mean general function (gaf) follow up- adults in the intervention groups was 0.08 standard deviations higher (0.56 lower to 0.72 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear how randomisation was performed or if allocation concealment was conducted. Assessors were blind. High dropout rates were reported >20%

2 95% CI crossed 1 MID (-0.5)

3 95% CI crossed 1 MID (0.5)

1 **Table 80: Summary of findings for SSCM versus any other intervention at the end of treatment and at follow up in adults with anorexia**
2 **nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with	Risk difference with AN SSCM (95% CI)
BMI- Adults	269 (2 studies)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi- adults in the intervention groups was 0.04 standard deviations lower (0.28 lower to 0.21 higher)
EDE-Restraint- Adults	198 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,9} due to risk of bias, imprecision, inconsistency		Not calculable for SMD values	The mean ede-restraint- adults in the intervention groups was 0.58 standard deviations lower (1.41 lower to 0.24 higher)

EDE-Eating concerns- Adults	198 (2 studies)	⊕⊕⊖⊖ LOW1,2,3 due to risk of bias, imprecision		Not calculab le for SMD values	The mean ede-eating concerns- adults in the intervention groups was 0.04 standard deviations higher (0.33 lower to 0.24 higher)
EDE-Weight concerns- Adults	198 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculab le for SMD values	The mean ede-weight concerns- adults in the intervention groups was 0.07 standard deviations lower (0.36 lower to 0.22 higher)
EDE-Shape concerns- Adults	198 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculab le for SMD values	The mean ede-shape concerns- adults in the intervention groups was 0.11 standard deviations lower (0.39 lower to 0.18 higher)
EDE - Global- Adults	213 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculab le for SMD values	The mean ede - global- adults in the intervention groups was 0.00 standard deviations lower (0.27 lower to 0.27 higher)
EDI - Drive for thinness- Adults	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculab le for SMD values	The mean edi - drive for thinness- adults in the intervention groups was 0.29 standard deviations lower (0.88 lower to 0.29 higher)
EDI - Body dissatisfaction- Adults	56 (1 study)	⊕⊕⊖⊖ LOW4,5 due to risk of bias, imprecision		Not calculab le for SMD values	The mean edi - body dissatisfaction- adults in the intervention groups was 0.14 standard deviations higher (0.44 lower to 0.72 higher)
EDI - Bulimia- Adults	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculab le for SMD values	The mean edi - bulimia- adults in the intervention groups was 0.09 standard deviations lower (0.67 lower to 0.49 higher)
Depression - Adults	269 (3 studies)	⊕⊕⊖⊖ LOW1,3		Not calculab le for	The mean depression - adults in the intervention groups was

		due to risk of bias, imprecision		SMD values	0.15 standard deviations lower (0.4 lower to 0.09 higher)
General Function (GAF)- Adults	56 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean general function (gaf)- adults in the intervention groups was 0.83 standard deviations higher (0.22 to 1.43 higher)
Remission_ ITT- Adults	216 (2 studies)	⊕⊖⊖⊖ VERY LOW1,6,7 due to risk of bias, imprecision	RR 1.22 (0.52 to 2.82)	83 per 1000	18 more per 1000 (from 40 fewer to 150 more)
BMI - Follow-up- Adults	286 (3 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi - follow-up- adults in the intervention groups was 0.09 standard deviations lower (0.32 lower to 0.15 higher)
EDE-Weight concerns Follow-up- Adults	189 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concerns follow-up- adults in the intervention groups was 0.16 standard deviations higher (0.13 lower to 0.46 higher)
EDE-Shape concerns Follow-up- Adults	185 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concerns follow-up- adults in the intervention groups was 0.04 standard deviations higher (0.25 lower to 0.34 higher)
EDE-Restraint Follow-up- Adults	185 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-restraint follow-up- adults in the intervention groups was 0.20 standard deviations higher (0.09 lower to 0.5 higher)
EDE-Eating concerns Follow-up- Adults	185 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concerns follow-up- adults in the intervention groups was 0.24 standard deviations higher (0.06 lower to 0.53 higher)

EDE-Global FU- Adults	213 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-global fu- adults in the intervention groups was 0.13 standard deviations higher (0.14 lower to 0.4 higher)
EDI - Body dissatisfaction - FU- Adults	43 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction - fu- adults in the intervention groups was 0.2 standard deviations higher (0.47 lower to 0.87 higher)
EDI - Bulimia - Follow-up- Adults	43 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia - follow-up- adults in the intervention groups was 0.15 standard deviations lower (0.82 lower to 0.52 higher)
EDI - Drive for thinness - Follow-up- Adults	43 (1 study)	⊕⊖⊖⊖ VERY LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness - follow-up- adults in the intervention groups was 0.44 standard deviations higher (0.24 lower to 1.12 higher)
Depression Follow-up- Adults	256 (3 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression follow-up- adults in the intervention groups was 0.02 standard deviations lower (0.27 lower to 0.023 higher)
Bulimia- Adults	30 (1 study)	⊕⊖⊖⊖ VERY LOW7,8 due to risk of bias, imprecision	RR 1.31 (0.25 to 6.76)	143 per 1000	44 more per 1000 (from 107 fewer to 823 more)
General Function (GAF) Follow-up- Adults	43 (1 study)	⊕⊖⊖⊖ VERY LOW1,2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean general function (gaf) follow-up- adults in the intervention groups was 0.05 standard deviations lower (0.72 lower to 0.62 higher)
Remission FU_ITT- Adults	243 (3 studies)	⊕⊖⊖⊖ VERY LOW1,7	RR 0.80 (0.49 to 1.3)	233 per 1000	47 fewer per 1000 (from 119 fewer to 70 more)

		due to risk of bias, imprecision			
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; FU: Follow up					
1 Unclear if allocation concealment was performed. High dropout rates were reported >20% for McIntosh2005 and Schmidt 2015. It was unclear in McIntosh how randomisation was conducted. Across studies it was either unclear if participants and investigators were blind or they were not blind.					
2 95% CI crossed 1 MID (-0.5)					
3 For a continuous outcome, there were fewer than 400 participants.					
4 95% CI crossed 1 MID (1.25)					
5 95% CI crossed 1 MID (0.5)					
6 Unclear if allocation concealment was performed. Across studies it was either unclear if participants and investigators were blind.					
7 95% CI crossed 2 MIDs (0.75 and 1.25)					
8 Unclear if allocation concealment was performed. It was unclear if participants, assessors and investigators were blind. High drop outs were reported >20%					
9. Heterogeneity >50%					

1 **Table 81: Summary of findings table for MANTRA versus any other intervention at the end of treatment and at follow up in adults with**
2 **anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with AN MANTRA (95% CI)
BMI Adults	213 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI adults in the intervention groups was 0.08 standard deviations higher (0.18 lower to 0.35 higher)
EDI-Total Adults	213 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - total adults in the intervention groups was 0.00 standard deviations higher (0.27 lower to 0.27 higher)
Depression- Adults	213 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression- adults in the intervention groups was 0.01 standard deviations lower (0.28 lower to 0.26 higher)

Remission ITT- Adults	213 (2 studies)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	RR 0.82 (0.35 to 1.91)	103 per 1000	19 fewer per 1000 (from 67 fewer to 94 more)
BMI FU- Adults	213 (2 studies)	⊕⊖⊖⊖ VERY LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu- adults in the intervention groups was 0.11 standard deviations higher (0.16 lower to 0.37 higher)
Depression FU- Adults	213 (2 studies)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu- adults in the intervention groups was 0.01 standard deviations higher (0.25 lower to 0.28 higher)
EDI-Total Adults FU	213 (2 studies)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - total adults fu in the intervention groups was 0.13 standard deviations lower (0.4 lower to 0.14 higher)
Remission ITT FU- Adults	215 (2 studies)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	RR 1.22 (0.7 to 2.14)	165 per 1000	36 more per 1000 (from 50 fewer to 188 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 In Schmidt 2015, it was unclear if allocation concealment was performed. In both studies, the participants were not blinded, it was unclear in one if the investigators were blind, but in the other they were not. In both studies the assessors were blind, High dropouts were reported in one group >20%.

2 95% CI crossed 1 MID (0.5).

3 For a continuous outcome, there were fewer than 400 participants.

4 For a dichotomous outcome, there were fewer than 300 events.

5 95% CI crossed 2 MIDs (-0.5 and 0.5).

1 **Table 82: Summary of findings table for CBT-ED (1) compared with another CBT-ED (2) inpatient program at the end of treatment and**
2 **at follow up for adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with CBT-ED (2)	Risk difference with AN Inpatient CBT-ED (1) (95% CI)
BMI Adults	72 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI adults in the intervention groups was 0.09 standard deviations lower (0.56 lower to 0.37 higher)
EDE-Restraint Adults	72 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-restraint adults in the intervention groups was 0 standard deviations higher (0.46 lower to 0.46 higher)
EDE-Eating concerns Adults	72 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-eating concerns adults in the intervention groups was 0.09 standard deviations higher (0.37 lower to 0.56 higher)
EDE-Weight concerns Adults	72 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-weight concerns adults in the intervention groups was 0.07 standard deviations lower (0.54 lower to 0.39 higher)
EDE-Shape concerns Adults	72 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-shape concerns adults in the intervention groups was 0.06 standard deviations higher (0.4 lower to 0.52 higher)
General psychiatric features Adults	72 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean general psychiatric features adults in the intervention groups was 0.3 standard deviations higher (0.16 lower to 0.77 higher)
BMI - Adults FU	68 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI - adults fu in the intervention groups was 0.04 standard deviations higher (0.43 lower to 0.52 higher)
General psychiatric features - Adults FU	68 (1 study)	⊕⊕⊕⊖ LOW1,3	Not calculable for SMD values	The mean general psychiatric features - adults fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with CBT-ED (2)	Risk difference with AN Inpatient CBT-ED (1) (95% CI)
		due to risk of bias, imprecision		0.14 standard deviations higher (0.33 lower to 0.62 higher)
EDE-Restraint Adults FU	68 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-restraint adults fu in the intervention groups was 0.06 standard deviations lower (0.54 lower to 0.42 higher)
EDE-Eating concerns Adults FU	68 (1 study)	⊕⊕⊖⊖ LOW3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-eating concerns adults fu in the intervention groups was 0 standard deviations higher (0.48 lower to 0.48 higher)
EDE-Weight concerns Adults FU	68 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-weight concerns adults fu in the intervention groups was 0.2 standard deviations higher (0.27 lower to 0.68 higher)
EDE-Shape concerns Adults FU	68 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-shape concerns adults fu in the intervention groups was 0 standard deviations higher (0.48 lower to 0.48 higher)
<p><i>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</i></p> <p><i>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</i></p> <p><i>1 Unclear if allocation concealment was performed. It was also unclear if investigators, participants were blind, however, the assessors were blind.</i></p> <p><i>2 95% CI crossed 1 MID (-0.5)</i></p> <p><i>3 For a continuous outcome, there were fewer than 400 participants</i></p> <p><i>4 95% CI crossed 1 MID (0.5)</i></p>				

1 **Table 83: Summary of findings table for CBT compared with any other intervention in adults with severe and enduring anorexia**
2 **nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Other	Risk difference with Severe AN CBT (95% CI)
BMI- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean bmi- adults in the intervention groups was 0.00 standard deviations higher (0.49 lower to 0.49 higher)
Depression- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression- adults in the intervention groups was 0.24 standard deviations lower (0.74 lower to 0.25 higher)
EDE-Global- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede- global- adults in the intervention groups was 0.39 standard deviations lower (0.89 lower to 0.11 higher)
Quality of life- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean quality of life- adults in the intervention groups was 0.28 standard deviations lower (0.78 lower to 0.22 higher)
BMI FU- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI fu- adults in the intervention groups was 0.11 standard deviations higher (0.38 lower to 0.61 higher)
Depression FU- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression fu- adults in the intervention groups was 0.27 standard deviations lower (0.77 lower to 0.22 higher)
EDE-Global FU- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede- global fu- adults in the intervention groups was 0.57 standard deviations lower (1.08 lower to 0.07 higher)
Quality of life FU- Adults	63 (1 study)	⊕⊕⊕⊖ LOW1,3	Not calculable for SMD values	The mean quality of life fu- adults in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Other	Risk difference with Severe AN CBT (95% CI)
		due to risk of bias, imprecision		0.14 standard deviations lower (0.64 lower to 0.35 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).				
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up				
1 Unclear if allocation concealment was performed. It was unclear if the participants and investigators were blind. High dropouts were reported >20%				
2 For a continuous outcome, there were fewer than 400 participants.				
3 95% CI crossed 1 MID (-0.5)				
4 95% CI crossed 1 MID (0.5)				

1 **Table 84: Summary of findings table for SSCM versus any other intervention at the end of treatment and at follow up for adults with**
2 **severe and enduring anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Other	Risk difference with SSCM (95% CI)
BMI- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean bmi- adults in the intervention groups was 0.00 standard deviations higher (0.49 lower to 0.49 higher)
EDE-Global- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-global- adults in the intervention groups was 0.39 standard deviations higher (0.11 lower to 0.99 higher)
Quality of life- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean quality of life- adults in the intervention groups was 0.28 standard deviations higher (0.22 lower to 0.78 higher)
Depression- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression- adults in the intervention groups was 0.24 standard deviations higher (0.25 lower to 0.74 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Other	Risk difference with SSCM (95% CI)
BMI FU- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI fu- adults in the intervention groups was 0.11 standard deviations lower (0.61 lower to 0.38 higher)
EDE-Global FU- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede-global fu- adults in the intervention groups was 0.57 standard deviations higher (0.07 to 1.08 higher)
Quality of life FU- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean quality of life fu- adults in the intervention groups was 0.14 standard deviations higher (0.35 lower to 0.64 higher)
Depression FU- Adults	63 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression fu- adults in the intervention groups was 0.27 standard deviations higher (0.22 lower to 0.77 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).				
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up				
1 Unclear if allocation concealment was performed. It was unclear if the participants and investigators were blind. High dropouts were reported >20%				
2 For a continuous outcome, there were fewer than 400 participants.				
3 95% CI crossed 1 MID (0.5)				
4 95% CI crossed 1 MID (-0.5)				

1 Group therapy

2 No evidence was identified.

3 Self-help

1 **Table 85: Summary table of findings for guided self-help with an eating disorder focus (GHS-ED) versus another intervention (other)**
2 **for adults with anorexia nervosa at the end of treatment and follow up**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Other	Risk difference with AN Internet GSH (ED) (95% CI)
EDI-Total	219 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi - total in the intervention groups was 0.27 standard deviations lower (0.53 lower to 0 higher)
EDI- Drive for thinness	219 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi- drive for thinness in the intervention groups was 0.17 standard deviations lower (0.44 lower to 0.09 higher)
EDI- Bulimia	219 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi- bulimia in the intervention groups was 0.15 standard deviations lower (0.42 lower to 0.11 higher)
EDI- Body dissatisfaction	219 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi- body dissatisfaction in the intervention groups was 0.24 standard deviations lower (0.51 lower to 0.02 higher)
Depression	219 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression in the intervention groups was 0.2 standard deviations lower (0.46 lower to 0.07 higher)
Global Clinical Score (PSR)	239 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean global clinical score (psr) in the intervention groups was 0.21 standard deviations lower (0.47 lower to 0.04 higher)
Bulimic symptoms	226 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean bulimic symptoms in the intervention groups was 0.26 standard deviations lower (0.52 lower to 0 higher)
Morgan-Russell Menstrual Function	239 (1 study)	⊕⊕⊖⊖ LOW1,3	Not calculable	The mean Morgan-Russell menstrual function in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Other	Risk difference with AN Internet GSH (ED) (95% CI)
		due to risk of bias, imprecision	for SMD values	0.18 standard deviations lower (0.44 lower to 0.07 higher)
General psychopathology	239 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.1 standard deviations lower (0.35 lower to 0.15 higher)
General psychopathology FU	208 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean general psychopathology fu in the intervention groups was 0.07 standard deviations lower (0.34 lower to 0.21 higher)
Morgan-Russell Menstrual Function FU	208 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean Morgan-Russell menstrual function fu in the intervention groups was 0.07 standard deviations higher (0.2 lower to 0.35 higher)
Bulimic symptoms FU	208 (1 study)	See comment	Not calculable for SMD values	The mean bulimic symptoms fu in the intervention groups was 0.21 standard deviations lower (0.48 lower to 0.07 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was performed. Assessors were blind but it was unclear if investigators and participants were blind.

2 95% CI crossed 1 MID (-0.5)

3 For a continuous outcome, there were fewer than 400 participants.

1 Family therapy

2 **Table 86: Summary table of findings for family therapy and treatment as usual versus treatment as usual (TAU) in young inpatients**
3 **with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Family Therapy-ED (95% CI)
Remission (ITT) Morgan-Russell Good or Intermediate outcome	60 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision	RR 2.4 (0.96 to 5.98)	167 per 1000	233 more per 1000 (from 7 fewer to 830 more)
BMI (raw)	60 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean BMI (raw) in the intervention groups was 0.1 standard deviations higher (0.41 lower to 0.6 higher)
#>=BMI 10th Percentile (age-sex corrected)	59 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision	RR 1.93 (0.98 to 3.81)	276 per 1000	257 more per 1000 (from 6 fewer to 775 more)
EDI Total	59 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean edi global in the intervention groups was 0.03 standard deviations higher (0.48 lower to 0.54 higher)
Global Functioning Global Outcome Assessment Scale	59 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean global functioning in the intervention groups was 0.22 standard deviations higher (0.29 lower to 0.74 higher)
Amenorrhic patients	59 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision	RR 0.56 (0.33 to 0.96)	655 per 1000	288 fewer per 1000 (from 26 fewer to 439 fewer)
Hospitalizations to EoT	59 (1 study)	⊕⊕⊖⊖ LOW2 due to imprecision	RR 0.69 (0.37 to 1.3)	483 per 1000	150 fewer per 1000 (from 304 fewer to 145 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Family Therapy-ED (95% CI)
1 CI crosses either 0.75 or 1.25 (Risk Ratio), or either -0.5 or -0.5 (SMD).					
2 CI crosses both 0.75 and 1.25 (Risk Ratio).					

1 **Table 87: Summary table of findings for family therapy versus any other type of family intervention in young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Any other type of family intervention	Risk difference with Family Therapy-ED (95% CI)
% of Ideal Body Weight	25 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean % of ideal body weight in the intervention groups was 0.62 standard deviations lower (1.43 lower to 0.19 higher)
EDI Bulimia	25 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi bulimia in the intervention groups was 0.54 standard deviations lower (1.34 lower to 0.26 higher)
EDI Drive for Thinness	25 (1 study)	⊕⊕⊕⊕ VERY LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.13 standard deviations lower (0.91 lower to 0.66 higher)
EDI Body Dissatisfaction	25 (1 study)	⊕⊕⊕⊕ VERY LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.2 standard deviations lower (0.99 lower to 0.59 higher)
General Psychopathology BSI GSI	25 (1 study)	⊕⊕⊕⊕ VERY LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0 standard deviations higher (0.78 lower to 0.78 higher)
Depression CDI	25 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean depression in the intervention groups was 0.5 standard deviations lower (1.3 lower to 0.3 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Any other type of family intervention	Risk difference with Family Therapy-ED (95% CI)
Family Functioning FAM-III	25 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean family functioning in the intervention groups was 0.43 standard deviations lower (1.23 lower to 0.37 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).				
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up				
1 Geist 2000: Unclear randomization method, allocation concealment, no participant blinding, unclear assessor blinding.				
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).				
3 CI crosses both 0.74 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).				

1 **Table 88: Summary table of findings for family therapy versus general family therapy in young people with anorexia nervosa at end of**
2 **treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Family Therapy	Risk difference with Family Therapy-ED (95% CI)
Remission (ITT) % of patients achieving ≥ 95% IBW1	164 (1 study) 12 months	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision	RR 1.3 (0.79 to 2.14)	244 per 1000	73 more per 1000 (from 51 fewer to 278 more)
% of Ideal Body Weight	158 (1 study) 12 months	⊕⊕⊖⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean % of ideal body weight in the intervention groups was 0.16 standard deviations higher (0.15 lower to 0.47 higher)
EDE Global	158 (1 study) 12 months	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.26 standard deviations lower (0.58 lower to 0.05 higher)
Yale-Brown-Cornell Eating Disorder Scale	158 (1 study) 12 months	⊕⊕⊖⊖ LOW2,4		Not calculable for SMD values	The mean Yale-Brown-Cornell eating disorder scale in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Family Therapy	Risk difference with Family Therapy-ED (95% CI)
		due to risk of bias, imprecision			0.18 standard deviations lower (0.49 lower to 0.13 higher)
Depression BDI	158 (1 study) 12 months	⊕⊕⊖⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.09 standard deviations higher (0.22 lower to 0.4 higher)
Quality of Life Quality of Life and Enjoyment Scale (Short-Form)	158 (1 study) 12 months	⊕⊕⊖⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.15 standard deviations lower (0.46 lower to 0.16 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Combines data for 'full remission' and 'partial remission'.

2 Agras 2014: dropout rate for both arms>20% (Family Therapy 26%, Systematic Family Therapy 25%).

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4 <400 participants.

1 **Table 89: Summary table of findings for family therapy versus general family therapy in young people with anorexia nervosa at follow up**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Family Therapy	Risk difference with Family Therapy-ED (95% CI)
Remission FU (ITT) % of patients achieving ≥ 95% IBW	164 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 1.03 (0.7 to 1.52)	378 per 1000	11 more per 1000 (from 113 fewer to 197 more)
% of Ideal Body Weight FU	158 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean % of ideal body weight fu in the intervention groups was 0.16 standard deviations higher (0.15 lower to 0.47 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Family Therapy	Risk difference with Family Therapy-ED (95% CI)
EDE Global FU	158 (1 study)	⊕⊕⊖⊖ LOW1 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.26 standard deviations lower (0.58 lower to 0.05 higher)
Yale-Brown-Cornell Eating Disorder Scale FU	158 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean Yale-Brown-Cornell eating disorder scale fu in the intervention groups was 0.18 standard deviations lower (0.49 lower to 0.13 higher)
Depression FU BDI	158 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.09 standard deviations higher (0.22 lower to 0.4 higher)
Quality of Life FU Quality of Life and Enjoyment Scale (Short-Form)	158 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life fu in the intervention groups was 0.15 standard deviations lower (0.46 lower to 0.16 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Agras 2014: dropout rate for both arms>20% (Family Therapy 26%, Systematic Family Therapy 25%).

2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

3 <400 participants.

1 **Table 90: Summary table of findings for multi-family therapy versus family therapy at end of treatment in young people with anorexia nervosa**

2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy	Risk difference with Multi-Family Therapy (95% CI)
Remission (ITT)	167 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2	RR 1.31 (1.05 to 1.62)	585 per 1000	181 more per 1000 (from 29 more to 363 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy	Risk difference with Multi-Family Therapy (95% CI)
		due to indirectness, imprecision			
BMI - Change Scores	167 (1 study) 6 months	⊕⊕⊕⊖ LOW1,2 due to indirectness, imprecision		Not calculable for SMD values	The mean BMI - change scores in the intervention groups was 0.39 standard deviations higher (0.09 to 0.7 higher)
%mBMI - Change Scores	167 (1 study) 6 weeks	⊕⊕⊕⊖ LOW1,2 due to indirectness, imprecision		Not calculable for SMD values	The mean %mbmi - change scores in the intervention groups was 0.45 standard deviations higher (0.14 to 0.75 higher)
EDE Restraint - Change scores	167 (1 study) 6 weeks	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede restraint - change scores in the intervention groups was 0.38 standard deviations higher (0.08 to 0.69 higher)
EDE Eating Concerns - Change scores	167 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW1,3,4 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede eating concerns - change scores in the intervention groups was 0.12 standard deviations higher (0.18 lower to 0.43 higher)
EDE Shape Concerns - Change scores	167 (1 study) 6 weeks	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concerns - change scores in the intervention groups was 0.42 standard deviations higher (0.11 to 0.72 higher)
EDE Weight Concerns - Change scores	167 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede weight concerns - change scores in the intervention groups was 0.35 standard deviations higher (0.04 to 0.65 higher)
Depression - Change scores	167 (1 study) 6 weeks	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression - change scores in the intervention groups was 0.28 standard deviations higher (0.02 lower to 0.59 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy	Risk difference with Multi-Family Therapy (95% CI)
Carer - Experience of Caregiving - Positive - Change scores	167 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean carer - experience of caregiving - positive - change scores in the intervention groups was 0.15 standard deviations higher (0.16 lower to 0.45 higher)
Carer - Experience of Caregiving - Negative - Change scores	167 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean carer - experience of caregiving - negative - change scores in the intervention groups was 0.09 standard deviations lower (0.39 lower to 0.22 higher)
Service user experience - young person Client Satisfaction Questionnaire score 27-32	79 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision	RR 0.88 (0.47 to 1.65)	351 per 1000	42 fewer per 1000 (from 186 fewer to 228 more)
Service user experience - carer Client Satisfaction Questionnaire score 27-32	96 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,5} due to risk of bias, indirectness, imprecision	RR 1.03 (0.73 to 1.45)	574 per 1000	17 more per 1000 (from 155 fewer to 259 more)
<p><i>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</i></p> <p><i>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</i></p> <p><i>1 Sample consists of 120 AN and 40 Restricting EDNOS participants.</i></p> <p><i>2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).</i></p> <p><i>3 Eisler 2016: no participant nor investigator blinding.</i></p> <p><i>4 <400 participants (continuous outcome).</i></p> <p><i>5 CI crosses both 0.75 and 1.25 (Risk Ratio).</i></p>					

1 **Table 91: Summary table of findings for multi-family therapy versus family therapy in young people with anorexia nervosa at follow up**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy	Risk difference with Multi-Family Therapy (95% CI)
Remission FU (ITT)	167 (1 study)	⊕⊕⊕⊖ LOW1,2 due to indirectness, imprecision	RR 1.35 (1.09 to 1.69)	573 per 1000	201 more per 1000 (from 52 more to 395 more)
BMI FU - Change Scores	167 (1 study)	⊕⊕⊕⊖ LOW1,2 due to indirectness, imprecision		Not calculable for SMD values	The mean BMI fu - change scores in the intervention groups was 0.67 standard deviations higher (0.35 to 0.98 higher)
%mBMI FU - Change Scores	167 (1 study)	⊕⊕⊕⊖ LOW1,2 due to indirectness, imprecision		Not calculable for SMD values	The mean %mbmi fu - change scores in the intervention groups was 0.4 standard deviations higher (0.09 to 0.71 higher)
EDE Restraint FU - Change scores	167 (1 study)	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede restraint fu - change scores in the intervention groups was 0.37 standard deviations higher (0.06 to 0.67 higher)
EDE Eating Concerns FU - Change scores	167 (1 study)	⊕⊖⊖⊖ VERY LOW1,3,4 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede eating concerns fu - change scores in the intervention groups was 0.17 standard deviations higher (0.13 lower to 0.48 higher)
EDE Shape Concerns FU - Change scores	167 (1 study)	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concerns fu - change scores in the intervention groups was 0.42 standard deviations higher (0.12 to 0.73 higher)
EDE Weight Concerns FU - Change scores	167 (1 study)	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede weight concerns fu - change scores in the intervention groups was 0.35 standard deviations higher (0.05 to 0.66 higher)
Depression FU - Change scores	167 (1 study)	⊕⊖⊖⊖ VERY LOW1,3,4 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression fu - change scores in the intervention groups was 0.2 standard deviations higher (0.11 lower to 0.5 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy	Risk difference with Multi-Family Therapy (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Sample consists of 120 AN and 40 Restricting EDNOS participants.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 Eisler 2016: no participant nor investigator blinding.					
4 <400 participants (continuous outcome).					

1 **Table 92: Summary table of findings for family therapy versus any individual therapy in young people with anorexia nervosa at end of**
2 **treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Individual Therapy	Risk difference with Family Therapy-ED (95% CI)
Remission (ITT) See footnote.1	179 (3 studies) 5 years	⊕⊕⊕⊖ VERY LOW ^{2,3,4,5,6} due to risk of bias, inconsistency, imprecision	RR 1.45 (0.82 to 2.59)	506 per 1000	228 more per 1000 (from 91 fewer to 804 more)
BMI/Weight	160 (3 studies) 5 years	⊕⊕⊕⊖ LOW ^{2,3,4,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI/weight in the intervention groups was 0.51 standard deviations higher (0.19 to 0.82 higher)
Morgan-Russell Average Score	21 (1 study) 5 years	⊕⊕⊕⊖ LOW ^{4,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean Morgan Russell average score in the intervention groups was 1.92 standard deviations higher (0.85 to 2.99 higher)
EDE Global	103 (1 study) 12 months	⊕⊕⊕⊖ LOW ^{2,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.45 standard deviations lower (0.84 to 0.05 lower)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Individual Therapy	Risk difference with Family Therapy-ED (95% CI)
Depression Beck Depression Inventory	35 (1 study) 12 months	⊕⊕⊖⊖ LOW3,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.35 standard deviations higher (0.32 lower to 1.02 higher)
Carer Family Functioning - Conflict PARQ Mother + Father	65 (1 study) 12 months	⊕⊕⊖⊖ LOW3,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer family functioning - conflict in the intervention groups was 0.04 standard deviations lower (0.53 lower to 0.44 higher)
Carer Family Functioning – Communication McMaster Family Assessment Device	84 (1 study)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer family functioning – communication in the intervention groups was 0.48 standard deviations lower (0.92 to 0.05 lower)
Carer Family Functioning – Behaviour Control McMaster Family Assessment Device	84 (1 study)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer family functioning – behaviour control in the intervention groups was 0.59 standard deviations lower (1.03 to 0.16 lower)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 'Remission' here defined as follows: Lock 2010/Ciao 2014: All Ps who achieve weight more than 85% of expected IBW for sex, age and height (inc. full remission Ps and/or all Ps achieving 95% or greater IBW though who have elevated EDE scores (similar to Morgan-Russell intermediate outcome). Robin 1999: Morgan-Russell Good or Intermediate outcome (data from Eisler, I. (2005). The empirical and theoretical base of family therapy and multiple family day therapy for young people anorexia nervosa. Journal of Family Therapy, 27, 104-131). Russell 1987: Morgan-Russell Good or Intermediate outcomes.

2 Lock 2010/Ciao 2014: No participant blinding.

3 Robin 1999: inadequate randomization method, unclear allocation concealment, participant and assessor blinding, dropout data not provided.

4 Russell 1987/Eisler 1997: Unclear randomization method, allocation method, participant blinding, dropout rate both arms>20% (Family Therapy 40%, Individual Therapy 64%).

5 I2>=50%.

6 CI crosses 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

7 <400 participants.

1 **Table 93: Summary table of findings for family therapy versus any individual therapy in young people with anorexia nervosa at follow up**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Individual Therapy	Risk difference with Family Therapy-ED (95% CI)
Remission FU (ITT)	179 (3 studies) 5 years	⊕⊕⊖⊖ LOW1,2,3,4 due to risk of bias, imprecision	RR 1.01 (0.8 to 1.27)	618 per 1000	6 more per 1000 (from 124 fewer to 167 more)
BMI or Weight FU	150 (3 studies) 5 years	⊕⊕⊖⊖ LOW1,2,3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI or weight fu in the intervention groups was 0.24 standard deviations higher (0.08 lower to 0.56 higher)
EDE Global FU	93 (1 study) 12 months	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.23 standard deviations lower (0.63 lower to 0.18 higher)
Depression FU Beck Depression Inventory	35 (1 study) 12 months	⊕⊕⊖⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.87 standard deviations higher (0.17 to 1.57 higher)
Carer Family Functioning FU PARQ Mother +Father	65 (1 study) 12 months	⊕⊕⊖⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer family functioning fu in the intervention groups was 0.03 standard deviations higher (0.46 lower to 0.52 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Lock 2010: No participant blinding.

2 Robin 1999: inadequate randomization method, unclear allocation concealment, participant and assessor blinding, dropout data not provided.

3 Russell 1987/Eisler 1997: Unclear randomization method, allocation method, participant blinding, dropout rate both arms >20% (Family Therapy 40%, Individual Therapy 64%).

4 CI crosses 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1 **Table 94: Summary table of findings for family therapy-1 (conjoint family therapy) versus family therapy-2 (separated family therapy)**
2 **at end of treatment in young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy-ED (2)	Risk difference with Family Therapy-ED (1) (95% CI)
Full Remission (ITT) Morgan-Russell Good outcome; >=95% mBMI and EDE global <= 1.59	146 (2 studies) 12 months	⊕⊕⊕⊖ LOW1,2,3 due to risk of bias, imprecision	RR 0.52 (0.32 to 0.85)	444 per 1000	213 fewer per 1000 (from 67 fewer to 302 fewer)
BMI	146 (2 studies) 12 months	⊕⊕⊕⊖ LOW1,2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.34 standard deviations lower (0.67 to 0.02 lower)
% of Average Body Weight (change scores)	40 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean % of average body weight (change scores) in the intervention groups was 0.42 standard deviations lower (1.05 lower to 0.21 higher)
Morgan-Russell Outcome-Average	40 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean Morgan-Russell outcome-average in the intervention groups was 0.29 standard deviations higher (0.34 lower to 0.91 higher)
EDE Global	106 (1 study) 12 months	⊕⊕⊕⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.23 standard deviations higher (0.16 lower to 0.61 higher)
EDE Restraint	106 (1 study) 12 months	⊕⊕⊕⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint in the intervention groups was 0.21 standard deviations higher (0.17 lower to 0.59 higher)
EDE Eating Concerns	106 (1 study) 12 months	⊕⊕⊕⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concerns in the intervention groups was 0.13 standard deviations higher (0.26 lower to 0.51 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy-ED (2)	Risk difference with Family Therapy-ED (1) (95% CI)
EDE Weight Concerns	106 (1 study) 12 months	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concerns in the intervention groups was 0.26 standard deviations higher (0.12 lower to 0.64 higher)
EDE Shape Concerns	106 (1 study) 12 months	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concerns in the intervention groups was 0.25 standard deviations higher (0.13 lower to 0.63 higher)
Hospitalized during treatment	106 (1 study)	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision	RR 2.01 (0.83 to 4.89)	118 per 1000	119 more per 1000 (from 20 fewer to 458 more)
Depression Scale analogous to Morgan-Russell; CDI	146 (2 studies)	⊕⊕⊖⊖ LOW1,2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.12 standard deviations lower (0.44 lower to 0.21 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Eisler 2000: unclear randomization method, allocation concealment, participant blinding.

2 Le Grange 2016: no participant nor investigator blinding.

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4 <400 participants.

1 **Table 95: Summary table of findings for family therapy-1 (conjoint family therapy) versus family therapy-2 (separated family therapy)**
2 **at follow up in young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy-ED2	Risk difference with Family Therapy-ED1 (95% CI)
Full Remission (ITT) 12-mo FU >=95% mBMI and EDE global <= 1.59	106 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.78 (0.45 to 1.35)	373 per 1000	82 fewer per 1000 (from 205 fewer to 130 more)
%mBMI 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean %mBMI 12-mo fu in the intervention groups was 0.23 standard deviations lower (0.61 lower to 0.15 higher)
EDE Global 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global 12-mo fu in the intervention groups was 0.19 standard deviations higher (0.19 lower to 0.57 higher)
EDE Restraint 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint 12-mo fu in the intervention groups was 0.2 standard deviations higher (0.18 lower to 0.58 higher)
EDE Eating Concerns 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concerns 12-mo fu in the intervention groups was 0.12 standard deviations higher (0.26 lower to 0.5 higher)
EDE Weight Concerns 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concerns 12-mo fu in the intervention groups was 0.13 standard deviations higher (0.25 lower to 0.51 higher)
EDE Shape Concerns 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concerns 12-mo fu in the intervention groups was 0.2 standard deviations higher (0.18 lower to 0.58 higher)
Depression 12-mo FU	106 (1 study)	⊕⊕⊕⊕ LOW ^{1,2}		Not calculable for SMD values	The mean depression 12-mo fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy-ED2	Risk difference with Family Therapy-ED1 (95% CI)
		due to risk of bias, imprecision			0.42 standard deviations higher (0.04 to 0.81 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Le Grange 2016: no participant nor investigator blinding.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 <400 participants.					

1 **Table 96: Summary table of findings for long-term family therapy versus short-term family therapy at end of treatment in young**
2 **people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Family Therapy-ED Short-Term	Risk difference with Family Therapy-ED Long-Term (95% CI)
BMI	86 (1 study) 3.96 years	⊕⊕⊕⊖ MODERATE ¹ due to imprecision	Not calculable for SMD values	The mean BMI in the intervention groups was 0.22 standard deviations higher (0.2 lower to 0.65 higher)
EDE Restraint	86 (1 study) 3.96 years	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean ede restraint in the intervention groups was 0.24 standard deviations lower (0.67 lower to 0.18 higher)
EDE Weight Concerns	86 (1 study) 3.96 years	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean ede weight concerns in the intervention groups was 0.42 standard deviations lower (0.85 lower to 0.01 higher)
EDE Eating Concerns	86 (1 study) 3.96 years	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision	Not calculable for SMD values	The mean ede eating concerns in the intervention groups was 0.36 standard deviations lower (0.79 lower to 0.06 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Family Therapy-ED Short-Term	Risk difference with Family Therapy-ED Long-Term (95% CI)
EDE Shape Concerns	86 (1 study) 3.96 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean ede shape concerns in the intervention groups was 0.29 standard deviations lower (0.72 lower to 0.13 higher)
Yale-Brown-Cornell Eating Disorder Scale	86 (1 study) 3.96 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean Yale-Brown-Cornell eating disorder scale in the intervention groups was 0.54 standard deviations lower (0.97 to 0.11 lower)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

2 Lock 2005/2006: Participant not blind, assessor blinding unclear.

1 **Table 97: Summary table of findings for long-term family therapy versus short-term family therapy at follow up in young people with**
2 **anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy-ED Short-term	Risk difference with Family Therapy-ED Long-term (95% CI)
BMI (unadjusted) FU	71 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean BMI (unadjusted) fu in the intervention groups was 0.08 standard deviations higher (0.39 lower to 0.54 higher)
BMI>20 FU	71 (1 study)	⊕⊕⊖⊖ LOW2 due to imprecision	RR 0.91 (0.63 to 1.31)	649 per 1000	58 fewer per 1000 (from 240 fewer to 201 more)
# >90% Ideal BW FU	71 (1 study)	⊕⊕⊕⊖ MODERATE3 due to imprecision	RR 1.05 (0.89 to 1.24)	865 per 1000	43 more per 1000 (from 95 fewer to 208 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy-ED Short-term	Risk difference with Family Therapy-ED Long-term (95% CI)
Resumed Menstruation FU	71 (1 study)	⊕⊕⊖⊖ LOW2 due to imprecision	RR 0.98 (0.63 to 1.51)	541 per 1000	11 fewer per 1000 (from 200 fewer to 276 more)
Amenorrhic patients FU	71 (1 study)	⊕⊕⊖⊖ LOW2 due to imprecision	RR 0.36 (0.04 to 3.32)	81 per 1000	52 fewer per 1000 (from 78 fewer to 188 more)
EDE Eating Concerns FU	35 (1 study)	⊕⊖⊖⊖ VERY LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concerns fu in the intervention groups was 0.06 standard deviations lower (0.73 lower to 0.61 higher)
EDE Restraint FU	35 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint fu in the intervention groups was 0.39 standard deviations lower (1.06 lower to 0.29 higher)
EDE Weight Concerns FU	35 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concerns fu in the intervention groups was 0.32 standard deviations lower (1 lower to 0.35 higher)
EDE Shape Concerns FU	35 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concerns fu in the intervention groups was 0.39 standard deviations lower (1.07 lower to 0.28 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

2 CI crosses both 0.75 and 1.25 (Risk Ratio).

3 <300 events.

4 Lock 2005/2006: Participant not blind, assessor blinding unclear.

1 **Table 98: Summary table of findings for family therapy with family meal versus family therapy without family meal at end of treatment**
2 **in young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy without Family Meal	Risk difference with Family Therapy with Family Meal (95% CI)
Remission Morgan-Russell Good or Intermediate outcome	23 (1 study) 6 months	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	RR 2.18 (1.09 to 4.37)	417 per 1000	492 more per 1000 (from 38 more to 1000 more)
Weight (kg)	23 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) in the intervention groups was 0.31 standard deviations lower (1.13 lower to 0.52 higher)
% EBW	23 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean % ebw in the intervention groups was 0.41 standard deviations higher (0.42 lower to 1.23 higher)
Morgan-Russell Outcome - Average score	23 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean Morgan-Russell outcome - average score in the intervention groups was 0.15 standard deviations lower (0.97 lower to 0.67 higher)
EDI-2	23 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 in the intervention groups was 0.6 standard deviations higher (0.24 lower to 1.44 higher)
General Psychopathology SCL90-R GSI	23 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.92 standard deviations higher (0.05 to 1.79 higher)
Menstruation resumed	21 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 2.93 (1.06 to 8.08)	273 per 1000	526 more per 1000 (from 16 more to 1000 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy without Family Meal	Risk difference with Family Therapy with Family Meal (95% CI)
<i>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</i>					
<i>1 Herscovici 2015: unclear allocation concealment; no participant, investigator nor assessor blinding; EDI-2 and SCL-90-R GSI score significantly lower in FT group.</i>					
<i>2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).</i>					
<i>3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).</i>					

1 **Table 99: Summary table of findings for family therapy with family meal versus family therapy without family meal at follow up in**
2 **young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy without Family Meal	Risk difference with Family Therapy with Family Meal (95% CI)
Remission 6-mo FU Full and partial remission	23 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision	RR 1.45 (0.74 to 2.85)	500 per 1000	225 more per 1000 (from 130 fewer to 925 more)
Weight 6-mo FU	21 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight 6-mo fu in the intervention groups was 0.23 standard deviations lower (1.09 lower to 0.63 higher)
% EBW 6-mo FU	21 (1 study)	⊕⊕⊕⊕ LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean % ebw 6-mo fu in the intervention groups was 0.43 standard deviations higher (0.44 lower to 1.3 higher)
Morgan-Russell Outcome - Average score 6-mo FU	21 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean morgan-russell outcome - average score 6-mo fu in the intervention groups was 0.05 standard deviations higher (0.81 lower to 0.9 higher)
EDI-2 6-mo FU	21 (1 study)	⊕⊕⊕⊕ LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 6-mo fu in the intervention groups was 0.54 standard deviations higher (0.34 lower to 1.41 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Family Therapy without Family Meal	Risk difference with Family Therapy with Family Meal (95% CI)
General Psychopathology 6-mo FU	21 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology 6-mo fu in the intervention groups was 0.78 standard deviations higher (0.13 lower to 1.66 higher)
Menstruation resumed 6-mo FU	20 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	RR 2.14 (0.91 to 5.04)	364 per 1000	415 more per 1000 (from 33 fewer to 1000 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Herscovici 2015: unclear allocation concealment; no participant, investigator nor assessor blinding; EDI-2 and SCL-90-R GSI score significantly lower in FT group.

2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1 **Table 100: Summary table of findings for family therapy versus any other family intervention at end of treatment in adult inpatients with anorexia nervosa**

2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Any other type of family intervention	Risk difference with Family Therapy-ED (95% CI)
BMI	47 (1 study) 36 months	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean bmi in the intervention groups was 0.43 standard deviations lower (1.01 lower to 0.15 higher)
SEED Anorexia Severity Scale Scale from: 0 to 3.	25 (1 study) 36 months	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean seed anorexia severity scale in the intervention groups was 0.2 standard deviations higher (0.61 lower to 1 higher)
SEED Bulimia Severity Scale Scale from: 0 to 3.	25 (1 study) 36 months	⊕⊕⊕⊖ LOW1,2	Not calculable for SMD values	The mean seed bulimia severity scale in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Any other type of family intervention	Risk difference with Family Therapy-ED (95% CI)
		due to risk of bias, imprecision		0.48 standard deviations higher (0.34 lower to 1.29 higher)
Carer Quality of Life GHQ-12 Short Form. Scale from: 0 to 36.	77 (1 study) 36 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer quality of life in the intervention groups was 0.08 standard deviations higher (0.37 lower to 0.53 higher)
Carer Family Functioning Level of Expressed Emotion	66 (1 study) 36 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer family functioning in the intervention groups was 0.13 standard deviations higher (0.35 lower to 0.61 higher)
Carer Experience of Caregiving Inventory (ECI) Negative	75 (1 study) 36 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer experience of caregiving inventory (eci) negative in the intervention groups was 0.43 standard deviations lower (0.89 lower to 0.03 higher)
Carer Experience of Caregiving Inventory (ECI) Positive	75 (1 study) 36 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer experience of caregiving inventory (eci) positive in the intervention groups was 0.53 standard deviations lower (0.99 to 0.06 lower)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p> <p>1 Whitney 2012: Unclear whether baseline properties of two arms similar. No participant nor assessor blinding.</p> <p>2 CI crosses either 0.5 or -0.5 (SMD).</p> <p>3 CI crosses both 0.5 and -0.5 (SMD).</p>				

1 **Table 101: Summary table of findings for family therapy versus any other family intervention at follow up in adult inpatients with**
2 **anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Any other family intervention	Risk difference with Family Therapy-ED (95% CI)
BMI FU	44 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.41 standard deviations higher (0.19 lower to 1 higher)
SEED Anorexia Severity Scale FU	29 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean seed anorexia severity scale fu in the intervention groups was 0.24 standard deviations lower (0.97 lower to 0.49 higher)
SEED Bulimia Severity Scale FU	29 (1 study)	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision	Not calculable for SMD values	The mean seed bulimia severity scale fu in the intervention groups was 0.12 standard deviations higher (0.61 lower to 0.85 higher)
Carer Quality of Life FU GHQ-12 Short Form	69 (1 study) 36 months	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer quality of life fu in the intervention groups was 0.16 standard deviations lower (0.63 lower to 0.32 higher)
Carer Family Functioning FU Level of Expressed Emotion	58 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer expressed emotion fu in the intervention groups was 0.11 standard deviations lower (0.62 lower to 0.41 higher)
Carer Experience of Caregiving Inventory (ECI) Negative FU	63 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer experience of caregiving inventory (eci) negative fu in the intervention groups was 0.38 standard deviations lower (0.88 lower to 0.12 higher)
Carer Experience of Caregiving Inventory (ECI) Positive FU	63 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision	Not calculable for SMD values	The mean carer experience of caregiving inventory (eci) positive fu in the intervention groups was 0.23 standard deviations lower (0.73 lower to 0.26 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Anticipated absolute effects	
			Risk with Any other family intervention	Risk difference with Family Therapy-ED (95% CI)
1 Whitney 2012: Unclear whether baseline properties of two arms similar. No participant nor assessor blinding.				
2 CI crosses either 0.5 or -0.5 (SMD).				
3 CI crosses both 0.5 and -0.5 (SMD).				

1 **Table 102: Summary table of findings for general family therapy and any individual therapy compared to any nutritional**
2 **intervention in adults with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any individual intervention	Risk difference with General Family + any individual therapy (95% CI)
Weight (kg)	30 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) in the intervention groups was 0.13 standard deviations lower (0.85 lower to 0.59 higher)
Regular Menstruation	30 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1 (0.24 to 4.18)	200 per 1000	0 fewer per 1000 (from 152 fewer to 636 more)
Amenorrhoeic patients	30 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.8 (0.44 to 1.45)	667 per 1000	133 fewer per 1000 (from 373 fewer to 300 more)
Global Clinical Score	30 (1 study) 12 months	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean global clinical score in the intervention groups was 1.95 standard deviations higher (1.06 to 2.84 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Hall 1987: Randomization method and allocation concealment unclear. Control arm dropout rate was 27%.					
2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).					
3 <400 participants.					

1 **Table 103: Summary table of findings for family therapy compared to any individual therapy in adults with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Individual Therapy	Risk difference with Family Therapy-ED (95% CI)
All-cause Mortality	84 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.01 (0.9 to 1.13)	984 per 1000	10 more per 1000 (from 98 fewer to 128 more)
Recovered	84 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.94 (0.78 to 1.14)	903 per 1000	54 fewer per 1000 (from 199 fewer to 126 more)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Dare 2001: Unclear method of randomization and allocation concealment. No participant, investigator nor assessor blinding. Dropout rate>20% for all four arms.

2 <300 events.

2

1 6.2.3 Economic evidence

2 6.2.3.1 Systematic literature review

3 The systematic search of the literature identified:

- 4 • One US study that assessed the cost effectiveness of a family-based treatment (FBT) in
5 young people with anorexia nervosa (Agras et al., 2014);
- 6 • One German study that assessed the cost effectiveness and cost utility of a CBT-ED
7 compared with psychodynamic therapy (FPT) and treatment as usual (TAU) in adult
8 women with anorexia nervosa (Egger et al., 2016).

9 No studies assessing the cost effectiveness of other psychological interventions in people
10 with anorexia nervosa were identified by the systematic search of the economic literature
11 undertaken for this guideline.

12 References to all included studies and evidence tables for all economic evaluations included
13 in the systematic literature review are provided in Appendix P. Completed methodology
14 checklists of the studies are provided in Appendix O. Economic evidence profiles of studies
15 considered during guideline development (that is, studies that fully or partly met the
16 applicability and quality criteria) are presented in Appendix Q.

17 Agras (2014) evaluated the cost effectiveness of a family-based treatment (FBT) compared
18 with systemic family therapy (SyFT) in young people 12 to 18 years with the anorexia
19 nervosa in the US. The economic analysis was conducted alongside an RCT (Agras 2014)
20 (N=158). Both therapies involved 16 one hour sessions delivered over nine months. The
21 analysis was conducted from a health care provider perspective. The study considered
22 treatment costs and hospital admissions. The resource use estimates were based on the
23 RCT (N=158). The unit costs were obtained from state and local sources. The measure of
24 outcome for the economic analysis was the proportion of people in remission at the end of
25 treatment (36 weeks). Remission was defined as $\geq 95\%$ of IBW. The time horizon of the
26 analysis was 36 weeks.

27 FBT resulted in a greater proportion of people achieving remission at the end of treatment
28 (36 weeks) compared with SyFT (33% versus 25%, respectively; a difference 8%, $p = 0.22$).
29 From a health care provider perspective the mean total costs per participant over 36 weeks
30 were \$8,963 for FBT and \$18,005 for SyFT, a difference of -\$9,042 (p -value not reported) in
31 2007 US dollars. Based on the above, FBT was the dominant intervention (that is, it led to a
32 reduction in costs and a greater proportion of people in remission at the end of treatment).

33 The analysis was judged by the committee to be partially applicable to the NICE decision-
34 making context, as it was conducted in the US. The authors did not attempt to estimate
35 quality adjusted life years (QALYs) but interpretation of findings was straightforward, as FBT
36 was found to be dominant. This study was judged by the committee to have potentially
37 serious methodological limitations, including its short time horizon (36 weeks), the fact that
38 significance levels for costs not reported and some unit costs being from local sources.

39 Egger and colleagues (2016) evaluated the cost effectiveness and cost utility of a CBT-ED
40 compared with psychodynamic therapy (FPT) and TAU in adult women with a BMI between
41 18 and 18.5 kg/m² and a primary diagnosis of anorexia nervosa or sub-syndromal anorexia
42 nervosa in Germany. The economic analysis was conducted alongside an RCT (Zipfel 2014)
43 (N=242 baseline, N=156 follow-up). CBT-ED and FPT were individual outpatient therapies.
44 Each intervention comprised up to 40 sessions and was delivered over 10 months.
45 Participants in the TAU group were given details of psychotherapists in their area who might
46 be able to offer outpatient treatment for anorexia nervosa according to German
47 psychotherapy guidelines. Additionally, their family doctors monitored them regularly. The
48 analysis was conducted from healthcare payer and societal perspectives. The study

1 considered a range of direct costs including outpatient treatment by physicians,
2 psychologists and other therapists, pharmacotherapy, and formal nursing care). The study
3 also considered a range of indirect costs including informal care, travel costs, and
4 productivity losses. The productivity losses were estimated using human capital approach.
5 The resource use estimates were based on the RCT (N=242 baseline, N=156 follow-up).
6 Multiple imputation techniques were employed to account for missing resource use and
7 outcome data. The unit costs were obtained from national sources. The measure of outcome
8 for the economic analysis was the full recovery, defined as having a BMI >17.5 kg/m² and a
9 score on the psychiatric status rating scale of 1 or 2; and also QALYs. The time horizon of
10 the analysis was 22 months.

11 FPT resulted in a greater proportion of people in full recovery at 22 months compared with
12 CBT-ED (35.2% versus 21%, respectively; a difference of 14.2%, p = ns) and TAU (35.2%
13 versus 12.5%, respectively; a difference of 22.7%, p = 0.036). Also, CBT-ED resulted in a
14 greater proportion of people in full recovery at 22 months compared with TAU (21% versus
15 12.5%, respectively; a difference of 8.5%, p = ns). Similarly, FTP resulted in a greater
16 number of QALYs at 22 months compared with CBT-ED (1.53 versus 1.48, respectively; a
17 difference of 0.05 QALYs) and TAU (1.53 versus 1.44, respectively; a difference of 0.09
18 QALYs, p = ns). Also, CBT-ED resulted in a greater proportion of people in full recovery at
19 22 months compared with TAU (1.48 versus 1.44, respectively; a difference of 0.04, p = ns).

20 The mean total direct costs per participant over 22 months were €10,052 (SD: €2,047) for
21 FPT, €11,826 (SD: €1,850) for CBT-ED, and €13,448 (SD: €2,351) for TAU (in 2008 Euros).
22 FPT compared with CBT-ED and TAU resulted in the cost savings of €1,774 and €3,396,
23 respectively. CBT-ED compared with TAU resulted in the cost savings of €1,622. None of the
24 differences were statistically significant. The mean societal costs per participant over 22
25 months were €21,512 (SD: €3,625) for FPT, €24,690 (SD: €3,538) for CBT-ED, and €24,827
26 (SD: €4,697) for TAU. FPT compared with CBT-ED and TAU resulted in the cost savings of
27 €3,178 and €3,315, respectively. CBT-ED compared with TAU resulted in the cost savings of
28 €137. None of the cost differences were statistically significant.

29 Based on the above costs and outcomes FPT was dominant using both direct only and
30 societal costs, and also full recovery and QALYs as outcome measures. However, due to a
31 high dropout rate, there were significant differences between groups regarding illness
32 duration, co-morbid affective disorder, and comorbid anxiety disorder. As a result, the
33 authors conducted a regression analysis on the net benefits. In the regression analysis the
34 costs and outcomes were controlled for differences in baseline costs and other covariates.

35 Using direct costs and intention to treat sample FPT's probability of being cost effective
36 compared with TAU was less than 68%; FPT compared with CBT-ED was less than 67%,
37 and CBT compared with TAU was less than 55% for WTP of €50,000 per additional QALY.
38 The probability for cost effectiveness of FTP compared with TAU and CBT-ED was ≥85% if
39 the willingness-to-pay (WTP) per additional recovery was approximately ≥€10,000 and
40 ≥€25,000, respectively. Comparing CBT-ED with TAU, the probability of being cost effective
41 remained <50% for all WTPs. The results using the base case sample (N=156, with no
42 imputation of missing data) were similar. However, the associated probabilities of cost
43 effectiveness were generally slightly higher.

44 The analysis was judged by the committee to be partially applicable to the NICE decision
45 making context, as it has been conducted in Germany. The authors estimated QALYs and
46 conducted extensive statistical analyses. Overall, given the data limitations in this area, this
47 was a well-conducted study and was judged by the committee to have only minor
48 methodological limitations.

1 6.2.4 Clinical evidence statements

2 6.2.4.1 Individual Therapy

3 **CBT-ED versus another intervention in adults with anorexia nervosa at the end of** 4 **treatment**

5 Very low quality evidence from two RCTs (n=298) showed no difference in the effect of CBT-
6 ED on body weight compared with any other treatment.

7 Low quality evidence from one RCT (n=56) showed no difference in the effect of CBT-ED on
8 EDE-restraint, EDE-EDE-weight concern, EDE-shape concern, EDE-eating concern, EDI-
9 drive for thinness, EDI- body dissatisfaction or EDI-bulimia compared with any other
10 treatment.

11 Low quality evidence from one RCT (n=242) showed no difference in the effect of CBT-ED
12 on EDI-total compared with any other treatment.

13 Very low quality evidence from two RCTs (n=130) showed that CBT-ED may be more
14 effective at improving general psychopathology compared with any other treatment but there
15 was some uncertainty.

16 Low quality evidence from one RCT (n=56) showed no difference in the effect of CBT-ED on
17 depression compared with any other treatment.

18 Low quality evidence from one RCT (n=33) showed no difference in the effect of CBT-ED on
19 relapse compared with any other treatment.

20 Very low quality evidence from two RCTs (n=275) showed no difference in the effect of CBT-
21 ED on remission compared with any other treatment.

22 **CBT-ED versus another intervention in adults with anorexia nervosa at follow up**

23 Very low quality evidence from two RCTs (n=274) showed no difference in the effect of CBT-
24 ED on weight compared with any other treatment.

25 Low quality evidence from one RCT (n=43) showed no difference in the effect of CBT-ED on
26 EDE-restraint, EDE-EDE-weight concern, EDE-shape concern, EDE-eating concern, EDI-
27 drive for thinness, EDI-body dissatisfaction or EDI-bulimia compared with any other
28 treatment.

29 Low quality evidence from one RCT (n=242) showed no difference in the effect of CBT-ED
30 on EDI-total compared with any other treatment.

31 Low quality evidence from one RCT (n=43) showed no difference in the effect of CBT-ED on
32 depression compared with any other treatment.

33 Low quality evidence from one RCT (n=43) showed no difference in the effect of CBT-ED on
34 general function compared with any other treatment.

35 Very low quality evidence from one RCT (n=242) showed no difference in the effect of CBT-
36 ED on general psychopathology compared with any other treatment.

37 Low quality evidence from one RCT (n=142) showed no difference in the effect of CBT-ED
38 on remission compared with any other treatment.

1 **CBT-ED versus another intervention in young people with anorexia nervosa at follow**
2 **up**

3 Low quality evidence from one RCT (n=98) showed no difference in the effect of CBT-ED on
4 BMI compared with any other treatment.

5 Low quality evidence from one RCT (n=82) showed no difference in the effect of CBT-ED on
6 EDI-total compared with any other treatment.

7 Low quality evidence from one RCT (n=110) showed no difference in the effect of CBT-ED
8 on remission compared with any other treatment.

9 **Psychiatric counselling versus another interventions in adults with anorexia nervosa**
10 **at end of treatment**

11 Low quality evidence from one RCT (n=104) showed psychiatric counselling may improve
12 remission compared with any other treatment but there was some uncertainty.

13 Low quality evidence from one RCT (n=84) showed no difference in the effect of psychiatric
14 counselling on all-cause mortality compared with any other treatment.

15 **Supportive therapy versus another intervention in young people with anorexia**
16 **nervosa at end of treatment**

17 Low quality evidence from one RCT (n=21) showed supportive therapy is less effective on
18 body weight and remission compared with any other treatment.

19 **Supportive therapy versus another intervention in young people with anorexia**
20 **nervosa at follow up**

21 Low quality evidence from one RCT (n=21) showed no difference in body weight and
22 remission rates between supportive therapy and any other treatment.

23 **Young people focused therapy versus another intervention in young people with**
24 **anorexia nervosa at end of treatment**

25 Low quality evidence from two RCTs (n=139) showed young people focused therapy is less
26 effective on BMI compared with any other treatment.

27 Very low quality evidence from two RCTs (n=158) showed young people focused therapy is
28 less effective on remission rates compared with any other treatment but there was some
29 uncertainty.

30 **Young people focused therapy versus another intervention in young people with**
31 **anorexia nervosa at follow up**

32 Low quality evidence from two RCTs (n=139) showed no difference in BMI between young
33 people focused therapy and any other treatment.

34 Very low quality evidence from two RCTs (n=158) showed no difference in remission rates
35 between young people focused therapy and any other treatment.

36 **Psychodynamic therapy general versus another intervention in adults with anorexia**
37 **nervosa at the end of treatment**

38 Very low quality evidence from one RCT (n=84) showed no difference in the effect of
39 psychodynamic therapy general on remission and all-cause mortality compared with any
40 other treatment.

1 **Psychodynamic therapy general versus another intervention in adults with anorexia**
2 **nervosa at follow up**

3 Low quality evidence from one RCT (n=30) showed no difference in the effect of
4 psychodynamic therapy general on remission, BMI, Morgan-Russell symptoms and the
5 number of people developing bulimic symptoms, compared with any other treatment.

6

7 **Focal psychodynamic therapy versus another intervention in adults with anorexia**
8 **nervosa at end of treatment**

9 Low quality evidence from one RCT (n=242) showed focal psychodynamic therapy was less
10 effective on BMI and general psychopathology compared with any other treatment.

11 Low quality evidence from one RCT (n=242) showed no difference in the effect of focal
12 psychodynamic therapy on remission and EDI- total compared with any other treatment.

13 **Focal psychodynamic therapy versus another intervention in adults with anorexia**
14 **nervosa at follow up**

15 Low quality evidence from one RCT (n=242) showed focal psychodynamic therapy was more
16 effective on remission, BMI, and EDI-total compared with any other treatment.

17 Low quality evidence from one RCT (n=242) showed no difference in the effect of
18 psychodynamic therapy on general psychopathology compared with any other treatment.

19 **Interpersonal psychotherapy versus another intervention in adults with anorexia**
20 **nervosa at end of treatment**

21 Low quality evidence from one RCT (n=56) showed no difference in the effect of
22 interpersonal psychotherapy on BMI compared with any other treatment.

23 Low quality evidence from one RCT (n=56) showed interpersonal psychotherapy was less
24 effective on EDE-restraint compared with any other treatment.

25 Low quality evidence from one RCT (n=56) showed interpersonal psychotherapy was less
26 effective on EDE-eating concern compared with any other treatment but there was some
27 uncertainty.

28 Low quality evidence from one RCT (n=56) showed interpersonal psychotherapy was less
29 effective on general function compared with any other treatment but there was some
30 uncertainty.

31 Low quality evidence from one RCT (n=56) showed no difference in the effect of
32 interpersonal psychotherapy on EDE-weight concern and EDE-shape concern compared
33 with any other treatment.

34 Low quality evidence from one RCT (n=56) showed no difference in the effect of
35 interpersonal psychotherapy on depression compared with any other treatment.

36 Low quality evidence from one RCT (n=48) showed no difference in the effect of
37 interpersonal psychotherapy on EDI-drive for thinness, EDI-body dissatisfaction or EDI-
38 bulimia compared with any other treatment.

39 **Interpersonal psychotherapy versus another intervention in adults with anorexia**
40 **nervosa at follow up**

41 Low quality evidence from one RCT (n=43) showed no difference in the effect of
42 interpersonal psychotherapy on body weight compared with any other treatment.

1 Very low to low quality evidence from one RCT (n=43) showed no difference in the effect of
2 interpersonal psychotherapy on EDE-restraint, EDE-weight concern, EDE-shape concern,
3 EDE-eating concern, EDI-drive for thinness, EDI-body dissatisfaction and EDI-bulimia
4 compared with any other treatment.

5 Low quality evidence from one RCT (n=56) showed no difference in the effect of
6 interpersonal psychotherapy on depression compared with any other treatment.

7 Low quality evidence from one RCT (n=43) showed no difference in the effect of
8 interpersonal psychotherapy on general function compared with any other treatment.

9 **SSCM versus another intervention in adults with anorexia nervosa at end of treatment**

10 Low quality evidence from two RCTs (n=285) showed no difference in the effect of SSCM on
11 BMI compared with any other treatment.

12 Very low quality evidence from two RCTs (n=198) showed no difference in the effect of
13 SSCM on EDE-restraint compared with any other treatment.

14 Low quality evidence from two RCTs (n=198) showed no difference in the effect of SSCM on
15 EDE-eating concern, EDE-weight concern and EDE-shape concern and compared with any
16 other treatment.

17 Low quality evidence from two RCTs (n=213) showed no difference in the effect of SSCM on
18 EDE-global compared with any other treatment.

19 Low quality evidence from one RCT (n=56) showed no difference in the effect of SSCM on
20 EDI-drive for thinness, EDI-body dissatisfaction and EDI-bulimia compared with any other
21 treatment.

22 Low quality evidence from three RCTs (n=269) showed SSCM is more effective on
23 depression compared with any other treatment but there was some uncertainty.

24 Low quality evidence from one RCT (n=56) showed SSCM is more effective on general
25 function compared with any other treatment.

26 Very low quality evidence from one RCT (n=213) showed no difference in the effect of SSCM
27 on remission compared with any other treatment.

28 **SSCM versus another intervention in adults with anorexia nervosa at follow up**

29 Low quality evidence from three RCTs (n=286) showed no difference in the effect of SSCM
30 on BMI compared with any other treatment.

31 Low quality evidence from two RCTs (n=185) showed no difference in the effect of SSCM on
32 EDE-weight concern and EDE-shape concern and EDE-eating concern compared with any
33 other treatment.

34 Low quality evidence from two RCTs (n=185) showed SSCM is less effective on EDE-
35 restraint and EDE-eating concern compared with any other treatment but there was some
36 uncertainty.

37 Low quality evidence from two RCTs (n=213) showed no difference in the effect of SSCM on
38 EDE-global compared with any other treatment.

39 Low quality evidence from one RCT (n=43) showed no difference in the effect of SSCM on
40 EDI-drive for thinness, EDI-bulimia and EDI-body dissatisfaction compared with any other
41 treatment.

- 1 Low quality evidence from three RCTs (n=256) showed no difference in the effect of SSCM
2 on depression compared with any other treatment.
- 3 Very low quality evidence from one RCT (n=43) showed no difference in the effect of SSCM
4 on bulimia compared with any other treatment.
- 5 Very low quality evidence from one RCT (n=43) showed no difference in the effect of SSCM
6 on general function compared with any other treatment.
- 7 Very low quality evidence from three RCTs (n=243) showed no difference in the effect of
8 SSCM on remission rates compared with any other treatment.
- 9 **MANTRA versus another interventions in adults with anorexia nervosa at the end of**
10 **treatment**
- 11 Low quality evidence from two RCTs (n=213) showed no difference in the effect of MANTRA
12 on BMI, depression, EDE-global and quality of life compared with any other treatment.
- 13 **Inpatient CBT-ED versus another inpatient CBT-ED in adults with anorexia nervosa at**
14 **end of treatment**
- 15 Low quality evidence from one RCT (n=72) showed no difference in the effect of one type of
16 inpatient CBT-ED on BMI, general psychiatric features, EDE-restraint, EDE-weight concern,
17 EDE-shape concern and EDE-eating concern compared with another inpatient CBT-ED
18 therapy.
- 19 **Inpatient CBT-ED versus another inpatient CBT-ED in adults with anorexia nervosa at**
20 **follow up**
- 21 Low quality evidence from one RCT (n=68) showed no difference in the effect of one type of
22 inpatient CBT-ED on BMI, general psychiatric features, EDE-restraint, EDE-weight concern,
23 EDE-shape concern and EDE-eating concern compared with another inpatient CBT-ED
24 therapy.
- 25 **CBT-ED versus another interventions in adults with severe and enduring anorexia**
26 **nervosa at end of treatment**
- 27 Low quality evidence from one RCT (n=63) showed no difference in the effect of CBT-ED on
28 BMI, depression, EDE-global and quality of life compared with any other treatment.
- 29 **CBT-ED versus another interventions in adults with severe and enduring anorexia**
30 **nervosa at follow up**
- 31 Low quality evidence from one RCT (n=63) showed no difference in the effect of CBT-ED on
32 BMI, depression and quality of life compared with any other treatment.
- 33 Low quality evidence from one RCT (n=63) showed CBT-ED is more effective on improving
34 EDE-global compared with any other treatment but there was some uncertainty.
- 35 **SSCM versus another interventions in adults with severe and enduring anorexia**
36 **nervosa at the end of treatment**
- 37 Low quality evidence from one RCT (n=63) showed no difference in the effect of SSCM on
38 BMI, EDE-global, quality of life and depression compared with any other treatment.

1 **SSCM versus another interventions in adults with severe and enduring anorexia**
2 **nervosa at follow up**

3 Low quality evidence from one RCT (n=63) showed no difference in the effect of SSCM on
4 BMI, depression and quality of life compared with any other treatment.

5 Low quality evidence from one RCT (n=63) showed SSCM is less effective on EDE-global
6 compared with any other treatment.

7 **6.2.4.2 Group Therapy**

8 No evidence on group therapy in people with anorexia nervosa was identified.

9 **6.2.4.3 Self-help**

10 **Internet guided self-help versus treatment as usual in adults with anorexia nervosa at**
11 **the end of treatment**

12 Low quality evidence from one RCT (n=219 to 226) showed internet guided self-help is more
13 effective on EDI-total and bulimic symptoms compared with treatment as usual.

14 Low quality evidence from one RCT (n=219 to 239) showed internet guided self-help is more
15 effective on EDI-body dissatisfaction, depression, global clinical score compared with
16 treatment as usual, although there was some uncertainty.

17 Low quality evidence from one RCT (n=219) showed no difference in the effect of internet
18 guided self-help on EDI-drive for thinness, EDI-bulimia, menstrual function and general
19 psychopathology compared with treatment as usual, although there was some uncertainty

20 **Internet guided self-help versus treatment as usual in adults with anorexia nervosa at**
21 **follow up**

22 Low quality evidence from one RCT (n=208) showed no difference in the effect of internet
23 guided self-help on general psychopathology and menstrual function and compared with
24 treatment as usual.

25 Low quality evidence from one RCT (n=208) showed internet guided self-help is more
26 effective on bulimic symptoms compared with treatment as usual, although there was some
27 uncertainty.

28 **6.2.4.4 Family Therapy**

29 **Family therapy and treatment as usual versus treatment as usual in young people with**
30 **anorexia nervosa at end of treatment**

31 Moderate quality evidence from one RCT (n=60) showed family therapy is more effective on
32 remission and the number of people in the BMI 10th percentile (age-sex corrected)
33 compared with treatment as usual, although there was some uncertainty.

34 Moderate to low quality evidence from one RCT (n=59) showed no difference in the effect of
35 family therapy on BMI, EDI-total, global functioning and number of people hospitalised during
36 treatment compared with treatment as usual.

37 Moderate quality evidence from one RCT (n=59) showed family therapy may be more
38 effective on reducing the number of amenorrheic patients compared with treatment as usual.

1 **Family therapy versus any other type of family intervention in young people with**
2 **anorexia nervosa at end of treatment**

3 Very low to low quality evidence from one RCT (n=25) showed no difference in the effect of
4 family therapy on % ideal body weight, EDI-bulimia, EDI-drive for thinness, EDI-body
5 dissatisfaction, general psychopathology, depression and family functioning compared with
6 any other type of family intervention.

7 **Family therapy versus general family therapy in young people with anorexia nervosa**
8 **at end of treatment**

9 Low quality evidence from one RCT (n=164) showed no difference in the effect of family
10 therapy on remission compared with general family therapy.

11 Low quality evidence from one RCT (n=158) showed family therapy may be more effective
12 on EDE-global compared with general family therapy, although there was some uncertainty.

13 Low quality evidence from one RCT (n=158) showed no difference in the effect of family
14 therapy on % ideal body weight, YBC-EDS scores, depression and quality of life compared
15 with general family therapy.

16 **Family therapy versus general family therapy in young people with anorexia nervosa**
17 **at follow up**

18 Very low quality evidence from one RCT (n=164) showed no difference in the effect of family
19 therapy on remission compared with general family therapy.

20 Low quality evidence from one RCT (n=158) showed no difference in the effect of family
21 therapy on % ideal body weight , YBC-EDS score, depression and quality of life compared
22 with general family therapy.

23 Low quality evidence from one RCT (n=158) showed family therapy may be more effective
24 on EDE-global compared with general family therapy, although there was some uncertainty.

25 **Multi-family therapy versus family therapy in young people with anorexia nervosa at**
26 **end of treatment**

27 Low quality evidence from one RCT (n=167) showed multi-family therapy is more effective on
28 remission and change in BMI compared with family therapy.

29 Very low quality evidence from one RCT (n=167) showed multi-family therapy is less
30 effective on change in EDE-restraint, EDE-shape concern and EDE-weight concern
31 compared with family therapy.

32 Very low quality evidence from one RCT (n=167) showed no difference in the effect of multi-
33 family therapy on change in EDE-eating concerns and both positive and negative experience
34 of caregiving compared with family therapy.

35 Very low quality evidence from one RCT (n=167) showed multi-family therapy may be less
36 effective on change in depression compared with family therapy, although there was some
37 uncertainty.

38 Very low quality evidence form one RCT (n=96) showed no difference in the effect of multi-
39 family therapy on the carer's service user compared with family therapy.
40

41 Very low quality evidence form one RCT (n=79) showed no difference in the effect of multi-
42 family therapy on the young person's service user compared with family therapy.

1 **Multi-family therapy versus family therapy in young people with anorexia nervosa at**
2 **follow up**

3 Low quality evidence from one RCT (n=167) showed multi-family therapy was more effective
4 on remission and change in BMI compared with family therapy.

5 Very low quality evidence from one RCT (n=167) showed multi-family therapy is less
6 effective on change in both EDE-restraint, EDE-shape concern and EDE-weight concern
7 compared with family therapy.

8 Very low quality evidence from one RCT (n=167) showed no difference in the effect of multi-
9 family therapy on EDE-eating concerns and depression compared with family therapy.

10 **Family therapy versus individual therapy in young people with anorexia nervosa at**
11 **end of treatment**

12 Very low quality evidence from three RCTs (n=179) showed no difference in the effect of
13 family therapy on remission compared with individual therapy.

14 Low quality evidence from three RCTs (n=160) showed family therapy is more effective on
15 BMI/weight compared with individual therapy.

16 Low quality evidence from one RCT (n=21) showed family therapy is more effective on
17 Morgan-Russell Average score compared with individual therapy.

18 Low quality evidence from one RCT (n=103) showed family therapy is more effective on
19 EDE-global compared with individual therapy.

20 Low quality evidence from one RCT (n=35) showed no difference in the effect of family
21 therapy on depression compared with individual therapy.

22 Low quality evidence from one RCT (n=65) showed no difference in the effect of family
23 therapy on family functioning-conflict compared with individual therapy.

24 Low quality evidence from one RCT (n=84) showed family therapy is more effective on family
25 functioning-communication and family functioning-behaviour control compared with individual
26 therapy.

27 **Family therapy versus individual therapy in young people with anorexia nervosa at**
28 **follow up**

29 Low quality evidence from three RCTs (n=179) showed no difference in the effect of family
30 therapy on remission compared with individual therapy.

31 Low quality evidence from three RCTs (n=150) showed family therapy may be more effective
32 on BMI/weight compared with any individual therapy, although there was some uncertainty.

33 Low quality evidence from one RCT (n=93) showed no difference in the effect of family
34 therapy on EDE-global compared with individual therapy.

35 Low quality evidence from one RCT (n=35) showed family therapy is less effective on
36 depression compared with individual therapy.

37 Low quality evidence from one RCT (n=65) showed no difference in the effect of family
38 therapy on carer family functioning compared with individual therapy.

1 **Family therapy-1 (conjoint family therapy) versus family therapy-2 (separated family**
2 **therapy) at end of treatment in young people with anorexia nervosa**

3 Low quality evidence from two RCTs (n=146) showed conjoint family therapy is less effective
4 on remission and BMI compared with separated family therapy-2.

5 Low quality evidence from one RCT (n=40) showed no difference in the effect of conjoint
6 family therapy on change in % average body weight and Morgan-Russell outcome-average
7 compared with separated family therapy.

8 Low quality evidence from one RCT (n=106) showed no difference in the effect of conjoint
9 family therapy on EDE-global, EDE-restraint, EDE-eating concern, EDE-weight concern and
10 EDE-shape concern compared with separated family therapy.

11 Low quality evidence from one RCT (n=106) showed conjoint family therapy may be less
12 effective on the number of people hospitalized during treatment compared with separated
13 family therapy.

14 Low quality evidence from two RCTs (n=146) showed no difference in the effect of conjoint
15 family-based therapy on depression compared with separated family-based therapy.

16 **Family therapy-1 (conjoint family therapy) versus family therapy-2 (separated family**
17 **therapy) in young people with anorexia nervosa at follow up**

18 Very low to low quality evidence from one RCT (n=106) showed no difference in the effect of
19 conjoint family therapy on full remission, BMI, EDE-global, EDE-restraint, EDE-eating
20 concern, EDE-weight concern and EDE-shape concern compared with separated family
21 therapy.

22 Low quality evidence from one RCT (n=106) showed conjoint family therapy is less effective
23 on depression compared with separated family therapy.

24 **Long-term family therapy versus short-term family therapy in young people with**
25 **anorexia nervosa at end of treatment**

26 Moderate to low quality evidence from one RCT (n=86) showed no difference in the effect of
27 long-term family therapy on BMI, EDE-restraint and EDE-shape concern compared with
28 short-term family therapy.

29 Low quality evidence from one RCT (n=86) showed long-term family therapy may be more
30 effective on EDE-weight concern and EDE-eating concern compared with short-term family
31 therapy, although there was some uncertainty.

32 Low quality evidence from one RCT (n=86) showed long-term family therapy is more
33 effective on YBC-EDS score compared with short-term family therapy.

34 **Long-term family therapy versus short-term family therapy in young people with**
35 **anorexia nervosa at follow up**

36 Low to moderate quality evidence from one RCT (n=71) showed no difference in the effect of
37 long-term family therapy on BMI, the number who achieved 90% of ideal body weight, the
38 number who resumed menstruation and who were amenorrhoeic compared with short-term
39 family therapy.

40 Very low to low quality evidence from one RCT (n=35) showed no difference in the effect of
41 long-term family therapy on EDE-eating concerns, EDE-restraint, EDE-weight concerns and
42 EDE-shape concerns compared with short-term family therapy.

1 **Family therapy with family meal versus family therapy without family meal in young**
2 **people with anorexia nervosa at end of treatment**

3 Low quality evidence from one RCT (n=23) showed family therapy with family meal is more
4 effective on remission compared with family therapy without family meal.

5 Very low to low quality evidence from one RCT (n=23) showed no difference in the effect of
6 family therapy with family meal on weight, % expected body weight, EDI-2-total score and
7 Morgan-Russell outcome-average compared with family therapy without family meal.

8 Low quality evidence from one RCT (n=21) showed family therapy with family meal is less
9 effective on general psychopathology compared with family therapy without family meal.

10 Low quality evidence from one RCT (n=21) showed family therapy with family meal is more
11 effective on the number of people who resumed menstruation compared with family therapy
12 without family meal.

13 **Family therapy with family meal versus family therapy without family meal in young**
14 **people with anorexia nervosa at follow up**

15 Very low quality evidence from one RCT (n=23) showed no difference in the effect of family
16 therapy with family meal on remission compared with family therapy without family meal.

17 Very low to low quality evidence from one RCT (n=21) showed no difference in the effect of
18 family therapy with family meal on weight, % expected body weight, Morgan-Russell
19 outcome-average, EDI-2 score and general psychopathology compared with family therapy
20 without family meal.

21 Low quality evidence from one RCT (n=21) showed family therapy with family meal may be
22 more effective on increasing the number of people who resumed menstruation compared
23 with family therapy without family meal, although there was some uncertainty.

24 **Family-based therapy versus any other type of family intervention in adults with**
25 **anorexia nervosa at end of treatment**

26 Low quality evidence from one RCT (n=47) showed no difference in the effect of family
27 therapy on BMI compared with any other type of family intervention.

28 Very low to low quality evidence from one RCT (n=25) showed no difference in the effect of
29 family therapy on SEED Anorexia-severity and SEED Bulimia-severity compared with any
30 other type of family intervention.

31 Low quality evidence from one RCT (n=77) showed no difference in the effect of family
32 therapy on carer quality of life compared with any other type of family intervention.

33 Low quality evidence from one RCT (n=66) showed no difference in the effect of family
34 therapy on carer family functioning compared with any other type of family intervention.

35 Low quality evidence from one RCT (n=75) showed family therapy may be more effective on
36 improving the negative experience of caregiving compared with any other type of family
37 intervention, although there was some uncertainty.

38 Low quality evidence from one RCT (n=75) showed family therapy is less effective on
39 positive experience of caregiving compared with any other type of family intervention.

1 **Family therapy versus any other type of family intervention in adults with anorexia**
2 **nervosa at follow up**

3 Low quality evidence from one RCT (n=44) showed no difference in the effect family therapy
4 on BMI compared with any other type of family intervention.

5 Very low to low quality evidence from one RCT (n=29) showed no difference in the effect of
6 family therapy on SEED Anorexia-severity and SEED Bulimia-severity compared with any
7 other type of family intervention.

8 Low quality evidence from one RCT (n=69) showed no difference in the effect of family
9 therapy on carer quality of life compared with any other type of family intervention.

10 Low quality evidence from one RCT (n=58) showed no difference in the effect of family
11 therapy on carer family functioning compared with any other type of family intervention.

12 Low quality evidence from one RCT (n=63) showed no difference in the effect of family
13 therapy on the positive and negative experience of caregiving compared with any other type
14 of family intervention.

15 **General family and any individual therapy versus any nutritional intervention in adults**
16 **with anorexia nervosa**

17 Very low quality evidence from one RCT (n=30) showed no difference in the effect of general
18 family therapy on weight, the number of people experiencing regular menstruation and the
19 number of people experiencing amenorrhea compared with any nutritional intervention.

20 Very low quality evidence from one RCT (n=30) showed general family therapy is more
21 effective on global clinical score compared with any nutritional intervention.

22 **Family therapy versus any individual therapy in adults with anorexia nervosa at the**
23 **end of treatment**

24 Low quality evidence from one RCT (n=84) showed no difference in the effect of family
25 therapy on all-cause mortality or the number who recovered compared with individual
26 therapy.

27 **6.2.5 Economic evidence statements**

28 There was evidence from one German study (N=242) showing that psychodynamic therapy
29 when compared with CBT-ED and TAU was dominant in adult women with AN. This
30 evidence came from a partially applicable study that was characterised by minor
31 methodological limitations.

32 There was evidence from one US study (N=158) showing that family-based treatment was
33 dominant when compared with systemic family therapy. This evidence came from a partially
34 applicable study and was characterised by potentially serious limitations.

35 No economic evidence on the cost effectiveness of other psychological interventions for
36 children and young people, and adults with anorexia nervosa was identified.

37 **6.2.6 Recommendations and link to evidence**

38 **Psychological treatments for anorexia nervosa in adults**

58. Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention. Support should:

- include psychoeducation about the disorder
- include monitoring of weight, mental and physical health, and any risk factors
- be multidisciplinary and coordinated between services
- involve the person's family members or carers (as appropriate).

59. When treating anorexia nervosa, be aware that:

- helping people to reach a healthy body weight or BMI for their age is a key goal **and**
- weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery.

60. When weighing people with anorexia nervosa, consider sharing the results with them and (if appropriate) their family members or carers.

People with anorexia nervosa who are not having treatment

61. For people with anorexia who are not having treatment (for example because it has not helped or because they have declined it) and who do not have severe or complex problems:

- discharge them to primary care
- tell them they can ask their GP to refer them again for treatment at any time.

62. For people with anorexia who have declined or do not want treatment and who have severe or complex problems, eating disorder services should provide support as covered in recommendation 56.

First-line psychological treatments for anorexia nervosa

63. For adults with anorexia nervosa, consider one of:

- individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- specialist supportive clinical management (SSCM).

Explain to the person what the treatments involve to help them choose which they would prefer.

64. Individual CBT-ED programmes for adults with anorexia nervosa should:

- typically consist of up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks

- aim to reduce the risk to physical health and any other symptoms of the eating disorder
- encourage healthy eating and reaching a healthy body weight
- cover nutrition, cognitive restructuring, mood regulation, social skills, body image concern, self-esteem, and relapse prevention
- create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- explain the risks of malnutrition and being underweight
- enhance self-efficacy
- include self-monitoring of dietary intake and associated thoughts and feelings
- include homework, to help the person practice in their daily life what they have learned.

65. MANTRA for adults with anorexia nervosa should:

- typically consist of 20 sessions, with:
 - weekly sessions for the first 10 weeks, and a flexible schedule after this
 - up to 10 extra sessions for people with complex problems
- base treatment on the MANTRA workbook
- motivate the person and encourage them to work with the practitioner
- be flexible in how the modules of MANTRA are delivered and emphasised
- when the person is ready, cover nutrition, symptom management, and behaviour change
- encourage the person to develop a 'non-anorexic identity'
- involve family members or carers to help the person:
 - understand their condition and the problems it causes and the link to the wider social context
 - change their behaviour.

66. SSCM for adults with anorexia nervosa should:

- typically consist of 20 or more weekly sessions (depending on severity)
- assess, identify, and regularly review key problems
- aim to develop a positive relationship between the person and the practitioner
- aim to help people recognise the link between their symptoms and their abnormal eating behaviour
- aim to restore weight
- provide psychoeducation, and nutritional education and advice

	<ul style="list-style-type: none"> • include physical health monitoring • establish a weight range goal • encourage reaching a healthy body weight and healthy eating • allow the person to decide what else should be included as part of their therapy. <p>67. If individual CBT-ED, MANTRA, or SSCM is unacceptable, contraindicated or ineffective for adults with anorexia nervosa, consider:</p> <ul style="list-style-type: none"> • one of these 3 treatments that the person has not had before or • eating-disorder-focused focal psychodynamic therapy (FPT). <p>Second-line psychological treatment for adult anorexia nervosa</p> <p>68. FPT for adults with anorexia nervosa should:</p> <ul style="list-style-type: none"> • typically consist of up to 40 sessions over 40 weeks • make a patient-centred focal hypothesis that is specific to the individual and addresses: <ul style="list-style-type: none"> ○ what the symptoms mean to the person ○ how the symptoms affect the person ○ how the symptoms influence the person's relationships with others and with the therapist • in the first phase, focus on developing the therapeutic alliance between the therapist and person with anorexia nervosa, addressing pro-anorexic behaviour and ego-syntonic beliefs (beliefs, values and feelings consistent with the person's sense of self) and building self-esteem • in the second phase, focus on relevant relationships with other people and how these affect eating behaviour • in the final phase, focus on transferring the therapy experience to situations in everyday life and address any concerns the person has about what will happen when treatment ends.
<p>Relative value of different outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating anorexia nervosa in children, young people and adults. For this population, body weight or BMI and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p>

	<p>Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>First-line psychological treatment for adults</p> <p>Individual CBT-ED for adults</p> <p>In adults, individual CBT for eating disorders (CBT-ED) was more effective at improving remission versus any other intervention but there was some uncertainty (this uncertainty was increased when a random effects meta-analysis was used). At 12 months follow up, the benefits of CBT-ED on remission were no longer evident, nor was any difference found in body weight.</p> <p>General psychopathology was better in the CBT-ED group compared with any other intervention at the end of treatment; however, all other important outcomes showed no difference, including depression, EDE and EDI subscales and relapse. At follow up there was no difference between any of the key outcomes. No data was available on family functioning, service user experience, all-cause mortality, adverse events, quality of life, and resource use.</p> <p>Comparing one CBT-ED programme with another in hospital showed no difference in any outcomes including BMI, EDE-subcales, general psychiatric features at the end of treatment and 12 months follow up. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, adverse events, quality of life, resource use or relapse.</p> <p>For people with severe and enduring anorexia nervosa, CBT-ED appeared to have similar effects on BMI, depression, EDE global and quality of life as any other treatment. At 12 months follow up similar results were found but there was a trend for more favourable results on EDE-global in the CBT-ED treated group. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, adverse events, resource use or relapse.</p> <p>MANTRA for adults</p> <p>Comparing MANTRA with any other intervention showed no difference in the critical outcomes BMI or remission at the end of treatment and at follow up. Other outcomes, depression and EDI-total, also showed no difference at the end of treatment and at follow up between the two treatment arms. No harms were detected. No data was available on general functioning, family functioning, service user experience, adverse events, quality of life, resource use or relapse.</p> <p>SSCM for adults</p> <p>Comparing specialist supportive clinical management (SSCM) with any other interventions showed no difference in BMI or remission rates at the end of the intervention and at 2 months up to 6.7 years follow up.</p> <p>Other outcomes showed favourable results for SSCM including depression and general function at the end of treatment. All other outcomes were no different between the two treatment arms including EDE-global, EDI-restraint and EDE and EDI subscales.</p> <p>At follow up, none of the outcomes were different between SSCM and any other intervention except EDE-restraint and EDE-eating concern favoured any other outcome with some uncertainty. No harms were detected for SSCM. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use or relapse.</p>

Comparing SSCM to the other therapies recommended for adults with anorexia nervosa showed SSCM is equally effective as CBT-ED on BMI at the end of the intervention and at follow up. Remission rates were not considered since the duration over which the symptoms were measured was not clear. The committee agreed that a minimum of two weeks was required for remission to be considered.

Comparing SSCM with psychodynamic therapy showed no difference in BMI or remission rates at follow up. No data was available at the end of treatment nor on the outcomes of general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, general psychopathology or relapse.

Finally, comparing SSCM directly with MANTRA showed no difference in BMI or remission at the end of treatment or at 2 to 6 months follow up. One death in a patient with long-standing anorexia nervosa in the SSCM group was reported in one of the studies. No data was available on general functioning, family functioning, service user experience, adverse events, quality of life, resource use, general psychopathology or relapse.

One study investigated the effects of SSCM on adults with severe and enduring anorexia nervosa. Compared with other treatments (CBT-ED) it showed no difference at the end of treatment or at follow up for BMI, depression or quality of life. Only at 12 months follow up was SSCM less effective on EDE-global compared with any other treatment. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, resource use or relapse.

No interventions on SSCM or MANTRA were identified in children or young people.

Second-line psychological treatment for adults

Focal psychodynamic therapy

General psychodynamic therapy appeared to improve remission rates but not BMI compared with any other intervention at the end of treatment. Other outcomes, including EDI total, general psychopathology and all-cause mortality were no different at the end of treatment.

Similarly at 26 to 32 months follow up remission favoured focal psychodynamic therapy compared with any other intervention but no difference was found in weight, EDE-bulimia, EDI-total, Morgan–Russell symptoms, general psychopathology. No harms were identified. No data was available on general functioning, family functioning, service user experience, adverse events, quality of life, resource use or relapse.

Focal psychodynamic therapy for eating disorders (FPT) showed no difference on remission, BMI, EDI-total and general psychopathology. At 12-month follow up, FPT showed no difference on BMI, general psychopathology, and EDI-total. However, it was more effective on remission compared with other interventions. No interventions on focal psychodynamic therapy were identified in children or young people.

Other treatments for adults

Counselling compared with any other interventions showed a small positive effect on remission rates but there was some uncertainty. No difference between the groups was found on all-cause mortality. No data was available on body weight, general functioning, family functioning, service user experience, adverse events, quality of life, general psychopathology, resource use or relapse.

	<p>Interpersonal psychotherapy (IPT) showed no difference in BMI compared with any other treatment at end of treatment. No differences were found in EDE-weight concern, EDE-shape concern, depression, EDI-drive for thinness, EDI-bulimia, EDI-body dissatisfaction. IPT was less effective on EDE-restraint and showed a trend to be less effective on general function and EDE-eating concerns. At 6.7 years follow up no differences were found in any of the outcomes. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, adverse events, quality of life, resource use or relapse.</p> <p>One study on self-help for anorexia nervosa was identified but it did not report data on remission or body weight. However, compared with treatment as usual it showed favourable results on EDI-total at the end of treatment and a trend for favourable results on EDI-drive for thinness, EDI-body dissatisfaction, depression, global clinical score and bulimic symptoms. No difference was found in EDI-bulimia, general psychopathology or menstrual function. At 9 months follow up, no difference was found in general psychopathology or menstrual function but a trend for favourable results on bulimic symptoms. No data was available general functioning, family functioning, service user experience, all-cause mortality, adverse events, quality of life, resource use or relapse.</p> <p>Refer to the following LETR for results on psychodynamic therapy and focal psychodynamic therapy for eating disorders.</p> <p>Family therapy in adults</p> <p>In adults no differences were found in an eating disorder-focused family therapy compared with another family intervention (family day workshop) on BMI, severity of anorexia nervosa or bulimia nervosa, quality of life, family functioning. However, favourable results were found on negative carer experiences (but with some uncertainty) and less favourable results were found on positive carer experiences (with some uncertainty). At 36 months follow up, no differences were found in any of these reported outcomes. No evidence was found on the critical outcome of remission, nor the important outcomes of general psychopathology, general functioning, resource use, adverse events, quality of life, all-cause mortality and relapse.</p> <p>In another study, no difference was found between general family therapy and a nutritional intervention on body weight, menstruation, number who had amenorrhea, but there was a favourable outcome on global clinical score. The study did not report the critical outcome of remission, nor on the important outcomes of general psychopathology, general functioning, family functioning, service user experience, resource use, adverse events, quality of life, all-cause mortality or relapse.</p> <p>Finally, family therapy had a similar effect on all-cause mortality and the number of people who recovered compared with individual therapy. No evidence was found on the critical outcomes of remission and weight, nor on the important outcomes of general psychopathology, general functioning, family functioning, service user experience, resource use, adverse events, quality of life or relapse.</p> <p>Refer to LETR on young people with anorexia nervosa for evidence on this age-group.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>Provision of support and care for people with anorexia nervosa</p> <p>The committee expressed the view that providing support and care (for example, psychoeducation, involvement of the person's family members or carers, etc.) for all people with anorexia nervosa may incur additional healthcare resources (that is, time required to provide such support and care). However, the committee</p>

	<p>considered the cost of providing such support and care to be modest, taking into account the potential reduction in burden and improvements in outcomes (including family and carers) and it is expected to lead to overall savings.</p> <p>Psychological treatment for adults with anorexia nervosa</p> <p>There was existing economic evidence study suggesting that psychodynamic therapy was cost effective when compared with CBT-ED and TAU in adults with anorexia nervosa. However, this evidence came from a single non-UK study. There was no evidence on the cost effectiveness of other psychological therapies (e.g. MANTRA or SSCM) in adults with anorexia nervosa.</p> <p>The clinical evidence indicated that all therapies (e.g. CBT-ED, psychodynamic, MANTRA and SSCM) offer similar clinical benefits. According to the committee, all therapies would consist of up to 40 sessions, which could be facilitated by a band 7 worker at a cost of approximately of £3,370 per person (in 2014/15 prices). The committee considered the consequences of anorexia nervosa including very high morbidity and associated high cost to the healthcare system. For example, Beat (2015) estimated the cost to health service resources of the treatment element of eating disorders was £8,850 per individual per annum. The committee also took into account the increased mortality rate; psychological and financial burden for the individual and for their families, as well as the other clinical benefits associated with the treatment. Given the benefits associated with the psychological therapies, the committee expressed the view that the provision of such therapies represent good value for money and are worth the investment. However, the committee noted that the manual for the focal psychodynamic therapy is not available in the English language. They have also noted potentially high training costs associated with the implementation of focal psychodynamic therapy. As a result, the committee expressed the view that only CBT-ED, MANTRA, and SSCM should be available as first-line treatment options for adults with anorexia nervosa.</p>
<p>Quality of evidence</p>	<p>The quality of the evidence was low to very low. The evidence was downgraded for indirectness, imprecision and risk of bias for reasons such as lack of clarity on how randomisation was conducted or if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded, and high dropouts were detected >20%. To account for high dropouts rates, intention-to-treat analysis was used for remission results, with the assumption that any dropouts did not recover from the eating disorder.</p> <p>The committee discussed how little evidence there is on people with anorexia nervosa and the difficulty in recruiting and retaining people in the study. The majority of the comparisons included 1-2 studies and a very low number of participants. The studies on MANTRA and SSCM were small and few of them could be meta-analysed.</p> <p>One study (Zipfel 2014), which compared focal psychodynamic therapy with CBT-ED and optimised treatment as usual, was downgraded for indirectness since a number of participants received inpatient treatment during the study. Between baseline and the end of six months' treatment, 8% of people in the focal psychodynamic group, 10% of CBT-ED and 11% of optimised treatment as usual received additional inpatient treatment. Dare 2001 also reported similar numbers. The committee were therefore concerned that any improvements in remission and body weight might be due to the time spent in hospital rather than the effectiveness of the intervention. The committee also noted that inpatient hospital stay may reflect treatment failure. The adherence to the CBT-ED manual was also queried, however, the study reported a good overall adherence of 0.74 to 0.82 (greater than 0.75 is considered good conformity).</p> <p>After examining other studies, it was revealed that Dare 2001, Touyz 2013 and Schmidt 2012 included a similar number of participants who required a hospital</p>

	<p>stay. Zipfel 2014 was considered a well-designed study with a relatively high number of participants. Ultimately, and for consistency, the committee included Zipfel 2014 and other studies where participants required inpatient care during the intervention. It also reflects what happens in the 'real' world.</p> <p>Another study included in the CBT-ED versus another analysis that was downgraded for indirectness was Pike 2003. This paper included a population different to other studies, wherein the participants had just been discharged from hospital. Consequently, the aim of this study is different to other studies, where the investigators aimed to maintain and consolidate on the gains achieved in the inpatient unit rather than aim to compare the effectiveness of different therapies and/or increase remission rates. Nevertheless, the paper was still included in the analysis but downgraded for indirectness.</p> <p>Heterogeneity was detected for remission in response to CBT-ED versus any other intervention, however the reason could not be deciphered since Pike and Zipfel 2014 were both considered to have a high risk of bias for reasons discussed above. Also, duration or severity of illness were similar between the 2 studies (>6 years of anorexia nervosa). Comorbidities were also not reported, which might have allowed an explanation of the high heterogeneity. In the absence of an explanation for the heterogeneity, the meta-analysis is presented as a random effects model (versus fixed effects). This increases the precision of the effect size.</p> <p>Other interventions considered for adults but not recommended included: interpersonal psychotherapy, psychodynamic counselling, nutritional counselling, Internet-guided self-help and family therapy. Only one study was identified for most of these studies and included very small numbers. For the critical outcomes, either body weight or remission was reported, or remission was excluded because the investigators did not measure symptoms over a minimum of two weeks (which was considered the minimum duration by the committee).</p>
<p>Other considerations</p>	<p>The therapies to offer adults with anorexia nervosa – CBT-ED, MANTRA and SSCM - are not recommended in any particular order. The committee recognised that there was evidence of no difference between the three interventions and agreed that it was important to recommend them as first-line treatments especially because many healthcare professionals are currently trained to deliver these therapies and they were considered effective. Although there were no studies that compared SSCM and MANTRA with wait list controls, they were similarly effective as other interventions including CBT-ED and focal psychodynamic therapy and they did not show any harms.</p> <p>There was some evidence to show SSCM is equally effective as CBT-ED in adults with severe (BMI 11.8 to 18.5 with a mean of 16.2) and enduring anorexia nervosa (more than seven years of illness with a mean duration of 16.6 years). However, the committee were not confident in making a recommendation explicitly for this population given that it was only 1 study with n=63.</p> <p>Although the committee recognised that there are people who have a severe and chronic form of anorexia nervosa, the committee was of the view that the label 'SEED' ('severe and enduring eating disorder') could not be adopted, as there was no evidence to suggest an association with differential treatment outcomes.</p> <p>Despite the fact that there was evidence that there was no difference between focal psychodynamic therapy for eating disorders (FPT) and CBT-ED and treatment as usual at end of treatment, and evidence that it was more effective to treatment as usual at follow up, the committee recognised that it will be difficult for services to immediately implement it in routine care as very few therapists in the NHS have been trained to deliver FPT and the manual is currently only available in the German language (an English-language version will be published in late-2017).</p>

	<p>In addition, a number of other treatments have been recommended that offer service users a choice.</p> <p>The other therapies included in this review but were not recommended because they were either not effective on remission, the sample size was too small, or the quality was too low; these included self-help, interpersonal therapy, psychiatric counselling and family therapy.</p> <p>The committee discussed whether or not to consider cohort studies or those with other designs but recognised that the identified RCTs showed relatively little benefit. Given the potential problems in the interpretation of cohort studies, they decided not to look at them given the 30 RCTs already examined in the evidence review.</p> <p>The committee agreed it was important to state the typical number of sessions (40) that therapy might consist in. The committee emphasised the importance of clinicians showing some flexibility in delivering treatment as some may achieve remission early or they may not respond to this type of treatment and need treatment to be extended or alternatives to be considered. The recommendations regarding the general principles for the care of people with anorexia nervosa were made using informal consensus. The committee highlighted the importance of openly weighing the person with anorexia nervosa, so that they are made aware of the results, and if treating a child or young person that their family or carers are also aware of the results. This was because the restoration of a healthy weight is a priority of treatment, the committee agreed that it was important that the person with anorexia nervosa is made aware of their progress.</p> <p>The committee also agreed that it was important to make a recommendation about people who refuse or do not engage in treatment. They agreed that for people who do not have severe or complex problems, healthcare professionals should discharge them to primary care and suggest that they could ask their GP to re-refer them for treatment; for people who have severe or complex problems, the committee agreed that they should be given support in line with recommendation 55.</p> <p>Given the relatively low sample sizes and remission rates in the studies examining the recommended psychological treatments and the failure to sustain any benefits at long-term follow up, the committee agreed that two research recommendations for anorexia nervosa are warranted regarding (i) the effectiveness of psychological interventions and (ii) the factors associated with maintaining the benefits of successful treatment.</p> <p>More generally, the majority of studies on treatments for all eating disorders (especially, though not limited to, anorexia nervosa – see Chapters 7-9 for the reviewed evidence on other eating disorders) are conducted in females. Whilst the committee recognised that the prevalence of eating disorders in men is probably much lower than in women, thus making it difficult to conduct this research, they felt that it was important that the dearth of research should be highlighted in the hope that it be rectified.</p>
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- 1 **3. Research recommendation: What are the effective interventions for the treatment**
2 **of anorexia nervosa?**
- 3 **4. Research recommendation: What factors are associated with the maintenance of**
4 **benefit after successful treatment for anorexia nervosa?**
- 5 **5. Research recommendation: What is the effectiveness of psychological**
6 **interventions for treatment of eating disorders in men?**

1

Psychological treatments for children and young people with anorexia nervosa

First-line psychological treatment for children and young people

69. Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions:

- separately from their family members or carers and
- together with their family members or carers.

70. FT-AN for children and young people with anorexia nervosa should:

- typically consist of 18–20 sessions over 1 year
- review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last
- emphasise the role of the family in helping the person to recover
- not blame the person or their family members or carers
- include psychoeducation about nutrition and the effects of malnutrition
- support the parents or carers to take a central role in helping the person manage their eating early in treatment and emphasise that this is a temporary role
- in the first phase, aim to establish a good therapeutic alliance with the person, their parents or carers and other family members
- in the second phase, support the person (with help from their parents or carers) to establish a level of independence appropriate for their level of development
- in the final phase:
 - focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention
 - address how the person can get support if treatment is stopped.

71. Consider support for family members who are not involved in the family therapy, to help them cope with distress caused by the condition.

72. Consider giving children and young people with anorexia nervosa additional appointments separate from their family members or carers.

73. Assess whether family members or carers (as appropriate) need support if the child or young person with anorexia nervosa is having therapy on their own.

74. If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN).

75. Individual CBT-ED for children and young people with anorexia nervosa should:

- typically consist of up to 40 sessions over 40 weeks, with:
 - twice-weekly sessions in the first 2 or 3 weeks
 - 8–12 additional brief family sessions with the person and their parents or carers (as appropriate)
- in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition
- in family sessions:
 - identify anything in the person's home life that could make it difficult for them to change their behaviour, and find ways to address this
 - discuss meal plans
- aim to reduce the risk to physical health and any other symptoms of the eating disorder
- encourage reaching a healthy body weight and healthy eating
- cover nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body image concern and self-esteem
- create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- take into account the person's specific development needs
- explain the risks of malnutrition and being underweight
- enhance self-efficacy
- include self-monitoring of dietary intake and associated thoughts and feelings
- include homework, to help the person practice what they have learned in their daily life
- address how the person can get support if treatment is stopped.

76. AFP-AN for children and young people should:

- typically consist of 32–40 individual sessions over 12–18 months, with:

	<ul style="list-style-type: none"> ○ more regular sessions early on, to help the person build a relationship with the practitioner and motivate them to change their behaviour ○ 8–12 additional family sessions with the person and their parents or carers (as appropriate) ● review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last ● in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition ● focus on the person’s self-image, emotions and interpersonal processes, and how these affect their eating disorder ● develop a formulation of the person’s psychological issues and how they use anorexic behaviour as a coping strategy ● address fears about weight gain, and emphasise that weight gain and healthy eating is a critical part of therapy ● find alternative strategies for the person to manage stress ● in later stages of treatment, explore issues of identity and build independence ● towards end of treatment, focus on transferring the therapy experience to situations in everyday life ● in family sessions, help parents or carers support the person to change their behaviour ● address how the person can get support if treatment is stopped.
<p>Critical and important outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating anorexia nervosa in children and young people. For this population, body weight or BMI and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade off benefits and harms</p>	<p>First-line psychological treatment for children and young people Family therapy in children and young people</p> <p>In children and young people with anorexia nervosa, family therapy was the most effective compared with other interventions including CBT-ED (see also the LETR for individual therapy) and (young people) adolescent-focused psychotherapy.</p>

One study compared eating disorder-focused family therapy to treatment as usual in an inpatient setting. Compared with treatment as usual, family therapy showed a trend to be more effective on remission rates and those who achieved a target body weight (BMI greater than 10th percentile), and a clear benefit on reducing the number who were amenorrhic. No difference was found on BMI, EDI-global, global functioning, number who were amenorrhic or required hospitalisation. No data was available at long-term follow up. No evidence was found on the important outcomes of general psychopathology, family functioning, service user experience, resource use, adverse events, quality of life, all-cause mortality or relapse.

In young people with anorexia nervosa, no differences were found in an eating disorder-focused family therapy compared with another family intervention on body weight, EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction, general psychopathology, depression and family functioning. No evidence was found on the critical outcome of remission, nor on the important outcomes of service user experience, resource use, adverse events, quality of life, all-cause mortality or relapse.

In young people with anorexia nervosa, no differences were found between eating disorder-focused family therapy and general family therapy on body weight, remission rates, eating disorder scale, depression or quality of life at the end of treatment or at follow up. There was a trend for EDE-global to favour the eating-disorder-focused family therapy at both time points, however there was some uncertainty. No evidence was found on general functioning, family functioning, service user experience, resource use, adverse events, all-cause mortality or relapse.

Comparing multi-family and single family therapy with single family therapy only in young people, the results showed greater improvements in body weight and rates of remission in the multi-family therapy group at the end of treatment and at follow up. Change in EDE-restraint, EDE-shape concern and EDE-weight concern scores favoured single family therapy at both time points. At end of treatment, no difference was found in EDE-eating concern, positive caregiving experience, negative caregiving experience or service user experience. There was a trend for depression scores to be higher in the multi-family therapy. At 6 months follow up, caregiving or service user experience was not reported and depression scores showed no difference nor EDE-eating concern.

Family therapy showed favourable results on body weight, Morgan-Russell scores and EDE-global compared with individual therapy in young people with anorexia nervosa. No difference was found in remission, depression or carer family functioning. At 5 years follow up, no difference was found in remission, EDE-global, carer family functioning. However, body weight showed a trend to still favour family therapy over individual therapy but not depression. No evidence was found on the important outcomes of general functioning, family functioning, resource use, adverse events, quality of life, all-cause mortality and relapse.

Two studies compared conjoint family therapy with separated family therapy in young people with anorexia nervosa and showed separated family therapy was more effective on remission, and that it may be more effective on BMI and on the number of people hospitalised (although on the there was some uncertainty). Other results showed no difference between the two arms including EDE-subcales and depression. At follow up, one study reported no difference in remission or BMI, along with the EDE-subcales. Depression appeared to favour separate family therapy. No evidence was found on the important outcomes of general functioning, family functioning, service user experience, resource use, adverse events, quality of life, all-cause mortality and relapse.

	<p>Different durations of family therapy, long-term versus short-term, showed no difference at the end of treatment in BMI and most EDE-subcales, although there was some uncertainty. An eating disorder scale (YBC-EDS) did favour long-term family therapy over short-term family therapy. At 12 months follow up, no difference in any of the outcomes was found between the two durations of treatment. No evidence was found on the critical outcome of remission, nor the important outcomes of general psychopathology, general functioning, family functioning, service user experience, resource use, adverse events, quality of life, all-cause mortality and relapse.</p> <p>If family therapy is supplemented with a family meal compared with family therapy alone, there was evidence to show that the addition of a family meal may improve remission rates. However, no difference was found in weight, EDI-2-total score and Morgan-Russell scores. The family meal may also be less effective on general psychopathology compared with family therapy alone (although there was some uncertainty). At 6 months follow up, no difference was found in remission or weight, and all other outcomes showed no difference. There was some evidence that the family meal may be more effective on restoring menstruation at follow up but there was some uncertainty. No evidence was found on the important outcomes of general functioning, family functioning, service user experience, resource use, adverse events, quality of life, all-cause mortality and relapse.</p> <p>Second-line psychological treatment for children and young people</p> <p>When family therapy is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, there was some evidence that showed CBT-ED and adolescent (young people) focused psychotherapy may be viable alternatives.</p> <p>One study was identified that compared the effectiveness of CBT-ED with treatment as usual. No data was available at the end of treatment but at follow up there was no difference in BMI or remission compared treatment as usual. Quality of life and EDI-total were also similar between the two arms. Treatment as usual was non-prescriptive and included a multidisciplinary approach with family therapy, dietetic and individual supportive therapy. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, resource use or relapse.</p> <p>Adolescent-focused eating disorder individual therapy was less effective than family-based treatment) for body weight and remission at the end of treatment. No differences between the two interventions were found on depression. At follow up, there was also no difference on remission and BMI between the two interventions, nor on EDE-global and family functioning. However, adolescent-focused eating disorder individual therapy was more effective on depressive symptoms compared to family therapy). No other relevant outcomes were reported.</p> <p>Supportive therapy in young people appears to be less effective on weight and remission compared with other treatments at the end of treatment, though more effective on improving average Morgan-Russell score. No differences were found at follow up. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, general psychopathology or relapse.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>Provision of support and care for children and young people</p> <p>The committee expressed the view that providing support and care (for example, psychoeducation, involvement of the person's family members or carers, etc.) for all people with anorexia nervosa may incur additional healthcare resources (that is, time required to provide such support and care). However, the committee considered the cost of providing such support and care to be modest, taking into</p>

	<p>account the potential reduction in burden and improvements in outcomes (including family and carers) and it is expected to lead to overall savings.</p> <p>First-line psychological treatment for children and young people There was very limited UK-based existing economic evidence in young people with anorexia nervosa. The evidence indicated that family therapy may potentially be cost effective. According to the committee family therapy would consist of approximately 20 sessions, which could be facilitated by a band 7 worker at a cost of approximately of £2,200 per person (in 2014/15 prices). The committee took into account the physical consequences of anorexia nervosa and high costs associated with managing these; psychological and financial burden both for children and young people and for their families. For example, Beat (2015) estimated the cost to health service resources of the treatment element of eating disorders was £8,850 per individual per annum. Given the clinical benefits associated with the family therapy and very high costs associated with anorexia nervosa the committee expressed the view that the provision of such treatment represent good value for money and are worth the investment.</p> <p>Second-line psychological treatment for children and young people There was no evidence on the cost effectiveness of CBT-ED and adolescent-focused psychotherapy in children or young people with anorexia nervosa. According to the committee the intervention costs are likely to be similar to those of family therapy. However, there was uncertainty pertaining to the clinical benefits. As a result, the committee expressed the view that if family therapyfamily-based therapy is unacceptable, contraindicated or ineffective CBT-ED and adolescent-focused psychotherapy could potentially be considered.</p>
Quality of the evidence	<p>The quality of the evidence was mostly low. The evidence was downgraded for imprecision and risk of bias for reasons such as it was unclear how they randomised or if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded, and high dropouts were detected >20%. To account for high dropouts rates, intention-to-treat analysis was used for remission results, with the assumption that any dropouts did not recover from the eating disorder.</p> <p>The committee noted the indirectness in the study from Le Grange 2016 that was recently added to the conjoint versus separate family therapy review. It was pointed out that 23.6% participants in the conjoint therapy were hospitalised during treatment and 11.8% from the separate family therapy. In addition, 57% of participants continued to receive treatment during the six months' follow up. Also, 9% of the conjoined and 19.6% of the separate family therapy were hospitalised during the follow up period. The study also included people who were up to 95% of expected weight in the trial.</p> <p>The majority of the comparisons did not support a meta-analysis since only one study was available. The study numbers were also relatively low. Nevertheless, the committee agreed that family therapy provided the strongest evidence on young people with anorexia nervosa.</p> <p>In a number of the studies (Eisler 2000, Herscovici 2015, Lock 2010, Robin 1999 and Russell 1989), partial and full remission results were combined since the definition of remission varied across the studies and the partial remission definition in these studies compared closely with the full remission definition in other studies.</p>
Other considerations	<p>The majority of the studies in this review used either 'Family-Based Treatment' manual (see e.g. Lock 2013) or 'Maudsley-based Family Therapy' manual (see e.g. Eisler & Simic 2016). The committee agreed that although there were</p>

differences between these two forms of 'family therapy', these manual-based therapies were sufficiently similar to allow pooling studies that used them against other types of intervention.

The committee agreed that family therapy showed the most promising results in children and young people with anorexia nervosa compared with CBT-ED and adolescent- focused individual therapy (as reviewed in following LETR).

Although few studies were identified, three studies with 179 participants showed family therapy was more effective on BMI and favoured remission compared with individual therapy at the end of treatment. A sensitivity analysis, which was conducted due to high heterogeneity (>50%), showed that family therapy to have a stronger effect on remission. The studies also showed that family-based therapy was more effective on EDE-global and improved family functioning. However, at follow up, there were no differences on any outcome although family therapy showed a trend favouring EDE-global and depression.

The evidence reviewed suggested that multifamily-based therapy (which also includes single family therapy) may be more effective than single family therapy on body weight and rates of remission. The committee agreed that the family therapy could be delivered in either a multi- or single family format.

There was also two studies that supported a recommendation that separate family therapy (parents or carers are treated separately from the young person with the eating disorder) may be more effective than conjoint family therapy (all together). Given that most of the evidence to date has been on conjoint family therapy, the committee agreed that either could be recommended.

The committee agreed that family therapy should include all family members including siblings where possible, given the impact that having a person with an eating disorder can have to the family. If family therapy is not being delivered or if family members such as siblings are not involved in the therapy sessions, the committee agreed that it was important to offer them support to help them to cope with distress caused by the condition.

The committee also acknowledged that some children and young people with an eating disorder may need to discuss concerns independent of their family, so for those who are receiving conjoint family therapy they agreed that it was important to consider the need for additional separate appointments to their family members or carers. Equally, when children and young people are receiving separate family therapy (that is, which does not involve the family or carers), the committee agreed that it was important for family members and carers to receive support if needed. They therefore recommended that such family members or carers (as appropriate) be assessed for this need. It is important to note that these recommendations are not evidence based but based on committee experience and expertise. Therefore, it is not a strong recommendation and only for the health professional to consider. The committee agreed that it was important to offer an alternative therapy to family therapy for young people with anorexia nervosa, especially if it is unacceptable, contraindicated or ineffective because of e.g. problems within the family. One study on CBT-ED showed it was equally effective on remission and body weight as treatment as usual (that included family therapy), thus suggesting it was a good alternative. Conversely, the studies on adolescent-focused psychotherapy showed it may be less effective compared with any other treatment (family therapy). The other intervention where evidence was found in young people was supportive therapy. However, the committee agreed that this was only a control intervention and not one that would ever be recommended.

Besides some evidence to support a recommendation on CBT-ED as an alternative to family therapy for young people, the committee agreed the remainder of the evidence was not convincing and to instead recommend what is offered to adults with a few minor amendments given the age group. As they pointed out, many young people with anorexia nervosa are close in age to the adults used in the studies.

In adults the 2 psychotherapies that proved the most effective were CBT-ED and focal psychodynamic therapy (FPT). However, instead of offering adult FPT for young people (see relevant LETR above for discussion), the committee agreed to offer the age-appropriate version of adolescent (young people) focused psychotherapy.

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3 6.3 Carer interventions

4 6.3.1 Review question: Does any psychological intervention produce benefits/harms 5 in the parents or carers of children or young people with an eating disorder 6 compared with any other intervention or controls?

7 The review protocol summary, including the review question and the eligibility criteria used
8 for this section of the guideline, can be found in Table 104. Further information about the
9 search strategy can be found in Appendix H; the full review protocols can be found in
10 Appendix F.

11 This review considers all psychological interventions for the parents or carers of children or
12 young people with AN. The interventions were categorised according to their mode of
13 delivery (e.g. group, self-help), the age of the people with the eating disorder and the type of
14 eating disorder and were compared to wait list controls, treatment as usual or any other
15 intervention.

16 **Table 104: Clinical review protocol summary**

Component	Description
Review question(s)	Does any psychological intervention produce benefits/harms in the parents or carers of children or young people with an eating disorder compared with any other intervention or controls?
Population	<ul style="list-style-type: none"> Family or carers of people with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder).
Intervention(s)	Psychological interventions may include: <ul style="list-style-type: none"> Family-based Parent only (not necessarily focussed on eating disorder) Parent-focused therapy (PFT) Group Parent-Training (GPT) Separated family therapy Parents with person with ED (greater focus on eating disorder) Behavioural Family Therapy (BFT) Behavioural family systems therapy (BFST). Family-based Treatment (FBT) Family Day Workshops (FDW) Family Therapy (FT) Family therapy for anorexia nervosa (FT-AN)

Component	Description
	<ul style="list-style-type: none"> • Multi-Family Group Day Treatment (MFGDT) • Multi-Family Group Therapy (MFGT) • Systemic Family Therapy (SFT) • Systemic Family Therapy for AN (SFT-AN) • Multifamily therapy (MFT) is synonymous with (MFGT; MFGDT). • Uniting couples in the treatment of AN (UCAN) • Conjoint family therapy
Comparison	<ul style="list-style-type: none"> • Wait list control • Treatment as usual • Another intervention
Critical outcomes	<ul style="list-style-type: none"> • Parent's or carer's general psychopathology (including mood/depression/anxiety) • Family functioning • Quality of life <p>Other primary outcomes commonly reported in studies that just target the family/carer</p> <ul style="list-style-type: none"> • The following outcomes will be included if the family or carer intervention includes the child or person with an eating disorder: • Remission and long-term recovery (if symptoms were measured over a minimum two week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • General functioning • Resource use. • Service user experience • All-cause mortality. • Adverse events • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 6.3.2 Clinical evidence

2 Four RCTs met the eligibility criteria for this review, the majority of which were in female
3 carers of adults with anorexia nervosa (Grover et al., 2011; Hibbs et al., 2015; Hoyle et al.,
4 2013; Magill et al., 2016; Salerno et al., 2016). An overview of all the trials included in the
5 meta-analysis can be found in Table 105.

6 One study (n=149 patients, n=225 carers; Salerno 2016) compared self-help or guided self-
7 help and treatment as usual with treatment as usual for carers of young people with anorexia
8 nervosa recently referred for outpatient treatment. Summaries of the findings regarding carer
9 and patient outcomes can be found in Table 106.

10 One study (n=178 patients/n=268 carers; Hibbs 2015/Magill 2016) compared guided self-
11 help combined with treatment as usual with treatment as usual only for carers of adults with
12 anorexia nervosa recently discharged from inpatient care. Summaries of the findings
13 regarding carer and patient outcomes can be found in Table 107 and Table 108.

1 One study (n=67 carers; Grover 2011) compared web-based guided self-help with treatment
2 as usual for carers of young people and adults with anorexia nervosa. Summary of findings
3 regarding carer outcomes can be found in Table 109 and Table 110.

4 One study (n=37 carers; Hoyle 2013) compared web-based guided self-help with web-based
5 self-help for carers of young people and adults with anorexia nervosa. Summary of findings
6 regarding carer outcomes for interventions for carers of anorexia nervosa can be found in
7 Table 111 and Table 112.

8 Further information about both included and excluded studies can be found in Appendix J.
9 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
10 evidence tables in Appendix L and exclusion list in Appendix J.

11

1 **Table 105: Study information for trials included in review of self-help versus any other intervention for carers of people with**
2 **anorexia nervosa.**

Study_ID	Mean Age of Carer (SD)	Female carers (%)	Mean Age of patient (SD)	Female patients (%)	Sample and duration of illness	N Initially Randomised	Intervention	Comparison	Sessions N	Treatment Length
Grover 2011	48.2 (7.6)	Not reported	20.4 (6.2) (range: 12-44)	Not reported	Full- and sub-threshold AN. Duration=4.3 (4.5) years	64 carers	Web-based Guided Self-Help (OAO)	Ad-hoc usual support (Beat)	16 x weekly 20m email or telephone clinical guidance sessions	4 months + 6-mo FU
Hibbs 2015/ Magill 2015	52.7	60	26 (9)	95	AN. Mean duration=75 months (range: 9-480)	268 carers	Guided Self-Help (ECHO) + TAU	TAU	Variable; minimum of 4 calls (per family) or 75% of the book read to be considered as completer	12-mo from IP discharge + 24-mo FU from IP discharge
Salerno 2016	48.3 (5.5)	95/69	16.9 (2.1)	92	Newly referred for OP treatment; Full- and sub-threshold AN.	149 patient-carer dyads	Guided Self-Help or Self Help (ECHO) + TAU	TAU	Variable; A: Guidance was 10 x 30-60min telephone sessions.	12 months
Hoyle 2013	Not reported	89	Not reported	Not reported	AN. Duration not reported	37 carers	Web-based Guided Self-Help (OAO)	Web-based Self-Help (OAO) only	Weekly email or telephone guidance	7 weeks + 3-mo FU

Study_ID	Mean Age of Carer (SD)	Female carers (%)	Mean Age of patient (SD)	Female patients (%)	Sample and duration of illness	N Initially Randomised	Intervention	Comparison	Sessions N	Treatment Length
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1 Abbreviations: ECHO, Experienced Carers Helping Others; IP; inpatient; OAO, Overcoming Anorexia Online; OP, outpatient; TAU, treatment as usual.

2 **Table 106: Summary table of findings for self-help or guided self-help and treatment as usual (TAU) versus treatment as usual at**
 3 **12 months after referral for outpatient treatment for carers of young people with anorexia nervosa – patient and carer**
 4 **outcomes.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Self-Help or Guided Self-Help + TAU (95% CI)
Carer General Psychopathology at 12 months DASS-21. Scale from: 0 to 126.	149 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer general psychopathology at 12 months in the intervention groups was 0.03 standard deviations higher (0.31 lower to 0.37 higher)
Patient General Psychopathology DASS-21. Scale from: 0 to 126.	149 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean patient general psychopathology in the intervention groups was 0.09 standard deviations lower (0.43 lower to 0.25 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Salerno 2016: no participant blinding; dropout rate of TAU group >20%. Unclear whether baseline demographic and clinical features similar. 50 carer-patient dyads received ECHO with guidance, 49 carer-patient dyads received ECHO without guidance.

2 <400 participants.

1 **Table 107: Summary table of findings for guided self-help and treatment as usual (TAU) versus treatment as usual at 12 and 24**
2 **months after inpatient discharge for carers of adults with anorexia nervosa – carer outcomes**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Guided Self-Help+TAU (95% CI)
Carer Burden at 12 months EDSIS. Scale from: 0 to 96.	182 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden at 12 months in the intervention groups was 0.24 standard deviations lower (0.54 lower to 0.05 higher)
Carer Quality of Life at 12 months WHO-Quol. Scale from: 4 to 20.	182 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer quality of life at 12 months in the intervention groups was 0.32 standard deviations higher (0.03 to 0.61 higher)
Carer Accommodation & Enabling at 12 months AESED. Scale from: 0 to 132.	182 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer accommodation & enabling at 12 months in the intervention groups was 0.19 standard deviations lower (0.48 lower to 0.1 higher)
Carer Burden after 24 months EDSIS. Scale from: 0 to 96.	185 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden after 24 months in the intervention groups was 0.2 standard deviations lower (0.49 lower to 0.09 higher)
Carer Quality of Life after 24 months WHO-Quol. Scale from: 4 to 20.	185 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer quality of life after 24 months in the intervention groups was 0.24 standard deviations higher (0.05 lower to 0.53 higher)
Carer Accommodation & Enabling after 24 months AESED. Scale from: 0 to 132.	185 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer accommodation & enabling after 24 months in the intervention groups was 0.23 standard deviations lower (0.52 lower to 0.06 higher)
Carer General Psychopathology after 24 months DASS-21. Scale from: 0 to 126.	185 (1 study)	⊕⊕⊖⊖ LOW1,2		Not calculable for	The mean carer general psychopathology after 24 months in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Guided Self-Help+TAU (95% CI)
		due to risk of bias, imprecision		SMD values	0.23 standard deviations lower (0.52 lower to 0.06 higher)
Carer Time Spent Caring after 24 months CSRI	185 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer time spent caring after 24 months in the intervention groups was 0.2 standard deviations lower (0.49 lower to 0.09 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval;

1 Hibbs 2015/Magill 2015: No participant nor assessor blinding. Dropout rate>50% 12 months after discharge.

2 CI crosses either 0.5 or -0.5 (SMD).

3 <400 participants.

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2 **Table 108: Summary table of findings for guided self-help and treatment as usual versus treatment as usual at 12 and 24 months**
3 **after inpatient discharge for carers of adults with anorexia nervosa – patient outcomes**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Guided Self-Help+TAU (95% CI)
Patient deaths	178 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 1.07 (0.07 to 16.84)	11 per 1000	1 more per 1000 (from 10 fewer to 172 more)
Readmitted to hospital for ED during course of study	178 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 0.85 (0.53 to 1.35)	11 per 1000	2 fewer per 1000 (from 5 fewer to 4 more)
Patient Relapse after inpatient discharge Readmission to hospital for ED and/or drop 2 BMI points measured monthly from discharge	178 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	RR 0.82 (0.6 to 1.13)	522 per 1000	94 fewer per 1000 (from 209 fewer to 68 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Guided Self-Help+TAU (95% CI)
BMI at 12 months after inpatient discharge	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi at 12 months after inpatient discharge in the intervention groups was 0.11 standard deviations higher (0.26 lower to 0.48 higher)
EDE-Q Global at 12 months after inpatient discharge Scale from: 0 to 6.	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global at 12 months after inpatient discharge in the intervention groups was 0.08 standard deviations lower (0.45 lower to 0.29 higher)
General Psychopathology at 12 months after inpatient discharge DASS-21. Scale from: 0 to 126.	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology at 12 months after inpatient discharge in the intervention groups was 0.03 standard deviations lower (0.4 lower to 0.34 higher)
Quality of Life at 12 months after inpatient discharge WHO-QL. Scale from: 4 to 20.	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life at 12 months after inpatient discharge in the intervention groups was 0.1 standard deviations higher (0.27 lower to 0.47 higher)
BMI at 24 months after inpatient discharge	119 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi at 24 months after inpatient discharge in the intervention groups was 0.28 standard deviations higher (0.08 lower to 0.64 higher)
EDE-Q Global at 24 months after inpatient discharge Scale from: 0 to 6.	119 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global at 24 months after inpatient discharge in the intervention groups was 0.3 standard deviations lower (0.66 lower to 0.07 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Guided Self-Help+TAU (95% CI)
General Psychopathology at 24 months after inpatient discharge DASS-21. Scale from: 0 to 126.	119 (1 study)	⊕⊕⊖⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology at 24 months after inpatient discharge in the intervention groups was 0.27 standard deviations lower (0.63 lower to 0.1 higher)
Quality of Life at 24 months after inpatient discharge WHO-QL. Scale from: 4 to 20.	119 (1 study)	⊕⊕⊖⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life at 24 months after inpatient discharge in the intervention groups was 0.29 standard deviations lower (0.65 lower to 0.07 higher)

**The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).*

CI: Confidence interval; RR: Risk ratio;

1 Hibbs 2015/Magill 2015: No participant nor assessor blinding. Dropout rate >50% 12 months after discharge.

2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4 <300 events (Risk Ratio) or <400 participants (SMD).

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3 **Table 109: Summary table of findings for web-based guided self-help versus treatment as usual at end of treatment for carers of**
4 **people with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Web-based Guided Self-Help (95% CI)
Carer Accommodation & Enabling AESED	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer accommodation & enabling in the intervention groups was 0.34 standard deviations lower (0.84 lower to 0.16 higher)
Carer Burden EDSIS; Experience of Caregiving Inventory (ECI) Negative	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden in the intervention groups was 0.32 standard deviations lower (0.67 lower to 0.04 higher)
Carer Experience of Caregiving (ECI) Positive	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer experience of caregiving (eci) positive in the intervention groups was 0.06 standard deviations higher (0.44 lower to 0.55 higher)
Carer General Psychopathology DASS-21	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer general psychopathology (distress) in the intervention groups was 0.55 standard deviations lower (1.05 to 0.05 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Web-based Guided Self-Help (95% CI)
CI: Confidence interval;					
1 Grover 2011: Participant not blinded. Unclear whether baseline similar.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 110: Summary table of findings for web-based guided self-help versus treatment as usual at follow up for carers of people with anorexia nervosa.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Web-based Guided Self-Help (95% CI)
Carer Accommodation & Enabling FU AESED	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer accommodation & enabling fu in the intervention groups was 0.02 standard deviations lower (0.52 lower to 0.47 higher)
Carer Burden FU EDSIS; Experience of Caregiving Inventory (ECI) Negative	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden fu in the intervention groups was 0.15 standard deviations lower (0.5 lower to 0.2 higher)
Experience of Caregiving (ECI) Positive FU	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean experience of caregiving (eci) positive fu in the intervention groups was 0.18 standard deviations higher (0.32 lower to 0.67 higher)
Carer General Psychopathology (Distress) FU HADS	63 (1 study) 3 months	⊕⊕⊖⊖ LOW1,3		Not calculable	The mean carer general psychopathology (distress) fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Web-based Guided Self-Help (95% CI)
		due to risk of bias, imprecision		ble for SMD values	0.01 standard deviations lower (0.5 lower to 0.49 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Grover 2011: Participant not blinded. Unclear whether baseline similar.					
2 CI crosses either 0.5 or -0.5 (SMD).					
3 <400 participants.					

1 **Table 111: Summary table of findings for web-based guided self-help versus web-based self-help at end of treatment for carers of people with anorexia nervosa – carer outcomes**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Web-based Self-Help	Risk difference with Web-based Guided Self-Help (95% CI)
Carer Burden EDSIS; ECI negative	27 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden in the intervention groups was 0.31 standard deviations higher (0.23 lower to 0.85 higher)
Carer Experience of Caregiving (ECI) Positive	27 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer experience of caregiving (eci) positive in the intervention groups was 0.45 standard deviations higher (0.32 lower to 1.21 higher)
Carer Quality of Life GHQ-28; SF-36	27 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer quality of life in the intervention groups was 0.15 standard deviations lower (0.69 lower to 0.39 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Web-based Self-Help	Risk difference with Web-based Guided Self-Help (95% CI)
Carer General Psychopathology (Distress) DASS-21	27 (1 study) 3 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean carer general psychopathology (distress) in the intervention groups was 0.48 standard deviations lower (1.25 lower to 0.28 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Hoyle 2013: Unclear randomization method, allocation concealment, participant and assessor blinding.					
2 CI crosses 0.5 or -0.5 (SMD).					

1 **Table 112: Summary table of findings for web-based guided self-help versus web-based self-help at follow up for carers of people with anorexia nervosa – carer outcomes**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Web-based Self-Help	Risk difference with Web-based Guided Self-Help (95% CI)
Carer Burden FU EDSIS, ECI Negative	29 (1 study) 3 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden fu in the intervention groups was 0.46 standard deviations higher (0.06 lower to 0.99 higher)
Carer Experience of Caregiving (ECI) Positive FU	29 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean carer experience of caregiving (eci) positive fu in the intervention groups was 0.18 standard deviations higher (0.56 lower to 0.91 higher)
Carer Quality of Life FU	29 (1 study) 3 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean carer quality of life fu in the intervention groups was 0.11 standard deviations lower (0.63 lower to 0.4 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Web-based Self-Help	Risk difference with Web-based Guided Self-Help (95% CI)
Carer General Psychopathology (Distress) FU DASS-21	29 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer general psychopathology (distress) fu in the intervention groups was 0.35 standard deviations lower (1.09 lower to 0.39 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Hoyle 2013: Unclear randomization method, allocation concealment, participant and assessor blinding.					
2 CI crosses 0.5 or -0.5 (SMD).					
3 CI crosses both 0.5 and -0.5 (SMD).					

1

1 **6.3.3 Economic evidence**

2 No economic evidence on the cost effectiveness of interventions for the parents or carers of
3 children or young people with anorexia nervosa was identified by the systematic search of
4 the economic literature undertaken for this guideline. Details on the methods used for the
5 systematic search of the economic literature are described in Chapter 3.

6 **6.3.4 Clinical evidence statements**

7 **6.3.4.1 Self-help or guided self-help and treatment as usual versus treatment as usual for** 8 **carers of young people with anorexia nervosa – patient and carer outcomes**

9 Very low quality evidence from one RCT (n=149) showed no difference in the effect of self-
10 help or guided self-help and treatment as usual on patient and carer general
11 psychopathology (at 12 months) compared with treatment as usual.

12 **6.3.4.2 Guided self-help and treatment as usual versus treatment as usual for carers of adults** 13 **with anorexia nervosa – carer outcomes**

14 Low quality evidence from one RCT (n=182) showed guided self-help and treatment as usual
15 may be more effective on carer burden at 12 months after inpatient discharge compared with
16 treatment as usual, although there was some uncertainty.

17 Low quality evidence from one RCT (n=185) showed guided self-help and treatment as usual
18 may be more effective on carer burden at 24 months after inpatient discharge compared with
19 treatment as usual, although there was some uncertainty.

20 Low quality evidence from two RCTs (n=182) showed no difference in the effect of guided
21 self-help and treatment as usual on carer accommodation and enabling at 12 months after
22 inpatient discharge compared to treatment as usual.

23 Low quality evidence from one RCT (n=185) showed guided self-help and treatment as usual
24 may be more effective on carer accommodation and enabling at 24 months after inpatient
25 discharge compared to treatment as usual, although there was some uncertainty.

26 Low quality evidence from one RCT (n=182) showed guided self-help and treatment as usual
27 is more effective on quality of life at 12 months after inpatient discharge compared with
28 treatment as usual.

29 Low quality evidence from one RCT (n=185) showed guided self-help and treatment as usual
30 may be more effective on quality of life at 24 months after inpatient discharge compared with
31 treatment as usual, although there was some uncertainty.

32 Low quality evidence from one RCT (n=154) showed no difference in the effect of guided
33 self-help and treatment as usual on carer skills and general psychopathology at 12 months
34 after inpatient discharge compared with treatment as usual.

35 Low quality evidence from one RCT (n=185) showed guided self-help and treatment as usual
36 may be more effective on general psychopathology and time spent caring at 24 months after
37 inpatient discharge compared with treatment as usual, although there was some uncertainty.

38 **6.3.4.3 Guided self-help and treatment as usual versus treatment as usual for carers of adults** 39 **with anorexia nervosa – patient outcomes**

40 Very low to low quality evidence from one RCT (n=178) showed guided self-help and
41 treatment as usual may be more effective on reducing the number of deaths, the number of
42 people readmitted to hospital for treatment and the number of people experiencing relapse

1 during the course of the study compared with treatment as usual, although there was some
2 uncertainty.

3 Low quality evidence from one RCTs (n=112) showed no difference in the effect of guided
4 self-help and treatment as usual at 12 months after inpatient discharge on BMI and general
5 psychopathology compared with treatment as usual.

6 Low quality evidence from one RCT (n=112) showed no difference in the effect of guided
7 self-help and treatment as usual at 12 months after inpatient discharge on EDE-Q-global,
8 SEED score, clinical impairment due to eating disorder and quality of life compared with
9 treatment as usual.

10 Low quality of evidence from one RCT (n=119) showed guided self-help and treatment as
11 usual may be more effective at 24 months after inpatient discharge on BMI, EDE-Q-global
12 and quality of life compared with treatment as usual, although there was some uncertainty.

13 Low quality evidence from one RCT (n=119) showed no difference in the effect of guided
14 self-help and treatment as usual at 24 months after inpatient discharge on general
15 psychopathology compared with treatment as usual.

16 **6.3.4.4 Web-based guided self-help versus treatment as usual for carers of anorexia nervosa** 17 **at end of treatment**

18 Low quality evidence from one RCT (n=63) showed no difference in the effect of web-based
19 guided self-help on accommodation and enabling and the positive experience of caregiving
20 compared with treatment as usual.

21 Low quality from one RCT (n=63) showed web-based guided self-help may be more effective
22 on family functioning and carer burden compared with treatment as usual, although there
23 was some uncertainty.

24 Low quality evidence from one RCT (n=63) showed web-based guided self-help is more
25 effective on general psychopathology compared with treatment as usual.

26 **6.3.4.5 Web-based guided self-help versus treatment as usual for carers of anorexia nervosa** 27 **at follow up**

28 Low quality evidence from one RCT (n=63) showed no difference in the effect of web-based
29 guided self-help on accommodation and enabling, family functioning, carer burden, positive
30 experience of caregiving and general psychopathology compared with treatment as usual.

31 **6.3.4.6 Web-based guided self-help versus web-based self-help at end of treatment for carers** 32 **of anorexia nervosa**

33 Low quality of evidence from one RCT (n=27) showed no difference in the effect of web-
34 based guided self-help on family functioning compared with web-based self-help.

35 Low quality of evidence from one RCT (n=27) showed no difference in the effect of web-
36 based guided self-help on carer burden, positive experience of caregiving, quality of life and
37 general psychopathology compared with web-based self-help.

38 **6.3.4.7 Web-based guided self-help versus web-based self-help at follow up for carers of** 39 **anorexia nervosa**

40 Low quality of evidence from one RCT (n=29) showed that web-based guided self-help is
41 more effective on family functioning than web-based self-help.

1 Low quality of evidence from one RCT (n=29) showed web-based guided self-help may be
2 less effective on carer burden compared with web-based self-help, though there was some
3 uncertainty.
4 Very low to low quality of evidence from one RCT (n=29) showed no difference in the effect
5 of web-based guided self-help on positive experience of caregiving, quality of life and general
6 psychopathology compared with web-based self-help.

7 **6.3.5 Economic evidence statements**

8 No economic evidence on the cost effectiveness of interventions for the parents or carers of
9 children or young people with anorexia nervosa was available.

10 **6.3.6 Recommendations and link to evidence**

11 **Working with family members and carers**

	<p>77. Be aware that the family members or carers of a person with an eating disorder may experience severe distress. Offer family members or carers assessments of their own needs as treatment progresses (see NICE’s guideline on supporting adult carers), including:</p> <ul style="list-style-type: none"> • what impact the eating disorder has on them and their mental health • what support they need, including practical support and emergency plans if the person with the eating disorder is at high medical or psychiatric risk. <p>78. If appropriate, provide written information for family members or carers who do not attend assessment or treatment meetings with the person with an eating disorder.</p>
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes in the assessment of whether any interventions can help the parents and carers of children and young people with an eating disorder. The critical outcomes for the parents and carers were agreed to be general psychopathology, family functioning, quality of life and other primary outcomes reported by the study.</p> <p>Other outcomes that were agreed to be critical for the child or young person with the eating disorder include remission and binge eating or body weight, depending on the eating disorder.</p> <p>Other outcomes that are of lesser importance but clearly important outcomes include, general functioning, service user experience, all-cause mortality, adverse events and eating disorder psychopathology.</p>
Trade-off between clinical benefits and harms	<p>One randomised controlled trial (RCT) was aimed at carers of young people with anorexia nervosa and compared the effectiveness of guided self-help or self-help (and treatment as usual) with treatment as usual alone. After 12 months there was no difference in carer and patient general psychopathology. No evidence was found on the critical outcomes of carer general psychopathology, carer family functioning, carer quality of life, nor the important outcomes of eating psychopathology, carer general functioning, service user experience, resource use, adverse events or all-cause mortality.</p>

	<p>One RCT compared guided self-help (and treatment as usual) with treatment as usual for the family/carers of adults recently discharged from inpatient care. At 12 months after inpatient discharge, there was a trend for positive outcomes in the combined treatment group on carer burden and quality of life, but no difference in carer accommodation and enabling. At 24 months after inpatient discharge, there was a trend for a positive result on carer burden, quality of life, carer accommodation and enabling, carer general psychopathology and time spent caring. No evidence was found on the important outcomes of service user experience and resource use.</p> <p>In the same RCT, guided self-help did not translate into many benefits for the adults with anorexia nervosa whom they care for. At 12 months after inpatient discharge, no differences were found in mortality, readmission to hospital, BMI, EDE-global, general psychopathology and quality of life, although there was a positive trend for relapse. At 24 months after inpatient discharge, there was a trend for positive increases in BMI, EDE-global, general psychopathology, and quality of life. No evidence was found on the critical outcome of remission, nor on the important outcomes of adverse events and all-cause mortality.</p> <p>Web-based guided self-help also failed to show convincing benefits for the carers of young people with anorexia nervosa compared with treatment as usual. At the end of treatment, a poorer outcome in distress was found but there was some uncertainty. The other outcomes, such as carer accommodation and enabling, family functioning, carer burden and caregiving experience showed no difference. No evidence was found on the critical outcome of quality of life nor on the important outcome of resource use.</p> <p>Web-based guided self-help compared with web-based self-help showed no difference in the outcomes for carers at the end of treatment. At follow up, no difference in carer experience, quality of life, and general psychopathology was found. There was a trend for poorer results in carer burden, but there was some uncertainty. No evidence was found on the critical outcome of quality of life nor on the important outcome of resource use.</p> <p>For discussion of carer interventions for other eating disorders, see the LETRs in the relevant chapters.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>The committee expressed the view that offering family members and carers an assessment of their own needs may incur additional healthcare resources (that is, time required to perform such assessment). However, the committee considered the cost of providing such assessment to be small, taking into account the potential reduction in family and carers' burden, potential depression and other health vulnerabilities that may be costly to other parts of the healthcare system, especially considering that the burden on family and carers can last for many years and increase their morbidity and stress. Consequently, the committee judged that assessment that aims to improve family and carers' experience are likely to represent good value for money.</p>
<p>Quality of evidence</p>	<p>The quality of the evidence was mostly very low. The outcomes were downgraded because of unclear randomisation method, it was unclear if allocation concealment was performed or if participants and investigators were blinded. In some, not all, assessors were blinded. High dropout rates were also detected in some groups >20%.</p> <p>Outcomes were not always measured at the end of treatment or at follow up. It is not known if any improvements in the carer's general psychopathology also translated to benefits in the children with the eating disorder.</p>

Other considerations	<p>Given the very low quality of the data with very few positive findings favouring one arm over the other, the committee came to the consensus that there was not enough evidence to support a recommendation on any specific treatment for parents or carers of people with an eating disorder.</p> <p>Nevertheless, the committee acknowledged the stress and burden that a person with an eating disorder, in particular anorexia nervosa, can have on family members over a long period of time. Therefore, they agreed that offering family members and carers an assessment of their own needs, including: personal, social and emotional support available to them, the need for support in the caring role for example if the child should need urgent care and there are other children to take care of, and to offer advice on where they can get some practical support.</p> <p>The extent to which the family need to be involved in treatment depends on the age and developmental needs of the person with the eating disorder, the severity of the illness, the risk from harm and the person receiving treatment's wishes. In general, parents and other family members will want to be involved in the treatment. If a parent or carer does not attend a meeting the healthcare professional should provide written information on the outcome of an assessment or treatment where appropriate.</p> <p>The committee acknowledged the importance of consent and confidentiality, and their discussion can be found in the LETRs relating to this in Chapter 5.</p> <p>They also discussed that although the majority of evidence found was for carers and parents of people with anorexia nervosa or any eating disorder, the recommendations were relevant for parents and carers of people with bulimia nervosa and binge eating disorder. This is mostly due to the fact that no specific intervention was recommended and, moreover, that family members or carers of people with any eating disorder can experience extreme distress whilst the person is receiving treatment.</p> <p>In absence of good evidence, the committee agreed to generate two research recommendations to examine the effectiveness of (i) peer-support interventions for people with eating disorders and their families or carers, and (ii) psychological interventions for the parents or carers of people with eating disorders.</p>
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1 **6. Research recommendation: What is effectiveness of peer-support interventions**
2 **for people with eating disorders and their families or carers?**

3 **7. Research recommendation: What is the effectiveness of psychological**
4 **interventions for the families or carers of people with eating disorders?**

5 **6.4 Pharmacological interventions**

6 **6.4.1 Review question: Does any pharmacological intervention produce**
7 **benefits/harms on specified outcomes in people with eating disorders?**

8 Further information about the search strategy can be found in Appendix H; the full review
9 protocols can be found in Appendix F.

10 This review considers all pharmacological interventions that may be delivered to children,
11 young people and adults with an eating disorder. The interventions were categorised
12 according to type of physical intervention, the age of the participants and the type of eating
13 disorder and were compared to wait list controls, placebo, treatment as usual or any other
14 intervention.

1

Table 113: Clinical review protocol summary

Topic	Interventions to treat eating disorders in children, young people and adults
Review question	Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Strata: children (≤ 12), young people (13- ≤ 17 years), adults ≥ 18 years eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical eating disorder)
Intervention	Pharmacological intervention Pharmacological + psychological: Pharmacological interventions may include: Anti-depressants i.e. SSRIs, Fluoxetine – Prozac Anxiolytic (antianxiety) Antipsychotic Anti-emetic medication. i.e. Ondansetron Anticonvulsant topiramate/antiepileptic (Topomax) Appetite suppressant (i.e. lisdexamfetamine dimesylate)
Control	Placebo Wait list control Treatment as usual Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes for decision-making	Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED. Body weight / BMI for AN. Adverse events
Study design	Systematic Reviews RCTs

2 **6.4.1 Clinical evidence for: Does any pharmacological intervention produce**
3 **benefits/harms on specified outcomes in people with eating disorders?**

4 16 RCTs (n=555) fulfilled the criteria for the review on the effect of pharmacological
5 interventions on people with anorexia nervosa, the majority were on adults (Andries et al.,
6 2014; Andries et al., 2015; Attia et al., 1998; Attia et al., 2011; Bissada et al., 2008; Brambilla
7 et al., 2007; Court et al., 2010; Fassino et al., 2002; Hagman et al., 2011; Halmi et al., 1986;
8 Kaye et al., 2001; Kafantaris et al., 2011; Misra et al., 2013; Ruggiero et al., 2001; Walsh et
9 al., 2006).

10

Table 114: Study information for trials included in the analysis of pharmacological interventions versus any other intervention or wait list control for people with anorexia nervosa.

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N Initially Randomised	Intervention Category	Comparison Arm Category	Treatment Length
Andries 2014 & Andries 2015	33.3 (28.0 to 38.7)	15.7 (15 to 16.4)	100%	Duration of illness 15 (10.2 to 19.9) years	25	Dronabinol (synthetic cannabinoid agonist) 5mg/day	Placebo	4 weeks
Attia 1998	26.2 (7.4)	15.0 (4.2)	100%	In patient	33	fluoxetine (SSRI, 20mg to 60 mg/day) + CBT	Placebo+ CBT	37 days
Attia 2011	27.7 (9.1)	17.1 (1.3)	99%	NR	23	Olanzapine (Antipsychotic, 7.95 mg)	Placebo	8 weeks
Bissada 2008	23.61 (6.5)	16.4 (1.1)	100%	NR	34	Olanzapine. (Antipsychotic, 2.5 to 10 mg/day.	Placebo	10 week
Brambilla 2007b	23 (4.8)	15.7 (2.1)	100%	Duration of illness 5.1 (4.0) years	20	Olanzapine (Antipsychotic, 2.5 to 5 mg/day)+CBT	CBT+Nutrition+Placebo	3 months
Brambilla 2007a	23.7 (4.8)	15.5 (1.9)	100%	Duration of illness 6.3 (5.0) years	35	Olanzapine (Antipsychotic, 2.5 to 5 mg/day)+CBT	Placebo + Psychotherapy	3 months
Court 2010	23.8 (9.4)	16.9 (1.7)	99%	NR	33	Quetiapine (antipsychotic, 50 to 400 mg/day)	Treatment as usual	12 weeks
Fassino 2002	24.3 (5.4)	16.2 (0.8)	100%	Duration of illness: 5.7 (4.9) years	52	Citalopram (SSRI)	Wait list control	3 months 52 weeks FU
Hagman 2011	16.2 (2.5)	IBW 78 (5)%	100%	NR	41	Risperidone (antipsychotic, 0.5 to 4 mg/day)	Placebo	7 weeks

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N Initially Randomised	Intervention Category	Comparison Arm Category	Treatment Length
Halmi 1986	20.56 (5.1)	79 (7)% target weight	100%	Duration of illness 2.9 (2.3) years	72	Amitriptyline (TCA, max 160 mg/day) Cyproheptadine (Antihistamine, max 32 mg/day)	Placebo	unclear up to 35 days
Kaye 2001	23.0 (9.0)	% Average BW: 89 (6)	100%	Duration of illness: 7 years	39	Fluoxetine (SSRI, 20 mg/day up)	Placebo	12 months
Kafantaris 2011	17.1 (2.4)	16.4 (1.2)	100%	NR	20	Olanzapine(antipsychotic, 85 mg/day)	Placebo	10 weeks
Misra 2013	16.9 (0.2)	17.2 (0.2)	100%	Duration since diagnosis: 14.5 (2.8) months	72	Transdermal 17β-estradiol	Placebo	18 months
Ruggiero 2001	24.5 (5.1)	40.9 (7.0) kg	NR	Hospitalized weight restoration treatment participated in the study.	35	Fluoxetine (SSRI, 26 mg/day) Clomipramine (TCA. 57 mg/day)	Antipsychotic. D2 and D3 receptor antagonist, 50mg/day	3 months
Walsh 2006	22.4 (4.5)	20.2 (0.5)	100%	Duration of illness: 4.1 (3.1) years	93	Fluoxetine + CBT (SSRI, 20 to 60mg/day + CBT)	Placebo + CBT	12 months

Abbreviations: CBT – cognitive behavioural therapy; FU – follow up; SSRI – selective serotonin reuptake inhibitor; TCA - tricyclic antidepressants.

Table 115: Summary of findings table for antidepressant (SSRI or TCA) compared with placebo in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with Antidepressant (95% CI)
BMI. Adults - SSRIs	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias,		Not calculabl	The mean bmi. adults - ssris in the intervention groups was

		imprecision, publication bias		e for SMD values	0.72 standard deviations higher (0.16 to 1.29 higher)
Change in % average body weight. Adults - SSRIs	23 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean change in % average body weight. adults - ssris in the intervention groups was 0.61 standard deviations lower (1.45 lower to 0.23 higher)
Depression. Adults	88 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression. adults in the intervention groups was 0.58 standard deviations lower (1.01 to 0.15 lower)
Depression. Adults - SSRI	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression. adults - ssri in the intervention groups was 0.67 standard deviations lower (1.23 to 0.11 lower)
Depression. Adults - TCA	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression. adults - tca in the intervention groups was 0.45 standard deviations lower (1.12 lower to 0.22 higher)
EDI-Bulimia. Adults - SSRI	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - bulimia. adults - ssri in the intervention groups was 0.26 standard deviations lower (0.81 lower to 0.28 higher)
Achieved target weight. Adults - TCA	48 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias,	RR 1.15 (0.7 to 1.42)	640 per 1000	96 more per 1000 (from 192 fewer to 269 more)

		imprecision, publication bias		
Relapse (LSE because of deteriorating clinical state). Adults - SSRIs	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,8} due to risk of bias, imprecision, publication bias	RR 0.45 (0.23 to 0.86)	842 per 1000 463 fewer per 1000 (from 118 fewer to 648 fewer)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how random sequence was generated and if allocation concealment was conducted. Neither the participants, assessors nor investigators were blind. High dropouts were reported >20%.

2 95% CI crossed 1 MID (0.5).

3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.

4 It was unclear how random sequence was generated and if allocation concealment was conducted. The participants and investigators were blind but it was unclear if the assessors were blind. High dropouts were reported >20%.

5 95% CI crossed 1 MID (-0.5).

6 It was unclear how random sequence was generated and if allocation concealment was conducted. In one study, neither the participants, assessors nor investigators were blind. The other study was double blind but it was unclear if assessors were blind. High dropouts were reported >20%.

7 95% CI crossed 1 MID (1.25).

8 95% CI crossed 1 MID (0.75).

Table 116: Summary of findings table for antidepressant (SSRI) compared with another antidepressant (TCA) in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant	Risk difference with Antidepressant (95% CI)
No episodes of vomiting. Adults - SSRI vs. TCA	23 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias	RR 0.61 (0.37 to 1.01)	0 per 1000	-
Binge eating. Adults - SSRI vs. TCA	23 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4}	RR 1.3 (0.68 to 2.48)	538 per 1000	162 more per 1000 (from 172 fewer to 797 more)

		due to risk of bias, imprecision, publication bias			
Amenorrhoea. Adults - SSRI vs. TCA	23 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias	RR 1.3 (0.68 to 2.48)	538 per 1000	162 more per 1000 (from 172 fewer to 797 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 It was unclear how random sequence was generated and if allocation concealment was conducted. The participants and investigators were blind but it was unclear if the assessors were blind. High dropouts were reported >20%.					
2 95% CI crossed 1 MID (0.75).					
3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.					
4 95% CI crossed 2 MIDs (0.75 and 1.25).					

Table 117: Summary of findings table for antipsychotic compared with placebo in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with Antipsychotic (95% CI)
Weight - Adults	57 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean weight - adults in the intervention groups was 0.15 standard deviations lower (0.67 lower to 0.37 higher)
Depression - Adults	26 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression - adults in the intervention groups was 0.54 standard deviations higher (0.25 lower to 1.32 higher)
No side-effects - Young people	60 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{3,6,7} due to risk of bias, imprecision, publication bias	RR 1.04 (0.91 to 1.18)	62 per 1000	2 more per 1000 (from 6 fewer to 11 more)

No side-effects - Adults	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,8} due to risk of bias, imprecision, publication bias	Not estimable	See comment	-
Remission - Young people_ITT	41 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,9,10} due to risk of bias, imprecision, publication bias	RR 0.69 (0.31 to 1.55)	455 per 1000	141 fewer per 1000 (from 314 fewer to 250 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 High dropouts were reported in one study.

2 95% CI crossed 1 MID (-0.5).

3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.

4 95% CI crossed 1 MID (0.5).

5 Studies were randomised, however it was unclear if allocation concealment was conducted. Two studies were triple-blinded and one was double-blinded. High dropouts were reported >20%.

6 For a dichotomous outcome there were fewer than 300 events.

7 Studies were randomised, however it was unclear if allocation concealment was conducted. One study was triple-blinded and one was double-blinded. High dropouts were reported >20%.

8 It was unclear if allocation concealment was conducted. The study was triple-blinded. High dropouts were reported >20%

9 Studies were randomised, however it was unclear if allocation concealment was conducted. The study was double-blinded but it was unclear if assessors were blind.

10 95% CI crossed 2 MIDs (0.75 and 1.25)

Table 118: Summary of findings table for antipsychotic and psychotherapy (CBT and nutritional) compared with placebo and psychotherapy (CBT and nutritional) in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo + Therapy	Risk difference with Combined Antipsychotic + Psychotherapy (95% CI)
BMI. Adults	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean bmi. adults in the intervention groups was 0.18 standard deviations higher (0.54 lower to 0.89 higher)

EDI-Total. Adults	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - total. adults in the intervention groups was 0.47 standard deviations higher (0.26 lower to 1.19 higher)
EDI-Drive for thinness. Adults	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - drive for thinness. adults in the intervention groups was 0.36 standard deviations higher (0.37 lower to 1.08 higher)
EDI-Bulimia. Adults	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - bulimia. adults in the intervention groups was 0.18 standard deviations higher (0.54 lower to 0.9 higher)
EDI - Body dissatisfaction. Adults	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - body dissatisfaction. Adults in the intervention groups was 0.43 standard deviations higher (0.29 lower to 1.16 higher)
Yale - eating disorder rating scale. Adults	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean yale - eating disorder rating scale. adults in the intervention groups was 0.53 standard deviations lower (1.26 lower to 0.2 higher)
No side-effects. Adults	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias	RR: 1.00 (0.90 to 1.10)	See comment**	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

**Because the results included zero events an absolute risk difference could not be calculated.

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how random sequence was generated or if allocation concealment was conducted. The study was double-blind but it was unclear if allocation concealment was conducted.

2 95% CI crossed 1 MID (0.5).
 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
 4 It was unclear how random sequence was generated or if allocation concealment was conducted in both studies. The study was double-blind but it was unclear if allocation concealment was conducted.
 5 95% CI crossed 1 MID (-0.5).

Table 119: Summary of findings table for antidepressant and psychotherapy compared with psychotherapy in adults with anorexia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Therapy	Risk difference with Combined Antidepressant + Psychotherapy (95% CI)
Weight % Ideal BW (final)-SSRI Adult	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean weight % ideal bw (final)-ssri adult in the intervention groups was 0.14 standard deviations lower (0.85 lower to 0.56 higher)
Weight % Ideal BW (change)-SSRI Adult	93 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean weight % ideal bw (change)-ssri adult in the intervention groups was 0.46 standard deviations lower (0.87 to 0.04 lower)
Depression (change and final) SSRI Total	124 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The difference in mean depression score (change and final) ssri total in the intervention groups was 0.32 standard deviations higher (0.03 lower to 0.68 higher)
Quality of life SSRI Adults	93 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean quality of life ssri adults in the intervention groups was 0.38 standard deviations lower (0.79 lower to 0.03 higher)
Remission SSRI Adults_ITT	93 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,6} due to risk of bias, imprecision, publication bias	RR 1.57 (0.49 to 5.01)	91 per 1000	52 more per 1000 (from 46 fewer to 365 more)

Global Improvement (CGI) SSRI Adults	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean global improvement (cgi) ssri adults in the intervention groups was 0.20 standard deviations lower (0.91 lower to 0.51 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 It was unclear if allocation concealment was conducted. Studies were triple blinded. High dropouts were reported >20%. 2 95% CI crossed 1 MID (0.5). 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded. 4 95% CI crossed 1 MID (-0.5). 5 For a continuous outcome there were fewer than 400 participants. 6 95% CI Crossed 2 MIDs (0.75 and 1.25). 7 95% CI crossed 2 MID (-0.5 and 0.5).					

Table 120: Summary of findings table for antihistamine compared with placebo in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Other medication (not antidepressants) (95% CI)
Achieved target weight. Adults - Antihistamine	48 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias	RR 1.15 (0.79 to 1.69)	640 per 1000	96 more per 1000 (from 134 fewer to 442 more)
Depression, Adults - Antihistamine	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression, adults - antihistamine in the intervention groups was 0.58 standard deviations lower (1.23 lower to 0.07 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					

1 It was unclear how random sequence was generated or if allocation concealment was conducted. The study was double-blind but it was unclear if assessor was blind. High dropouts were reported >20%.
 2 95% CI crossed 1 MID (1.25).
 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
 4 95% CI crossed 1 MID (-0.5).

Table 121: Summary of findings table for antipsychotics compared with antidepressant in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant	Risk difference with AN Antipsychotics (95% CI)
No binge eating	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias	RR 0.87 (0.61 to 1.24)	174 per 1000	23 fewer per 1000 (from 68 fewer to 42 more)
No vomiting	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias	RR 0.87 (0.6 to 1.25)	130 per 1000	17 fewer per 1000 (from 52 fewer to 33 more)
Amenorrhea	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias	RR 1.08 (0.65 to 1.81)	609 per 1000	49 more per 1000 (from 213 fewer to 493 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how the randomisation sequence was generated or if allocation concealment was conducted. Participants were blind, but investigators were not. It was unclear if the assessors were blind.
 2 95% CI crossed 1 MID (0.75).
 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
 4 95% CI crossed 2 MIDs (0.75 and 1.25).

Table 122: Summary of findings table for cannabinoid agonist compared with placebo in adults with anorexia nervosa.

Outcomes				Anticipated absolute effects
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	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Risk with placebo	Risk difference with Cannaboid agonist (95% CI)
Weight gain. Adults	48 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain. adults in the intervention groups was 1.6 standard deviations higher (0.95 to 2.26 higher)
Intensity of physical activity. Adults	48 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean intensity of physical activity. adults in the intervention groups was 0.18 standard deviations higher (0.39 lower to 0.74 higher)
Change in total EDI-2. Adults	48 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in total edi-2. adults in the intervention groups was 0.78 standard deviations lower (1.36 to 0.19 lower)
Change in EDI-2 Body dissatisfaction. Adults	48 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in edi-2 body dissatisfaction. adults in the intervention groups was 0.07 standard deviations lower (0.64 lower to 0.5 higher)
Change EDI-2 Drive for thinness. Adults	48 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change edi-2 drive for thinness. adults in the intervention groups was 1.15 standard deviations higher (0.53 to 1.76 higher)
Change in EDI-2 Bulimia. Adults	48 (1 study)	⊕⊕⊕⊖ MODERATE1 due to risk of bias		Not calculable for SMD values	The mean change in bulimia. adults in the intervention groups was 0.72 standard deviations higher (0.13 to 1.3 higher)

No adverse events. Adults	25 (1 study)	⊕⊕⊕⊖ MODERATE ¹ due to risk of bias	Not estimable	See comment	-
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
¹ The study was double-blind but it was unclear if investigator was blind.					
² 95% CI crossed 1 MID (0.5).					
³ 95% CI crossed 1 MID (-0.5).					

Table 123: Summary of findings table for oestrogen treatment compared with placebo in adults with anorexia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo (AN)	Risk difference with oestrogen(95% CI)
Change in body weight – Young people	37 (1 study)	⊕⊕⊕⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean change in body weight - young people in the intervention groups was 0.38 standard deviations higher (0.27 lower to 1.03 higher)
Dropout for any reason - Young people	72 (1 study)	⊕⊖⊖⊖ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 0.95 (0.59 to 1.52)	500 per 1000	25 fewer per 1000 (from 205 fewer to 260 more)
Change in fat mass - Young people	37 (1 study)	⊕⊕⊕⊖ LOW ^{2,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean change in fat mass - young people in the intervention groups was 0.98 standard deviations lower (1.67 to 0.29 lower)
Change in EDI-Drive for thinness - Young people	37 (1 study)	⊕⊕⊕⊖ LOW ^{2,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean change in edi - drive for thinness - young people in the intervention groups was 0.38 standard deviations lower (1.03 lower to 0.28 higher)
Change in EDI-Bulimia - Young people	37 (1 study)	⊕⊕⊕⊖ LOW ^{2,5}		Not calculable for SMD values	The mean change in edi - bulimia - young people in the intervention groups was

		due to risk of bias, imprecision			1.41 standard deviations lower (2.14 to 0.68 lower)
Change EDI-Body dissatisfaction - Young people	37 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change edi - body dissatisfaction - young people in the intervention groups was 0.8 standard deviations higher (0.12 to 1.47 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 95% CI crossed 1 MID (0.5).					
2 Unclear if allocation concealment was performed. It is also unclear either the participants, investigators or assessors were blind. High dropouts were reported >20%.					
3 95% CI crossed 2 MIDs (0.75 and 1.25).					
4 95% CI crossed 1 MID (-0.5).					
5 Fewer than 400 participants were used in meta-analysis.					

1 **6.4.2 Economic evidence**

2 No economic evidence on the cost effectiveness of pharmacological interventions for people
3 with anorexia nervosa was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **6.4.3 Clinical evidence statements**

7 **6.4.3.1 Antidepressant versus placebo in adults with anorexia nervosa at the end of treatment**

8 **SSRIs**

9 Very low quality evidence from one RCT (n=35 to 52) showed SSRI's have a positive effect
10 on BMI, depression and relapse rates compared with placebo.

11 Very low quality evidence from one RCT (n=23) showed no difference on the effect of SSRI's
12 on change in percent body weight and EDI-bulimia compared with placebo.

13 **TCAs**

14 Very low quality evidence from one RCT (n=36 to 48) showed no difference on the effect of
15 TCAs on achieving target body weight and depression compared with placebo.

16 **6.4.3.2 Antidepressant versus another antidepressant in adults with anorexia nervosa at the
17 end of treatment**

18 **SSRIs vs. TCAs**

19 Very low quality evidence from one RCT (n=23) showed SSRI's may have a positive effect
20 on reducing vomiting rates compared with TCAs, but there was some uncertainty.

21 Very low quality evidence from one RCT (n=23) showed no difference in the effect of SSRI's
22 on binge eating and amenorrhea compared with TCAs.

23 **6.4.3.3 Antipsychotics versus placebo in adults with anorexia nervosa at the end of treatment**

24 Very low quality evidence from two RCTs (n=57) showed no difference in the effect of
25 antipsychotics on weight compared with placebo.

26 Very low quality evidence from one RCT (n=26 to 34) showed no difference on the effect of
27 antipsychotics on depression and the number of side-effects compared with placebo.

28 **6.4.3.4 Antipsychotics versus placebo in young people with anorexia nervosa at the end of
29 treatment**

30 Very low quality evidence from two RCTs (n=60) showed no difference in the effect of
31 antipsychotics on the number of side-effects compared with placebo.

32 Very low quality evidence from one RCT (n=41) showed no difference in the effect of
33 antipsychotics on remission compared with placebo.

1 **6.4.3.5 Antipsychotic and psychotherapy (CBT and nutritional) compared with placebo and**
2 **psychotherapy (CBT and nutritional) in adults with anorexia nervosa at the end of**
3 **treatment**

4 Very low quality evidence from one RCT (n=30) showed no difference in the effect of an
5 antipsychotic and psychotherapy on BMI, EDI-subscales, Yale eating disorder and side-
6 effects compared with placebo and psychotherapy.

7 **6.4.3.6 Antidepressant and psychotherapy (CBT and nutritional) compared with placebo and**
8 **psychotherapy (CBT and nutritional) in adults with anorexia nervosa at the end of**
9 **treatment**

10 Very low quality evidence from one RCT (n=31) showed no difference in the effect of
11 antidepressant and psychotherapy on body weight and global improvement compared with
12 psychotherapy.

13 Very low quality evidence from one RCT (n=91) showed no difference in the effect of
14 antidepressant and psychotherapy on remission compared with psychotherapy.

15 Very low quality evidence from two RCTs (n=93) showed the change in weight gain is less in
16 the antidepressant and psychotherapy group compared with psychotherapy.

17 Very low quality evidence from one RCT (n=93) showed antidepressant and psychotherapy
18 group are less effective on depression and quality of life compared with psychotherapy, but
19 there was some uncertainty.

20 **6.4.3.7 Antihistamine versus placebo in adults with anorexia nervosa at the end of treatment**

21 Very low quality evidence from one RCT (n=48) showed no difference in the effect of
22 antidepressant and psychotherapy group on the numbers who achieved their target body
23 weight compared with placebo.

24 Very low quality evidence from one RCT (n=38) showed antidepressant and psychotherapy
25 group is more effective on depression compared with placebo, but there was some
26 uncertainty.

27 **6.4.3.8 Antipsychotics versus antidepressant in adults with anorexia nervosa at the end of**
28 **treatment**

29 Very low quality evidence from one RCT (n=35) showed no difference in the effect of
30 antipsychotics on vomiting, binge eating and amenorrhea compared with antidepressants.

31 **6.4.3.9 Cannabinoid agonist versus placebo in adults with anorexia nervosa at the end of**
32 **treatment**

33 Low quality evidence from one RCT (n=48) showed no difference in the effect of cannabinoid
34 agonists on intensity of physical activity, change in EDI-body dissatisfaction or the number of
35 adverse events compared with placebo.

36 Low quality evidence from one RCT (n=48) showed cannabinoid agonists may be more
37 effective on gain in body weight and change in EDI-2 total compared with placebo.

38 Low quality evidence from one RCT (n=48) showed cannabinoid agonists may be less
39 effective on change in EDI-2-drive for thinness and change in EDI-bulimia compared with
40 placebo.

1 **6.4.3.10 Oestrogen versus placebo in young people with anorexia nervosa at the end of**
2 **treatment**

3 Low quality evidence from one RCT (n=37) showed no difference in the effect of oestrogen
4 on change in body weight or change in EDI-drive for thinness compared with placebo.

5 Low quality evidence from one RCT (n=72) showed no difference in drop-out rates in the
6 oestrogen treated group compared with placebo.

7 Low quality evidence from one RCT (n=37) showed oestrogen treatment is less effective on
8 change in fat mass and change in EDI-body dissatisfaction compared with placebo.

9 Low quality evidence from one RCT (n=37) showed oestrogen treatment is more effective on
10 change in EDI-bulimia compared with placebo.

11 **6.4.4 Economic evidence statements**

12 No economic evidence on the cost effectiveness of pharmacological interventions for people
13 with anorexia nervosa was available.

14 **6.4.5 Recommendations and link to evidence**

15 **Medication for anorexia nervosa**

79. Do not offer medication as the sole treatment for anorexia nervosa.	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of pharmacological for treating anorexia nervosa in children, young people and adults. For this population and review, body weight or BMI, depression and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>To investigate the effectiveness of a pharmacotherapy on treating anorexia nervosa, studies comparing the drug with a placebo are the first to consider. Trials on two antidepressants, selective serotonin reuptake inhibitor (SSRIs) and tricyclic antidepressants (TCA), were identified.</p> <p>SSRIs showed a benefit on body weight and depression at the end of treatment, remission was not reported. However, relapse rates were lower in the SSRI group but no difference was found in EDI-bulimia scores. Outcomes at follow up were not reported. Nor was any data available on remission, general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, or relapse.</p> <p>TCA treatment was no different to placebo on depression scores or at achieving target weight at the end of treatment. No long-term outcomes were reported. Nor was data available on remission, general functioning, family functioning, service</p>

user experience, adverse events, all-cause mortality, quality of life, resource use, or relapse.

Directly comparing SSRIs and TCAs, showed no difference on binge eating or the number of participants who had amenorrhea. There was, however, a reduced number of vomiting episodes in the SSRI group compared with TCA. No data was available at follow up nor on body weight, remission, general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, general psychopathology or relapse.

Antipsychotic medication showed no difference in its effectiveness compared with placebo at the end of treatment. There was also no difference in young people on body weight, depression, EDI-total, adverse events and remission. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, or relapse. In adults, there was no difference at end of treatment on body weight and depression. No data was available on remission, general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, eating disorder psychopathology, resource use, or relapse.

One study comparing an antidepressant with antipsychotic medication showed that they were equally effective on the number of episodes of vomiting, binge eating and the number of adults with amenorrhea at end of treatment. No long-term outcomes were reported nor any data on remission, general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, general psychopathology or relapse.

Adding an antipsychotic to psychotherapy compared with psychotherapy alone showed no difference in the following outcomes at the end of treatment: BMI, EDI-total, EDI-drive for thinness, EDI-bulimia, EDI- body dissatisfaction, Yale-Cornell-Brown Eating Disorder Scale and the number of side-effects. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use, general psychopathology or relapse.

Adding an antidepressant to psychotherapy compared with psychotherapy alone showed the change in body weight was lower in the combination treatment group. However, the mean percentage ideal body weight in both groups was similar at the end of treatment. Remission and change in quality of life were similar at the end of treatment between the two groups. There was also less change in depression and global improvement scores in the combined treatment group but there was some uncertainty. No data was available on family functioning, service user experience, adverse events, all-cause mortality, resource use or relapse.

An RCT on antihistamines compared with placebo showed no difference in the number of people who achieved the target body weight and a trend for depression scores to be lower in the antihistamine group. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use or relapse.

A cannabinoid agonist showed greater improvements in body weight and EDI-total at the end of treatment compared with placebo. There was no difference in the other reported outcomes, including intensity of physical activity, EDI- body dissatisfaction or adverse events. However, the cannabinoid agonist was less beneficial on change in EDI-drive for thinness and EDI-bulimia. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use or relapse.

	<p>Comparing a combined treatment of an antipsychotic, CBT and nutritional therapy with placebo, CBT and nutritional therapy showed no difference in effectiveness at the end of treatment on BMI. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, resource use, general psychopathology or relapse.</p> <p>Finally, oestrogen treatment showed mixed results in adults with anorexia nervosa compared with placebo. No difference in change in body weight, change in EDI-drive for thinness was found between the two arms. However, change in fat mass and EDI-body dissatisfaction was less in the oestrogen treatment group, but change in EDI-bulimia favoured the oestrogen treated group compared with placebo. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, quality of life, general psychopathology, resource use or relapse.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>There was no evidence for the effectiveness of pharmacological interventions for the management of people with anorexia nervosa. As a result, such treatments are also unlikely to be cost effective.</p>
<p>Quality of evidence</p>	<p>The quality of the evidence was low to very low. The evidence was downgraded for imprecision and risk of bias for reasons such as it was unclear how they randomised or if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded and high dropouts were detected >20%. To account for high drop-outs rates, intention-to-treat analysis was used for remission results, with the assumption that dropouts did not recover from the eating disorder.</p> <p>The committee agreed that all outcomes should be downgraded for risk of publication bias since the studies were sponsored by pharmaceutical companies and in the 1980s, 1990s and early 2000s there is a risk that (i) only positive findings were published, (ii) outliers were excluded, and (iii) there was selective outcome reporting.</p> <p>The committee was not confident in the outcomes due to the often small number of participants (n=16 to 124) and studies for each comparison. There was also often imprecision due to the width of the 95% confidence interval or the failure to satisfy optimal information size (300 events or 400 participants). The committee also noted that in many of studies, participants in both arms were receiving additional treatment such as individual psychotherapy.</p> <p>Remission, one of the critical outcomes, was also not often reported, thus making it difficult for the committee to know just how effective pharmacological agents are in treating people with anorexia nervosa. Also, only one study, which compared an antipsychotic with placebo, was found on children and young people with anorexia nervosa.</p> <p>Another factor the committee considered important if they were to recommend a drug was the setting (e.g. inpatient, outpatient) in which the study was conducted. The following comparisons included studies that treated the participants in hospital: TCA versus placebo, SSRI versus TCA, antipsychotic versus placebo in young people and adults, antipsychotics versus antidepressants, some combined therapies, antihistamine versus placebo. The following studies were conducted in outpatient settings: SSRI versus placebo, antipsychotic versus placebo study, some combined therapies and the cannabinoid agonist versus placebo.</p> <p>The committee were also interested in any reported mental health comorbidities as this could aid interpretation of the of the various studies' findings. However, the</p>

	<p>influence of mental health comorbidities on the effectiveness of pharmacological interventions in people with anorexia nervosa could not be fully examined as several studies (e.g. Attia 1998, Attia 2001 Andries 2014, Bissada 2008, Fassino 2002, Ruggiero 2001) excluded participants with a mental health comorbidity, whilst in other studies information about comorbidities was not provided.</p> <p>Interestingly, the cannabinoid agonist showed a positive effect on weight gain compared with placebo but there was some uncertainty. No data was available on remission or depression at the end of treatment or long-term follow up. However, it was also only one study and had only 48 participants. The committee discussed the possibility of making a research recommendation on this but ultimately decided against this.</p>
Other considerations	<p>The committee agreed that the evidence was not strong enough to recommend pharmacological treatments as the sole or primary treatment for anorexia nervosa. The combined treatment of psychotherapy and a pharmacological agent also showed no benefit compared with psychotherapy alone.</p> <p>The committee discussed the fact that the pharmacological studies included in this review did not examine the potential benefits of treating people with anorexia nervosa who have a mental health comorbidity as the majority of the studies excluded such cases. The committee thus agreed it was best to refer to the relevant NICE guidelines when treating the comorbidity.</p> <p>Given the wide use of psychotropic medication in the treatment of eating disorders, and lack of convincing evidence for their efficacy (see also the reviews of pharmacological interventions in the other chapters), the committee agreed that a research recommendation was merited examining the efficacy of psychotropic interventions combined with treatment as usual compared to treatment as usual only.</p>

1 **8. Research recommendation: What is the effectiveness of psychotropic**
2 **medications, alone or in conjunction with treatment as usual, on the symptoms of**
3 **eating disorders?**

4

5 **6.5 Nutritional interventions**

6 **6.5.1 Review question: Does any nutritional intervention produce benefits/harms on**
7 **specified outcomes in people with eating disorders?**

8 The review protocol summary, including the review question and the eligibility criteria used
9 for this section of the guideline, can be found in Table 124. Further information about the
10 search strategy can be found in Appendix H; the full review protocols can be found in
11 Appendix F.

12 This review considers all nutritional interventions that may be delivered to children, young
13 people and adults with an eating disorder with or without a pharmacological intervention. The
14 interventions were categorised according to the type of eating disorder being treated.

15 **Table 124: Clinical review protocol summary**

Component	Description
Review question(s)	Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?

Component	Description
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). <p>Strata:</p> <ul style="list-style-type: none"> Children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years Eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Physical interventions may include:</p> <ul style="list-style-type: none"> transcranial magnetic stimulation deep brain stimulation physiotherapy yoga physical exercise acupuncture mandometer massage
Comparison	<ul style="list-style-type: none"> Placebo Wait list control Treatment as usual Another intervention
Critical outcomes	<ul style="list-style-type: none"> Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> Adverse events All-cause mortality Cost effectiveness Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) Family functioning General psychopathology (including mood/depression/anxiety) General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) Quality of life Relapse Resource use Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs

1 **6.5.2 Clinical evidence**

2 **6.5.2.1 Nutritional intervention versus any other intervention or wait list control**

3 Three RCTs (N =117) met the eligibility criteria for this review and were all on adults with an
4 eating disorder (Birmingham et al., 2004b; Hall and Crisp, 1987; Pike et al., 2003).

5 No nutritional intervention studies on any other eating disorder were identified that met the
6 eligibility criteria for this review.

7 Summary of findings for those on anorexia nervosa can be found in Table 126 and Table
8 127. See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
9 evidence tables in Appendix L and exclusion list in Appendix J.

10

1 **Table 125: Study information for trials included in the meta-analysis of a nutritional intervention versus any other intervention or wait list controls in people with anorexia nervosa.**

Study	Age mean (SD)	Body weight	Stage of illness for AN	Female	Randomised	Experimental arm	Control arm	Duration
Birmingham 1994	20.6 (3.8)	15.6 (1.2) BMI	Years since diagnosis: 3.6 (2.0)	100%	54	Zinc supplement (50 mg) containing 14 mg of elemental zinc	Placebo	25 days
Hall 1987	19.6 (14 to 25)	Deviation from matched population mean weight 25.4%	Mean duration of illness 29.7 months	100%	30	Nutritional counselling	Family/individual psychotherapy	12-24 weeks 6 months FU
Pike 2003	26.1 (6.2)	16.0 (2.1) BMI	1 year after hospitalisation	100%	33	Nutritional counselling	CBT-ED	12 months

3 Abbreviations: CBT-ED – cognitive behavioural therapy with an eating disorder focus; FU – follow up.

4 **Table 126: Summary table of findings for nutritional counselling versus any other intervention.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with AN. Nutritional counselling (95% CI)
Did not achieve remission (ITT)	33 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	RR 1.68 (1.09 to 2.59)	444 per 1000	302 more per 1000 (from 40 more to 707 more)
Relapse	33 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision	RR 2.40 (0.9 to 6.43)	222 per 1000	311 more per 1000 (from 22 fewer to 1000 more)

Weight FU	30 (1 study)	⊕⊕⊕⊕ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight fu in the intervention groups was 0.11 standard deviations higher (0.61 lower to 0.82 higher)
Menstruation absent FU	30 (1 study)	⊕⊕⊕⊕ VERY LOW4,6 due to risk of bias, imprecision	RR 1.25 (0.69 to 2.26)	533 per 1000	133 more per 1000 (from 165 fewer to 672 more)
Menstruation regular FU	30 (1 study)	⊕⊕⊕⊕ VERY LOW4,6 due to risk of bias, imprecision	RR 1 (0.24 to 4.18)	200 per 1000	0 fewer per 1000 (from 152 fewer to 636 more)
Did not achieve remission (ITT) FU	30 (1 study)	⊕⊕⊕⊕ VERY LOW3,4,7 due to risk of bias, indirectness, imprecision	RR 1.35 (0.98 to 1.85)	267 per 1000	93 more per 1000 (from 5 fewer to 227 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how randomisation was conducted, and if allocation concealment was performed. It was unclear if either the participants, investigators or assessors were blind. High dropouts were reported >20%.

2 95% CI crossed 1 MID (0.75).

3 95% CI crossed 1 MID (1.25).

4 It was unclear how randomisation was conducted, and if allocation concealment was performed. It was unclear if either the participants or investigators were blind. The assessors were blinded. High dropouts were reported >20%.

5 95% CI crossed 2 MIDs (-0.5 and 0.5).

6 95% CI crossed 2 MIDs (0.75 and 1.25).

7 No definition provided. Based on investigators decision if further treatment is required

1 .

2 **Table 127: Summary table of findings for zinc versus placebo in adults with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with AN. Zinc (95% CI)

BMI gain/day	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI gain/day in the intervention groups was 0.6 standard deviations higher (0.08 lower to 1.29 higher)
Did not have side-effects	35 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision	RR 1 (0.9 to 1.11)	Not estimable.	Not estimable.
% body fat gain/day	35 (1 study)	⊕⊕⊕⊕ LOW ^{1,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean % body fat gain/day in the intervention groups was 0.67 standard deviations higher (0.02 lower to 1.36 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how the random sequence was generated or if they performed allocation concealment. Participants and staff were blind but it was unclear if assessors were blind. High dropout rates were detected >20%.

2 95% CI crossed 2 MIDs (-0.5 and 0.5).

3 For a dichotomous outcome, there were fewer than 300 events.

4 95% CI crossed 1 MID (0.5).

- 1
- 2
- 3

6.5.31 Economic evidence

2 No economic evidence on the cost effectiveness of nutritional interventions for people with
3 anorexia nervosa was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6.5.46 Clinical evidence statements for nutritional interventions people with anorexia 7 nervosa

6.5.4.18 Nutritional counselling versus another intervention in adults with anorexia nervosa at 9 the end of treatment

10 Low quality evidence from one RCT (n=33) showed nutritional counselling is less effective
11 than any other intervention on remission rates.

12 Low quality evidence from one RCT (n=33) showed nutritional counselling is equally effective
13 as any other intervention on relapse rates.

6.5.4.24 Nutritional counselling versus another intervention in adults with anorexia nervosa at 15 follow up

16 Low quality evidence from one RCT (n=30) showed nutritional counselling is equally effective
17 as any other intervention on body weight.

18 Very low quality evidence from one RCT (n=30) showed nutritional counselling is equally
19 effective as any other intervention on menstrual function (absent and regular).

20 Low quality evidence from one RCT (n=30) showed nutritional counselling is less effective
21 than any other intervention on remission rates, but there was some uncertainty.

6.5.4.32 Zinc supplementation versus placebo in adults with anorexia nervosa at end of 23 treatment

24 Very low quality evidence from one RCT (n=35) showed zinc supplementation is more
25 effective on BMI gain per day than compared with placebo but there was some uncertainty.

26 Low quality evidence from one RCT (n=35) showed no difference in side-effects reported
27 between zinc supplementation and placebo.

28 Low quality evidence from one RCT (n=35) showed zinc supplementation may be more
29 effective on percent fat gain per day than compared with placebo but there was some
30 uncertainty.

6.5.51 Economic evidence statements

32 No economic evidence on the cost effectiveness of nutritional interventions for people with
33 anorexia nervosa was available.

6.5.64 Recommendations and link to evidence

35 Dietary counselling

80. Only offer dietary counselling as part of a multidisciplinary approach.

	<p>81. Encourage people with anorexia nervosa to take an age-appropriate oral multi-vitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values.</p> <p>82. Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are having therapy on their own.</p> <p>83. Offer supplementary dietary advice to children and young people with anorexia nervosa and their family or carers (as appropriate) to help them meet their dietary needs for growth and development (particularly during puberty)</p>
<p>Critical and important outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of nutritional interventions for treating anorexia nervosa in children, young people and adults. For this population, body weight or BMI and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade off benefits and harms</p>	<p>Two studies were identified that investigated the effects of nutritional counselling on adults with anorexia nervosa, with one reporting data at end of treatment, the other at 6-months follow up. At the end of treatment, remission rates were lower in the nutritional counselling group compared with any other treatment and relapse rates were not different between the two treatment arms.</p> <p>At follow up, another study showed body weight was no different between people assigned to nutritional counselling and those assigned to another treatment. Menstrual function (absent and regular) was also similar. Remission was also lower in the nutritional counselling arm but there was some uncertainty. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, general psychopathology or relapse.</p> <p>No nutritional intervention studies were identified in children and young people.</p> <p>One study on zinc supplementation was found. Compared with placebo, gain in BMI per day and percentage gain in body fat per day was higher although there was some. No harms were detected. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, quality of life, resource use, general psychopathology or relapse.</p> <p>No other supplementation studies were found.</p>
<p>Trade-off between net health benefits</p>	<p>The committee expressed the view that dietary advice is an integral part of most eating disorder specific psychological interventions and providing such supplementary advice would not incur significant extra resource implications to the healthcare system.</p>

and resource use	
Quality of the evidence	<p>The quality of the evidence low to very low quality. In the nutritional counselling and zinc supplementation studies, it was unclear how randomisation was conducted and if allocation concealment was performed. It was unclear if either the participants or investigators were blind. In one nutritional study at follow up, the assessors were blinded, however, high dropouts were reported >20%. Imprecision was also detected mostly because either the 95% confidence interval crossed one or more MIDs or the evidence did not meet the optimal information size (300 events or 400 participants).</p>
Other considerations	<p>The committee agreed that the evidence was not strong enough to recommend nutritional counselling as the sole treatment for adults with anorexia nervosa. However, they highlighted that dietary advice and counselling (dietetics) are an integral part of CBT-ED, SSCM, MANTRA and family therapy.</p> <p>They agreed that dietary advice should be offered to ensure their food intake (including calcium and vitamin D) meets the nutritional needs of children and young people with anorexia nervosa for growth and development (particularly during puberty), if it is not part of any psychotherapy they are receiving.</p> <p>The committee considered the zinc supplementation evidence but were not confident recommending one supplement on its own or using evidence from 1 study alone. They agreed that people with anorexia nervosa may be deficient in many nutrients and decided it is best to encourage them to take age-appropriate multivitamins and multi-mineral supplements in oral form until dietary intake meets dietary reference values.</p> <p>For children and young people with anorexia nervosa, there was no RCT evidence on how to address the nutritional needs for growth and development particularly during puberty. However, the dietitian and paediatrician on the committee discussed the importance of offering advice to children and young people on this, in particular the need for an adequate intake of calcium and vitamin D for the growth and development of healthy bones. Although there are no similar studies on children with anorexia nervosa, they noted that there is ample evidence on the effectiveness of calcium supplements in children. These studies show that calcium supplements are most effective in children with a low intake of calcium. For this reason, the committee suggested that health professionals should promote adequate calcium and vitamin D through diet, but to consider supplementation if intake is below dietary reference values.</p> <p>If children or young people are receiving individual treatment, and not family therapy, the committee agreed that it was important to have a recommendation regarding the role of the family or carers (if appropriate). They therefore developed a recommendation to include them in the provision of any dietary education or meal planning. The committee noted that the primary goal of dietary education and/or meal planning, as with all treatments for anorexia nervosa in the majority of cases, is to achieve and maintain a healthy body weight and that the health professional, most likely a dietitian, can discuss the nutritional value of certain foods, help devise a plan and take the personal preferences of the child or young person into account.</p>

6.6.1 Physical interventions

6.6.12 Review question: Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?

5 The review protocol summary, including the review question and the eligibility criteria used
6 for this section of the guideline, can be found in Table 128. Further information about the
7 search strategy can be found in Appendix H; the full review protocols can be found in
8 Appendix F.

9 This review considers all physical interventions that may be delivered to children, young
10 people and adults with an eating disorder. The interventions were categorised according to
11 type of physical intervention, the age of the participants and the type of eating disorder and
12 were compared to wait list controls, placebo, treatment as usual or any other intervention.

13 Table 128: Clinical review protocol summary

14

6.6.25 Clinical evidence

16 Six RCTs (n=169) and one systematic review (n=372) met the eligibility criteria for this
17 review, all of which were conducted in an inpatient or day care setting (Birmingham et al.,
18 2004a; del Valle et al., 2010; Del Valle et al., 2014; Janas-Kozik et al., 2011; McClelland et
19 al., 2016; Smith et al., 2014; Touyz et al., 1994; Yang et al., 2016). The majority of
20 participants in these studies were young people females, whilst three of the studies
21 concerned people diagnosed with restrictive anorexia nervosa. An overview of the trials
22 included in the analysis can be found in Table 129. Further information about both included
23 and excluded studies can be found in Appendix J.

24 One systematic review (n=372) found five studies comparing the traditional Chinese
25 medicine version of chiropractic therapy with traditional Chinese or western medicines (e.g.
26 supplements) or any other intervention. Summary of findings can be found in Table 138

27 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
28 evidence tables in Appendix L and exclusion list in Appendix J.

1 **Table 129: Study information for trials included in the analysis of physical interventions versus any other intervention or wait list**
2 **control for people with anorexia nervosa.**

Study ID	N Randomized	Female (%)	Mean BMI, kg/m ² (SD)	Sample	Intervention	Comparison	Duration
Birmingham 2004	21	100	Admission: 17.7 (2.8); Discharge: 18.4 (2.9)	Adult AN inpatients hospitalized for refeeding	Warming therapy + refeeding Duration of illness: 11.7 (7.1) years (n=7)	No warming + refeeding Length of illness: 15 (6.3) years (n=9)	3 weeks
del Valle 2010	22	91	18.5 (1.6)	Young people AN-R in day care program	Resistance training + TAU Time since initial diagnosis=42 days (11)	TAU Time since initial diagnosis=72 days (31)	3 months
del Valle 2014	44	100	17.7 (2.3)	Young people AN-R in day care program	Resistance training + TAU Time since admission: 50.8 (36.4) days	TAU Time since admission: 61.6 (37.3) days	8 weeks + 4 week FU
Janas-Kozik 2011	24	100	15.3 (2)	Young people AN-R inpatients with concomitant depressive symptoms	Bright light therapy + CBT	CBT	6 weeks
McClelland 2016	60	100	16.5 (1.7)	Adult AN	Repetitive transcranial magnetic stimulation Duration of illness: 9.1 (7.0) years	'Sham' repetitive transcranial magnetic stimulation Duration of illness: 11.3 (8.0) years	20 min + 1 day FU
Smith 2014	26	96	17 (2.6)	Adult AN inpatients	Acupuncture + TAU	Acupressure + massage + TAU	6 weeks
Touyz 1994	32	100	15.3 (1.5)	Young people AN inpatients	Video feedback of eating behaviour + TAU	TAU	6 weeks
Yang 2016 (5 studies)	372	not reported	Not reported	Children and young people AN	Traditional Chinese Chiropractic therapy	Traditional Chinese or Western medicine or other interventions	Variable

3 *Abbreviations: AN-R- anorexia nervosa restricted; CBT- cognitive behavioural therapy; FU – follow up; TAU – treatment as usual*

1 **Table 130: Summary table of findings for repetitive transcranial magnetic stimulation versus ‘sham’ repetitive transcranial magnetic stimulation at end of treatment in adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with RTMS (95% CI)
VAS Core AN symptoms	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas core an symptoms in the intervention groups was 0.57 standard deviations lower (1.14 lower to 0.01 higher)
VAS Restrict	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas restrict in the intervention groups was 0.2 standard deviations lower (0.77 lower to 0.36 higher)
VAS Feeling Full	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas feeling full in the intervention groups was 0.45 standard deviations lower (1.02 lower to 0.12 higher)
VAS Feeling Fat	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas feeling fat in the intervention groups was 0.71 standard deviations lower (1.29 to 0.13 lower)
VAS Mood	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas mood in the intervention groups was 0.17 standard deviations higher (0.4 lower to 0.73 higher)
VAS Hunger	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas hunger in the intervention groups was 0.24 standard deviations lower (0.81 lower to 0.33 higher)
VAS Urge to Eat	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas urge to eat in the intervention groups was 0.16 standard deviations lower (0.73 lower to 0.4 higher)
VAS Urge to Binge Eat	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas urge to binge eat in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with RTMS (95% CI)
					0.3 standard deviations lower (0.87 lower to 0.27 higher)
VAS Urge to be Sick/Purge	49 (1 study) 1 days	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas urge to be sick/purge in the intervention groups was 0.53 standard deviations lower (1.11 lower to 0.04 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 131: Summary table of findings for repetitive transcranial magnetic stimulation versus ‘sham’ repetitive transcranial magnetic stimulation at follow up for adult anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with RTMS (95% CI)
VAS Restrict 24-hr FU	49 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas restrict 24-hr fu in the intervention groups was 0.53 standard deviations lower (1.1 lower to 0.05 higher)
VAS Feeling Full 24-hr FU	49 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas feeling full 24-hr fu in the intervention groups was 0.65 standard deviations lower (1.23 to 0.06 lower)
VAS Feeling Fat 24-hr FU	49 (1 study)	⊕⊕⊕⊖ MODERATE1 due to imprecision		Not calculable for SMD values	The mean vas feeling fat 24-hr fu in the intervention groups was 0.71 standard deviations lower (1.29 to 0.13 lower)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with RTMS (95% CI)
CI: Confidence interval; FU: follow up					
1 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 132: Summary table of findings for bright light treatment and CBT versus any other intervention in young people and adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT only	Risk difference with Light Therapy+CBT (95% CI)
Depression	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 1.14 standard deviations lower (2.01 to 0.27 lower)
Remission of Depression (HAM-D≤8)	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision	RR 0.27 (0.1 to 0.74)	917 per 1000	669 fewer per 1000 (from 238 fewer to 825 fewer)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Janas-Kozik 2011: Unclear randomization method and allocation concealment. No participant, investigator, nor assessor blinding.

2 Sample was participants diagnosed with Anorexia Nervosa-Restricting type with concomitant depressive symptoms.

3 CI crosses -0.5.

4 <300 events.

1 **Table 133: Summary table of findings for warming therapy and refeeding versus any other intervention.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Refeeding	Risk difference with Warming (95% CI)
BMI - change scores	21 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI - change scores in the intervention groups was 0.02 standard deviations higher (0.84 lower to 0.87 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Birmingham 2004: Unclear randomization method, unclear allocation concealment. No participant, investigator, nor assessor blinding. Dropout rate of control group >20%, reasons not stated. 2 CI crosses both 0.5 and -0.5 (SMD).					

2 **Table 134: Summary table of findings for video feedback and treatment as usual versus treatment as usual in young people with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Video Feedback + TAU (95% CI)
BMI (change scores)	32 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI (change scores) in the intervention groups was 0.16 standard deviations higher (0.53 lower to 0.86 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Touyz 1994: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear. Significant difference at baseline in EDI Body Dissatisfaction score. 2 Participants were diagnosed according to DSM-III-R. 3 CI crosses both 0.5 and -0.5.					

1 **Table 135: Summary table of findings for acupuncture and treatment as usual versus any other intervention in adults with anorexia**
2 **nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Acupressure+Massage+TAU	Risk difference with Acupuncture+TAU (95% CI)
BMI - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI - change scores in the intervention groups was 0.07 standard deviations lower (0.94 lower to 0.81 higher)
EDI-3 Bulimia - change scores	20 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-3 bulimia - change scores in the intervention groups was 0.45 standard deviations higher (0.44 lower to 1.34 higher)
EDI-3 Drive for Thinness - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-3 drive for thinness - change scores in the intervention groups was 0.26 standard deviations higher (0.62 lower to 1.14 higher)
EDI-3 Body Dissatisfaction - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-3 body dissatisfaction - change scores in the intervention groups was 0.14 standard deviations higher (0.73 lower to 1.02 higher)
EDE-Q Global - change scores	20 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global - change scores in the intervention groups was 0.47 standard deviations higher (0.42 lower to 1.36 higher)
EDE-Q Restraint - change scores	20 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q restraint - change scores in the intervention groups was 0.67 standard deviations higher (0.24 lower to 1.58 higher)
EDE-Q Eating Concerns - change scores	20 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concerns - change scores in the intervention groups was 0.44 standard deviations higher (0.45 lower to 1.33 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Acupressure+Massage+TAU	Risk difference with Acupuncture+TAU (95% CI)
EDE-Q Weight Concerns - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concerns - change scores in the intervention groups was 0.07 standard deviations lower (0.94 lower to 0.81 higher)
EDE-Q Shape Concerns - change scores	20 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concerns - change scores in the intervention groups was 1.38 standard deviations lower (2.38 to 0.38 lower)
General Psychopathology - DASS Total - change scores Depression, Anxiety, and Stress Scale (DASS)	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology - dass total - change scores in the intervention groups was 0.03 standard deviations higher (0.84 lower to 0.91 higher)
Depression - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - change scores in the intervention groups was 0.03 standard deviations higher (0.85 lower to 0.91 higher)
Stress - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean stress - change scores in the intervention groups was 0.14 standard deviations higher (0.73 lower to 1.02 higher)
Quality of Life - EDQoL - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life - edqol - change scores in the intervention groups was 0.05 standard deviations higher (0.83 lower to 0.92 higher)
EDQoL Psychological - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edqol psychological - change scores in the intervention groups was 0.11 standard deviations lower (0.99 lower to 0.76 higher)
EDQoL Physical/Cognitive - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edqol physical/cognitive - change scores in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Acupressure+Massage+TAU	Risk difference with Acupuncture+TAU (95% CI)
					0 standard deviations higher (0.88 lower to 0.88 higher)
EDQoL Financial - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edqol financial - change scores in the intervention groups was 0.34 standard deviations higher (0.54 lower to 1.23 higher)
EDQoL Work/School - change scores	20 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edqol work/school - change scores in the intervention groups was 0.12 standard deviations lower (1 lower to 0.75 higher)
Withdrawn due to Adverse Events	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1 (0.25 to 4.07)	231 per 1000	0 fewer per 1000 (from 173 fewer to 708 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Smith 2014: No participant blinding. Dropout rate of both groups>20%.
2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
3 CI crosses either 0.5 or -0.5 (SMD).

1 **Table 136: Summary table of findings for resistance training and treatment as usual versus treatment as usual at end of treatment in young people with anorexia nervosa-restricting.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Resistance Training + TAU (95% CI)
BMI	64 (2 studies) 3 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.21 standard deviations lower (0.70 lower to 0.29 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Resistance Training + TAU (95% CI)
Quality of Life SF-36 Mental, SF-36 Physical	22 (1 study) 3 weeks	⊕⊖⊖⊖ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.39 standard deviations higher (0.2 lower to 0.99 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval;</p> <p>1 del Valle 2010: Unclear randomization method and allocation concealment. No participant blinding, unclear investigator and assessor blinding. 2 del Valle 2014: Unclear whether baseline similar. Randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. 3 Sample consisted of participants diagnosed with Anorexia Nervosa-Restricting type. Participants in both groups also received psychotherapy 3 days a week and were on diet. 4 CI crosses either 0.5 or -0.5 (SMD).</p>					

1 **Table 137: Summary table of findings for resistance training and treatment as usual versus treatment as usual at follow up in young people with anorexia nervosa-restricting.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Resistance Training + TAU (95% CI)
BMI FU	36 (1 study) 4 weeks	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.53 standard deviations lower (1.19 lower to 0.14 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; FU: follow up</p> <p>1 del Valle 2014: Unclear whether baseline similar. Randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. 2 Sample consisted of participants diagnosed with Anorexia Nervosa-Restricting type. Participants in both groups also received psychotherapy 3 days a</p>					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Resistance Training + TAU (95% CI)
week and were on diet. 3 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 138: Summary table of findings for traditional Chinese chiropractic therapy versus traditional Chinese or Western medicine or**
2 **other interventions in children and young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Chiropractic therapy (95% CI)
Efficacy rate (Recovered+Significant Improvement)/Total N	371 (5 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.24 (1.14 to 1.35)	772 per 1000	185 more per 1000 (from 108 more to 270 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 **Yang 2016: data from meta-analysis of chiropractic therapy studies published in Chinese or English. All studies were: low risk of bias for random sequence generation, unclear allocation concealment, unclear blinding of participants/assessors/investigators. Only one study reported dropout data.**

2 **CI crosses either 0.75 or 1.25 (Risk Ratio).**

3

4

1 **6.6.3 Economic evidence**

2 No economic evidence on the cost effectiveness of physical interventions for people with
3 anorexia nervosa was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **6.6.4 Clinical evidence statements**

7 **6.6.4.1 Repetitive transcranial magnetic stimulation (rTMS) versus ‘sham’ repetitive** 8 **transcranial magnetic stimulation in adults with anorexia nervosa at end of treatment**

9 Moderate quality of evidence from one RCT (n=49) showed rTMS may improve anorexia
10 nervosa symptoms and urge to be sick/purge compared with sham, although there was some
11 uncertainty.

12 Moderate quality of evidence from one RCT (n=49) showed rTMS is more effective on feeling
13 fat compared with sham.

14 Moderate quality of evidence from one RCT (n=49) showed no difference in the effect of
15 rTMS on food restriction, feeling full, mood, hunger, urge to eat and urge to binge compared
16 with sham.

17 **6.6.4.2 Repetitive transcranial magnetic stimulation (rTMS) versus ‘sham’ repetitive** 18 **transcranial magnetic stimulation in adults with anorexia nervosa at follow up**

19 Moderate quality of evidence from one RCT (n=49) showed rTMS is more effective on feeling
20 full and feeling fat compared with sham.

21 Moderate quality of evidence from one RCT (n=49) showed rTMS may be more effective on
22 restrict compared with sham, although there was some uncertainty.

23 **6.6.4.3 Bright light treatment and CBT versus any other intervention in young people with** 24 **anorexia nervosa-restricting**

25 Very low quality evidence from one RCT (n=24) showed bright light treatment and CBT is
26 more effective on remission from depression and reducing depression compared to any other
27 intervention.

28 **6.6.4.4 Warming therapy and refeeding versus refeeding in adults with anorexia nervosa**

29 Very low quality evidence from one RCT (n=21) showed no difference in the effect of adding
30 warming therapy to refeeding on change in BMI compared with refeeding alone.

31 **6.6.4.5 Video feedback and treatment as usual versus treatment as usual in young people** 32 **with anorexia nervosa**

33 Very low quality evidence from one RCT (n=32) showed no difference in the effect of video
34 feedback and nutritional counselling on change in BMI compared with nutritional counselling.

35 **6.6.4.6 Acupuncture and treatment as usual versus acupressure, massage and treatment as** 36 **usual in adults with anorexia nervosa**

37 Very low quality evidence from one RCT (n=20) showed acupuncture treatment as usual is
38 more effective in reducing scores on EDE-Q-shape concerns compared with acupressure,
39 massage and treatment as usual.

1 Very low quality evidence from one RCT (n=20) showed no difference in the effect of
2 acupuncture and treatment as usual on change in BMI, EDI-3-bulimia, EDI-3-drive for
3 thinness, EDI-3-body dissatisfaction, EDE-Q-Global, EDE-Q-restraint, EDE-Q-eating
4 concerns, EDE-Q-weight concerns, general psychopathology, depression, stress, EDQoL
5 Total, EDQoL Psychological, EDQoL-physical/cognitive, EDQoL-financial and EDQoL-
6 work/school compared with acupuncture, massage and treatment as usual.

7 **6.6.4.7 Resistance training and treatment as usual versus treatment as usual at end of**
8 **treatment in young people with anorexia nervosa-restricting**

9 Very low quality evidence from two RCTs (n=64) showed no difference in the effect of
10 resistance training and treatment as usual on BMI compared with treatment as usual.

11 Very low quality evidence from one RCT (n=22) showed no difference in the effect of
12 resistance training and treatment as usual on mental and physical general functioning
13 compared with treatment as usual.

14 **6.6.4.8 Resistance training and treatment as usual versus treatment as usual at follow up in**
15 **young people with anorexia nervosa-restricting**

16 Very low quality evidence from one RCT (n=36) showed no difference in the effect of
17 resistance training and treatment as usual on BMI compared with treatment as usual.

18 **6.6.4.9 Traditional Chinese chiropractic therapy versus traditional Chinese or Western**
19 **medicine or other interventions in children and young people with anorexia nervosa**

20 Low quality evidence from five RCTs (n=371) showed traditional Chinese chiropractic
21 therapy is more effective on the number of people recovered or significantly improved from
22 anorexia nervosa compared with traditional Chinese or Western medicine or other
23 intervention.

24 **6.6.5 Economic evidence statements**

25 No economic evidence on the cost effectiveness of physical interventions for people with
26 anorexia nervosa was available.

27 **6.6.6 Recommendations and link to evidence**

28 **Physical therapy for any eating disorder**

84. Do not offer a physical therapy (such as transcranial magnetic stimulation, acupuncture, weight training, yoga or warming therapy) as part of the treatment for eating disorders.	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes for the review on the effectiveness of physical interventions, such as transcranial magnetic stimulation or physiotherapy in people with eating disorders and it was agreed that for any eating disorder remission is of greatest concern. The other critical outcomes for anorexia nervosa are body weight and BMI and for binge eating disorder and bulimia nervosa it is bingeing.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in randomised controlled trials for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse, thus they were extracted where possible, but did not factor strongly in the decision making.</p>

	<p>Other outcomes of concern for people with an eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>Young people with anorexia nervosa</p> <p>For young people with anorexia nervosa, bright light treatment and CBT improved depression scores compared with any other intervention. No evidence was found on the critical outcomes of remission and weight, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, relapse, general functioning, family functioning, resource use or service user experience.</p> <p>Video feedback and nutritional counselling compared with nutritional counselling alone showed no additional benefit of the video feedback on BMI. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, resource use or service user experience.</p> <p>Resistance training and treatment as usual showed no difference on BMI nor general (mental or physical) functioning in young people with anorexia nervosa compared with treatment as usual. At 4 weeks follow up, resistance training and treatment as usual appeared to have no effect on BMI compared with treatment as usual. No evidence was found on the critical outcomes of remission, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, family functioning, resource use or service user experience.</p> <p>Adults with anorexia nervosa</p> <p>Repetitive transcranial magnetic stimulation versus sham showed no difference in anorexia nervosa symptoms (urge to restrict, feeling full, mood, hunger, urge to eat and urge to binge), but the treatment did improve feeling fat and core anorexia nervosa symptoms and urge to be sick/purge (however there was some uncertainty for the last two outcomes). At one day follow up some benefits were detected on anorexia nervosa symptoms including feeling full and feeling flat compared with sham, and some benefit on the urge to restrict but there was some uncertainty. No evidence was found on the critical outcomes of remission and weight, nor on the important outcomes of quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, resource use or service user experience.</p> <p>Warming therapy on top of refeeding had no effect on weight compared with refeeding alone in adults with anorexia nervosa. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, resource use or service user experience.</p> <p>Acupuncture and treatment as usual compared with acupressure, massage and treatment as usual showed acupuncture is more effective on EDE-shape concerns but no other outcome was different between the two groups including EDI-subscales, EDE-subscales, depression, general psychopathology and weight. No evidence was found on the critical outcome of remission, nor on the important outcomes of all-cause mortality, relapse, general functioning, family functioning, resource use or service user experience.</p> <p>For discussion of physical interventions for other eating disorders, see the LETRs in the relevant chapters.</p>

Trade-off between net health benefits and resource use	There was no evidence for the effectiveness of physical interventions in people with eating disorders. As a result, such interventions are not likely to be cost effective.
Quality of evidence	<p>The evidence for physical interventions was mostly very low quality. The evidence was downgraded for imprecision and risk of bias for reasons such as it was unclear how they randomised or if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded. High dropout rates were also detected, with more than 20% dropping out in each arm.</p> <p>Most of the outcomes were the result of a single study with a very low number of participants, only binge eating disorder had more than 100 participants in total.</p> <p>Few studies measured remission and/or compensatory behaviours relevant to that eating disorder. Some outcomes were excluded from the study because it was either unclear over what duration they measured the symptoms or it was less than the two week minimum required by the committee.</p>
Other considerations	The committee agreed that the evidence presented was not strong enough or of sufficient quality to recommend a physical intervention to people with an eating disorder. However, the committee decided to make a research recommendation on adding exercise to a recommended psychotherapy to determine whether it may add any benefit to those with bulimia nervosa or binge eating disorder. Exercise may be useful adjunct to psychological therapies to address any co-existing weight or obesity-related issues and mood disorders, such as depression and anxiety. The committee discussed the importance of any future research exploring what the right amount of exercise is, what is the best type of exercise and what the potential harms are.

1 **9. Research recommendation: Does exercise in addition to a recommended**
2 **psychotherapy add any benefit to those with bulimia nervosa or binge eating**
3 **disorder?**

4 **6.7 Management of long- and short-term physical**
5 **complications of eating disorders**

6 **6.7.1 Review question: What interventions are effective at managing or reducing**
7 **short and long-term physical complications of eating disorders?**

8 The review protocol summary, including the review question and the eligibility criteria used
9 for this section of the guideline, can be found in Table 139. Further information about the
10 search strategy can be found in Appendix H; the full review protocols can be found in
11 Appendix F.

12 This review considers all interventions that may be delivered to manage or reduce the short-
13 or long-term physical complications of eating disorders in children, young people and adults
14 and includes recovered as well as current service users. The interventions were categorised
15 according to type of physical complication and intervention, the age of the participants and
16 the type of eating disorder and were compared to the control arm as reported in the relevant
17 studies.

1

Table 139: Clinical review protocol summary

Component	Description
Review question(s)	What interventions are effective at managing or reducing short and long-term physical complications of eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) recovered or current service users <p>Strata:</p> <ul style="list-style-type: none"> children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Interventions to address the following:</p> <ul style="list-style-type: none"> Low bone mineral density (risk of fracture) Growth (physical development) Pubertal development Tooth wear Low body weight <p>Interventions to address the long-term physical complications may include:</p> <ul style="list-style-type: none"> GH/IGF-I Calcium with and without Vitamin D Bisphosphonates (age dependent and exclude pregnancy) Exercise (low impact)/Physiotherapy Oestrogen (patches/exogenous/pills other) Testosterone (males/females) Weight gain vs. Weight restoration (brain size) <p>Interventions to address the short-term physical complications may include</p> <ul style="list-style-type: none"> Phosphates supplementation (refeeding) Potassium Thiamine (refeeding) Laxatives (for when underweight patients are constipated) Salbutamol (reduce food intake)
Comparison	<ul style="list-style-type: none"> Control arm as defined by study
Critical outcomes	<ul style="list-style-type: none"> Primary outcome as reported by study
Important outcomes	<ul style="list-style-type: none"> Secondary outcome as reported by study
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs Observational studies: including prospective or retrospective cohort studies, (if no RCTs) (if no RCTs)

2 6.7.2 Clinical evidence

3 6.7.2.1 Low bone mineral density

4 12 RCTs (n=749) were identified that addressed the effects of pharmacological interventions
5 to treat people with anorexia nervosa and low bone mineral density (Divasta et al., 2012;
6 Divasta et al., 2014; Fazeli et al., 2014; Golden et al., 2005; Gordon et al., 2002; Grinspoon

1 et al., 2002; Grinspoon et al., 2003; Klibanski et al., 1995; Misra et al., 2011; Nakahara et al.,
2 2006; Strokosch et al., 2006). All the studies used female samples.

3 **6.7.2.2 Low hormone levels**

4 One RCT (n=21) was identified that addressed what are the effects of pharmacological
5 interventions to treat people with anorexia nervosa and low background rhIGF-I levels
6 (recombinant human insulin-like growth [IGF] factor-I) (Fazeli et al., 2010).

7 **6.7.2.3 Low body weight and malnourishment**

8 Two RCTs (n=117) (O'Connor et al., 2016b; Rigaud et al., 2007) and four observational
9 studies (n=803) (Born et al., 2015; Diamanti et al., 2008; Rigaud et al., 2010; Robb et al.,
10 2002) looked at how to address low body weight and/or malnourishment. All of the studies
11 were conducted in an inpatient setting and the majority of participants were female and
12 hospitalised for low body weight and/or malnourishment. One of the studies compared
13 parenteral and enteral nutrition with enteral nutrition alone (Diamanti 2008), whilst the
14 remaining studies all examined various forms of enteral nutrition. An overview of the RCTs
15 and observational studies included in the review can be found in Table 142 and Table 143.
16 Summary of findings can be found in Table 152, Table 153, Table 154, Table 155, Table
17 156, Table 157, Table 158 and Table 159.

18 **6.7.2.4 Cardiac dysfunction**

19 One observational study (n=28) was identified that examined the effect of a 4 week oral
20 potassium aspartate supplementation (60 mmol) on QT-dispersion in people with anorexia
21 nervosa and self-induced malnutrition (Franzoni et al., 2002). An overview of the study can
22 be found in Table 144, whilst a summary of findings can be found in Table 160.

1 **Table 140: Study information for RCTs included in the analysis of interventions to treat low bone mineral density or growth in**
2 **people with anorexia nervosa.**

Study_ID	Age years	BMI	Stage of illness	Number randomised	Females	Intervention	Other arms	Duration of treatment
Divasta 2012 Divasta 2014	18.1 (2.7)	18.0 (1.5)	Duration of AN 12 (6-40)	94	100%	DHEA (50mg daily) + Ethinyl estradiol + levonorgestrel	Placebo	18 months
Fazeli 2014	47 (2.7)	17.6 (0.4)	Years since onset of AN 20.4 (3.7)	21	100%	Teriparatide (Human PTH (1-34))	Placebo	6 months
Golden 2005	16.9 (1.6)	16.3 (1.4)	Duration of illness 25.7 (14.6) months	32	100%	Alendronate Bisphosphonate (10 mg daily)	Placebo	12 months
Gordon 2002	17.8 (2.9)	NR	NR	61	100%	DHEA 50 mg/d orally.	HRT Alesse (20 g ethinyl estradiol and 0.1 mg levonorgestr el). rhIGF-I (30 g/kg sc twice daily) & OCP (Ovcon 35, once a day, containing 35 g ethinyl estradiol and norethindron e 0.4 mg) IGF-I	12 months
Grinspoon 2002	25.2 (0.7)	17.8 (0.3)	NR	60	100%	OCP (Ovcon 35, once a day) + Placebo	Placebo. Oestrogen (Ovcon 35, 35 g	9 months

Study_ID	Age years	BMI	Stage of illness	Number randomised	Females	Intervention	Other arms	Duration of treatment
							ethinyl estradiol, and 0.4 mg of norethindrone) rhIGF-I I (30 g/kg d sc twice daily (BID))	
Grinspoon 2003	25.6 (0.8)	16.6 (0.2)	NR	59	100%	rhIGF-I + oestrogen	Placebo	3 months
Klibanski 1995	24.9 (6.9)	NR	Amenorrhea 3.3 (3.1) years	48	100%	Oestrogen + Progesterone (Premarin 0.625 mg, days 1-25) and Provera (5 mg)	Control	1.5 years
Misra 2011	16.5 (0.2)	17.4 (0.1)	Amenorrhea duration 0.9 (0.08) years	110	100%	Oestrogen Mature girls = 17b-estradiol (100-mg patch applied twice weekly Immature girls = oral ethinyl estradiol (3.75 mg to 11.25 mg daily)	Placebo	18 months
Miller 2011	25.3 (6.3)	17.6 (1.2)	NR	77	100%	Risendronate (35 mg/daily) Bisphosphonates	Testosterone Risendronate (Bisphosphonate) + Testosterone 35 mg + 150 mg/daily Placebo	12 months

Study_ID	Age years	BMI	Stage of illness	Number randomised	Females	Intervention	Other arms	Duration of treatment
Nakahara 2006	26.2 (8.5)	14.4 (1.7)	Duration of illness 57.3 (27.7) months	41	100%	Etidronate (200 mg/day) Bisphosphonates	Placebo Calcium and vitamin D 600 mg/d calcium L-aspartate and 1 mg/day alfacalcidol	3 months
Strokosch 2006	15.2 (1.2)	17.9 (2.3)	Duration of secondary amenorrhea 9.7 (8.0) months	146	100%	Norgestimate (180-250 g) /Ethinyl Estradiol. OCP (35 g)	Placebo	13 months

1 Abbreviations: g-grams; mg – milligrams; NR – not reported; rhIGF-I – recombinant human insulin-like growth factor –I; OCP – oral contraceptive pill.

2 **Table 141: Study information for RCTs included in the analysis of interventions to treat low hormones levels in people with anorexia nervosa.**

Study_ID	Age	BMI	Stage of illness	Number randomised	Females	Intervention	Other arms	Duration of treatment
Fazeli 2010	28 (2.1)	17.4 (0.4)	Duration of AN 2 years	21	100%	(rhGH) Supraphysiological recombinant human GH	Placebo	12 weeks

4 **Table 142: Study information for RCTs included in the analysis of interventions to treat low body weight and malnourishment in people with anorexia nervosa.**

Study ID	N randomised	Age years (SD)	BMI (SD), kg/m ²	Female (%)	Sample	Intervention	Comparison	Duration
O'Connor 2016	36	13.8 (1.8)	13.5 (1.1)	94	Moderately malnourished young people	High-calorie (1200 kcal/day) refeeding diet	Low-calorie (500 kcl/day) refeeding diet	Variable, >10 days

Study ID	N randomised	Age years (SD)	BMI (SD), kg/m ²	Female (%)	Sample	Intervention	Comparison	Duration
Rigaud 2007	81	23.3 (4.2)	12.4 (1.8)	98	Malnourished adults	Enteral Nutrition: Nasogastric Tube Feeding + Meals/snacks	Enteral Nutrition: Meals/snacks only	8 weeks

1 **Table 143: Study information for observational studies in the analysis of interventions to treat low body weight and/or**
2 **malnourishment in people with anorexia nervosa.**

Study ID	Number of participants	Mean Age, years (SD)	BMI (SD), kg/m ²	Female (%)	Sample	Intervention	Comparison	Duration
Born 2015	100	26.5 (8.5) Range: 16-61	12.3 (1.4)	96	Severely underweight adults	Parenteral Nutrition: Compulsory Percutaneous Gastric Tube Feeding + Meals	Enteral Nutrition: Meals + either Nasogastric Tube Feeding or No Tube Feeding	Until BMI ≈ 17 kg/m ² ; tube removed if stable body weight ≥ 2 weeks
Diamanti 2008	261	15 (1.2)	15.1 (0.9)	100	Young people with nutritional, metabolic, or psychiatric instability or cardiac dysfunction	Parenteral + Enteral Nutrition: Peripheral or intravascular infusion + Oral Feeding	Enteral Nutrition: Oral Feeding	Parenteral nutrition suspended when patients achieve intake ≥ 50 kcl/kg/day. Discharged when agreement to continue outpatient pharmacological + behavioural treatment and ≥ 60 kcal/kg/day
Rigaud 2010	284	23.1 (5.0)	13.3 (1.3)	98	Malnourished adults	Enteral Nutrition: Normal Sodium diet (10-12g NaCl/day) via Nasogastric	Enteral Nutrition: Low Sodium diet (4-5g NaCl/day) via Nasogastric	2 months

Study ID	Number of participants	Mean Age, years (SD)	BMI (SD), kg/m ²	Female (%)	Sample	Intervention	Comparison	Duration
						Tube Feeding + Meals/snacks	Tube Feeding + Meals/snacks	
Robb 2002	158	14.9 (1.8)	15.7 (1.8)	100	Young people <85% ideal body weight	Enteral Nutrition: Nocturnal Nasogastric Feeding + Meals/snacks	Enteral Nutrition: Meals/snacks only	Until ideal body weight >95%

1 Abbreviations: EBW, Expected Body Weight; IBW, Ideal Body Weight; IP, kcal, kilocalories; OCP, oral contraceptive pill

2 **Table 144: Study information for observational studies for treating cardiac dysfunction in female adult anorexia nervosa.**

Study ID	Number of participants	Mean Age, years (SD)	BMI (SD), kg/m ²	Female (%)	Sample	Intervention	Comparison	Duration
Franzoni 2002	28	20.1 (4.5)	15.9 (2.4)	100	Adult AN with self-induced malnutrition	Oral potassium aspartate supplementation (60 mmol)	No supplementation	4 weeks

3 **Table 145: Summary table of findings for DHEA versus hormone replacement therapy in young people with anorexia nervosa at the end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with DHEA vs.HRT (95% CI)
Change in Total Hip BMD - Young people	61 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in total hip bmd - young people in the intervention groups was 0.11 standard deviations lower (0.61 lower to 0.39 higher)
Change in LS BMD - Young people	61 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in ls bmd - young people in the intervention groups was 0.49 standard deviations lower (1 lower to 0.02 higher)

Did not dropout due to side effects	61 (1 study)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision	RR: 1.00 (0.94 to 1.06)	See comment**	-
Change in Weight - Young people	61 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in weight - young people in the intervention groups was 0.13 standard deviations higher (0.38 lower to 0.63 higher)
Regular menses - Young people	61 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision	RR 0.73 (0.51 to 1.03)	800 per 1000	216 fewer per 1000 (from 392 fewer to 24 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

** Absolute effect could not be calculated in GRADE because zero events were detected in the outcome.

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was conducted. Staff and participants were blind to study allocation, but it was unclear if assessors were blind. The control arm had a 20% dropout rate.

2 95% CI crossed 1 MID (-0.5)

3 For a continuous outcome, there were fewer than 400 participants.

4 95% CI crossed 1 MID (0.5).

5 95% CI crossed 1 MID (0.75)

6 For a dichotomous outcome, there were fewer than 300 events.

1 **Table 146: Summary table of findings for DHEA and combined oral contraceptive (COC) versus placebo in adults with anorexia nervosa at the end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with DHEA+COC (95% CI)
Change in Femoral Shaft BMD - Adults	73 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in femoral shaft bmd - adults in the intervention groups was 12.86 standard deviations higher (10.66 to 15.05 higher)
Change in Femoral Neck BMD - Adults	76 (1 study)	⊕⊕⊕⊖ LOW1,2		Not calculable	The mean change in femoral neck bmd - adults in the intervention groups was

		due to risk of bias, imprecision		for SMD values	14.38 standard deviations higher (11.99 to 16.77 higher)
Change in Femoral Shaft Bone Strength Index - Adults	73 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in femoral shaft bone strength index - adults in the intervention groups was 18.99 standard deviations higher (15.79 to 22.19 higher)
Change in FN Bone Strength Index - Adults	76 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in fn bone strength index - adults in the intervention groups was 0.95 standard deviations lower (1.43 to 0.47 lower)
Change in Weight - Adults	60 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in weight - adults in the intervention groups was 0.99 standard deviations higher (0.45 to 1.53 higher)
Change in BMI (% median for age) - Adults	60 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in BMI (% median for age) - adults in the intervention groups was 0.96 standard deviations higher (0.42 to 1.5 higher)
Amenorrhoeic - Adults	60 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision	RR 1 (0.94 to 1.07)	1000 per 1000	0 fewer per 1000 (from 60 fewer to 70 more)
Did not dropout due to side-effects	60 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision	RR 1.00 (0.94 to 1.07)	See comment**	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

** Absolute effects could not be calculated because zero events were included in the original analysis.

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Randomisation method was unclear and it was unclear if allocation concealment was conducted. Participants, investigators and assessors were blind. High dropout rates were detected in both arms >20%.

2 For a continuous outcome, there were fewer than 400 participants.

3 95% CI crossed 1 MID (-0.5)

4 95% CI crossed 1 MID (0.5)

5 For a dichotomous outcome, there were fewer than 300 events.

1 **Table 147: Summary table of findings for PTH versus placebo in adults with anorexia nervosa at the end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with PTH (95% CI)
% Change in Weight - Adults	21 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean % change in weight - adults in the intervention groups was 2.45 standard deviations lower (3.63 to 1.26 lower)
Change in Lateral Spine BMD - Adults	21 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in lateral spine bmd - adults in the intervention groups was 5.09 standard deviations higher (3.18 to 7 higher)
Change in Total Hip BMD - Adults	21 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in total hip bmd - adults in the intervention groups was 0.19 standard deviations lower (1.05 lower to 0.67 higher)
Change in FN BMD - Adults	21 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in fn bmd - adults in the intervention groups was 0.86 standard deviations lower (1.77 lower to 0.04 higher)
Change in AP Spine BMD - Adults	21 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision			The mean change in ap spine bmd - adults in the intervention groups was 4.61 standard deviations higher (2.84 to 6.38 higher)
Did not dropout due to side effects	21 (1 study)	See comment	Not estimable	See comment	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Randomisation method was unclear and it was unclear if allocation concealment was conducted. It was unclear if either the participants, investigators or assessors were blind. No dropouts were reported.

2 Short intervention of 6 months.

3 For a continuous outcome there were fewer than 400 participants.

4 95% CI crossed 2 MIDs (-0.5 and 0.5).

5 95% CI crossed 1 MID (-0.5).

1 **Table 148: Summary table of findings for effects of IGF in adults with anorexia nervosa at the end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with IGF (95% CI)
Change in Total Hip BMD - IGF-I vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in total hip bmd - igf-i vs. placebo in the intervention groups was 0.37 standard deviations higher (0.36 lower to 1.11 higher)
Change in Total Hip BMD - IGF + OCP vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in total hip bmd - igf + ocp vs. placebo in the intervention groups was 0.49 standard deviations higher (0.23 lower to 1.2 higher)
Change in Total Hip BMD - IGF vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in total hip bmd - igf vs. ocp in the intervention groups was 1.08 standard deviations higher (0.29 to 1.86 higher)
Change in Total Hip BMD - IGF-I + OCP vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in total hip bmd - igf-i + ocp vs. ocp in the intervention groups was 1.18 standard deviations higher (0.41 to 1.95 higher)
Change in Total Hip BMD - IGF-I + OCP vs. IGF-I	32 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in total hip bmd - igf-i + ocp vs. igf-i in the intervention groups was 0.10 standard deviations higher (0.62 lower to 0.82 higher)
Change Total Body BMD - IGF-I vs. placebo	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change total body bmd - igf-i vs. placebo in the intervention groups was 0.10 standard deviations higher (0.63 lower to 0.83 higher)
Change Total Body BMD - IGF + OCP vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change total body bmd - igf + ocp vs. placebo in the intervention groups was 1.27 standard deviations higher (0.49 to 2.05 higher)
Change Total Body BMD - IGF vs. OCP	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5}		Not calculable	The mean change total body bmd - igf vs. ocp in the intervention groups was

		due to risk of bias, indirectness, imprecision		for SMD values	1.33 standard deviations higher (0.51 to 2.15 higher)
Change Total Body BMD - IGF-I + OCP vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change total body bmd - igf-i + ocp vs. ocp in the intervention groups was 2.55 standard deviations higher (1.58 to 3.53 higher)
Change Total Body BMD - IGF-I + OCP vs. IGF-I	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change total body bmd - igf-i + ocp vs. igf-i in the intervention groups was 1.17 standard deviations higher (0.38 to 1.95 higher)
Change in Radial BMD - IGF-I vs. placebo	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in radial bmd - igf-i vs. placebo in the intervention groups was 0.25 standard deviations higher (0.48 lower to 0.98 higher)
Change in Radial BMD - OCP vs. placebo	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in radial bmd - ocp vs. placebo in the intervention groups was 0.62 standard deviations higher (0.12 lower to 1.35 higher)
Change in Radial BMD - IGF + OCP vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in radial bmd - igf + ocp vs. placebo in the intervention groups was 1.34 standard deviations higher (0.55 to 2.13 higher)
Change in Radial BMD - IGF vs. OCP	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in radial bmd - igf vs. ocp in the intervention groups was 0.29 standard deviations lower (1.02 lower to 0.44 higher)
Change in Radial BMD - IGF-I + OCP vs. IGF-I	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in radial bmd - igf-i + ocp vs. igf-i in the intervention groups was 0.88 standard deviations higher (0.12 to 1.63 higher)
Change in AP Spine BMD - IGF-I vs. placebo	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in ap spine bmd - igf-i vs. placebo in the intervention groups was 1.17 standard deviations higher (0.37 to 1.96 higher)
Change in AP Spine BMD - IGF + OCP vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5}		Not calculable	The mean change in ap spine bmd - igf + ocp vs. placebo in the intervention groups was

		due to risk of bias, indirectness, imprecision		for SMD values	2.34 standard deviations higher (1.4 to 3.28 higher)
Change in AP Spine BMD - IGF vs. OCP	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in ap spine bmd - igf vs. ocp in the intervention groups was 0.58 standard deviations higher (0.16 lower to 1.33 higher)
Change in AP Spine BMD - IGF-I + OCP vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in ap spine bmd - igf-i + ocp vs. ocp in the intervention groups was 1.75 standard deviations higher (0.91 to 2.6 higher)
Change in AP Spine BMD - IGF-I + OCP vs. IGF-I	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in ap spine bmd - igf-i + ocp vs. igf-i in the intervention groups was 1.17 standard deviations higher (0.38 to 1.95 higher)
Change in Lean Mass - IGF-I vs. placebo	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in lean mass - igf-i vs. placebo in the intervention groups was 1.59 standard deviations higher (0.74 to 2.44 higher)
Change in Lean Mass - IGF + OCP vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in lean mass - igf + ocp vs. placebo in the intervention groups was 2.34 standard deviations higher (1.4 to 3.28 higher)
Change in Radial BMD - IGF-I + OCP vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in radial bmd - igf-i + ocp vs. ocp in the intervention groups was 0.58 standard deviations higher (0.14 lower to 1.31 higher)
Change in Lean Mass - IGF vs. OCP	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in lean mass - igf vs. ocp in the intervention groups was 1.46 standard deviations higher (0.63 to 2.29 higher)
Change in Lean Mass - IGF-I + OCP vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in lean mass - igf-i + ocp vs. ocp in the intervention groups was 2.12 standard deviations higher (1.22 to 3.03 higher)
Change in Lean Mass - IGF-I + OCP vs. IGF-I	59 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable	The mean change in lean mass - igf-i + ocp vs. igf-i in the intervention groups was

		due to risk of bias, indirectness, imprecision		for SMD values	0.60 standard deviations higher (0.08 to 1.13 higher)
Change in Weight - IGF-I vs. placebo	59 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in weight - igf-i vs. placebo in the intervention groups was 0.54 standard deviations higher (0.02 to 1.07 higher)
Change in Weight - IGF-I + Oestrogen vs. placebo	59 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,5,7,8} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean change in weight - igf-i + oestrogen vs. placebo in the intervention groups was 0.14 standard deviations lower (0.72 lower to 0.44 higher)
Change in Weight - IGF-I + oestrogen vs. Oestrogen	60 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,5,7,8} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean change in weight - igf-i + oestrogen vs. oestrogen in the intervention groups was 0.53 standard deviations lower (1.07 lower to 0.01 higher)
Change in Weight - IGF-I + oestrogen vs. IGF-I	60 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,5,7,8} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in weight - igf-i + oestrogen vs. igf-i in the intervention groups was 0.48 standard deviations lower (1.06 lower to 0.09 higher)
Change in Weight - IGF-I vs. Oestrogen	60 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,7,8} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in weight - igf-i vs. oestrogen in the intervention groups was 0.35 standard deviations higher (0.18 lower to 0.89 higher)
Change in BMI - IGF-I vs. placebo	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in BMI - igf-i vs. placebo in the intervention groups was 0.76 standard deviations higher (0 to 1.52 higher)
Change in BMI - IGF-I + Oestrogen vs. placebo	29 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,5,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in BMI - igf-i + oestrogen vs. placebo in the intervention groups was 1.46 standard deviations lower (2.29 to 0.63 lower)
Change in BMI - IGF-I + oestrogen vs. Oestrogen	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,6,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in BMI - igf-i + oestrogen vs. oestrogen in the intervention groups was

					0.97 standard deviations lower (1.74 to 0.21 lower)
Change in BMI - IGF-I + oestrogen vs. IGF-I	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,5,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in BMI - igf-i + oestrogen vs. igf-i in the intervention groups was 1.91 standard deviations lower (2.79 to 1.02 lower)
Change in BMI - IGF-I vs. Oestrogen	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean change in BMI - igf-i vs. oestrogen in the intervention groups was 1.14 standard deviations higher (0.36 to 1.93 higher)
Did not drop out due to side-effects - OCP vs. placebo	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,7, 9} due to risk of bias, indirectness, imprecision	RR 1.00 (0.88 to 1.13)	See comment ^{**}	-
Did not drop out due to side-effects - IGF-I + OCP vs IGF-I	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,7, 9} due to risk of bias, indirectness, imprecision	RR 1.00 (0.88 to 1.13)	See comment ^{**}	-
Did not drop out due to side-effects - IGF-I vs. OCP	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2, 9} due to risk of bias, indirectness, imprecision	RR 0.94 (0.78 to 1.12)	Not calculable for SMD values	-
Did not drop out due to side-effects. Combined vs. placebo	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,7, 9} due to risk of bias, indirectness, imprecision	RR 1.00 (0.89 to 1.13)	See comment ^{**}	-
Did not drop out due to side-effects. IGF-I + OCP vs. OCP	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,7, 9} due to risk of bias, indirectness, imprecision	RR 1.00 (0.89 to 1.13)	See comment ^{**}	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

** Absolute effects could not be calculated because zero events were included in the original analysis.

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 Randomisation method was unclear and it was unclear if allocation concealment was conducted. Participants were blind, investigators were not and it was unclear if assessors were blind. A high dropout rate was detected in control arm >20%.
- 2 Relatively short period, 9 months
- 3 95% CI Crossed 1 MID (0.5)
- 4 95% CI Crossed 2 MIDs (-0.5 and 0.5)
- 5 For a continuous outcome, there were fewer than 400 participants.
- 6 95% CI Crossed 1 MID (-0.5)
- 7 Relatively short study duration, 3 months
- 8 Heterogeneity detected, I²>80%
- 9. For a dichotomous outcome, there were fewer than 300 events

1 **Table 149: Summary table of findings for oestrogen versus placebo in young people and adults with anorexia nervosa at the end of**
2 **treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with oestrogen(95% CI)
Change LS BMD - Young people	222 (2 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change ls bmd - young people in the intervention groups was 1.05 standard deviations higher (0.74 to 1.36 higher)
Change LS BMD - Adults	74 (2 studies)	⊕⊕⊕⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean change ls bmd - adults in the intervention groups was 1.05 standard deviations higher (0.74 to 1.36 higher)
Change in FN BMD - Young people	112 (1 study)	⊕⊕⊕⊖ LOW1 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in fn bmd - young people in the intervention groups was 0.22 standard deviations lower (0.15 lower to 0.6 higher)
Change Total Hip BMD - Young people	222 (2 studies)	⊕⊕⊕⊖ VERY LOW1,2,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean change total hip bmd - young people in the intervention groups was 0.61 standard deviations higher (0.33 to 0.88 higher)
Change Total Hip BMD - Adults	30 (1 study)	⊕⊕⊕⊖ VERY LOW2,5,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean change total hip bmd - adults in the intervention groups was 1.02 standard deviations lower (1.79 to 0.25 lower)

Change in Weight - Young people	222 (2 studies)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in weight - young people in the intervention groups was 0.34 standard deviations higher (0.07 to 0.6 higher)
Change in Weight - Adults	29 (1 study)	⊕⊕⊕⊕ LOW2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in weight - adults in the intervention groups was 0.39 standard deviations lower (1.13 lower to 0.35 higher)
Change in BMI - Young people	110 (1 study)	⊕⊕⊕⊕ LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in BMI - young people in the intervention groups was 0.27 standard deviations higher (0.11 lower to 0.64 higher)
Change in BMI - Adults	139 (1 study)	⊕⊕⊕⊕ LOW5,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in BMI - adults in the intervention groups was 0.11 standard deviations higher (0.22 lower to 0.45 higher)
Change in Lean mass - Young people	110 (1 study)	⊕⊕⊕⊕ LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in lean mass - young people in the intervention groups was 0.17 standard deviations higher (0.2 lower to 0.55 higher)
Change in Lean Mass - Adults	140 (1 study)	⊕⊕⊕⊕ LOW5,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in lean mass - adults in the intervention groups was 0.13 standard deviations higher (0.2 lower to 0.47 higher)
Change in Fat Mass - Young people	110 (1 study)	⊕⊕⊕⊕ LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in fat mass - young people in the intervention groups was 0.17 standard deviations higher (0.2 lower to 0.55 higher)
Change in Total Body BMD - Adults	30 (1 study)	⊕⊕⊕⊕ LOW9,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in total body bmd - adults in the intervention groups was 1.23 standard deviations lower (2.02 to 0.44 lower)
Did not achieve normal menses Young people	110 (1 study)	⊕⊕⊕⊕ LOW7,11 due to risk of bias, imprecision	RR 1.0 (1 to 1.2)	91 per 1000	0 fewer per 1000 (from 0 more to 18 more)

Did not achieve remission - Adults	44 (1 study)	⊕⊕⊖⊖ LOW1,12 due to risk of bias, imprecision	RR 1.10 (0.9 to 1.54)	240 per 1000	24 more per 1000 (from 24 fewer to 130 more)
Did not drop out due to side-effects- Young people	123 (1 study)	⊕⊕⊖⊖ LOW1,11 due to risk of bias, imprecision	RR 0.97 (0.91 to 1.03)	16 per 1000	0 fewer per 1000 (from 1 fewer to 0 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 It was unclear in all studies if allocation concealment was conducted, the investigators and participants were blind, but it was unclear if the assessors were blind. High dropouts were reported >20%.
- 2 95% CI Crossed 1 MID (0.5).
- 3 It was unclear in all studies if allocation concealment was conducted. In one study the investigators were not blind and in the other it was unclear. Participants were blind in one study but it was unclear in the other study. It was also unclear for both studies if the assessors were blind. High dropouts were reported across studies >20%.
- 4 Heterogeneity was detected I2 >80%.
- 5 It was unclear in all studies if allocation concealment was conducted. In Grinspoon, the investigators were not blind but the participants were blind and it was unclear if assessors were blind. High dropouts were reported in both studies >20%.
- 6 Heterogeneity was detected I2 >50%.
- 7 It was unclear if allocation concealment was conducted, The investigators and participants were blind, but it was unclear if the assessors were blind. High dropouts were reported >20%.
- 8 For a continuous outcome there were fewer than 400 participants.
- 9 It was unclear in all studies if allocation concealment was conducted. In both studies the participants were blind. In Grinspoon, the investigators were not blind and it was unclear if assessors were blind. High dropouts were reported >20%.
- 10 95% CI Crossed 1 MID (-0.5).
- 11 For a dichotomous outcome, there were fewer than 300 events.
- 12 It was unclear if allocation concealment was conducted. It was unclear in Klibanski if either the participants, investigators or assessors were blind. High dropouts were reported in both studies >20%

1 **Table 150: Summary table of findings for bisphosphonates versus placebo in adults and young people with anorexia nervosa at the**
2 **end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Bisphosphonate (95% CI)

Tibia SOS - Etidronate vs. placebo	26 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean tibia sos - etidronate vs. placebo in the intervention groups was 0.33 standard deviations higher (0.45 lower to 1.1 higher)
Tibia SOS - Etidronate vs. Calcium Vit D	29 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean tibia sos - etidronate vs. calcium vit d in the intervention groups was 0.47 standard deviations lower (1.21 lower to 0.27 higher)
Tibia Z Score - Etidronate vs. placebo	26 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean tibia z score - etidronate vs. placebo in the intervention groups was 0.64 standard deviations higher (0.15 lower to 1.43 higher)
Tibia Z Score - Etidronate vs. Calcium Vit D	29 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean tibia z score - etidronate vs. calcium vit d in the intervention groups was 0.24 standard deviations lower (0.97 lower to 0.49 higher)
Difference in Lateral spine BMD	39 (1 study)	⊕⊕⊖⊖ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in lateral spine bmd in the intervention groups was 1.35 standard deviations higher (2.05 to 0.64 lower)
Difference in hip BMD	38 (1 study)	⊕⊕⊖⊖ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean difference in hip bmd in the intervention groups was 1.42 standard deviations higher (2.13 to 0.71 lower)
PA Spine BMD Z score	38 (1 study)	⊕⊕⊖⊖ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean pa spine bmd z score in the intervention groups was 1.26 standard deviations higher (0.56 to 1.96 higher)
LS BMD Z score change - Young people	29 (1 study)	⊕⊕⊖⊖ LOW6,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ls bmd z score change - young people in the intervention groups was 0.05 standard deviations lower (0.78 lower to 0.68 higher)
FN BMD Z score change - Young people	29 (1 study)	⊕⊖⊖⊖ VERY LOW6,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean fn bmd z score change - - young people in the intervention groups was 0.39 standard deviations higher (0.34 lower to 1.13 higher)

Trochanter BMD Change - Young people	29 (1 study)	⊕⊕⊕⊖ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean trochanter bmd change - young people in the intervention groups was 4.60 standard deviations higher (3.13 to 6.07 higher)
Wards Triangle Change BMD - Young people	29 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean wards triangle change bmd - young people in the intervention groups was 0.54 standard deviations higher (0.2 lower to 1.28 higher)
Total Hip BMD Change - Young people	29 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean total hip bmd change - young people in the intervention groups was 0.24 standard deviations higher (0.49 lower to 0.97 higher)
Did not drop out due to SE - Bisphosphonates vs. placebo	95 (3 studies)	⊕⊕⊕⊖ LOW1,8 due to risk of bias, imprecision	RR 1.02 (0.94 to 1.1)	21 per 1000	0 more per 1000 (from 1 fewer to 2 more)
Did not drop out due to SE - Bisphosphonates vs. Ca Vit D	29 (1 study)	⊕⊕⊕⊖ LOW1,8 due to risk of bias, imprecision	RR 1.01 (0.96 to 1.09)	See comment	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

** Absolute effects could not be calculated because zero events were included in the original analysis.

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was conducted. Both the participants and investigators were blind but it was unclear if assessors were blind.

2 95% CI crossed 1 MID (0.5).

3 95% CI Crossed 1 MID (-0.5).

4 Unclear how randomisation sequence was generated or if allocation concealment was performed. Double-blind study, but unclear if the assessors were blind. Not clear what groups the dropouts were in.

5 For a continuous outcome there were fewer than 400 participants.

6 Unclear how randomisation sequence was generated and unclear if allocation concealment was conducted. The participants, investigators and assessors were blind. Low dropout rates.

7 95% CI crossed 2 MIDs (-0.5 and 0.5)

8 For a dichotomous outcome, there were fewer than 300 events.

1 Low hormone levels

2 **Table 151: Summary table of findings for growth hormone versus placebo in adults with anorexia nervosa at the end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo (AN)	Risk difference with Growth Hormone (rhGH) (95% CI)
Change in body weight. Adults	21 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in body weight. adults in the intervention groups was 0.7 standard deviations lower (1.59 lower to 0.19 higher)
IGF-I. Adults	21 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean igf-i. adults in the intervention groups was 1.92 standard deviations higher (0.85 to 2.99 higher)
Change in IGF-I. Adults	21 (1 study)	⊕⊖⊖⊖ VERY LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in igf-i. adults in the intervention groups was 0.9 standard deviations higher (0.01 lower to 1.81 higher)
Dropout for any reason. Adults	21 (1 study)	See comment	RR 0.22 (0.01 to 4.06)	182 per 1000	142 fewer per 1000 (from 180 fewer to 556 more)
Dropout due to side-effects. Adults	21 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision	Not estimable	See comment	See comment

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear methods of randomisation or if allocation concealment was performed. It is also unclear either the participants, investigators or assessors were blind.

2 95% CI crossed 1 MID (-0.5)

3 Fewer than 400 participants were available for this outcome.

4 95% CI crossed 2 MIDs (-0.5 and 0.5)

5 Fewer than 300 events were available for this outcome.

1 Low body weight and malnourishment

2 **Table 152: Summary table of findings for parenteral and enteral refeeding diet versus enteral refeeding diet in young females with**
3 **anorexia nervosa at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Enteral Refeeding	Risk difference with (Obs) Parenteral+Enteral Refeeding (95% CI)
BMI	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.28 standard deviations lower (0.56 lower to 0 higher)
% Ideal Body Weight - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean % ideal body weight - young people in the intervention groups was 0.37 standard deviations lower (0.65 to 0.09 lower)
Weight Gain (g/week) - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain (g/week) - young people in the intervention groups was 16.27 standard deviations higher (14.63 to 17.91 higher)
Length of Treatment (days) - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean length of treatment (days) - young people in the intervention groups was 8.66 standard deviations higher (7.75 to 9.56 higher)
Maximum Energy Intake (kcal/day) - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean maximum energy intake (kcal/day) - young people in the intervention groups was 3.06 standard deviations higher (2.64 to 3.47 higher)
Abdominal Pain - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.4 (0.18 to 0.88)	191 per 1000	115 fewer per 1000 (from 23 fewer to 157 fewer)
Bloating - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.45 (0.19 to 1.07)	149 per 1000	82 fewer per 1000 (from 121 fewer to 10 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Enteral Refeeding	Risk difference with (Obs) Parenteral+Enteral Refeeding (95% CI)
Constipation - Young people	198 (1 study) 33.3 months	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 0.72 (0.3 to 1.76)	106 per 1000	30 fewer per 1000 (from 74 fewer to 81 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Diamanti 2008: high selection bias(significantly higher psychiatric comorbidity, weight loss at diagnosis, and resting energy expenditure in parenteral group; significantly lower % Ideal Body Weight, Weight at diagnosis and BMI in parenteral group).
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 <300 events or <400 participants.
4 CI crosses both 0.75 and 1.25 (Risk Ratio).

1 **Table 153: Summary table of findings for parenteral and enteral refeeding diet versus enteral refeeding diet in young females with anorexia nervosa at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Enteral Refeeding	Risk difference with (Obs) Parenteral and Enteral Refeeding (95% CI)
Recovered after nutritional rehabilitation - Young people	129 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.95 (0.73 to 1.25)	642 per 1000	32 fewer per 1000 (from 173 fewer to 160 more)
Rehospitalized - Young people	129 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 0.89 (0.48 to 1.65)	254 per 1000	28 fewer per 1000 (from 132 fewer to 165 more)
Length of 2nd rehospitalisation - Young people	129 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean length of 2nd rehospitalisation - young people in the intervention groups was 0.62 standard deviations higher (0.27 to 0.98 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Enteral Refeeding	Risk difference with (Obs) Parenteral and Enteral Refeeding (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Diamanti 2008: high selection bias(significantly higher psychiatric comorbidity, weight loss at diagnosis, and resting energy expenditure in parenteral group; significantly lower % Ideal Body Weight, Weight at diagnosis and BMI in parenteral group).					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 CI crosses both 0.75 and 1.25 (Risk Ratio).					

1 **Table 154: Summary table of findings for percutaneous gastric refeeding diet versus nasogastric tube refeeding diet or No Refeeding**
2 **in low body weight adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Nasogastric Feeding/No Tube	Risk difference with (Obs) Percutaneous Gastric (95% CI)
Weight Gain (kg) at discharge - Adult	68 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain (kg) at discharge - adult in the intervention groups was 0.17 standard deviations higher (0.47 lower to 0.82 higher)
Length of Treatment (days) - Adult	68 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean length of treatment (days) - adult in the intervention groups was 0.87 standard deviations higher (0.21 to 1.54 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Born 2015: high selection bias (method of allocation to groups related to potential confounding factors), high performance bias (participants received various forms of therapies).					
2 CI crosses 0.5 or -0.5.					

1 **Table 155: Summary table of findings for nasogastric tube and oral refeeding versus oral refeeding in young underweight females**
2 **with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding	Risk difference with (Obs) Nasogastric+Oral (95% CI)
BMI - Young people	100 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI - Young people in the intervention groups was 0.48 standard deviations higher (0.08 to 0.88 higher)
BMI change at discharge - Young people	100 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI change at discharge - Young people in the intervention groups was 1 standard deviations higher (0.58 to 1.42 higher)
Weight (kg) - Young people	100 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) - Young people in the intervention groups was 0.27 standard deviations higher (0.13 lower to 0.66 higher)
Weight Gain at discharge - Young people	100 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain at discharge - Young people in the intervention groups was 0.95 standard deviations higher (0.54 to 1.36 higher)
Length of Stay (days) - Young people	100 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean length of stay (days) - Young people in the intervention groups was 0.02 standard deviations higher (0.38 lower to 0.41 higher)
Maximum Caloric Intake (kcal/day) - Young people	100 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean maximum caloric intake (kcal/day) - Young people in the intervention groups was 1.27 standard deviations higher (0.84 to 1.7 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Robb 2002: high selection bias (significantly higher number of hospitalisations in nocturnal NG + oral refeeding group); high performance bias (participants received various therapies during course of treatment).					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding	Risk difference with (Obs) Nasogastric+Oral (95% CI)
2 CI crosses 0.5 or -0.5.					
3 <300 events or <400 participants.					

1 **Table 156: Summary table of findings for nasogastric and oral refeeding versus oral refeeding in malnourished adults with anorexia nervosa at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding for adult AN	Risk difference with (RCT) Nasogastric+Oral (95% CI)
BMI>18.5	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 5.2 (1.64 to 16.49)	75 per 1000	315 more per 1000 (from 48 more to 1000 more)
Weight (kg)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) in the intervention groups was 0.63 standard deviations higher (0.18 to 1.08 higher)
Weight (kg) - AN-R	56 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) - an-r in the intervention groups was 1.13 standard deviations higher (0.56 to 1.7 higher)
Weight (kg) - AN-BP	25 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) - an-bp in the intervention groups was 1.15 standard deviations higher (0.29 to 2.01 higher)
Weight Gain (g/day)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain (g/day) in the intervention groups was 4.04 standard deviations higher (3.27 to 4.82 higher)
Relapse-Free Period (weeks)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3		Not calculable for SMD values	The mean relapse-free period (weeks) in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding for adult AN	Risk difference with (RCT) Nasogastric+Oral (95% CI)
		due to risk of bias, imprecision			0.94 standard deviations higher (0.48 to 1.41 higher)
Change in Extracellular fluids (kg)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in extracellular fluids (kg) in the intervention groups was 5.03 standard deviations lower (5.94 to 4.13 lower)
Creatinine urinary output (mg/day)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean creatinine urinary output (mg/day) in the intervention groups was 0.67 standard deviations higher (0.22 to 1.12 higher)
Fat Free Mass (kg)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean fat free mass (kg) in the intervention groups was 1.04 standard deviations higher (0.57 to 1.5 higher)
Fat Free Mass Gain (g/day)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean fat free mass gain (g/day) in the intervention groups was 3.06 standard deviations higher (2.41 to 3.71 higher)
Fat Mass Gain (g/day)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean fat mass gain (g/day) in the intervention groups was 0.55 standard deviations higher (0.1 to 0.99 higher)
Added Sugar (sucrose) (g/day)	81 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean added sugar (sucrose) (g/day) in the intervention groups was 0.45 standard deviations lower (0.89 to 0.01 lower)
Added Fat (g/day)	81 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean added fat (g/day) in the intervention groups was 0.24 standard deviations higher (0.2 lower to 0.68 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding for adult AN	Risk difference with (RCT) Nasogastric+Oral (95% CI)
Energy Intake (kcal/day) - AN-R	56 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean energy intake (kcal/day) - an-r in the intervention groups was 0.46 standard deviations higher (0.08 lower to 0.99 higher)
Energy Intake (kcal/day) - AN-BP	25 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean energy intake (kcal/day) - an-bp in the intervention groups was 0.93 standard deviations lower (1.77 to 0.1 lower)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Rigaud 2007: no details of randomization method provided; unclear whether participant, investigator or assessor blinded.					
2 <300 events or <400 participants.					
3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 **Table 157: Summary table of findings for nasogastric and oral refeeding versus oral refeeding in malnourished adults with anorexia nervosa at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding	Risk difference with (RCT) Nasogastric+Oral (95% CI)
Weight (kg) - AN-R 12-mo FU	56 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) - an-r 12-mo fu in the intervention groups was 0.99 standard deviations higher (0.43 to 1.55 higher)
Weight (kg) AN-BP 12-mo FU	25 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) an-bp 12-mo fu in the intervention groups was 1.2 standard deviations higher (0.33 to 2.06 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding	Risk difference with (RCT) Nasogastric+Oral (95% CI)
# Relapsed 12-mo FU	81 (1 study) 1 years	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision	RR 0.84 (0.53 to 1.32)	525 per 1000	84 fewer per 1000 (from 247 fewer to 168 more)
Energy Intake - AN-R 12-mo FU (kcal/day)	56 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean energy intake - an-r 12-mo fu (kcal/day) in the intervention groups was 0 standard deviations higher (0.52 lower to 0.53 higher)
Energy Intake AN-BP 12-mo FU (kcal/day)	25 (1 study) 1 years	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean energy intake an-bp 12-mo fu (kcal/day) in the intervention groups was 0.28 standard deviations lower (1.07 lower to 0.51 higher)
# BMI>18.5 + adequate energy intake 12-mo FU	81 (1 study) 1 years	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision	RR 1.33 (0.7 to 2.53)	275 per 1000	91 more per 1000 (from 83 fewer to 421 more)
EDI Total 12-mo FU	81 (1 study) 1 years	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total 12-mo fu in the intervention groups was 0.15 standard deviations lower (0.59 lower to 0.28 higher)
Resumed menses 12-mo FU	26 (1 study) 1 years	⊕⊕⊕⊕ LOW _{1,2} due to risk of bias, imprecision	RR 1.11 (0.88 to 1.4)	909 per 1000	100 more per 1000 (from 109 fewer to 364 more)
# taking antidepressants 12-mo FU	81 (1 study) 1 years	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision	RR 1.17 (0.39 to 3.53)	125 per 1000	21 more per 1000 (from 76 fewer to 316 more)
# taking anxiolytics 12-mo FU	81 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,3} due to risk of bias, imprecision	RR 0.76 (0.31 to 1.84)	225 per 1000	54 fewer per 1000 (from 155 fewer to 189 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Oral Refeeding	Risk difference with (RCT) Nasogastric+Oral (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Rigaud 2007: no details of randomization method provided; unclear whether participant, investigator or assessor blinded.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).					

1 **Table 158: Summary table of findings for high-calorie diet versus low-calorie diet in malnourished young people with anorexia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low-Calorie Diet	Risk difference with (RCT) High-Calorie Diet (95% CI)
QT-corrected Interval at 4 days - QT-c (ms)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean qt-corrected interval at 4 days - qt-c (ms) in the intervention groups was 0.01 standard deviations higher (0.64 lower to 0.67 higher)
QT-corrected Interval at 4 days - Change scores	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean qt-corrected interval at 4 days - change scores in the intervention groups was 0.24 standard deviations higher (0.42 lower to 0.89 higher)
Heart Rate at 4 days - Heart Rate (bpm)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean heart rate at 4 days - heart rate (bpm) in the intervention groups was 0.58 standard deviations higher (0.09 lower to 1.25 higher)
Heart Rate at 4 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias,		Not calculable for SMD values	The mean heart rate at 4 days - change in the intervention groups was 0 standard deviations higher (0.65 lower to 0.65 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low-Calorie Diet	Risk difference with (RCT) High-Calorie Diet (95% CI)
		indirectness, imprecision			
Weight (kg) at 4 days - Weight (kg)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight (kg) at 4 days - weight (kg) in the intervention groups was 0.21 standard deviations lower (0.86 lower to 0.45 higher)
Weight (kg) at 4 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight (kg) at 4 days - change in the intervention groups was 0.64 standard deviations higher (0.03 lower to 1.31 higher)
BMI at 4 days - BMI	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI at 4 days - BMI in the intervention groups was 0.37 standard deviations higher (0.29 lower to 1.03 higher)
BMI at 4 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI at 4 days - change in the intervention groups was 0.44 standard deviations higher (0.22 lower to 1.11 higher)
mBMI (%) at 4 days - mBMI (%)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean mbmi (%) at 4 days - mbmi (%) in the intervention groups was 0.47 standard deviations higher (0.2 lower to 1.13 higher)
mBMI (%) at 4 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean mbmi (%) at 4 days - change in the intervention groups was 0.56 standard deviations higher (0.11 lower to 1.23 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low-Calorie Diet	Risk difference with (RCT) High-Calorie Diet (95% CI)
Serum Phosphate Concentration at 4 days - Nadir (mmol/L)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean serum phosphate concentration at 4 days - nadir (mmol/l) in the intervention groups was 0.06 standard deviations higher (0.6 lower to 0.71 higher)
Serum Phosphate Concentration at 4 days - Change (mmol/L)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean serum phosphate concentration at 4 days - change (mmol/l) in the intervention groups was 0.17 standard deviations lower (0.82 lower to 0.49 higher)
Energy Intake at 4 days - Kcal/day	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean energy intake at 4 days - kcal/day in the intervention groups was 2.16 standard deviations higher (1.32 to 3 higher)
Energy Intake at 4 days - Kcal/g	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean energy intake at 4 days - kcal/g in the intervention groups was 1.78 standard deviations higher (0.99 to 2.56 higher)
Weight (kg) at 10 days - Weight (kg)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight (kg) at 10 days - weight (kg) in the intervention groups was 0.18 standard deviations lower (0.84 lower to 0.47 higher)
Weight (kg) at 10 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight (kg) at 10 days - change in the intervention groups was 0.49 standard deviations higher (0.17 lower to 1.16 higher)
BMI at 10 days - BMI	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias,		Not calculable for SMD values	The mean BMI at 10 days - BMI in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low-Calorie Diet	Risk difference with (RCT) High-Calorie Diet (95% CI)
		indirectness, imprecision			0.32 standard deviations higher (0.34 lower to 0.98 higher)
BMI at 10 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI at 10 days - change in the intervention groups was 0.55 standard deviations higher (0.11 lower to 1.22 higher)
mBMI (%) at 10 days	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean mbmi (%) at 10 days in the intervention groups was 0.5 standard deviations higher (0.17 lower to 1.16 higher)
mBMI (%) at 10 days - Change	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean mbmi (%) at 10 days - change in the intervention groups was 0.64 standard deviations higher (0.04 lower to 1.31 higher)
Energy Intake at 10 days - Kcal/day	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean energy intake at 10 days - kcal/day in the intervention groups was 0.95 standard deviations higher (0.25 to 1.64 higher)
Energy Intake at 10 days - Kcal/g	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean energy intake at 10 days - kcal/g in the intervention groups was 0.91 standard deviations higher (0.22 to 1.6 higher)
Glucose (mmol/L) at 10 days	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean glucose (mmol/l) at 10 days in the intervention groups was 0.39 standard deviations higher (0.27 lower to 1.05 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low-Calorie Diet	Risk difference with (RCT) High-Calorie Diet (95% CI)
Insulin (miu mol/L) at 10 days	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean insulin (miu mol/l) at 10 days in the intervention groups was 0.34 standard deviations higher (0.32 lower to 1 higher)
HOMA at 10 days Homeostatic Model Assessment Insulin Resistance	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean homa at 10 days in the intervention groups was 0.62 standard deviations higher (0.05 lower to 1.29 higher)
White Blood Cell Count (x 10 ⁹ /L)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean white blood cell count (x 10 ⁹ /l) in the intervention groups was 0.42 standard deviations higher (0.24 lower to 1.08 higher)
No adverse Events within first 4 days of treatment	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision	RR 1.06 (0.91 to 1.23)	944 per 1000	57 more per 1000 (from 85 fewer to 217 more)
No Oral Phosphate Supplementation due to low PO	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision	RR 1 (0.85 to 1.17)	944 per 1000	0 fewer per 1000 (from 142 fewer to 161 more)
Hypophosphatemia within first 2 days	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision	RR 2.5 (0.56 to 11.25)	111 per 1000	167 more per 1000 (from 49 fewer to 1000 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low-Calorie Diet	Risk difference with (RCT) High-Calorie Diet (95% CI)
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 O'Connor 2016: no info regarding allocation concealment; no participant nor investigator blinding. Two participants in each group required nasogastric tube feeding due to failing to achieve >=80% expected energy intake within 48 hours of admission.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or 0.5 or -0.5 (SMD).					
3 Sample was participants diagnosed with anorexia nervosa or atypical anorexia nervosa.					
4 CI crosses both 0.75 and 1.25 (Risk Ratio) or 0.5 and -0.5 (SMD).					
5 <300 events (dichotomous outcome) or <400 participants (continuous outcome).					

1 **Table 159: Summary table of findings for normal-sodium nasogastric tube and oral refeeding diet versus low-sodium nasogastric tube and oral refeeding diet in malnourished adults with anorexia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low Sodium diet	Risk difference with (Obs) Nasogastric+Oral Refeeding for adult AN: Normal Sodium (95% CI)
Weight (kg)	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight (kg) in the intervention groups was 0.25 standard deviations higher (0.09 lower to 0.59 higher)
BMI	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.13 standard deviations lower (0.47 lower to 0.21 higher)
Fat Free Mass (kg; skinfold)	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean fat free mass (kg; skinfold) in the intervention groups was 0.41 standard deviations higher (0.07 to 0.75 higher)
Active Fat Free Mass (kg)	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean active fat free mass (kg) in the intervention groups was 0.32 standard deviations lower (0.66 lower to 0.02 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Low Sodium diet	Risk difference with (Obs) Nasogastric+Oral Refeeding for adult AN: Normal Sodium (95% CI)
Fat Mass (kg; skinfold and BIA) - Fat Mass skinfold	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean fat mass (kg; skinfold and bia) - fat mass skinfold in the intervention groups was 0.36 standard deviations lower (0.7 to 0.03 lower)
Fat Mass (kg; skinfold and BIA) - Fat Mass BIA	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean fat mass (kg; skinfold and bia) - fat mass bia in the intervention groups was 0.16 standard deviations lower (0.5 lower to 0.18 higher)
Energy Input (kcal/day)	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean energy input (kcal/day) in the intervention groups was 0.19 standard deviations higher (0.14 lower to 0.53 higher)
Energy input tube feeding (kcal/day)	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean energy input tube feeding (kcal/day) in the intervention groups was 0.52 standard deviations lower (0.86 to 0.18 lower)
Edema of legs	218 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision	RR 3.43 (1.52 to 7.74)	62 per 1000	152 more per 1000 (from 32 more to 421 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Rigaud 2010: Method of analysis not clear and data throughout study not reported for all participants. No restriction in sodium and water intake in normal sodium group. Sample was 98% women, duration of illness not reported.

2 CI crosses 0.5 or -0.5.

3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

1 **Table 160: Summary table of findings for oral potassium supplementation versus no supplementation for adults with anorexia**
2 **nervosa and self-induced malnutrition.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with (Obs) Oral Potassium Supplementation (95% CI)
Corrected QT Dispersion (ms)	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean corrected qt dispersion (ms) in the intervention groups was 1.03 standard deviations lower (1.83 to 0.23 lower)
QT Dispersion (ms)	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean qt dispersion (ms) in the intervention groups was 1.47 standard deviations lower (2.32 to 0.62 lower)
Serum potassium (mmol l-1)	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean serum potassium (mmol l-1) in the intervention groups was 0.82 standard deviations higher (0.04 to 1.59 higher)
Urinary potassium excretion (mmol 24h-1)	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean urinary potassium excretion (mmol 24h-1) in the intervention groups was 1.79 standard deviations higher (0.9 to 2.69 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Franzoni 2002: high selection bias (unclear method of allocation to groups). Demographic and baseline details of treated and untreated group not provided.					
2 CI crosses 0.5 or -0.5.					
3 <400 participants.					

3

4

1 **6.7.3 Economic evidence**

2 No economic evidence on the cost effectiveness of interventions for the management of
3 short and long-term physical complications of anorexia nervosa was identified by the
4 systematic search of the economic literature undertaken for this guideline. Details on the
5 methods used for the systematic search of the economic literature are described in Chapter
6 3.

7 **6.7.4 Clinical evidence statements**

8 **6.7.4.1 DHEA versus HRT for young people with anorexia nervosa at the end of treatment**

9 Low quality evidence from one RCT (n=61) showed DHEA is less effective on change in
10 lumbar spine BMD compared with HRT, but there was some uncertainty.

11 Low quality evidence from one RCT (n=61) showed no difference in the effect of DHEA
12 change in total hip BMD, change in body weight and dropouts due to side-effects compared
13 with HRT.

14 Low quality evidence from one RCT (n=61) showed DHEA is less effective on achieving a
15 resumption in menses compared with HRT, but there was some uncertainty.

16 **6.7.4.2 DHEA and combined oral contraceptive pill (COC) versus placebo for adults with 17 anorexia nervosa at the end of treatment**

18 Low quality evidence from one RCT (n=60 to 76) showed DHEA and COC is more effective
19 on change in femoral shaft BMD, femoral neck BMD, change in femoral shaft bone strength
20 index, change in body weight and BMI compared with placebo.

21 Low quality evidence from one RCT (n=60) showed no difference in the effect DHEA and
22 COC has on menstrual function and dropouts due to side-effects compared with placebo.

23 Low quality evidence from one RCT (n= 76) showed DHEA and COC is less effective on
24 change in femoral neck bone strength index compared with placebo.

25 **6.7.4.3 PTH versus placebo for adults with anorexia nervosa at the end of treatment**

26 Very low quality evidence from one RCT (n=21) showed PTH is less effective on change in
27 body weight compared with placebo.

28 Very low quality evidence from one RCT (n=21) showed PTH is more effective on change in
29 lateral spine BMD and change in anteroposterior spine BMD compared with placebo.

30 Very low quality evidence from one RCT (n=21) showed no difference in the effect of PTH on
31 change in total body BMD and the number of dropouts due to side-effect compared with
32 placebo.

33 Very low quality evidence from one RCT (n=21) showed PTH is less effective on change in
34 femoral neck BMD compared with placebo, but there was some uncertainty.

35 **6.7.4.4 IGF-I versus placebo for adults with anorexia nervosa at the end of treatment**

36 Very low quality evidence from one RCT (n=29 to 31) showed no difference in the effect of
37 IGF-I on change in total body, total hip and radial BMD compared with placebo.

38 Very low quality evidence from one RCT (n=31) showed IGF-I is more effective on change in
39 anteroposterior BMD, change in lean mass, change in BMI compared with placebo.

1 Very low quality evidence from two RCTs (n=59) showed IGF-I is more effective on change
2 in weight compared with placebo.

3 **6.7.4.5 IGF-I and oral contraceptive pill (OCP) versus placebo for adults with anorexia**
4 **nervosa at the end of treatment**

5 Very low quality evidence from one RCT (n=31) showed no difference in the effect of IGF-I
6 and OCP on change in total hip BMD and dropouts due to side-effects compared with
7 placebo.

8 Very low quality evidence from one RCT (n=29 to 31) showed IGF-I and OCP are more
9 effective on change in total body, radial, anteroposterior BMD, change in lean mass,
10 compared with placebo.

11 Very low quality evidence from one RCT (n=31) showed IGF-I and OCP are less effective on
12 change in BMI compared with placebo.

13 Very low quality evidence from two RCTs (n=59) showed no difference in the effect of IGF-
14 and OCP on change in weight compared with placebo.

15 **6.7.4.6 IGF-I versus oral contraceptive pill (OCP) for adults with anorexia nervosa at the end**
16 **of treatment**

17 Very low quality evidence from one RCT (n= 31) showed IGF-I is more effective on change
18 in total hip and total body BMD and change in lean mass and BMI compared with placebo.

19 Very low quality evidence from one RCT (n= 29 to 31) showed no difference in the effect of
20 IGF-I on change in radial and anteroposterior BMD and number of dropouts due to side-
21 effects compared with placebo.

22 Very low quality evidence from two RCTs (n= 60) showed no difference in the effect of IGF-I
23 on change in weight compared with placebo.

24 **6.7.4.7 IGF-I and oral contraceptive pill (OCP) versus OCP for adults with anorexia nervosa at**
25 **the end of treatment**

26 Very low quality evidence from one RCT (n= 31) showed IGF-I and OCP is more effective on
27 change in total hip, total body, anteroposterior BMD, change in lean mass compared with
28 OCP.

29 Very low quality evidence from one RCT (n= 31) showed no difference in the effect of IGF-I
30 and OCP on change in radial BMD and dropouts due to side-effects compared with OCP.

31 Very low quality evidence from two RCTs (n= 60) showed IGF-I and OCP is less effective on
32 change in weight compared with OCP, but there was some uncertainty.

33 Very low quality evidence from one RCT (n= 30) showed IGF-I and OCP is less effective on
34 change in BMI compared with OCP.

35 **6.7.4.8 IGF-I and oral contraceptive pill (OCP) versus IGF-I for adults with anorexia nervosa at**
36 **the end of treatment**

37 Very low quality evidence from one RCT (n= 31) showed no difference in the effect of IGF-I
38 and OCP on change in total hip and radial BMD, change in BMI dropouts due to side-effects
39 compared with IGF-I.

40 Very low quality evidence from one RCT (n= 31) showed IGF-I and OCP is more effective on
41 change in total body and anteroposterior BMD and change in lean mass compared with IGF-
42 I.

- 1 Very low quality evidence from two RCTs (n= 60) showed IGF-I and OCP is less effective on
2 change in weight compared with IGF-I, but there was some uncertainty.
- 3 **6.7.4.9 Oral contraceptive pill (OCP) versus placebo for adults with anorexia nervosa at the**
4 **end of treatment**
- 5 Very low quality evidence from one RCT (n= 30) showed no difference in the effect of OCP
6 on change in radial BMD and dropouts due to side-effects compared with placebo.
- 7 **6.7.4.10 Oestrogen versus placebo for young people with anorexia nervosa at the end of**
8 **treatment**
- 9 Low quality evidence from two RCTs (n= 222) showed oestrogen is more effective on change
10 in lumbar spine and total hip BMD and change in weight compared with placebo.
- 11 Low quality evidence from one RCT (n= 110) showed no difference in the effect of oestrogen
12 change in femoral neck BMD, BMI, lean mass, fat mass and the number who dropped out
13 due to side-effects compared with placebo.
- 14 Low quality evidence from two RCTs (n= 222) showed oestrogen is less effective on the
15 number who achieved normal menses compared with placebo.
- 16 **6.7.4.11 Oestrogen versus placebo for adults with anorexia nervosa at the end of treatment**
- 17 Low quality evidence from two RCTs (n= 74) showed oestrogen is more effective on change
18 in lumbar spine BMD compared with placebo.
- 19 Low quality evidence from one RCT (n= 29) showed no difference in the effect of oestrogen
20 on change in weight compared with placebo.
- 21 Low quality evidence from one RCT (n= 139 to 140) showed no difference in the effect of
22 oestrogen on change in BMI or lean mass compared with placebo.
- 23 Low quality evidence from one RCT (n= 44) showed no difference in the effect of oestrogen
24 on remission compared with placebo.
- 25 Very low quality evidence from one RCT (n= 30) showed oestrogen is less effective on
26 change in total hip and total body BMD compared with placebo.
- 27 **6.7.4.12 Bisphosphonates versus placebo for adults with anorexia nervosa at the end of**
28 **treatment**
- 29 Low quality evidence from one RCT (n= 26) showed no difference in the effect of etidronate
30 on ultrasound tibia speed of sound (SOS) and tibia Z score compared with placebo.
- 31 Low quality evidence from one RCT (n= 39) showed risendronate may be more effective on
32 lateral spine and hip BMD and anteroposterior spine BMD Z scores compared with placebo.
- 33 Low quality evidence from two RCTs (n= 66) showed no difference in the effect of
34 bisphosphonates on dropouts due to side-effects compared with placebo.
- 35 **6.7.4.13 Bisphosphonates versus placebo for young people with anorexia nervosa at the end**
36 **of treatment**
- 37 Low quality evidence from one RCT (n= 26 to 29) showed no difference in the effect of
38 alendronate on change in total hip, lumbar spine, wards triangle or femoral neck BMD Z
39 score compared with placebo.

- 1 Low quality evidence from one RCT (n= 29) showed alendronate is more effective on change
2 trochanter BMD compared with placebo.
- 3 Low quality evidence from one RCT (n= 29) showed no difference in the effect of
4 bisphosphonates on dropouts due to side-effects compared with placebo.
- 5 **6.7.4.14 Biosphosphonates versus calcium and vitamin D for adults with anorexia nervosa at
6 the end of treatment**
- 7 Low quality evidence from one RCT (n= 29) showed no difference in the effect of etidronate
8 on ultrasound tibia speed of sound (SOS), tibia Z score or dropouts due to side-effects
9 compared with calcium and vitamin D.
- 10 **6.7.4.15 Growth hormone versus placebo for adults with anorexia nervosa at the end of
11 treatment**
- 12 Low quality evidence from one RCT (n= 21) showed no difference in the effect of growth
13 hormone (rhGH) on change in body weight or dropouts due to any reason or because of
14 side-effects compared with placebo.
- 15 Low quality evidence from one RCT (n= 21) showed growth hormone (rhGH) is more
16 effective on serum IGF-I levels compared with placebo.
- 17 Low quality evidence from one RCT (n= 21) showed growth hormone (rhGH) is more
18 effective on change in serum IGF-I levels compared with placebo, but there was some
19 uncertainty.
- 20 **6.7.4.16 Parenteral and enteral nutrition versus enteral nutrition in young people with anorexia
21 nervosa at end of treatment**
- 22 Very low quality evidence from one observational study (n=198) showed parenteral and
23 enteral nutrition is less effective on BMI, % ideal body weight and length of treatment
24 compared with enteral nutrition.
- 25 Very low quality evidence from one observational study (n=198) showed parenteral and
26 enteral nutrition is more effective on weekly weight gain, maximum daily energy intake and
27 number of people experiencing abdominal pain compared with enteral nutrition.
- 28 Very low quality evidence from one observational study (n=198) showed parenteral and
29 enteral nutrition may be more effective on the number of people experiencing bloating
30 although there was some uncertainty.
- 31 Very low quality evidence from one observational study (n=198) showed no difference in the
32 effect of parenteral and enteral nutrition on the number of people experiencing constipation.
- 33 **6.7.4.17 Parenteral and enteral nutrition versus enteral nutrition in young people with anorexia
34 nervosa at follow up**
- 35 Very low quality evidence from one observational study (n=129) showed no difference in the
36 effect of parenteral and enteral nutrition on number of people recovering from anorexia
37 nervosa and number of people who were rehospitalised compared with enteral nutrition.
- 38 Very low quality evidence from one observational study (n=129) showed parenteral and
39 enteral nutrition is less effective on length of second rehospitalisation compared with enteral
40 nutrition.

1 **6.7.4.18 Percutaneous gastric refeeding and meals versus meals with or without nasogastric**
2 **tube feeding for underweight adults with anorexia nervosa**

3 Very low quality evidence from one observational study (n=68) showed no difference in the
4 effect of percutaneous gastric tube feeding with meals on weight gain compared with meals
5 with or without nasogastric tube feeding.

6 Very low quality evidence from one observational study (n=68) showed percutaneous gastric
7 tube feeding with meals is less effective on length of treatment compared with meals with or
8 without nasogastric tube feeding.

9 **6.7.4.19 Nasogastric tube and oral refeeding diet versus oral refeeding diet in malnourished**
10 **young people with anorexia nervosa**

11 Very low quality evidence from one observational study (n=100) showed nasogastric tube
12 and oral refeeding diet is more effective on BMI (absolute and change scores), weight gain
13 and daily maximum caloric intake compared with oral refeeding diet.

14 Very low quality evidence from one observational study (n=100) showed no difference in the
15 effect of nasogastric tube and oral refeeding diet on weight and length of inpatient stay
16 compared with oral refeeding.

17 **6.7.4.20 Nasogastric and oral refeeding diet versus oral refeeding diet in malnourished adults**
18 **with anorexia nervosa at end of treatment**

19 Low quality evidence from one RCT (n=81) showed that a nasogastric and oral refeeding diet
20 is more effective on weight, daily weight gain, extracellular fluids, fat free mass, daily fat free
21 mass gain and daily fat mass gain compared with an oral refeeding diet alone.

22 Low quality evidence from one RCT (n=81) showed that a nasogastric and oral refeeding
23 diet is more effective at increasing the number of people achieving a BMI greater than 18.5
24 kg/m² and the number of people having a relapse-free period compared with an oral
25 refeeding diet alone.

26 Low quality evidence from one RCT (n=25) showed that a nasogastric and oral refeeding diet
27 is more effective at increasing weight in binge-purge anorexia nervosa participants compared
28 with an oral refeeding diet alone.

29 Low quality evidence from one RCT (n=56) showed that a nasogastric and oral refeeding diet
30 is more effective at increasing weight in restricting anorexia nervosa participants compared
31 with an oral refeeding diet alone.

32 Low quality evidence from one RCT (n=81) showed that a nasogastric and oral refeeding diet
33 is more effective on change in extracellular fluids and creatinine urinary output compared
34 with an oral refeeding diet alone.

35 Low quality evidence from one RCT (n=81) showed that a nasogastric and oral refeeding diet
36 is less effective at increasing daily added sucrose levels compared with an oral refeeding diet
37 alone.

38 Low quality evidence from one RCT (n=81) showed no difference in the effect of a
39 nasogastric and oral refeeding diet in increasing daily added fat compared with an oral
40 refeeding diet alone.

41 Low quality evidence from one RCT (n=56) showed that a nasogastric and oral refeeding diet
42 is more effective at increasing daily energy intake in people with restricting anorexia nervosa
43 compared with an oral refeeding diet alone, although there was some uncertainty.

1 Low quality evidence from one RCT (n=25) showed a nasogastric and oral refeeding diet is
2 less effective at increasing daily energy intake in people with binge-purge anorexia nervosa
3 compared with an oral refeeding diet alone, although there was some uncertainty.

4 **6.7.4.21 Nasogastric and oral refeeding diet versus oral refeeding diet in malnourished adults**
5 **with anorexia nervosa at follow up**

6 Low quality evidence from one RCT (n=56) showed nasogastric and oral refeeding diet is
7 more effective on weight for people with the restricting subtype of anorexia nervosa
8 compared with oral refeeding diet alone.

9 Low quality evidence from one RCT (n=25) showed nasogastric and oral refeeding diet is
10 more effective on weight for people with the binge-purge subtype of anorexia nervosa
11 compared with oral refeeding diet alone.

12 Very low quality evidence from one RCT (n=81) showed no difference in the effect of
13 nasogastric and oral refeeding diet on the number of people who relapsed compared with
14 oral refeeding alone.

15 Very low quality evidence from one RCT (n=81) showed no difference in the effect of
16 nasogastric and oral refeeding diet on improving EDI-total scores and decreasing the number
17 of people taking anxiolytics compared with oral refeeding diet alone.

18 Very low quality evidence from one RCT (n=81) showed no difference in the effect of
19 nasogastric and oral refeeding diet on increasing the number of people achieving both a BMI
20 greater than 18.5 kg/m² and adequate energy intake compared with oral refeeding diet
21 alone.

22 Very low quality evidence from one RCT (n=56) showed no difference in the effect of
23 nasogastric and oral refeeding diet on the daily energy intake of people with the restricting
24 subtype of anorexia nervosa compared with oral refeeding diet alone.

25 Very low quality evidence from one RCT (n=25) showed no difference in the effect of
26 nasogastric and oral refeeding diet on the daily energy intake of people with the binge-purge
27 subtype of anorexia nervosa compared with oral refeeding diet alone.

28 Low quality evidence from one RCT (n=26) showed no difference in the effect of nasogastric
29 and oral refeeding diet on the number of people who had resumed menses compared with
30 oral refeeding diet alone.

31 Very low quality evidence from one RCT (n=81) showed nasogastric and oral refeeding diet
32 may be less effective on the number of people taking antidepressants compared with oral
33 refeeding diet alone, although there was some uncertainty.

34 **6.7.4.22 High-calorie refeeding diet versus low-calorie refeeding diet for malnourished young**
35 **people with anorexia nervosa**

36 Very low quality evidence from one RCT (n=36) showed no difference in the effect of high-
37 calorie refeeding diet at 4 days on QT-corrected interval (absolute and change scores),
38 change in heart rate, weight, BMI (absolute and change scores), %mBMI (absolute and
39 change scores) and serum phosphate concentration (absolute and change scores)
40 compared with low-calorie refeeding diet.

41 Very low quality evidence from one RCT (n=36) showed no difference in the effect of high-
42 calorie refeeding diet at 10 days on weight (absolute and change scores), BMI (absolute and
43 change scores), %mBMI (absolute), glucose level, insulin level, white blood cell count and
44 number of people free of oral phosphate supplementation compared with low-calorie
45 refeeding diet.

1 Very low quality evidence from one RCT (n=36) showed high-calorie refeeding diet at 4 days
2 is more effective on heart rate and change in weight at 4 days compared with low-calorie
3 refeeding diet, although there was some uncertainty.

4 Very low quality evidence from 1 RCT (n=36) showed high-calorie diet is more effective at 4
5 days on kcal/day and kcl/g energy intake (i.e. had higher energy intake) compared with low-
6 calorie refeeding diet.

7 Very low quality evidence from one RCT (n=36) showed high-calorie refeeding diet is more
8 effective at 10 days on kcal/day and kcal/g energy intake compared with low-calorie
9 refeeding diet.

10 Very low quality evidence from one RCT (n=36) showed no difference in the effect of a high-
11 calorie refeeding diet on the number of people experiencing adverse events within first 4
12 days of treatment compared with low-calorie refeeding diet.

13 Very low quality evidence from one RCT (n=36) showed high-calorie refeeding diet is more
14 effective at 10 days on change in %MBMI and change in insulin resistance compared with
15 low-calorie refeeding diet, but there was some uncertainty.

16 Very low quality evidence from one RCT (n=36) showed no difference in the effect of a high-
17 calorie refeeding diet on the number of people experiencing hypophosphatemia within the
18 first 2 days of treatment compared with a low-calorie refeeding diet.

19 **6.7.4.23 Normal-sodium nasogastric and oral refeeding diet versus low-sodium diet in adults** 20 **with anorexia nervosa**

21 Very low quality evidence from one observational study (n=218) showed a normal-sodium
22 refeeding diet is more effective on weight compared with low-sodium refeeding diet, but there
23 was some uncertainty.

24 Very low quality evidence from one observational study (n=218) showed no difference in the
25 effect of normal-sodium refeeding diet on BMI, fat mass-BIA, daily energy input and edema
26 compared with low-sodium refeeding diet.

27 Very low quality evidence from one observational study (n=218) showed normal-sodium
28 refeeding diet is more effective on fat free mass-skinfold compared with low-sodium
29 refeeding diet.

30 Very low quality evidence from one observational study (n=218) showed a normal-sodium
31 refeeding diet is less effective active fat free mass compared with low-sodium refeeding diet
32 but there was some uncertainty.

33 Very low quality evidence from one observational study (n=218) showed normal-sodium
34 refeeding diet is less effective on fat mass-skinfold and energy input tube feeding compared
35 with low-sodium refeeding diet.

36 **6.7.4.24 Oral potassium supplementation versus no supplementation for cardiac dysfunction** 37 **in female adult anorexia nervosa**

38 Very low quality evidence from one observational study (n=28) showed oral potassium
39 supplementation is more effective in reducing QT dispersion (corrected and uncorrected),
40 serum potassium and urinary potassium excretion compared with no supplementation at all.

41 **6.7.5 Economic evidence statements**

42 No economic evidence on the cost effectiveness of interventions for the management of
43 short and long-term physical complications of anorexia nervosa was available.

1 **6.7.6 Recommendations and link to evidence**

2 **Low bone mineral density in people with anorexia nervosa**

85. Bone mineral density results should be interpreted and explained to people with anorexia nervosa by a professional with the knowledge and competencies to do this.

86. Before deciding whether to measure bone density, discuss with the person and their family members or carers why it could be useful.

87. Explain to people with anorexia nervosa that the main way of preventing and treating low bone mineral density is reaching and maintaining a healthy body weight or BMI for their age.

88. Consider a bone mineral density scan:

- after 1 year of underweight in children and young people, or earlier if they have bone pain or recurrent fractures
- after 2 years of underweight in adults, or earlier if they have bone pain or recurrent fractures.

89. Use measures of bone density that correct for bone size (such as bone mineral apparent density [BMAD]) in children and young people with faltering growth.

90. Consider repeat bone mineral density scans in people with ongoing persistent underweight, especially when using or deciding whether to use hormonal treatment.

91. Do not repeat bone mineral density scans for people with anorexia nervosa more frequently than once per year, unless they develop bone pain or recurrent fractures.

92. Do not routinely offer oral or transdermal oestrogen therapy to treat low bone mineral density in children or young people with anorexia nervosa.

93. Seek specialist paediatric or endocrinological advice before starting any hormonal treatment for low bone mineral density. Coordinate any treatment with the eating disorders team.

94. Consider transdermal 17 β estradiol (with cyclic progesterone) for young women (13–17 years) with anorexia nervosa who have long-term low body weight and low bone mineral density with a bone age over 15.

95. Consider incremental physiological doses of oestrogen in young women (13–17 years) with anorexia nervosa who have delayed puberty, long-term low body weight and low bone mineral density with a bone age under 15.

	<p>96. Consider bisphosphonates for women (18 years and over) with anorexia nervosa who have long-term low body weight and low bone mineral density. Discuss the benefits and risks (including risk of teratogenic effects) with women before starting treatment.</p> <p>97. Advise people with anorexia nervosa and osteoporosis or related bone disorders to avoid high-impact physical activities and activities that significantly increase the chance of falls or fractures.</p> <p>98. For guidance on osteoporosis risk assessment, see the NICE guideline on assessing the risk of fragility fractures in osteoporosis.</p>
<p>Relative value of different outcomes</p>	<p>For the review on how to treat the short and long-term physical health conditions associated with eating disorders, the committee agreed that the critical outcomes will depend on the health condition under review. For treating low bone mineral density (BMD), the committee agreed that the critical outcomes are BMD and bone strength.</p> <p>Other outcomes that are important include quality of life, weight or BMI, dropouts due to side-effects, resumption of menses, remission and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>People with anorexia nervosa</p> <p>One study aimed to reduce bone loss in young people with anorexia nervosa by treating them for 12 months with either dehydroepiandrosterone (DHEA) or HRT. At the end of treatment, change in BMD at the lumbar spine was lower and there were fewer girls who had resumed menses in the DHEA-treated group compared with HRT. However, there was some uncertainty in the results. Other outcomes including change in total hip BMD, weight and dropouts due to side-effects were no different between the two treatment arms at the end of treatment. No data was reported on quality of life, remission or service user experience.</p> <p>One study compared the effects of a bisphosphonate with placebo in young girls with anorexia nervosa and a low BMD at baseline. At the end of 12 months of treatment there was no difference in the change in BMD Z-score at the spine and femoral neck nor in final BMD at the wards triangle and total hip. However, favourable changes in BMD were found in response to bisphosphonates at the trochanter compared with placebo. No harms were detected. No data was reported on body weight, remission, quality of life or service user experience.</p> <p>Another study investigated the effects of oestrogen versus placebo in young girls with anorexia nervosa who had low BMD compared with controls at baseline. The results showed no difference in the change in lean mass or fat mass after 18 months of treatment. However, change in weight and change in BMD at the lumbar spine and total hip was greater in the oestrogen-treated group compared with placebo. The change in femoral neck BMD and dropouts due to side-effects were similar and the number who did not achieve normal menses was lower in the oestrogen-treated group. No data was reported on remission, quality of life or service user experience.</p> <p>Adults with anorexia nervosa</p> <p>In adults, one study compared the effects of DHEA combined with an oral contraceptive pill with placebo in preserving bone mass in women with anorexia nervosa. The results showed that, after 18 months of treatment, change in weight and BMI and change in femoral shaft and femoral neck BMD were greater in the</p>

combined treatment arm compared with placebo. Change in femoral shaft bone strength index was also higher in the combined treatment arm but not change in the femoral neck bone strength index. Other outcomes were no different between the combined treatment group and the placebo group including change in the number of women with amenorrhea or who had dropped out due to side-effects of treatment. No data was reported on quality of life, remission and service user experience.

Six months of bisphosphonate treatment in women with anorexia nervosa with a low BMD T-score resulted in greater improvements in hip, lateral spine and anteroposterior spine BMD compared with placebo, but there was no benefit at the tibia. No side-effects were detected. No data was reported on body weight, quality of life, remission or service user experience.

One study compared bisphosphonates with calcium and vitamin D and showed no difference after three months on tibia ultrasound density score or tibia Z-score. No side-effects were detected. No data was reported on body weight, quality of life, remission or service user experience.

IGF alone or combined with oral contraceptive pill was also investigated in women with anorexia nervosa and osteopenia (T-score 1.0 or less) at the spine. Two studies were conducted by the same research group, one for three months and the other for nine months.

Comparing IGF-I with placebo showed change in BMD at the spine was greater in the IGF-I-treated group, along with weight, lean mass and BMI. No difference in BMD was found at the hip, total body and radius. No drop-outs due to side-effects were reported. No data was reported on quality of life, remission or service user experience.

Comparing IGF-I with an oral contraceptive group showed greater improvements in the former group at the hip and total body, in addition to change in lean mass and BMI. No difference in BMD was found at the radius and anteroposterior spine or weight. No drop-outs due to side-effects were reported. No data was reported on quality of life, remission or service user experience.

Combining IGF-I with an oral contraceptive pill showed that it was advantageous on spine, radial and total body BMD and lean mass, but that the change in BMI was less compared with placebo. There was no difference between the groups on all other outcomes including hip BMD and change in weight. No drop-outs due to side-effects were reported. No data was reported on quality of life, remission or service user experience.

A combination of IGF-I and an oral contraceptive pill compared to an oral contraceptive pill showed that the combination treatment was still beneficial on change in hip BMD, total body BMD and lean mass. No difference in change in radial BMD or spine BMD was detected. However, there was a reduced gain in body weight in this group. No drop-outs due to side-effects were reported. No data was reported on quality of life, remission or service user experience.

Comparing the combined treatment of IGF-I and an oral contraceptive pill with IGF-I only showed that the combined treatment may improve total body BMD, radial BMD and spine BMD but has no significant effect on hip BMD or lean mass. Again, a reduced gain in body weight and BMI was found in the combined treatment group. No drop-outs due to side-effects were reported. No data was reported on quality of life, remission or service user experience.

	<p>Parathyroid treatment showed mixed results compared with placebo in women with anorexia nervosa and low BMD. After six months, change in lateral spine and anteroposterior spine BMD was greater in the parathyroid-treated group, but change in femoral neck BMD and body weight was less. No difference was detected in total hip BMD. No drop-outs due to side-effects were reported. No data was reported on quality of life, remission or service user experience.</p> <p>Finally, two studies comparing the effects of oestrogen treatment with placebo in women with anorexia nervosa and low BMD. After nine to 18 months of treatment, there was no difference between the groups on lumbar spine BMD, weight, BMI and lean mass. There were smaller changes over time on total BMD and hip BMD in the oestrogen group time compared with the placebo group. No difference in remission was detected. No data was reported on quality of life, remission, adverse events or service user experience.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>No economic studies assessing the cost effectiveness of interventions aimed at managing short and long-term physical complications of eating disorders were identified. The committee considered the low body weight as a clinical risk factor for low BMD. The committee considered that offering a bone mineral density scan (including repeat scans) to children and adults to identify and monitor low bone mineral density may have resource implications the NHS. The committee also noted that this may also lead to more endocrinology referrals. The cost of bone density scan is £69.41. The cost of an outpatient paediatric and adult endocrinology visit is £245 and £158, respectively (NHS Reference costs 2015/2016). The committee considered these costs to be low considering high prevalence of osteoporosis in people with anorexia. Also, anorexia is often identified during mid to late adolescence, a critical period for bone development. If undetected, bone loss can progress for many years and it may never recover completely even once weight is restored. Fractures from osteoporosis can result in significant pain and disability throughout life and can require expensive hospital care (including admissions). The committee expressed the view that early recognition and monitoring is key and it may result in significant cost savings to the NHS. Also, the committee expressed the view that seeking specialist paediatric or endocrinological advice before starting any hormonal treatment may incur additional healthcare resources (that is, time required to facilitate such care). However, the committee considered the cost of providing such care to be modest, taking into account the potential improvements in outcomes and it is expected to lead to overall savings.</p>
<p>Quality of evidence</p>	<p>The majority of the evidence was low to very low quality. Outcomes were downgraded because it was unclear in the studies how the randomisation sequence was generated and if allocation concealment was performed. Across studies it was unclear at times if either the participants, investigators or assessors were blind. Dropouts of >20% were also detected. There was very little evidence for most comparisons, resulting in few studies and participants included in the meta-analysis. Imprecision was often detected. All of the studies were conducted in young girls or women.</p> <p>The best available evidence in girls and young women with long-term low body weight and low BMD supported the use of either transdermal 17β-estradiol (with cyclic progesterone) or physiological doses of oestrogen in girls depending on their bone age. Transdermal oestrogen is said to be less likely to suppress IGF-I. No long-term follow up data was available so it was difficult to know if the benefits were maintained. Nevertheless, the committee were confident making a consider recommendation based on this study.</p> <p>A limitation with this study on oestrogen treatment is that the changes in BMD were not adjusted for age or weight, only in the statistical analysis did the authors take this into account. However, given that body weight did not appear to differ between</p>

	<p>the oestrogen treated and placebo groups, it may not have a significant impact on the interpretation of the data.</p> <p>BMD needs to be adjusted for body weight since heavier individuals have higher BMD than individuals of lower body weight. Also, BMD should also ideally be adjusted for bone size where possible. Although BMD is a measure of bone mineral content per cm², it does not take into account the 3-dimensional, volumetric density (grams per cubic centimetre) of the bone. Thus, for girls with thicker bones, it may suggest they have high BMD but their bone mineral apparent density may be normal. This adjustment is particularly important during growth and only one bone mineral apparent density outcome for lumbar spine was provided for young women.</p> <p>For adult women, the committee agreed that the most convincing data was on bisphosphonates. However, as for children and young girls with anorexia nervosa, the first-line treatment should aim to restore and maintain a healthy body weight. However, for women who have long-term low body weight and low BMD, bisphosphonates could be considered. The benefits and risks would need to be discussed given possible teratogenic effects.</p> <p>The evidence used to generate the bisphosphonate recommendation was of low quality, with only one study for each outcome and at most 39 participants. In the study by Miller 2011, there were two additional groups, one that received testosterone and the other combined testosterone with the bisphosphonate. However, the data was only presented in graph format and could not be extracted. Despite the little data available, the committee were confident recommending bisphosphonates since NICE recommends alendronate or risedronate for people without eating disorders but at high risk of osteoporotic fracture.</p> <p>The lack of follow up data was one of the reasons the committee were reluctant to recommend IGF-I, despite the finding that IGF-I increased bone formation compared with those who did not receive IGF-I. Additionally, IGF-I with an oestrogen-progesterone combination pill significantly increased BMD compared with placebo, a finding that was not seen with administration of oestrogen or IGF-I alone. Because of the very low number of participants in each treatment arm (n=15) the committee agreed that more data is needed before they would consider it. They also pointed out that IGF-I is not currently recommended for treating people with osteoporosis.</p> <p>A critical outcome that was rarely reported was bone strength. Just like volumetric bone density, the distribution of bone or bone shape is a better estimate of bone strength compared with bone density alone. There are a number of ways of calculating bone strength and one study estimated this on the femur of adults treated with DHEA and oestrogen or placebo. The results showed the femoral shaft was stronger in the DHEA and oestrogen treated group but not the femoral neck.</p> <p>Other limitations with the identified studies was that no long-term follow up data was reported. It is therefore not known if the gains in BMD are sustained years after the treatment has finished, what duration of treatment is needed for BMD to be restored to normal levels, nor whether the changes in BMD translate to a reduction in the future risk of fracture. Furthermore, no studies in boys or men were identified.</p>
<p>Other considerations</p>	<p>The committee noted that no studies were available in young or adult men but felt it important that the recommendations apply to them where applicable.</p> <p>Despite the evidence to support the use of pharmacological treatments in people with anorexia nervosa and a low BMD, the committee agreed that primary</p>

prevention and treatment of a low BMD is to achieve and maintain a healthy body weight. For this reason, it should not be routine treatment to offer oral or transdermal oestrogen therapy to treat low BMD in children or young people with anorexia nervosa. Restoring and maintaining a healthy body weight will help return oestrogen levels to normal and (not included in review) any delayed bone growth may be partially restored and improve BMD. The committee were also concerned that oestrogen therapy may result in premature closure of growth plates.

The committee agreed it was important that a collaborative approach to care be used if pharmacological agents are being prescribed for people with anorexia nervosa. Given that weight gain is the primary concern and this is not likely to change in response to oestrogen or bisphosphonate treatment, it is important that the specialists treating low BMD communicate with the eating disorders team.

Given the risk of fracture for people with an eating disorder and osteoporosis, the committee agreed it is important to advise them to avoid high-impact physical activities, such as skipping, or activities that increase the risk of falls, such as contact sports.

For guidance on osteoporosis risk assessment, the committee recommended referring to the NICE guideline CG146 on assessing the risk of fragility fractures in osteoporosis.

To ensure a low BMD is detected, the committee agreed based on current good practice that a bone density scan should be offered after 1 year of underweight in children and young people and after 2 years of underweight in adults. However, a scan should occur earlier than this in both age groups if bone pain is reported or they sustain recurrent fractures.

The committee also highlighted when estimating the risk of fracture for children and young people it is important that healthcare professionals use Z-scores rather than T-scores and that BMD is corrected for bone size. They also reached an informal consensus, based on their knowledge and experience, that repeat bone mineral density scans should be considered (though not more than once a year) with ongoing persistent underweight (especially when using or deciding to use hormonal treatment).

Regarding the use of transdermal 17- β -oestradiol with cyclic progesterone, the committee agreed that for a number of women who have had long standing underweight and progressively decreasing BMD z-scores, incremental oral or patch oestrogen represents an intervention and moreover that it should only be considered in these groups. The committee separated it from use of higher dose oral oestrogen as there is no evidence for its efficacy at higher doses.

The committee agreed that more research is needed on the impact of low bone mineral density in (i) children and young people with eating disorders, especially males. As such, they developed three research recommendations.

First, whilst the impact of underweight on health problems has been well studied, little is known (with only a few studies examining the issue) about the long-term growth and developmental effects of underweight in children and young people with anorexia nervosa. Second, anorexia nervosa in children and young people can have a substantial impact in terms of experiencing bone fractures later in their lives. It is still unclear how current measures of bone mineral density can be used to predict fractures later on in children and young people with anorexia nervosa, and whether the risk differs in those who recover weight and those who do not. Third, whilst research has focused on the efficacy of oestrogen treatment in women to treat low bone mineral density, there is a clear lack of data on (i) the use of testosterone in males to treat it, and (ii) the effect of testosterone on growth and ameliorating pubertal delay. The committee agreed that a better understanding of

these issues would be extremely valuable for the care of young men with anorexia nervosa.

- 1 **10. Research recommendation: What is the impact of underweight in children and**
 2 **young people with eating disorders in early life on the critical periods of growth**
 3 **and development?**
- 4 **11. Research recommendation: What is the validity of bone measures in children and**
 5 **young people with anorexia nervosa who have recovered weight, compared to**
 6 **those who have not, in predicting fractures later in adult life?**
- 7 **12. Research recommendation: Does testosterone confer any benefit in a. in**
 8 **improving bone density in men, and b. growth and pubertal delay in young men?**

9
10 **Growth and development**

99. Seek specialist paediatric or endocrinology advice for delayed physical development or faltering growth in children and young people with an eating disorder.	
Relative value of different outcomes	For the review on how to manage, treat or reduce the short and long-term physical health conditions associated with eating disorders, the committee agreed that the critical outcomes will depend on the health condition under review. For treating delayed physical development or stunted growth, the committee agreed that the critical outcome is growth. Other outcomes that are important include quality of life, weight or BMI, compensatory behaviours, side-effects, resumption of menses, remission and service user experience.
Trade-off between clinical benefits and harms	Only one study was identified that compared the effects of growth hormone with placebo in adults with anorexia nervosa who had low recombinant human insulin-like growth (IGF-I) factor-I. At the end of treatment, IGF-I levels were higher in the IGH-I treated group, as was the change in IGF-I levels but there was some uncertainty. Change in body weight was not significantly different between the two treatment arms. No data on quality of life, compensatory behaviours, side effects, resumption of menses, remission or service user experience. No relevant published evidence was identified on how to managing or reduce delayed physical development or faltering growth in people with an eating disorder.
Trade-off between net health benefits and resource use	The committee considered that providing specialist paediatric or endocrinology advice for delayed physical development or stunted growth may have resource implications in terms of the extra time required to facilitate such advice. However, the committee expressed the view that this could lead to better identification of health needs and result in appropriate subsequent treatment and management of underlying health problems at an earlier stage, before individuals require more resource intensive management, then the additional costs associated with facilitating such specialist care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.
Quality of evidence	Only one study was identified that was considered relevant but t growth related outcomes, such as sexual development or height, were reported. The study examined only whether growth hormone compared with placebo could significantly change IGF-I levels and body weight in a population who had low background IGF-I levels. The outcomes were graded low to very low because it was unclear what the

	<p>randomisation method was n and whether allocation concealment was performed. It was also unclear whether the participants, investigators and assessors were blinded to group assignment.</p> <p>In the absence of evidence on how to manage or reduce delayed development or stunted growth, the committee agreed by informal consensus that it was best to seek advice specialist paediatrician or endocrinologist if identified in children and young children with an eating disorder.</p>
Other considerations	<p>The committee discussed how delayed physical development or faltering growth indicates that the child or young person may have nutritional deficiencies as a result of anorexia nervosa. The effects of malnutrition are extensive and negatively affect the pituitary gland, thyroid gland, adrenal glands, gonads and bones. Thus, short stature, osteoporosis and infertility are indicators of an eating disorder and even if the person recovers, there may be long-lasting complications.</p> <p>It is thought that with weight gain, growth can ‘catch-up’, at least until fusion of the epiphysis occurs. Although hormonal treatments are used to treat delayed physical development or faltering growth, there is no RCT evidence on this in young people with an eating disorder. The committee was also concerned about its side-effects. For example, there is a risk that oestrogen therapy may cause premature epiphyseal fusion and faltering growth. Nevertheless, the committee acknowledged there may be circumstances where children and young people will need hormonal treatment, for example to induce puberty or if recovery is not sufficient to normalise bone accrual. In such cases it is important that specialist paediatric or endocrinologist advice is sought before starting any treatment.</p> <p>Due to the concerns surrounding delayed physical development and faltering growth the committee agreed that growth and development should be monitored in children and young people with an eating disorder who have not completed puberty (for example, not reached menarche or final height). The committee generated a recommendation to “monitor growth and development in children and young people with anorexia nervosa who have not completed puberty [for example, not reached menarche or final height]”. Details on this can be found in the above LETR on low bone mineral density.</p>

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Refeeding

	<p>100. Ensure that staff of day patient, inpatient, or acute services who treat eating disorders are trained to recognise the symptoms of refeeding syndrome and how to manage it.</p> <p>101. Use a standard operating procedure for refeeding that emphasises the need to avoid under-nutrition and refeeding syndrome. Refer to existing national guidance, such as MARSIPAN and junior MARSIPAN.</p>
Relative value of different outcomes	<p>For the review on how to address the short-term complications of eating disorders the committee considered the critical outcomes to be the primary outcomes reported by the study and the important outcomes to be secondary outcomes reported by the study. This was because the physical complications could cover a large number of conditions.</p>
Trade-off between clinical	<p>Randomised control trials</p> <p>A randomised control trial that compared nasogastric and oral refeeding with oral refeeding only in malnourished adults with anorexia nervosa showed favourable</p>

<p>benefits and harms</p>	<p>outcomes for nasogastric feeding on weight and BMI, creatinine urinary output, extracellular fluid scores, fat mass, fat free mass, and prolonging recovery. However, it was less effective on increasing sucrose intake and no different on fat intake. It was also less effective on increasing energy intake for adults with binge-purge type of anorexia nervosa.</p> <p>At 12 months' follow up, the nasogastric and oral refeeding group still showed benefits compared to oral refeeding only on weight and may favour the use of antidepressants. However, there was no difference on EDI-total, energy intake, energy intake by type of anorexia nervosa, relapse rates, resumption of menses, and the use of anxiolytics or antidepressants.</p> <p>Another RCT compared four days of high versus low calorie refeeding diets for malnourished young people with anorexia nervosa. The results showed no difference in weight or BMI, heart function, adverse events, need for oral phosphate supplementation (due to low levels), serum phosphate concentrations but it did favour high calorie intake for a higher energy intake (thus the intervention was working). After 10 days of refeeding, a high calorie refeeding diet still favoured energy intake and there were no other differences on any other outcome.</p> <p>Observational studies</p> <p>Parenteral and enteral refeeding in young people showed mixed results when compared with enteral refeeding. It showed unclear trends on weight versus BMI. Some benefit was found on energy intake, reduction in some side-effects (bloating, abdominal pain) but hospital stay was longer. No difference in the incidence of constipation was found.</p> <p>At 33 months' follow up, there was no difference between the two treatment groups for rehospitalisation and recovery but if they were readmitted, the parenteral refeeding group had a longer hospital stay compared with enteral refeeding group (it was unclear what subsequent treatment they had).</p> <p>Percutaneous gastric feeding compared with nasogastric tube refeeding for adults with anorexia nervosa showed no difference in weight gain but length of hospital stay was longer in the percutaneous gastric feeding group.</p> <p>Nasogastric tube and oral refeeding was compared with oral refeeding in young underweight girls with anorexia nervosa. The results favoured the combined treatment with a nasogastric tube feed. Better outcomes were also found for BMI and weight, calorie intake but no difference in hospital stay.</p> <p>Another observational study compared normal sodium nasogastric tube and oral refeeding with low sodium nasogastric and oral refeeding. The results showed that in malnourished adults with anorexia nervosa, there was no difference between the groups on BMI, though there was some improvement on weight and a clear benefit for fat free mass in the normal sodium group. Normal sodium refeeding was less effective on active fat free mass (though there was some uncertainty) and clearly less effective on fat mass and energy input from tube feeding. No difference in fat mass and energy input or oedema of the legs was found between the two groups.</p> <p>One study investigated the effects of oral potassium supplementation for cardiac dysfunction versus no treatment in young women with anorexia nervosa and found a benefit on cardiac function, serum potassium levels and kidney function.</p>
<p>Trade-off between net health</p>	<p>The committee considered that inpatient services for people with eating disorders must already be trained to recognise the symptoms of refeeding syndrome and how to manage it. So offering it in line with the outlined principles would not incur significant extra resource implications.</p>

benefits and resource use	
Quality of evidence	<p>The quality of the RCT evidence was low to very low quality. The evidence was downgraded for imprecision and risk of bias for reasons such as unclear randomisation, it was unclear if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded and high dropouts were detected >20%.</p> <p>Due to the scant evidence found, only one study with a small sample size was available for each comparison and imprecision was found for most outcomes.</p> <p>The outcomes from observational studies were all very low quality. In GRADE, all evidence from observational studies begin at very low quality because of the risk of bias in selecting the people for each cohort and can only be upgraded if large effect sizes are found (after adjustment) and a dose response is identified (this was not relevant for this review). Very few of the studies adjusted for any confounders.</p>
Other considerations	<p>The committee considered the refeeding studies and agreed that parenteral nutrition is not something that would be used in the UK for general refeeding. The results from the RCTs did not provide the committee with convincing evidence to merit a specific recommendation. The evidence from the observational studies was also all very low quality. That said, some favourable results for nasogastric refeeding compared with oral refeeding were evident.</p> <p>Given the lack of evidence, the committee agreed that it was best that healthcare professionals use existing local standard operating procedures (such as MARSIPAN or Junior MARSIPAN) or local protocols for refeeding and that they do not need to be modified in the light of the (little) evidence presented in the review. They also agreed that these procedures should include initial meal plans, guidance on monitoring of physical risk, the use of electrolyte, vitamin and mineral supplements, and when and how to use nasogastric feeding. The committee said specialist eating disorder units and general hospital wards undertaking refeeding should have standard operating procedures or local protocols in place.</p> <p>The committee agreed that the list of risk parameters contained in the MARSIPAN and junior MARSIPAN national guidelines are well-established and that they should be referred to when offering a refeeding treatment.</p> <p>The committee agreed that it was important that healthcare professionals are aware of the risk of refeeding syndrome, and trained how to recognise and treat it. Refeeding syndrome usually occurs within four days of when refeeding is instigated and can result in people developing fluid and electrolyte disorders, especially hypophosphatemia, along with neurologic, pulmonary, cardiac, neuromuscular, and haematological complications. The syndrome is generally the result of a shift in the electrolyte and fluid balance caused by a rise in blood sugar levels when receiving nutrients. This shift in balance can cause an increase in cardiac workload and heat rate, potentially leading to acute heart failure.</p> <p>Due to these risks, close monitoring of electrolyte disturbances and blood biochemistry is needed in the early refeeding period. If an imbalance is detected, the refeeding should be modified and appropriate treatment provided. Again, the committee highlighted that healthcare professionals should refer to the local protocols and the list of risk parameters contained in the MARSIPAN and junior MARSIPAN guidelines for further information.</p> <p>The committee discussed how the risk of refeeding syndrome risk may be increased if there is rapid weight loss, no calorie intake for over five days or BMI less than 16kg/m². Compensatory behaviours such as laxative misuse, vomiting,</p>

dehydration, diet pills, diuretics, water loading or excessive exercise can substantially increase the risk of refeeding syndrome.

1 6.8 Management of comorbidities

2 6.8.1 Review question: Does any intervention for an eating disorder need to be 3 modified in the presence of common long-term health conditions?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 161. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers whether any intervention used to treat eating disorders in children,
9 young people and adults needs to be modified in the presence of a common long-term health
10 condition (i.e. comorbidity). The interventions were categorised according to their type, the
11 type of eating disorder and comorbidity examined and the age of the participants. The
12 comparison arm was the same intervention delivered to participants with the relevant eating
13 disorder but without the relevant comorbidity.

14 **Table 161: Clinical review protocol summary**

Component	Description
Review question(s)	Does any intervention for an eating disorder need to be modified in the presence of common long-term health conditions?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) and a common comorbidity (e.g. diabetes, hypothyroidism). <p>Mental comorbidities may include:</p> <ul style="list-style-type: none"> Depression Anxiety Social anxiety Autism Obsessive Compulsive Disorder Personality Disorder Learning disability ADHD (Bulimia) Self-harm Substance misuse <p>Physical comorbidities may include:</p> <ul style="list-style-type: none"> Coeliac disease Diabetes (type II – relevant to obesity) Bowel Disease Cystic Fibrosis Strata: children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Trials will be included that address the ED as primary or secondary aim to treating the comorbidity. Interventions may include:</p> <ul style="list-style-type: none"> Psychotherapy (including psychoeducation)

Component	Description
	<ul style="list-style-type: none"> • Pharmacological • Nutritional • Physical • Combination of any listed above
Comparison	<ul style="list-style-type: none"> • The same intervention but delivered to people with an eating disorder without a comorbidity.
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs • Observational studies: including prospective or retrospective cohort studies, (if no RCTs) (if no RCTs)

1 6.8.2 Clinical evidence

2 No published studies were found for this review question in people with anorexia nervosa.

3 Although this review question includes people with any eating disorder (anorexia nervosa,
4 bulimia nervosa, binge eating disorder, EDNOS), the committee wanted to firstly consider the
5 evidence for individual eating disorders to see if specific recommendations could be made. If
6 none was available, or it was deemed insufficient, then they agreed to make a general
7 recommendation for treating people with any eating disorder and a common long-term health
8 condition.

9 6.8.3 Economic evidence

10 No economic evidence on the cost effectiveness of modified interventions for anorexia
11 nervosa in the presence of common long-term conditions was identified by the systematic
12 search of the economic literature undertaken for this guideline. Details on the methods used
13 for the systematic search of the economic literature are described in Chapter 3.

1 **6.8.4 Clinical evidence statements**

2 No published studies were found that met the eligibility criteria for this review in people with
3 anorexia nervosa. However, evidence was extrapolated from other eating disorders to make
4 a general recommendation for any eating disorder where a comorbidity is present.

5 **6.8.5 Economic evidence statements**

6 No economic evidence on the cost effectiveness of modified interventions for anorexia
7 nervosa in the presence of common long-term conditions was available.

8 **6.8.6 Recommendations and link to evidence**

9 **Physical and mental health comorbidities**

<p>102. Eating disorder specialists and other healthcare teams should collaborate to support effective treatment of physical or mental health comorbidities in people with an eating disorder.</p> <p>103. When collaborating, teams should use outcome measures for both the eating disorder and the physical and mental health comorbidities, to monitor the effectiveness of treatments for each condition and the potential impact they have on each other.</p> <p>Comorbid mental health problems</p> <p>104. When deciding which order to treat an eating disorder and a comorbid mental health condition (in parallel, as part of the same treatment plan or one after the other), take the following into account:</p> <ul style="list-style-type: none"> • the severity and complexity of the eating disorder and comorbidity • the person's level of functioning • the preferences of the person with the eating disorder and (if appropriate) those of their family or carers. <p>105. Refer to the NICE guidelines on specific mental health problems for further guidance on treatment.</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for OSFED, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p>
<p>Relative value of different outcomes</p>	<p>No relevant published evidence was identified in people with anorexia nervosa.</p>
<p>Trade-off between</p>	<p>No relevant published evidence was identified in people with anorexia nervosa.</p>

clinical benefits and harms	For discussion of interventions for treatment of other eating disorders with a comorbidity, see the LETRs in the relevant chapters.
Trade-off between net health benefits and resource use	The committee considered that providing care for people with eating disorders who have comorbid physical or mental health problems may have resource implications in terms of the extra time required to provide such collaborative care. The management and treatment of eating disorders and diabetes is discussed separately (see below). However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate subsequent treatment and management of underlying health problems at an earlier stage (including eating disorder and comorbid mental health problem), before individuals require more resource intensive management, then the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.
Quality of evidence	No evidence was identified for interventions in people with anorexia nervosa and a physical or mental health comorbidity.
Other considerations	<p>Studies were excluded from this review if they randomised people with an eating disorder and mental health comorbidity to different treatments since it did not answer the question of whether the eating disorder treatment should be modified in the presence of a comorbidity or if those with a comorbidity are equally able to respond to the same treatment as those who do not have a comorbidity.</p> <p>The committee used informal consensus to generate a recommendation (based on the limited data found and from their own experience) that eating disorder specialists and the other relevant healthcare teams should work closely when treating and caring for people with physical or mental health comorbidities, and that they should use appropriate outcome measures for the eating disorder and comorbidity to monitor how effective treatments are for each condition and the impact they have on each other.</p> <p>Again using informal consensus the committee agreed that when treating an eating disorder with a mental health comorbidity, on how the comorbidity should be treated – that is, whether in parallel with the eating disorder, as part of the eating disorder treatment or one at a time - will depend on the severity and complexity of the comorbidity and the eating disorder, the general functioning of the person, the preferences of the person with the eating disorder and the family or carer (if appropriate).</p> <p>The committee discussed the importance of taking into account the severity of the comorbidity and the eating disorder, when deciding how to sequence the treatment. Whilst some problems can be treated in parallel, there are instance where this is not always the case. For example, someone would not be offered CBT-ED for an eating disorder and obsessive compulsive disorder (OCD) at the same time, though the latter might be treated as part of the eating disorder treatment or the person might be referred for subsequent treatment. The committee also agreed it was important eating disorder treatment is not denied because of another mental health comorbidity such as personality disorder.</p> <p>Committee members also noted that, for example, if substance misuse were not interfering with the person’s ability to engage in psychological therapy then it may come to be reduced as part of the treatment of the eating disorder. Thus in some cases, treatment of the eating disorder may be sufficient to ameliorate the comorbidity.</p>

	<p>The committee also highlighted that if treatment of a comorbidity involves different services or agencies, a multidisciplinary approach should be used because the person with an eating disorder may risk being caught between two disciplines with a different focus.</p> <p>Given the lack of direct evidence to address this review question (see also discussion of other eating disorders, and the relevant sections of other eating disorders with diabetes or with substance/medication misuse see LETRs below) and the high levels of comorbidity found in eating disorder populations, the committee agreed to make a research recommendation on the effect of comorbidities on treatment outcomes for eating disorders and the effectiveness of approaches for managing comorbidities.</p> <p>See the LETR in Section 7.8.6 for further discussion of the treatment of eating disorders with comorbid diabetes.</p>
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13. Research recommendation: What is the impact of comorbidities on treatment outcomes for eating disorders, and what approaches are effective in managing these comorbidities?

Diabetes

106. See Section 7.8.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem. In the case of diabetes, HbA1c levels and insulin omission days were considered critical outcomes. The other critical outcomes depended on the eating disorder included in the study. The committee noted for Type I diabetes, severity should be measured, or at least heavily informed, by HBA1c since HBA1c/ DKA frequency is the immediate risk factor; furthermore, BMI is less of a risk factor for death in those with Type I diabetes than HBA1c.</p> <p>Remission is of greatest concern for any eating disorder. In addition, for those with anorexia nervosa body weight or BMI are of greatest concern. For bulimia nervosa and binge eating disorder, binge eating is a critical outcome.</p> <p>For any eating disorder, other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but are clearly still important outcomes include general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>The ideal study design to answer the question of whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem would be to randomise people with an eating disorder and diabetes to two different treatment groups: One modified to address both the eating disorder and diabetes and one non-modified eating disorder treatment.</p> <p>No published evidence was found on people with anorexia nervosa and diabetes, however there was a sub-group analysis (Olmsted 2002; see description below) on any eating disorder that showed those with anorexia nervosa and type I diabetes are equally responsive to treatment as those with anorexia nervosa alone.</p>

	<p>No data was available on HbA1c scores, remission, weight, all-cause mortality, adverse events, quality of life, resource use, relapse, general psychopathology, general functioning, family functioning or service user experience. For discussion of interventions for treatment of other eating disorders and diabetes, see the LETRs in the relevant chapters.</p> <p>Any eating disorder (as reviewed in chapter 9) One randomised control trial provided a subgroup analysis of anorexia nervosa and compared group psychoeducation (combined with treatment as usual) with treatment as usual (diabetes treatment only) in people with type I diabetes and disturbed eating behaviours. The study showed no difference at the end of treatment on bingeing, EDE-restraint, EDE-shape concern, EDE-eating concern, EDE-weight concern, EDI-drive for thinness, EDI-bulimia, insulin omission days and HbA1c (%). One outcome, EDI-body dissatisfaction, favoured group psychoeducation over treatment as usual but there was some uncertainty. At follow up some benefit was found in response to group psychoeducation on bingeing but there was some uncertainty. No data was available on remission, all-cause mortality, resource use, relapse, general functioning, family functioning, or service user experience.</p> <p>An observational study was identified that compared the same CBT-ED intervention but in two populations, one with any eating disorder and type I diabetes, and one with just any eating disorder. Thus, this design allowed us to see whether those with a comorbidity would respond equally well to treatment as those with just an eating disorder. The results showed adults with any eating disorder and a comorbidity are less likely to recover than those with just an eating disorder. No difference was found in dropouts. In adults with anorexia nervosa, binge eating disorder and EDNOS there was no difference in the responsiveness to treatment. No data was available on all-cause mortality, resource use, relapse, general functioning, family functioning, or service user experience.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>The committee considered that providing care for eating disorders in the presence of a long-term health problems, such as diabetes, may have resource implications in terms of extra time required to provide collaborative and comprehensive care. However, the committee expressed the view that if such care arrangements (that is, multidisciplinary approach, involvement of family members and carers, and the use of treatment plans) lead to better and appropriate treatment and management of health problems (including other long-term health problems such as diabetes) at an earlier stage, before individuals require more resource intensive management, then the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
<p>Quality of evidence</p>	<p>No relevant published evidence was identified that examined treatment of anorexia nervosa and diabetes.</p> <p>Any eating disorder (including subgroup analysis on anorexia nervosa) In the RCT where they compared group psychoeducation and management (and treatment as usual) with treatment as usual (diabetes only programme), it was unclear if allocation concealment was performed. Neither the participant, investigator or assessor were blind and it was unclear how many completed the intervention. The population was also indirect since it included those with disturbed eating. Also the comparison did not show whether a modified eating disorder programme is more effective at treating people with diabetes and an eating disorder compared with an eating disorder programme alone. Rather the study compared a modified diabetes programme with a regular diabetes programme. In the observational study where they compared CBT-ED in people with eating disorder alone or with a comorbidity, the authors attempted to match the groups based on age, marital status, education, catchment area and onset of diagnosis.</p>

	<p>However, it was unclear whether the two groups were followed up for the same duration and the sample size was very small.</p> <p>Overall discussion</p> <p>No RCT or observational study met the criteria of what would have been the ideal study design for this review (as described above). One RCT compared the effectiveness of an intervention that addressed both the eating disorder and diabetes, but the other arm addressed just the diabetes. In another RCT, one intervention was modified but it was compared with a control therapy.</p> <p>In the observational studies, one study compared the same intervention but in those with either an eating disorder and diabetes or just the eating disorder alone. So it only provided insight into whether one group was more responsive to treatment than the other. In the other observational study, inpatient integrated care was compared with treatment as usual, but the treatment as usual only addressed the diabetes not the eating disorder. Thus, it did not provide insight into whether a modified eating disorder treatment was needed for those with a comorbidity.</p>
<p>Other considerations</p>	<p>Overall, it was difficult for the committee to draw conclusions from these studies on whether treatment for an eating disorders should be modified in the presence of comorbid diabetes. The committee therefore agreed that it was best to instead provide guidance on how to manage the diabetes. Usually, the committee would refer to the diabetes NICE guideline, but because the diabetes guideline refers to this guideline, the committee needed to recommend what to do in the presence of both.</p> <p>The committee agreed on a series of recommendations based on their experience and knowledge on how to manage the diabetes in the presence of an eating disorder. A number of the recommendations are based on what would be considered good practice. For instance: i) establish who will monitor the physical health, ii) explain to the person that they need to monitor their diabetes during the treatment for the eating disorder, and iii) be aware of the problems caused by misuse of diabetes medication.</p> <p>The committee agreed that healthcare professionals should consider involving family members and carers (as appropriate) in the treatment of diabetes. They highlighted that the quality of the family environment has been shown to affect treatment compliance and metabolic control among young people with an eating disorder (Hauser et al., 1990). Family members may also need to care for someone if they hyper- or hypo- glycaemia (which is a case for medical emergency), so they know how to respond. There is also the possibility that eating disturbances in young girls with diabetes are associated with significantly more family dysfunction than girls with diabetes alone (i.e. 13 to 18 years of age). Specifically, they can receive less support, and have poorer communication and less trust in their relationship with their parents than diabetic girls without eating disturbances. For these reasons, the committee agreed that healthcare professionals should consider involving family members and carers (as appropriate) in their treatment.</p> <p>The committee identified that a key issue is getting the balance correct between managing diabetes and managing the eating disorder, especially when (or soon after) a diagnosis of either is made. The emphasis should be on a collaboration between the diabetes and eating disorder teams with a mutual understanding of the nuances of both conditions, which may sometimes at times be at odds with one another. The committee discussed how a good example of this is carbohydrate counting, which on the one hand is frequently essential to the management of diabetes mellitus and, on the other hand, often very challenging when managing an eating disorder. In such a case, a 'safe' compromise will need to be made between managing both conditions. The committee agreed that it is vital that both managing teams are cooperating and communicate to decide on a pragmatic</p>

	<p>approach and provide a clear and consistent message to both the person with the eating disorder and their family or carers.</p> <p>There was some indirect evidence to support the recommendation to address insulin misuse as part of any psychological treatment. One 1 RCT (n=85) showed that a modified group psychoeducation and management programme reduced bingeing episodes at follow up compared with a programme that just addressed the diabetes alone. This study was considered with the reservation that it was indirect because: 1) it did not investigate the effectiveness of a modified eating disorder psychological treatment and 2) the population had a disturbed eating behaviour, not a specific eating disorder diagnosis. Nevertheless, it showed that a psychoeducation and management programme may help reduce eating disorder psychopathology in those who also have diabetes.</p> <p>The committee discussed the problem of a relatively high prevalence of EDNOS in young girls with diabetes. In girls who have body dissatisfaction, diabetes provides a unique but dangerous opportunity to control weight by deliberate insulin omission, which can lead to hyperglycaemia and glycosuria. It is therefore important that insulin misuse is addressed in any psychological intervention. It can be noted that the recommendations relating to diet control were contributed to by the expert opinion of a dietitian on the committee, based on their experience of treating those with an eating disorder who misuse insulin. These recommendations are based upon the treatment approach of small, attainable and incremental goals. At the outset of treatment, intensive glucose management is not an appropriate goal. The first goal must be to establish medical safety for the person with diabetes by gradually increasing the doses of insulin and food intake (as described in the recommendation). Given the fear of weight gain in this population, the committee recommended that the diet is amended to prevent rapid weight gain. There was no evidence on how to treat the eating disorder in the presence of any other long-term physical health condition, such as cystic fibrosis, coeliac disease, or bowel disease.</p> <p>Some eating disorder specialists on the committee highlighted that they would generally refer someone with an eating disorder and diabetes to a diabetologist rather than address the points raised in the recommendations on diabetes. However, the committee agreed that it should be collaborative approach for the healthcare professionals who treat eating disorders and diabetes, especially for young people who may need to involve family members and carers in therapy sessions to help them with their blood glucose control.</p> <p>The committee agreed that more research is needed concerning diabetic ketoacidosis, caused by a lack of insulin in the body, in people with eating disorders since people with anorexia nervosa, in particular, are at risk given their low BMI. More generally, little is known about the effects of eating disorders on the long-term complications of both type 1 and type 2 diabetes.</p>
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1 **14. Research recommendation: What is the incidence, and differences in the**
2 **complication rate, of diabetic ketoacidosis in people with eating disorders?**

3 **15. Research recommendation: What are the effects of eating disorders on long-term**
4 **complications of type I and type II diabetes?**

5 **Substance and medication misuse for any eating disorder**

	107. See Section 7.8.6 for relevant recommendations
Relative value of	The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge

different outcomes	<p>eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for EDNOS, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>No relevant published RCT or observational evidence was found on people with anorexia nervosa and comorbid substance or medication misuse. Thus, extrapolations from the data on people with bulimia nervosa and EDNOS (see LETRs in relevant chapters for further discussion) to make a recommendation relevant for people with any eating disorder.</p>
Trade-off between net health benefits and resource use	<p>The committee considered that providing care for people with an eating disorder who are misusing substances or medication may have resource implications in terms of the extra time required to facilitate such care (in particular the use of a multi-disciplinary approach). However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate subsequent treatment and management of health problems (including eating disorder and substance and medication misuse) at an earlier stage, before individuals require more resource intensive management, then the additional costs associated with facilitating a multi-disciplinary care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>No evidence was identified that examined how an anorexia nervosa intervention should be modified in the presence of comorbid substance misuse.</p>
Other considerations	<p>Limited published evidence was found on individual eating disorders, so the committee generated a recommendation incorporating the evidence from people with bulimia nervosa and those with EDNOS and made it relevant for treating people with any eating disorder and a common long-term health condition.</p> <p>See the LETRs in the relevant chapters for each eating disorder for further details.</p>

7 Treatment and management of bulimia nervosa

7.1 Introduction

Bulimia nervosa is characterised by a recurrent cycle of dietary restriction, binge eating and purging. Although most people with bulimia nervosa are in the normal weight range, the illness often begins with a period of dieting. However, the extreme nature of the dieting invariably leads to episodes of binge eating that are commonly driven by hunger. During binge episodes an objectively large quantity of food is eaten in a relatively short period of time and this is accompanied by a sense of loss of control over eating. Following a binge and driven by an extreme fear of weight gain, those with bulimia nervosa engage in a range of compensatory behaviours which may include self-induced vomiting, misuse of laxatives or diuretics, excessive exercise, dietary restriction or, in the case of those with diabetes, insulin misuse. Over time a vicious cycle of dietary restriction, binge eating and purging develops. Bulimic behaviours are commonly associated with increased levels of impairment in day-to-day functioning (Mond et al., 2007).

The psychological processes of people with bulimia nervosa involve them trying to adhere to a range of strict eating and food-related rules that increase the risk of binge eating. Poor body image is very common and self-worth is appraised almost exclusively on the basis of weight and shape. Bulimia nervosa is also commonly associated with borderline personality disorder traits, including emotional dysregulation and impulsivity (Diaz-Marsa et al., 2000; Wonderlich et al., 2005) and often occurs alongside self-harm (Bulik et al., 2004; Paul et al., 2002), alcohol difficulties and substance misuse (Holderness et al., 1994). It is not uncommon for people to feel extremely guilty or ashamed of their condition and many will live with it for years before seeking help.

In Western Europe and the US, the prevalence of bulimia nervosa has been estimated to be about 1% in women and 0.1% in men (van Hoeken et al., 2003). Incidence studies suggest that there was an increase in diagnoses in the 1980s and mid-1990s, followed by a decrease in the late 1990s (Currin et al., 2005). Age of onset also appears to be decreasing, with the high risk group shifting from 25-29-year-old females to 15-24-year-old females (Smink et al., 2012). It is unclear whether this reflects earlier detection or earlier age of onset. A formal diagnosis using the DSM-5 classification system requires the occurrence of binge eating and compensatory behaviours for, on average, at least once a week for three months. For diagnosis, self-evaluation must also be significantly influenced by weight and shape and these symptoms should not occur exclusively during an episode of anorexia. Given the potential physical consequences of binge eating and purging, it is essential that treatment and management takes into consideration medical as well as psychiatric risk.

7.2 Psychological interventions

7.2.1 Review question: Does any psychological intervention produce benefits/harms in children, young people or adults with an eating disorder compared with any other intervention or controls?

The review protocol summary, including the review question and the eligibility criteria used for this section of the guideline, can be found in table 167. See also the study selection flow chart in Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and exclusion list in Appendix J. Further information about the search strategy can be found in Appendix H; the full review protocols can be found in Appendix F.

1 This review considers all psychological interventions that may be delivered to children, young
2 people and adults with an eating disorder with or without a pharmacological intervention. This
3 chapter focuses on the results relating to those with bulimia nervosa. The interventions were
4 categorised according to their mode of delivery, i.e. individual, group or self-help, the age of
5 the participants and the type of eating disorder. In addition, the interventions were grouped
6 according to their type of therapy and were compared to any other intervention or to wait list
7 controls.

8 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
9 evidence tables in Appendix L and exclusion list in Appendix J.

10 **Table 162: Review protocol summary**

Component	Description
Review question(s)	Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with eating disorders compared with any other intervention or controls?
Population	Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Strata: children (<12), young people (13-17 years), adults >18 years eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical eating disorder) mode of delivery (i. individual ii. family iii. group iv. self-help)
Intervention(s)	Psychological intervention including: <ul style="list-style-type: none"> • Dialectical behaviour therapy (DBT) • Counselling (Nutritional/Other) • Integrative Cognitive-Affective Therapy for Binge Eating (ICAT) • Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) • Cognitive remediation therapy (CRT) • Specialist supportive clinical management for anorexia nervosa (SSCM) • Behavioural therapy (BT) • CBT (General or ED specific) • Dynamic (IPT, Psychodynamic General or ED specific) • Guided Self Help with therapist guidance • Pure self help • E-therapies Psychological in combination with any pharmacological intervention.
Comparison	<ul style="list-style-type: none"> • wait list control • treatment as usual • another other intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2-week period) • Binge eating for bulimia nervosa and binge eating disorder; and weight/body mass index (Appropriate adjustment for age) for anorexia nervosa

Component	Description
Important outcomes	<ul style="list-style-type: none"> • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Family functioning • Service user experience • Quality of life. • All-cause mortality • Relapse • Adverse events • Resource use
Study design	<ul style="list-style-type: none"> • Systematic reviews • RCTs

1 7.2.2 Clinical evidence

2 7.2.2.1 Individual psychotherapy

3 28 RCTs (n=2308) met the eligibility criteria for this review, the majority of which were on
4 adults (Agras et al., 1989; Agras et al., 2000; Bulik et al., 1998; Carter et al., 2003; Chen et
5 al., 2003; Cooper and Steere, 1995; Fairburn, 1986; Fairburn et al., 2009; Fairburn et al.,
6 1991; Fairburn et al., 1993; Fairburn et al., 1995; Freeman et al., 1988; Garner et al., 1993;
7 Ghaderi, 2006; Griffiths et al., 1994; Le Grange et al., 2015; Leitenberg et al., 1988; McIntosh
8 et al., 2011; Nevoenen and Broberg, 2006; Olmsted et al., 1991b; Poulsen et al., 2014; Safer
9 et al., 2001; Schmidt et al., 2007a; Thackwray et al., 1993; Thiels et al., 1998a; Thompson-
10 Brenner et al., 2016; Treasure et al., 1994; Wilson et al., 1991; Wonderlich et al., 2014). The
11 two trials by LeGrange were on young people. An overview of the trials included in the meta-
12 analysis can be found in Table 2. Further information about both included and excluded
13 studies can be found in Appendix J.

14 No studies were identified that compared a combined individual psychotherapy with a
15 pharmacological agent with any other intervention or wait list controls.

16 The forest plots can be found in Appendix O, full GRADE evidence profiles be found in
17 Appendix N. See also the study selection flow chart in Appendix M, excluded studies in
18 Appendix J.

19 7.2.2.2 Group therapy

20 Ten RCTs (n=645) met the eligibility criteria for this review all of which were on adults (Bailer
21 et al., 2004; Chen et al., 2003; Hsu et al., 2001; Lavender et al., 2012; Lee and Rush, 1986;
22 Leitenberg et al., 1988; Mitchell et al., 1993; Nauta et al., 2001; Olmsted et al., 1991a; Wolf
23 and Crowther, 1992). An overview of the trials included in the meta-analysis can be found in
24 Table 2. Further information about both included and excluded studies can be found in
25 Appendix J.

26 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
27 evidence tables in Appendix L and exclusion list in Appendix J.

1 **7.2.2.3 Self-help**

2 15 RCTs (n=1494) met the eligibility criteria for this review the majority of which were in
3 adults (Bailer et al., 2004; Banasiak et al., 2005; Bauer et al., 2012; Carter et al., 2003;
4 Durand and King, 2003; Ljotsson et al., 2007; Mitchell et al., 2008; Palmer et al., 2002;
5 Ruwaard et al., 2013; Sanchez-Ortiz et al., 2011; Schmidt, 2006; Steele and Wade, 2008;
6 Thiels et al., 1998b; Treasure et al., 1994; Wagner et al., 2013; Walsh et al., 2004). An
7 overview of the trials included in the meta-analysis can be found in Table 165.

8 Further information about both included and excluded studies can found in Appendix J.

9 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
10 evidence tables in Appendix L and exclusion list in Appendix J.

11 **7.2.2.4 Family therapy**

12 Three RCTs (n=295) met the eligibility criteria for this review, all of which were for young
13 people in an outpatient setting (le Grange et al., 2007; Le Grange et al., 2015; Schmidt et al.,
14 2007b). An overview of the trials included in the meta-analysis can be found in Table 4.

15 Further information about both included and excluded studies can found in Appendix J.

16 No studies were identified that compared a combined family therapy and a pharmacological
17 agent with any other intervention or wait list controls.

18 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
19 evidence tables in Appendix L and exclusion list in Appendix J.

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Table 163: Study information for trials included in the meta-analysis of individual psychotherapy versus any other intervention or wait list controls for people with bulimia nervosa.

Study ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison	Sessions N	Treatment length	Long-term FU
Agras 1989	29.2 (8.6)	NR	100%	Duration of BN: 8.8 (6.6) years	77	CBT-ED	Wait List Control Self-monitoring BT	14	4 months	None reported
Agras 2000	28.3 (7.0)	22.7 (4.2)	100%	Duration of bingeing 11.4 (7.6) years	220	CBT-ED	IPT	19	20 weeks	8 or 12 months FU
Bulik 1998/Mclintosh 2011	26.1 (6.1)	22.4 (2.5)	100%	Duration of BN 6.0 (7.0) years.	111	CBT-ED 1	CBT-ED + physical therapy (breathing) CBT-ED 2	16	14 weeks	12 months FU
Chen 2003	25.8 (7.2)	22.2 (2.8)	100%	Duration of BN: 9.6 (7.3) years	71	CBT-ED	CBT-ED Group	19	4.5 months	6 months FU
Cooper 1995	23.8	NR	100%	Mean 56 months	31	CBT-ED	BT	19	18 weeks	12 months FU
Fairburn 1986	22.9 (4.4)	The weight within the normal range (mean weight = 96.9% MPMW, SD = 9.4)	100%	High EAT (mean score 48.8 [17.8])	24	CBT-ED	Psychodynamic - General	18	18 weeks	12 months FU

Study ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison	Sessions N	Treatment length	Long-term FU
Fairburn 1991 Fairburn 1993 Fairburn 2015	24.2 (22.8-25.6)	22.2 (21.5-23.0)	100%	Duration of BN 4.4 (3.4-5.3) years	75	CBT-ED	BT IPT	19	18 weeks	12 months FU 3 year FU
Fairburn 2009	26.1 (7.0)	18.7 - 26.4	96 %	Duration of BN 8.8 (6.9) years	154	CBT-ED.1	Wait List Control CBT-ED 2	21	8 weeks	60 week FU
Fairburn 2015	25.9 (7.7)	19.1 to 26.4	98%	Duration of BN 11.4 (9.6) years	130	CBT-ED	IPT	20	20 weeks	60 week FU
Freeman 1988	24.2 (5.6)	Weight as a % of matched population mean weight 108.2% (16.1)	100%	Duration of BN 6 (4.9) years	112	CBT-ED	Wait List Control BT Nutritional counselling	15	15 weeks	None reported
Garner 1993	23.7 (4.4)	Weight as a % of matched population mean weight 95.3% (9.8)	100%	Duration of BN 71.8 (47.6) months	60	CBT-ED	Dynamic psychotherapy-ED	18	18 weeks	None reported
Ghaderi 2006	27.2 (7.8)	25.0 (5.1)	NR	Duration of BN: 9.2 (6.3) years	50	CBT-ED	CBT-ED	19	19 weeks	18 months FU

Study ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison	Sessions N	Treatment length	Long-term FU
Griffiths 1994	25.91 (5.7)	21.9 (2.0)	100%	Duration of BN: 6.2 (5.2) years	78	CBT-ED	Wait List Control	7	8 weeks	None reported
Hsu 2001	24.5 (6.4)	112.2% Ideal BW	100%	Duration of BN: 5.5 (3.2) years	100	CT-ED	Nutrition counselling Nutrition and CT-ED Support group	16	14 weeks	None reported
Le Grange 2007	16.0 (1.7)	21.8 (2.5)	98%	At least 24 bulimic episodes in past 6 months	80	Supportive psychotherapy	Family therapy	20	6 months	6 months FU
Le Grange 2015	15.8 (1.5)	Mean % expected BW=109.4 (21.7)	94%	Duration of BN: 22.2 (16.2) months.	130	CBT-ED	Family therapy Supportive psychotherapy	18	6 months	6 months FU
Mitchell 2008	28.4 (10.4)	23.5 (5.4)	100%	NR BN 56%, EDNOS 44%	128	Guided Self-help ED	CBT-ED	20	16 weeks	12 months FU
Nevonen 2006	21.1 (2.0)	21.5 (2.1)	100%	Duration of BN: 5.1 (2.9) years	86	Hybrid - mixes/sequences therapies	Other hybrid	23	23 weeks	12 months FU
Olmsted 1991	24 (4.2)	NR	100%	NR	65	CBT-ED	Group psychoeducation	5	4 weeks	None reported
Poulsen 2014	25.8 (4.9)	22.24 (2.11)	97%	Duration of BN: 12.3 (6.2) years	70	Dynamic psychotherapy - ED	CBT-ED	21	14 weeks	None reported
Schmidt 2007	17.6 (1.7)	21.1 (2.6)	98	DSM-IV criteria for	85*	CBT-ED**	FT-ED	Up to 13 with close	6 months	6 months

Study ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison	Sessions N	Treatment length	Long-term FU
				BN or EDNOS				others + 2 individual sessions		
Thackwray 1993	31.3 (10.4)	NR	100%	Duration of BN: 6.7 (7.3) years	47	CBT-ED	BT Placebo	8	8 weeks	6 months FU
Thiels 1998	28.7 (9.1)	21.3 (3.1)	NR	Duration of BN 8.5 (9.2) years	62	Guided Self-Help-ED	CBT-ED	8	16 weeks	43 weeks FU
Thompson-Brenner 2016	25.6 (8.1)	23.7 (3.5)	100%	At least 3 months	50	CBT-ED (focused)	CBT-ED (enhanced)	16	8 weeks	6 months FU
Treasure 1994	26.0 (6.6)	26.8 (7.0)	100%	Actively bulimic criteria	110	CBT-ED	Wait List Control Self-help (ED)	8	8 weeks	None reported
Wilson 1991	19.8	22.0	90%	Had ED for at least 12 months	22	CBT-ED.1	CBT-ED.2	20	20 weeks	12 months FU
Wonderlich 2014	27.3 (9.6)	NR	90%	Had ED for at least 3 months	80	Integrative Cognitive-Affective Therapy (ICAT)	CBT-ED	21	19 weeks	4 months FU

Note: *, sample included 28% EDNOS participants; **, ***This was referred to as 'CBT-ED guided self-care' in the study but was classified by the committee as a form of CBT-ED. Abbreviations: BN – bulimia nervosa; BT – behavioural therapy; CBT-ED – cognitive behavioural therapy with an eating disorder focus; ED – eating disorder; FU – follow up; ICAT – integrative cognitive affective therapy; IPT – interpersonal psychotherapy; N – number; NR – not reported.

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Table 164: Study information for trials included in the meta-analysis of group psychotherapy versus any other intervention or wait list controls for people with bulimia nervosa.

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N Initially Randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU
Bailer 2004	23.3 (4.1)	21.7 (3.1)	100%	Duration of BN: 6 years	81	Group CBT-ED	Guided self-help ED	20	18 weeks	12 mo FU
Chen 2003	25.8 (7.2)	22.2 (2.8)	100%	Duration of BN: 9.6 (7.3) years	71	Group CBT-ED	CBT-ED-Individual	19	4.5 months	6 mo FU
Hsu 2001	24.5 (6.6)	112.2 % ideal body weight	100%	Duration of BN: 5.5 (3.2) years	100	Group Self-help	CBT-ED individual Hybrid (nutritional and CBT-ED) Nutritional counselling	16	14 weeks	None reported
Lavender 2012	27.7 (7.6)	24.4 (5.7)	92%	Patients were referred by GP. Duration of BN: 9.3 (7.6) years	74	Group CBT-ED	Emotional and Social Mind Training (ESM)	17	4 months	None reported
Lee 1986	27.7 (5.3)	NR	100%	First experienced bulimia in their late teens or early twenties.	30	Group CBT-ED	Wait list control	12	6 weeks	None reported
Leitenberg 1988	26 years	NR	100%	Duration of BN: 6.9 years	59	Group BT (ED)	Group BT (ED) Group CBT-ED Wait list control	24	14 weeks	6 months FU
Mitchell 1993	25.8 (6.8)	NR	100%	Average duration of illness was 8.8 years	76	Group CBT-ED	Group CBT-ED Low intensity High abstinence and Low abstinence	24	12 weeks	None reported

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N Initially Randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU
Nauta 2001	38.3 (7.1)	33.1 (4.3)	100%	Duration of BN: 12.5 (6.4) years	37	Group BT (ED)	Group nutritional counselling	15	15 weeks	6 months U
Olmsted 1991	24 (4.2)	Unclear	100%	Between 1 and 20 years	75	Group psychoeducation	CBT-ED individual	5	4 weeks	None reported
Wolf 1992	26.5 (8.1)	NR	100%	Bingeing for 8.8 years	42	Group CBT-ED	BT Group Wait list control	10	8 weeks	3 mo FU

Abbreviations: BN – bulimia nervosa; BT – behavioural therapy; CBT-ED – cognitive behavioural therapy with an eating disorder focus; ED – eating disorder; ESM - emotional and social mind training; FU – follow up; ICAT – integrative cognitive affective therapy; IPT – interpersonal psychotherapy; N – number; NR – not reported; WLC – wait list control

Table 165: Study information for trials included in the meta-analysis of self-help versus any other intervention or wait list controls for people with bulimia nervosa

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU
Bailer 2004	23.3 (4.1)	21.7 (3.1)	100%	Duration of BN: 6 years	81	Guided self-help ED	Group CBT-ED	20	18 weeks	12 months FU
Banasiask 2005	29.5 (8.7)	22.6 (3.6)	100%	Duration of BN: 9.2 (7.0)	109	Guided self-help ED	Wait list control	9	16 weeks	None reported
Bauer 2012	29.9 (7.9)	24.8 (6.8)	100%	Discharged from hospital. BN 60%, EDNOS 40%	165	Text Messaging Intervention	Wait list control	16	16 weeks	None reported
Carter 2003	27 (8) years	23 (5)	100%	Duration of BN: 7 (6) years	85	Self-help ED	Wait list control General self-help	0	8 weeks	None reported
Durand 2003	28.3 (6.5)	NR	100%	NR	68	Guided self-help ED	CBT and IPT combination	Self-help saw	Unclear if 6 or 9 months	None reported

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU
								GP 4.9 times		
Ljotsson 2007	35.5 (11.4)	35.5 (11.4)	94%	52% BED, 48% BN BN for at least 3 months or BED for at least 6 months	73	Guided self-help ED	Wait list control	12	12 weeks	None reported
Mitchell 2008	28.4 (10.4)	23.5 (5.4)	100%	NR BN 56%, EDNOS 44%	128	Guided self-help ED	CBT-ED	20	16 weeks	12 months FU
Palmer 2002	26.8 (9.5)	26.2 (7.9)	99%	NR BN 60% +BED 20% +EDNOS 20%	121	Guided self-help ED 1	Wait List Control Guided Self-help ED 2 Self-help (ED)	4	4 months	12 months FU
Ruwaard 2013	30 (10)	6% Obese, 20% overweight, 74% normal.	97%	Average duration of symptoms was 11 (9) years	105	On-line self-help ED	Self-help ED Wait list control	25	20 weeks	12 months FU
Sanchez-Ortiz 2011	23.9 (5.9)	22.0 (2.8)	99%	Duration of illness 5.2 (4.0) BN (51.3%) or EDNOS (48.7%)	76	On-line guided self-help	Wait list control	8	8-12 weeks up to 24 weeks	None reported

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU
Schmidt 2006	29.5 (9.2)	23.5 (4)	unclear	BN and EDNOS Median duration of illness 4 (1 to 6)	61	Guided self-help ED	Self-help ED	10	10 weeks	6 months FU
Steele 2008	24.7 (5.5)	21.4 (2.4)	99%	BN or BED (BN 59 to 100% per group) Duration of bulimic symptoms: 9.0 years	48	Guided self-help-ED	Placebo Guided self-help	8	6 weeks	None reported
Thiels 1988	28.7 (9.1)	21.3 (3.1)	NR	Duration of BN: 8.5 (9.2) years	62	Guided self-help ED	CBT-ED	8	16 weeks	43 weeks FU
Treasure 1994	25.7 (5.8)	24.0 (5.9)	100%	BN and atypical BN. Duration of BN 7.8 years	110	Self-Help ED	CBT-ED Wait List Control	16	8 weeks	None reported
Wagner 2013	24.2 (4.5)	20.6 (2.1)	100%	BN 90%; EDNOS 10% Duration of illness: 8.2 (5.2)	155	Self-help ED (internet)	Guided Self-help ED (traditional)	Weekly emails	7 months	11 months FU
Walsh 2004	30.6 (7.8)	> 17.5	100%	Mean duration 12.0 years (7.9)	47	Guided self-help ED	Placebo	6-8	4 months	None reported

Abbreviations: BN – bulimia nervosa; BT – behavioural therapy; CBT-ED – cognitive behavioural therapy with an eating disorder focus; ED – eating disorder; ESM - emotional and social mind training; FU – follow up; ICAT – integrative cognitive affective therapy; IPT – interpersonal psychotherapy; N – number; NR – not reported; WLC – wait list control

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Table 166: Study information for trials included in the meta-analysis of family therapy versus any individual therapy or wait list control for people with bulimia nervosa

Study ID	Mean age (SD)	Mean BMI, kg/m ² (SD)	Female (%)	Sample	N randomised	Intervention	Comparison	Number of sessions	Treatment Length	Long-term FU
Le Grange 2007	16.1	22.1 (3.0)	98	DSM-IV BN or at least 24 bulimic episodes in past 6 months	80	FBT-BN Duration: 22.3 (20.4) months	SPT-BN Duration: 20.1 (24.4) months	20	6 months	6 months
Le Grange 2015	15.8 (1.5)	Not reported	94	DSM-IV BN or partial BN	130	FBT-BN Duration: 19.6 (19.9) months	CBT-A Duration: 11.3 (10.4) months SPT-BN Duration: 22.2 (16.2) months	18 (Mean 14.7)	6 months	12 months
Schmidt 2007	17.6 (1.7)	21.1 (2.6)	98	DSM-IV criteria for BN or EDNOS	85*	FT-ED Age of ED onset: 15.2 (1.8) years	CBT-ED** Age of ED onset: 14.9 (2.1) years	Up to 13 with close others + 2 individual sessions	6 months	6 months

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Note: *sample consisted of 61 BN and 24 EDNOS; **This was referred to as 'CBT-ED guided self-care' in the study but was classified by the committee as a form of CBT-ED. Abbreviations: BN, bulimia nervosa; CBT-A, Cognitive Behavioural Therapy adapted for young people with eating disorders; ED, eating disorder; EDNOS, eating disorder not otherwise specified; FBT-BN, Family-based treatment for bulimia nervosa; FT, Family Therapy; SPT-BN, Supportive Psychotherapy for young people bulimia nervosa.

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Individual therapy

Table 167: Summary of findings table for CBT-ED versus any other intervention at the end of treatment in young people and adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN CBT-ED (95% CI)
Purges - Adolescents	86 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges - adolescents in the intervention groups was 0.33 standard deviations higher (0.1 lower to 0.75 higher)
Purges - Adults	359 (5 studies)	⊕⊖⊖⊖ VERY LOW3,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean purges - adults in the intervention groups was 0.59 standard deviations lower (0.8 to 0.37 lower)
Binges objective Adolescent	86 (1 study)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean binges objective adolescent in the intervention groups was 0.23 standard deviations higher (0.2 lower to 0.65 higher)
Binges objective Adults	689 (10 studies)	⊕⊕⊖⊖ LOW7,8 due to risk of bias, inconsistency		Not calculable for SMD values	The mean binges objective adults in the intervention groups was 0.25 standard deviations lower (0.41 to 0.1 lower)
Vomiting episodes Adults	484 (7 studies)	⊕⊖⊖⊖ VERY LOW4,5,7 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean vomiting episodes adults in the intervention groups was 0.32 standard deviations lower (0.51 to 0.13 lower)
Laxatives use/ fortnight	208 (2 studies)	⊕⊖⊖⊖ VERY LOW2,9,10 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean laxatives use/ fortnight in the intervention groups was 0.27 standard deviations higher (0.01 lower to 0.55 higher)
Symptom checklist (SCL-90-R)	261 (3 studies)	⊕⊖⊖⊖ VERY LOW5,8,11 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean symptom checklist (scl-90-r) in the intervention groups was 0.31 standard deviations lower (0.56 to 0.06 lower)
Quality of life	80 (1 study)	⊕⊕⊖⊖ LOW2,12		Not calculable for SMD values	The mean quality of life in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN CBT-ED (95% CI)
		due to risk of bias, imprecision			0.25 standard deviations higher (0.19 lower to 0.69 higher)
Depression - young people	110 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - young people in the intervention groups was 0.43 standard deviations higher (0 to 0.86 higher)
Depression - Adults	632 (10 studies)	⊕⊕⊕⊖ LOW8,13 due to risk of bias, inconsistency		Not calculable for SMD values	The mean depression - adults in the intervention groups was 0.31 standard deviations lower (0.47 to 0.14 lower)
EDE- Total score - young people	110 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- total score - young people in the intervention groups was 0.28 standard deviations higher (0.15 lower to 0.7 higher)
EDE - Total score - Adults	419 (5 studies)	⊕⊕⊕⊖ LOW5,14 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total score - adults in the intervention groups was 0.6 standard deviations lower (0.81 to 0.39 lower)
EDE-dietary restraint	725 (10 studies)	⊕⊖⊖⊖ VERY LOW4,5,15 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-dietary restraint in the intervention groups was 0.63 standard deviations lower (0.78 to 0.47 lower)
EDE-shape concern	725 (10 studies)	⊕⊖⊖⊖ VERY LOW4,15 due to risk of bias, inconsistency		Not calculable for SMD values	The mean ede-shape concern in the intervention groups was 0.08 standard deviations higher (0.07 lower to 0.23 higher)
EDE-weight concern	725 (10 studies)	⊕⊖⊖⊖ VERY LOW4,15 due to risk of bias, inconsistency		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.13 standard deviations lower (0.29 lower to 0.02 higher)
EDE-eating concern	477 (5 studies)	⊕⊕⊕⊖ LOW8,16 due to risk of bias, inconsistency		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.16 standard deviations lower (0.34 lower to 0.02 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN CBT-ED (95% CI)
EDI- Bulimia	242 (4 studies)	⊕⊕⊕⊖ LOW5,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- bulimia in the intervention groups was 0.3 standard deviations lower (0.57 to 0.04 lower)
EDI - Drive for thinness	243 (4 studies)	⊕⊕⊕⊖ VERY LOW4,17,18 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 0 standard deviations lower (0.27 lower to 0.27 higher)
EDI - Body Dissatisfaction	200 (4 studies)	⊕⊕⊕⊖ VERY LOW4,17,18 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was 0.05 standard deviations lower (0.35 lower to 0.24 higher)
Global Clinical Score	111 (3 studies)	⊕⊕⊕⊖ LOW5,19 due to risk of bias, imprecision		Not calculable for SMD values	The mean global clinical score in the intervention groups was 0.15 standard deviations lower (0.54 lower to 0.24 higher)
General psychopathology (PSE)	22 (1 study)	⊕⊕⊕⊖ LOW5,20 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology (pse) in the intervention groups was 0.77 standard deviations lower (1.64 lower to 0.1 higher)
Remission - Adolescents	215 (2 studies)	⊕⊕⊕⊖ VERY LOW21,22,23 due to risk of bias, indirectness, imprecision	RR 1.54 (0.96 to 2.47)	186 per 1000	100 more per 1000 (from 7 fewer to 273 more)
Remission - Adults	807 (8 studies)	⊕⊕⊕⊖ LOW24,25 due to risk of bias, imprecision	RR 1.77 (1.4 to 2.23)	200 per 1000	154 more per 1000 (from 80 more to 246 more)
Bulimic Inventory Test Edinburgh	47 (1 study)	⊕⊕⊕⊖ LOW5,26 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic inventory test edinburgh in the intervention groups was 0.77 standard deviations lower (1.37 to 0.18 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN CBT-ED (95% CI)
<p>CI: Confidence interval; RR: Risk ratio;</p> <p>1 The participants and investigators were not blind but the assessors were.</p> <p>2 95% CI crossed 1 MID (0.5)</p> <p>3 Unclear if allocation concealment was performed, except Poulsen 2014. It was unclear in two studies if assessors were blind and high drop out rates were reported in two studies >20%,</p> <p>4 Heterogeneity reported, I2 >80%</p> <p>5 95% CI crossed 1 MID (-0.5)</p> <p>6 Unclear randomization method; neither the investigators, assessors nor participants were blind.</p> <p>7 In half of the studies, it is unclear how the randomisation sequence was generated. In most studies it was unclear if allocation concealment was conducted. High drop outs were reported by Fairburn.</p> <p>8 Heterogeneity detected I2 >50%</p> <p>9 In half of the studies it is unclear how the randomisation sequence was generated. In most studies it was unclear if allocation concealment was conducted. High drop outs were reported by Fairburn and Freeman.</p> <p>10 <50% bulimia nervosa.</p> <p>11 Unclear in all studies, except Poulsen 2014, if allocation concealment was conducted. It was unclear how Fairburn 1991 generated the random sequence. A high number of drop outs were reported >20% in Agras 2000.</p> <p>12 Unclear if allocation concealment was performed. Unclear if assessor, investigators and patients was blind.</p> <p>13 In half of the studies, it is unclear how the randomisation sequence was generated. In all studies it was unclear if allocation concealment was conducted. High drop outs were reported Theils and Agras.</p> <p>14 Unclear in all studies, except Poulsen 2014, if allocation concealment was conducted. It was unclear how Fairburn 1986 generated the random sequence. In half of the studies a high number of drop outs were reported >20%</p> <p>15 In a few of the studies, it is unclear how the randomisation sequence was generated. In all studies it was unclear if allocation concealment was conducted. High drop outs (>20%) were reported by Treasure, Theils and Fairburn</p> <p>16 It was unclear is one study how randomisation was conducted and in all studies if allocation concealment was conducted. Half of the studies it was unclear if assessor was blind and high drop out rates were reported in half the studies >20%.</p> <p>17 In most of the studies, it is unclear how the randomisation sequence was generated. In all studies it was unclear if allocation concealment was conducted.</p> <p>18 Fewer than 400 patients for optimal sample size.</p> <p>19 It was unclear in two of the studies how the randomisation sequence was generated and in all studies if allocation concealment was conducted. One study reported high drop outs >20% and one study it was unclear if assessor was blind.</p> <p>20 It was unclear how randomisation sequence was generated and if allocation concealment was conducted.</p> <p>21 Unclear randomization method; no participant, investigator nor assessor blinding.</p> <p>22 Sample in one study consists of 61 bulimia nervosa and 24 EDNOS</p> <p>23 95% CI crossed 1 MID (1.25)</p> <p>24 In a few studies it was unclear how randomisation was performed and in all studies it was unclear if allocation concealment was performed. High drop</p>					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN CBT-ED (95% CI)
out rates were reported in a number of studies.					
25 For a dichotomous outcome, there are fewer than 300 events.					
26 Inadequate random sequence generation and unclear if allocation concealment was performed. High drop out rates were reported >20%					

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Table 168: Summary of findings table for CBT-ED versus any other intervention at follow up in young people and adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Follow-up	Risk difference with BN CBT-ED (95% CI)
Purges Follow-up - Adolescents	69 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges follow-up - adolescents in the intervention groups was 0 standard deviations higher (0.48 lower to 0.48 higher)
Purges Follow-up - Adults	208 (3 studies)	⊕⊕⊕⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges follow-up - adults in the intervention groups was 0.15 standard deviations lower (0.42 lower to 0.13 higher)
Binge episodes follow-up - Adolescents	69 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge episodes follow-up - adolescents in the intervention groups was 0.06 standard deviations lower (0.54 lower to 0.42 higher)
Binge episodes Follow-up - Adults	294 (5 studies)	⊕⊖⊖⊖ VERY LOW2,5,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean binge episodes follow-up - adults in the intervention groups was 0.19 standard deviations lower (0.38 lower to 0.04 higher)
Vomiting Follow-up - Adults	162 (3 studies)	⊕⊕⊕⊖ LOW4,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting follow-up - adults in the intervention groups was 0.19 standard deviations lower (0.51 lower to 0.12 higher)
Laxatives Follow-up - Adults	98 (1 study)	⊕⊕⊕⊖ LOW2,8		Not calculable for SMD values	The mean laxatives follow-up - adults in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Follow-up	Risk difference with BN CBT-ED (95% CI)
		due to risk of bias, imprecision			0.02 standard deviations lower (0.42 lower to 0.37 higher)
Symptom checklist Follow-up - Adults	236 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{4,9,10} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean symptom checklist follow-up - adults in the intervention groups was 0.41 standard deviations lower (0.68 to 0.14 lower)
Quality of life FU	52 (1 study)	⊕⊕⊕⊕ LOW ^{11,12} due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life fu in the intervention groups was 0.08 standard deviations higher (0.47 lower to 0.62 higher)
Depression - FU - Adults	410 (9 studies)	⊕⊕⊕⊕ MODERATE ¹³ due to risk of bias		Not calculable for SMD values	The mean depression - fu - adults in the intervention groups was 0.14 standard deviations lower (0.34 lower to 0.05 higher)
EDE - Total score Follow-up - Adults	307 (3 studies)	⊕⊕⊕⊕ LOW ^{2,14,15} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total score follow-up - adults in the intervention groups was 0.11 standard deviations lower (0.34 lower to 0.11 higher)
EDE - Restraint FU - Adults	126 (3 studies)	⊕⊕⊕⊕ LOW ^{2,16} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - restraint fu - adults in the intervention groups was 0.12 standard deviations lower (0.47 lower to 0.23 higher)
EDE - Shape concern FU - Adults	126 (3 studies)	⊕⊕⊕⊕ LOW ^{2,16} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - shape concern fu - adults in the intervention groups was 0.01 standard deviations lower (0.36 lower to 0.34 higher)
EDE - Weight concern FU - Adults	126 (3 studies)	⊕⊕⊕⊕ LOW ^{2,17} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - weight concern fu - adults in the intervention groups was 0.08 standard deviations lower (0.43 lower to 0.27 higher)
EDE - Eating concern FU - Adults	52 (1 study)	⊕⊕⊕⊕ LOW ^{4,11} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - eating concern fu - adults in the intervention groups was 0.25 standard deviations lower (0.8 lower to 0.29 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Follow-up	Risk difference with BN CBT-ED (95% CI)
Global clinical score FU - Adults	22 (1 study)	⊕⊕⊕⊖ LOW4,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean global clinical score fu - adults in the intervention groups was 0.81 standard deviations lower (1.69 lower to 0.07 higher)
General psychopathology - FU - Adults	49 (2 studies)	⊕⊕⊕⊖ LOW4,14 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology - fu - adults in the intervention groups was 0.5 standard deviations lower (1.07 lower to 0.07 higher)
Bulimic inventory test edinburgh	47 (1 study)	⊕⊕⊕⊖ LOW4,18,19 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic inventory test edinburgh in the intervention groups was 0.21 standard deviations lower (0.78 lower to 0.37 higher)
EDI - Bulimia FU - Adults	47 (1 study)	⊕⊕⊕⊖ LOW4,14 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia fu - adults in the intervention groups was 0.47 standard deviations lower (1.09 lower to 0.15 higher)
EDI - Drive for thinness FU - Adults	47 (1 study)	⊕⊕⊕⊖ LOW12,14 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness fu - adults in the intervention groups was 0.12 standard deviations higher (0.5 lower to 0.73 higher)
EDI - Body Dissatisfaction FU - Adults	27 (1 study)	⊕⊕⊕⊖ LOW4,14 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction fu - adults in the intervention groups was 0.36 standard deviations lower (1.12 lower to 0.4 higher)
Remission FU - young people	215 (2 studies)	⊕⊖⊖⊖ VERY LOW1,20,21,22 due to risk of bias, indirectness, imprecision	RR 0.85 (0.56 to 1.3)	363 per 1000	54 fewer per 1000 (from 160 fewer to 109 more)
Remission FU - Adults	629 (5 studies)	⊕⊕⊕⊖ LOW5,22 due to risk of bias, imprecision	RR 1.37 (1.08 to 1.74)	258 per 1000	95 more per 1000 (from 21 more to 191 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Follow-up	Risk difference with BN CBT-ED (95% CI)
CI: Confidence interval; RR: Risk ratio; 1 Unclear randomization method; no participant, investigator nor assessor blinding. 2 Fewer than optimal sample size was used <400 participants. 3 It was unclear in a few studies how the randomisation sequence was generated and in all studies if allocation concealment was performed. In one study high drop outs were reported >20%. 4 95% CI crossed 1 MID (-0.5) 5 In the majority of studies it was unclear how the randomisation sequence was generated. In all studies it was unclear if allocation concealment was performed and in half the studies a high drop out was reported >20%. 6 Heterogeneity reported I ² >50%. 7 It was unclear in one study how the randomisation sequence was generated and in all studies, except Poulsen, if allocation concealment was performed. In two studies high drop outs were reported >20%. 8 Unclear if allocation concealment was performed; unclear participant and investigator blinding. High drop outs >20% reported. 9 It was unclear how the random sequence was generated in one study and if allocation concealment was performed in majority of studies. In one study it was unclear if assessor was blind. 10 Heterogeneity was detected >80% 11 It was unclear how random sequence was generated and allocation concealment was performed. It was unclear if assessor was blind. 12 95% CI crossed 1 MID (0.5) 13 In half the studies it was unclear how randomisation sequence was generated. It was unclear in all of the studies if allocation concealment was performed. In few studies, high drop out rates were reported >20%. 14 Unclear if allocation concealment was performed. 15 Unclear if allocation concealment was performed in majority of studies. In half the studies, a high drop out was reported >20% 16 In one study it was unclear how the randomisation sequence was generated and in one study it was inadequate. It was unclear in both studies if allocation concealment was performed. In one study high drop out rates were reported >20%. 17 In two of three studies it was unclear how the randomisation sequence was generated and in one study it was inadequate. It was unclear in all studies if allocation concealment was performed. In one study high drop out rates were reported >20%. 18 No explanation was provided 19 Inadequate random sequence generation and unclear if allocation concealment was performed. High drop out rates were reported >20% 20 Sample in one study consists of 61 bulimia nervosa and 24 EDNOS 21 95% CI crossed 1 MID (0.75) 22 95% CI crossed 1 MID (1.25)					

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Table 169: Summary of interpersonal psychotherapy versus another intervention at the end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN IPT (95% CI)
EDE - Total	247 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total in the intervention groups was 0.52 standard deviations higher (0.27 to 0.77 higher)
EDE - Restraint	309 (3 studies)	⊕⊖⊖⊖ VERY LOW2,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - restraint in the intervention groups was 0.71 standard deviations higher (0.02 lower to 1.43 higher)
EDE - Weight concerns	309 (3 studies)	⊕⊖⊖⊖ VERY LOW3,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - weight concerns in the intervention groups was 0.63 standard deviations higher (0.53 lower to 1.79 higher)
EDE - Shape concerns	309 (3 studies)	⊕⊖⊖⊖ VERY LOW3,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - shape concerns in the intervention groups was 0.14 standard deviations lower (1.06 lower to 0.78 higher)
EDE - Eating concerns	247 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - eating concerns in the intervention groups was 0.47 standard deviations higher (0.22 to 0.73 higher)
Symptom checklist (SCL-90-R)	191 (2 studies)	⊕⊕⊖⊖ LOW1,5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist (scl-90-r) in the intervention groups was 0.11 standard deviations higher (0.19 lower to 0.4 higher)
Social adjustment scale	213 (3 studies)	⊕⊕⊖⊖ LOW2,6		Not calculable for SMD values	The mean social adjustment scale in the intervention groups was

		due to risk of bias, imprecision			0.33 standard deviations higher (0.06 lower to 0.61 higher)
Purges	129 (1 study)	⊕⊕⊕⊖ LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges in the intervention groups was 0.42 standard deviations higher (0.07 to 0.77 higher)
Self-induced vomiting	178 (2 studies)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean self-induced vomiting in the intervention groups was 0.64 standard deviations higher (0.33 to 0.96 higher)
Bulimic episodes (objective)	98 (2 studies)	⊕⊕⊕⊖ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic episodes (objective) in the intervention groups was 0.29 standard deviations higher (0.01 lower to 0.6 higher)
Depression	202 (3 studies)	⊕⊖⊖⊖ VERY LOW2,6,8 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.22 standard deviations higher (0.41 lower to 0.85 higher)
Laxative taking	116 (1 study)	⊕⊕⊕⊖ LOW7,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative taking in the intervention groups was 0.37 standard deviations lower (0.73 lower to 0 higher)
Remission_ITT	425 (3 studies)	⊕⊕⊕⊖ LOW7,10 due to risk of bias, imprecision	RR 0.33 (0.21 to 0.5)	342 per 1000	229 fewer per 1000 (from 171 fewer to 270 fewer)
General clinical score	22 (1 study)	⊕⊕⊕⊖ LOW2,11 due to risk of bias, imprecision		Not calculable for SMD values	The mean general clinical score in the intervention groups was 0.94 standard deviations higher (0.05 to 1.83 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear in all studies if allocation concealment was performed. Two studies reported high dropout rates >20%

2 95% CI crossed 1 MID (0.5)

3 It was unclear if allocation concealment was performed. In Fairburn 1991 (1993) it was unclear how the randomisation sequence was generated. Two

studies reported high dropout rates >20%
 4 Heterogeneity detected I2 >80%
 5 Optimal sample size was not met >400 participants
 6 It was unclear in one study how random sequence was generated and in all studies if allocation concealment was conducted. In one study high drop outs were reported >20%.
 7 It was unclear if allocation concealment was conducted. High dropout rates were reported >20%.
 8 Heterogeneity detected I2 >50%
 9 95% CI crossed 1 MID (-0.5)
 10 Optimal event size was not met >300 events
 11 It was unclear if allocation concealment was conducted. It was unclear if participants and investigators were blind, however, assessors were blind.

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Table 170: Summary of interpersonal psychotherapy (IPT) versus another intervention at follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Follow-up	Risk difference with BN IPT (95% CI)
EDE - Total FU	227 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total fu in the intervention groups was 0.22 standard deviations higher (0.04 lower to 0.48 higher)
EDE - Restraint FU	264 (3 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - restraint fu in the intervention groups was 0.33 standard deviations higher (0.08 to 0.57 higher)
EDE - Weight concerns FU	264 (3 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - weight concerns fu in the intervention groups was 0.11 standard deviations higher (0.13 lower to 0.35 higher)
EDE - Shape concerns FU	264 (3 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - shape concerns fu in the intervention groups was 0.03 standard deviations higher (0.21 lower to 0.27 higher)
EDE - Eating concerns FU	227 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - eating concerns fu in the intervention groups was 0.15 standard deviations higher (0.11 lower to 0.41 higher)
Symptom checklist (SCL-90-R) FU	166 (2 studies)	⊕⊕⊖⊖ LOW1,2		Not calculable for SMD values	The mean symptom checklist (scl-90-r) fu in the intervention groups was

		due to risk of bias, imprecision			0.02 standard deviations lower (0.32 lower to 0.29 higher)
Social adjustment scale FU	166 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean social adjustment scale fu in the intervention groups was 0.15 standard deviations higher (0.15 lower to 0.46 higher)
Purges FU	129 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges fu in the intervention groups was 0.18 standard deviations higher (0.16 lower to 0.53 higher)
Bulimic episodes (objective) FU	98 (1 study)	⊕⊕⊖⊖ LOW4 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic episodes (objective) fu in the intervention groups was 0.02 standard deviations higher (0.37 lower to 0.42 higher)
Self-induced vomiting FU	135 (2 studies)	⊕⊕⊖⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean self-induced vomiting fu in the intervention groups was 0.05 standard deviations higher (0.28 lower to 0.39 higher)
Laxative taking FU	98 (1 study)	⊕⊕⊖⊖ LOW2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative taking fu in the intervention groups was 0.02 standard deviations higher (0.37 lower to 0.42 higher)
Depression (Becks) FU	135 (3 studies)	⊕⊖⊖⊖ VERY LOW2,4,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression (becks) fu in the intervention groups was 0.10 standard deviations higher (0.22 lower to 2.05 higher)
Remission FU_ITT	425 (3 studies)	⊕⊖⊖⊖ VERY LOW4,6,7 due to risk of bias, inconsistency, imprecision	RR 0.84 (0.61 to 1.15)	293 per 1000	47 fewer per 1000 (from 114 fewer to 44 more)
Remission_ITT < 5 years	75 (1 study)	⊕⊕⊖⊖ LOW8,9 due to risk of bias, imprecision	RR 1.56 (0.83 to 2.93)	280 per 1000	157 more per 1000 (from 48 fewer to 540 more)
Remission_ITT > 5 years	350 (2 studies)	⊕⊕⊖⊖ LOW8,9	RR 0.71 (0.49 to 1.03)	297 per 1000	86 fewer per 1000 (from 152 fewer to 9 more)

		due to risk of bias, imprecision			
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 It was unclear if allocation concealment was conducted. Across studies, investigators, participants or assessors were not blind. High dropout rates were detected >20%.					
2 For continuous outcome, there were fewer than <400 participants.					
3 95% CI crossed 1 MID (0.5)					
4 It was unclear if allocation concealment was conducted. Across studies, investigators, participants or assessors were not blind or it was unclear. High dropout rates were detected >20%.					
5 It was unclear if allocation concealment was conducted. Assessors were blind but it was unclear if participants or investigators were blind. High dropout rates were detected >20%					
6 Heterogeneity was detected >50%					
7 95% CI crossed 1 MID (0.75)					
8. It was unclear if allocation concealment was conducted. High dropout rates were reported >20%.					
9. Optimal information size was not met (300 events)					

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Table 171: Summary of findings table for integrative cognitive-affective therapy (ICAT) versus any other intervention at the end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN ICAT (95% CI)
EDE - Total score	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total score in the intervention groups was 0.11 standard deviations lower (0.55 lower to 0.33 higher)
Purges	80 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges in the intervention groups was 0.05 standard deviations higher (0.39 lower to 0.49 higher)
Binges (objective)	80 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binges (objective) in the intervention groups was 0.06 standard deviations higher (0.37 lower to 0.5 higher)

Depression	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.08 standard deviations lower (0.52 lower to 0.36 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 It was unclear whether the participants, investigators or the assessors were blind.					
2 95% CI crossed 1 MID (-0.5).					
3. Fewer than 400 participants.					
4. 95% CI crossed 1 MID (-0.5).					

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Table 172: Summary of findings table for integrative cognitive-affective therapy (ICAT) versus any other intervention at follow up in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention FU	Risk difference with BN ICAT (95% CI)
EDE - Total score FU	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total score fu in the intervention groups was 0.19 standard deviations lower (0.63 lower to 0.25 higher)
Purges FU	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges fu in the intervention groups was 0.09 standard deviations lower (0.53 lower to 0.35 higher)
Binges (objective) FU	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binges (objective) fu in the intervention groups was 0.25 standard deviations lower (0.69 lower to 0.19 higher)
Depression FU	80 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.14 standard deviations higher (0.3 lower to 0.58 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					

CI: Confidence interval; FU: follow up

1 It was unclear whether the participants, investigators or the assessors were blind.

2 95% CI crossed 1 MID (-0.5).

3 95% CI crossed 1 MID (0.5).

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Table 173: Summary of findings table for CBT-ED (1) versus another CBT-ED (2) program at the end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-ED (2)	Risk difference with BN CBT-ED (1) (95% CI)
Symptom check list - 90	291 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean symptom check list - 90 in the intervention groups was 0.03 standard deviations lower (0.26 lower to 0.2 higher)
Depression	306 (5 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.08 standard deviations lower (0.31 lower to 0.14 higher)
Social adjustment score	142 (2 studies)	⊕⊕⊕⊕ LOW ^{5,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean social adjustment score in the intervention groups was 0.21 standard deviations lower (0.54 lower to 0.12 higher)
Binge eating (objective)	242 (4 studies)	⊕⊕⊕⊕ LOW ^{3,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating (objective) in the intervention groups was 0.20 standard deviations lower (0.43 lower to 0.03 higher)
Vomiting	122 (2 studies)	⊕⊕⊕⊕ LOW ^{3,8} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.09 standard deviations lower (0.45 lower to 0.26 higher)
Laxatives	72 (1 study)	⊕⊕⊕⊕ LOW ^{6,9} due to risk of bias, imprecision		Not calculable for SMD values	The mean laxatives in the intervention groups was 0.23 standard deviations lower (0.7 lower to 0.23 higher)

Purging (last 2 weeks)	114 (2 studies)	⊕⊕⊖⊖ LOW6,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging (last 2 weeks) in the intervention groups was 0.11 standard deviations lower (0.48 lower to 0.26 higher)
Remission_ITT	321 (4 studies)	⊕⊕⊖⊖ LOW8,10 due to risk of bias, imprecision	RR 1.13 (0.91 to 1.41)	456 per 1000	59 more per 1000 (from 41 fewer to 187 more)
EDI- Drive for thinness	72 (1 study)	⊕⊕⊖⊖ LOW9,11 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- drive for thinness in the intervention groups was 0.14 standard deviations higher (0.32 lower to 0.6 higher)
EDI- Bulimia	122 (2 studies)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- bulimia in the intervention groups was 0.02 standard deviations lower (0.37 lower to 0.34 higher)
EDI- Body dissatisfaction	122 (2 studies)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- body dissatisfaction in the intervention groups was 0.02 standard deviations higher (0.34 lower to 0.37 higher)
EDI- Total	319 (3 studies)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- total in the intervention groups was 0.01 standard deviations higher (0.21 lower to 0.23 higher)
EDE - Total	361 (4 studies)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total in the intervention groups was 0.04 standard deviations lower (0.25 lower to 0.17 higher)
Global Function (GAFS)	72 (1 study)	⊕⊕⊖⊖ LOW8,11 due to risk of bias, imprecision		Not calculable for SMD values	The mean global function (gafs) in the intervention groups was 0.36 standard deviations higher (0.1 lower to 0.83 higher)
General psychiatric features	149 (1 study)	⊕⊕⊖⊖ LOW3,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychiatric features in the intervention groups was 0.16 standard deviations higher (0.16 lower to 0.48 higher)

Binge eating episodes (28 d)	149 (1 study)	⊕⊕⊕⊖ LOW10,12 due to risk of bias, imprecision	RR 1.35 (0.81 to 2.24)	250 per 1000	88 more per 1000 (from 47 fewer to 310 more)
Vomiting episodes (28 d)	149 (1 study)	⊕⊕⊕⊖ LOW10,12 due to risk of bias, imprecision	RR 1.09 (0.7 to 1.69)	333 per 1000	30 more per 1000 (from 100 fewer to 230 more)
Purging (28 d)	149 (1 study)	⊕⊕⊕⊖ LOW10,12 due to risk of bias, imprecision	RR 1.12 (0.74 to 1.71)	347 per 1000	42 more per 1000 (from 90 fewer to 247 more)
Laxative misuse	149 (1 study)	⊕⊕⊕⊖ LOW10,12 due to risk of bias, imprecision	RR 1.05 (0.43 to 2.58)	111 per 1000	6 more per 1000 (from 63 fewer to 176 more)
Depression <18 binges month	50 (1 study)	⊕⊕⊕⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression <18 binges month in the intervention groups was 0.55 standard deviations higher (0.02 lower to 1.11 higher)
Depression >18 binges month	256 (4 studies)	⊕⊖⊖⊖ VERY LOW3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression >18 binges month in the intervention groups was 0.20 standard deviations lower (0.45 lower to 0.04 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

- 1 It was unclear if allocation concealment was conducted. Assessors were blind, but it was unclear if either participants or investigators were blind in two studies, but in Wilson 1991 it was unclear if any were blind and high drop outs were reported >20%.
- 2 Heterogeneity was detected I² >50%
- 3 For a continuous outcome there were fewer than 400 participants.
- 4 It was unclear if allocation concealment was conducted in all studies. In Ghaderi and Bulike it was unclear how randomisation was conducted. Across studies, it was either unclear whether the assessors, participants or investigators were blind, in Chen participants were not blind and Bulik assessors were blind. High dropouts were reported >20%.
- 5 It was unclear if allocation concealment was conducted. Only participants were not blind in study by Chen, it was not clear in investigators or assessors were blind, but it was unclear in other study/ies. High drop outs were reported >20%.
- 6 95% CI crossed 1MID (-0.05).
- 7 It was unclear if allocation concealment was conducted. Across studies, it was unclear if all or only participants, investigators or assessors were blind. High drop outs were reported >20%.
- 8 It was unclear if allocation concealment was conducted. Across studies, it was unclear if all or only participants, investigators or assessors were blind.

9 It was unclear how randomisation was conducted or if allocation concealment was performed. Assessors were blind but it was unclear if participants or investigators were blind.
10 95% CI crossed 1 MID (1.25).
11 95% CI crossed 1 MID (0.5)
12 It was unclear if allocation concealment was performed or if participants were blind.

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Table 174: Summary of findings table for CBT-ED versus another CBT-ED program at follow up in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-ED (2) - Follow up	Risk difference with BN CBT-ED (1) (95% CI)
Depression Follow up	280 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression follow up in the intervention groups was 0.00 standard deviations higher (0.23 lower to 0.24 higher)
Symptom check list - 90 Follow up	269 (2 studies)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom check list - 90 follow up in the intervention groups was 0.09 standard deviations higher (0.15 lower to 0.33 higher)
Binge eating episodes (28 d) FU	149 (1 study)	⊕⊕⊕⊕ LOW ^{4,5} due to risk of bias, imprecision	RR 1.13 (0.68 to 1.9)	264 per 1000	34 more per 1000 (from 84 fewer to 237 more)
Vomiting (28 d) Follow up	149 (1 study)	⊕⊕⊕⊕ LOW ^{4,6} due to risk of bias, imprecision	RR 1.18 (0.76 to 1.84)	319 per 1000	57 more per 1000 (from 77 fewer to 268 more)
Laxative misuse	149 (1 study)	⊕⊕⊕⊕ LOW ^{4,7} due to risk of bias, imprecision	RR 1.4 (0.53 to 3.74)	83 per 1000	33 more per 1000 (from 39 fewer to 228 more)
Purging (28 d) Follow up	149 (1 study)	⊕⊕⊕⊕ LOW ^{4,6} due to risk of bias, imprecision	RR 1.21 (0.79 to 1.85)	333 per 1000	70 more per 1000 (from 70 fewer to 283 more)

Binge eating Follow up	280 (4 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating follow up in the intervention groups was 0.01 standard deviations lower (0.25 lower to 0.22 higher)
Laxatives Follow up	72 (1 study)	⊕⊕⊖⊖ LOW8,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxatives follow up in the intervention groups was 0.12 standard deviations lower (0.58 lower to 0.34 higher)
Vomiting Follow up	232 (3 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting follow up in the intervention groups was 0.1 standard deviations higher (0.16 lower to 0.35 higher)
Purging (last 2 weeks) Follow up	111 (2 studies)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging (last 2 weeks) follow up in the intervention groups was 0.09 standard deviations higher (0.29 lower to 0.46 higher)
General psychiatric features - FU	149 (1 study)	⊕⊕⊖⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychiatric features - fu in the intervention groups was 0.05 standard deviations higher (0.28 lower to 0.37 higher)
Global Function (GAFS)	72 (1 study)	⊕⊕⊖⊖ LOW8,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean global function (gafs) in the intervention groups was 0.51 standard deviations higher (0.04 to 0.98 higher)
Social adjustment score Follow up	170 (2 studies)	⊕⊕⊖⊖ LOW1,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean social adjustment score follow up in the intervention groups was 0.44 standard deviations higher (0.14 to 0.75 higher)
EDI- Bulimia Follow up	122 (2 studies)	⊕⊕⊖⊖ LOW8,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- bulimia follow up in the intervention groups was 0.21 standard deviations lower (0.57 lower to 0.15 higher)
EDI- Body dissatisfaction Follow up	122 (1 study)	⊕⊕⊖⊖ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- body dissatisfaction follow up in the intervention groups was 0.10 standard deviations higher (0.25 lower to 0.46 higher)

EDI- Drive for thinness Follow up	72 (1 study)	⊕⊕⊕⊖ LOW8,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- drive for thinness follow up in the intervention groups was 0.26 standard deviations higher (0.2 lower to 0.73 higher)
EDI- Total Follow up	319 (3 studies)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- total follow up in the intervention groups was 0.02 standard deviations lower (0.24 lower to 0.2 higher)
EDE - Total - Follow up	237 (2 studies)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - total - follow up in the intervention groups was 0.10 standard deviations lower (0.35 lower to 0.16 higher)
Remission - FU _ ITT	144 (3 studies)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision	RR 1.30 (0.93 to 1.83)	408 per 1000	123 more per 1000 (from 29 fewer to 339 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was conducted. Across studies, it was unclear if either or all participants, investigators or assessors were blind.

2 Heterogeneity was detected 12 >50%

3 For a continuous outcome, fewer than 400 participants were available.

4 It was unclear if allocation concealment was conducted. Both investigators and assessors were blind but it was unclear if participants were blind.

5 95% CI crossed 1 MID (0.75).

6 95% CI crossed 1 MID (1.25)

7 95% CI crossed 2 MIDs (0.75 and 1.25)

8 It was unclear if allocation concealment was conducted. Assessors were blind but it was unclear if participants or investigators were blind.

9 95% CI crossed 1 MID (-0.5)

10 95% CI crossed 1 MID (0.5)

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Table 175: Summary of findings table for behavioural therapy versus any other intervention at the end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN BT (95% CI)
Bulimic episodes	183 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic episodes in the intervention groups was 0.10 standard deviations lower (0.41 lower to 0.21 higher)
Depression	185 (5 studies)	⊕⊕⊕⊖ VERY LOW1,2,3 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.36 standard deviations higher (0.25 lower to 0.98 higher)
Laxative use (no. tablets)	92 (1 study)	⊕⊕⊕⊖ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use (no. tablets) in the intervention groups was 0.33 standard deviations lower (0.77 lower to 0.11 higher)
Vomiting	160 (3 studies)	⊕⊕⊕⊖ VERY LOW1,2,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.52 standard deviations lower (0.86 to 0.18 lower)
Symptom Checklist	62 (1 study)	⊕⊕⊕⊖ LOW1,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist in the intervention groups was 0.89 standard deviations lower (0.31 lower to 1.46 higher)
EDE - Dietary restraint	89 (2 studies)	⊕⊕⊕⊖ VERY LOW1,6,7 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - dietary restraint in the intervention groups was 0.92 standard deviations higher (0.60 lower to 2.43 higher)
EDE - Attitudes towards weight	89 (2 studies)	⊕⊕⊕⊖ VERY LOW1,6,8 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - attitudes towards weight in the intervention groups was 2.23 standard deviations higher (0.68 lower to 5.15 higher)
EDE - Attitudes towards shape	89 (2 studies)	⊕⊕⊕⊖ VERY LOW1,6,7		Not calculable for SMD values	The mean ede - attitudes towards shape in the intervention groups was

		due to risk of bias, inconsistency, imprecision			1.87 standard deviations higher (0.47 lower to 4.21 higher)
EDI - Bulimia	139 (2 studies)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 0.42 standard deviations lower (0.78 to 0.06 lower)
EDI - Drive for thinness	139 (2 studies)	⊕⊕⊕⊖ LOW8,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 1.64 standard deviations lower (2.05 to 1.22 lower)
EDI - Body dissatisfaction	149 (2 studies)	⊕⊕⊕⊖ VERY LOW3,5,10 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was 1.21 standard deviations lower (2.27 to 0.16 lower)
Social adjustment scale	62 (1 study)	⊕⊕⊕⊖ VERY LOW1,3,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean social adjustment scale in the intervention groups was 0.48 standard deviations higher (0.47 lower to 1.44 higher)
Remission - ITT	106 (3 studies)	⊕⊕⊕⊖ VERY LOW1,8 due to risk of bias, imprecision	RR 1.01 (0.6 to 1.69)	364 per 1000	4 more per 1000 (from 145 fewer to 251 more)
Vomiting <5 years or <18 binges/mo	41 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting <5 years or <18 binges/mo in the intervention groups was 1.81 standard deviations lower (2.55 to 1.07 lower)
Vomiting >5 years or .18 binges/mo	119 (2 studies)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting >5 years or .18 binges/mo in the intervention groups was 0.18 standard deviations lower (0.56 lower to 0.20 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU:Follow up

1 It was unclear how randomisation was conducted or if allocation concealment was performed. Assessors were blind but it was unclear if investigators or participants were blind. High drop outs were reported >20%.

2 For a continuous outcome, there were fewer than 400 participants.

3 Heterogeneity was detected I2 >50%
 4 It was unclear allocation concealment was performed. In Freeman, it was unclear if either participants, investigators or assessors were blind. In Thackway, the assessors were blind. High drop outs were reported >20%.
 5 95% CI crossed 1 MID (-0.5)
 6 Heterogeneity was detected I2 >80%
 7 95% CI crossed 1 MID (0.5)
 8 95% CI Crossed 2 MIDs (0.75 and 1.25).
 9 It was unclear how randomisation sequence was conducted or if allocation concealment was conducted. Only assessors were blind.
 10 It was unclear how random sequence was generated or if allocation concealment was performed. It was unclear if participants and investigators were blind, the assessors were blind.

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Table 176: Summary of findings table for behavioural therapy versus any other intervention at follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention Follow up	Risk difference with BN BT (95% CI)
Vomiting or purging FU	27 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting or purging fu in the intervention groups was 1.00 standard deviations higher (0.19 to 1.80 higher)
Bulimic episodes FU	27 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic episodes fu in the intervention groups was 0.93 standard deviations higher (0.13 to 1.73 higher)
EDE - Dietary restraint FU	27 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - dietary restraint fu in the intervention groups was 0.45 standard deviations higher (0.32 lower to 1.21 higher)
EDE- Shape concerns FU	27 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concerns fu in the intervention groups was 0.35 standard deviations higher (0.42 lower to 1.11 higher)
EDE - Weight concerns FU	27 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - weight concerns fu in the intervention groups was 0.07 standard deviations higher (0.69 lower to 0.82 higher)

Depression FU	74 (2 studies)	⊕⊕⊖⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.04 standard deviations higher (0.44 lower to 0.53 higher)
EDI - Drive for thinness FU	47 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness fu in the intervention groups was 0.78 standard deviations lower (1.41 to 0.15 lower)
EDI- Body dissatisfaction FU	27 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- body dissatisfaction fu in the intervention groups was 0.36 standard deviations higher (0.40 lower to 1.12 higher)
EDI - Bulimia FU	47 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia fu in the intervention groups was 0.34 standard deviations lower (0.96 lower to 0.28 higher)
Remission FU_ITT	75 (1 study)	⊕⊕⊖⊖ LOW1,6 due to risk of bias, imprecision	RR 0.50 (0.21 to 1.18)	40 per 100	20 fewer per 100 (from 32 fewer to 7 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how randomisation sequence was generated or if allocation concealment was conducted. Assessors were blind but it was unclear if investigators or participants were blind. High drop outs were reported >20%

2 95% CI crossed 1 MID (0.5)

3 For a continuous outcome, there were fewer than 400 participants.

4 It was unclear how randomisation sequence was generated or if allocation concealment was conducted. Across studies, it was unclear if either or all of the investigators, participants and assessors were blind. High drop outs were reported >20%.

5 95% CI crossed 1 MID (-0.5)

6 95% CI crossed 1 MID (0.75)

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Table 177: Summary of findings table for behavioural therapy (BT) versus wait list control (WLC) at the end of treatment for adults with bulimia nervosa.

Outcomes				Anticipated absolute effects
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	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Risk with WLC	Risk difference with BN BT (95% CI)
Binge frequency	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 1.11 standard deviations lower (1.72 to 0.5 lower)
Self-induced vomiting	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean self-induced vomiting in the intervention groups was 0.76 standard deviations lower (1.34 to 0.17 lower)
Laxative use (no. tablets)	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use (no. tablets) in the intervention groups was 0.75 standard deviations lower (1.33 to 0.16 lower)
Depression	34 (1 study)	⊕⊕⊖⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.04 standard deviations higher (0.64 lower to 0.71 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 It was unclear how random sequence was generated and if allocation concealment was conducted. It was unclear if either participants, assessors or investigators were blind. High dropouts were reported >20%.					
2 95% CI crossed 1 MID (-0.5).					
3 It was unclear if allocation concealment was conducted. It was unclear if either participants, assessors or investigators were blind. High dropouts were reported >20%.					
4 95% CI crossed 2 MIDs (-0.5 and 0.5).					

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Table 178: Summary of findings table for hybrid treatment versus other intervention at the end of treatment and at follow up in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN other/hybrid (95% CI)

Binge Eating	86 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.21 standard deviations lower (0.63 lower to 0.21 higher)
Symptom check list - 90	86 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom check list - 90 in the intervention groups was 0 standard deviations higher (0.42 lower to 0.42 higher)
Depression - Becks	86 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - becks in the intervention groups was 0.3 standard deviations lower (0.73 lower to 0.12 higher)
EDI - 1-6 ED symptoms	86 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - 1-6 ed symptoms in the intervention groups was 0.07 standard deviations lower (0.49 lower to 0.35 higher)
Binge Eating - Follow up	86 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating - follow up in the intervention groups was 0.36 standard deviations lower (0.79 lower to 0.07 higher)
Symptom check list - 90 Follow up	86 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom check list - 90 follow up in the intervention groups was 0 standard deviations higher (0.42 lower to 0.42 higher)
Depression - Becks Follow up	86 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - becks follow up in the intervention groups was 0.16 standard deviations lower (0.58 lower to 0.26 higher)
EDI -1-6 Follow up	86 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi -1-6 follow up in the intervention groups was 0.18 standard deviations lower (0.6 lower to 0.25 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 It was unclear how randomisation sequence was generated or if allocation concealment was conducted. Assessors were blind but it was unclear if investigators or participants were blind.
2 95% CI crossed 1 MID (-0.5).
3 For a continuous outcome, fewer than 400 participants were included.

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Table 179: Summary of findings table for CBT-ED versus wait list control (WLC) at the end of treatment for adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN CBT-ED (95% CI)
Laxative use (no. tablets)	52 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use (no. tablets) in the intervention groups was 0.36 standard deviations lower (0.68 to 0.05 lower)
Binge eating	113 (3 studies)	⊕⊖⊖⊖ VERY LOW2,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 1.35 standard deviations lower (1.79 to 0.91 lower)
Purge frequency	21 (1 study)	⊕⊕⊖⊖ LOW2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean purge frequency in the intervention groups was 2.00 standard deviations lower (3.08 to 0.91 lower)
Vomiting	92 (2 studies)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 1.56 standard deviations lower (2.03 to 1.08 lower)
Overall severity	194 (2 studies)	⊕⊕⊖⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean overall severity in the intervention groups was 1.92 standard deviations lower (2.28 to 1.56 lower)

EDI - Body dissatisfaction	41 (1 study)	⊕⊕⊕⊖ LOW2,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was 0.37 standard deviations lower (0.99 lower to 0.25 higher)
EDI - Drive for thinness	41 (1 study)	⊕⊕⊕⊖ LOW2,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 1.02 standard deviations lower (1.68 to 0.36 lower)
EDI - Bulimia	41 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 1.48 standard deviations higher (2.18 to 0.78 lower)
Symptom checklist - 90 items	154 (1 study)	⊕⊕⊕⊖ LOW2,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist - 90 items in the intervention groups was 0.71 standard deviations lower (1.05 to 0.36 lower)
General psychiatric features	123 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychiatric features in the intervention groups was 0.81 standard deviations lower (1.18 to 0.43 lower)
Depression	35 (1 study)	⊕⊕⊕⊖ LOW7,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 1.43 standard deviations lower (2.18 to 0.67 lower)
Vomiting episodes	153 (1 study)	⊕⊕⊕⊖ LOW9,11 due to risk of bias, imprecision	RR 0.84 (0.62 to 1.13)	600 per 1000	96 fewer per 1000 (from 228 fewer to 78 more)
Purging	154 (1 study)	⊕⊕⊕⊖ LOW11,12 due to risk of bias, imprecision	RR 0.82 (0.63 to 1.08)	647 per 1000	116 fewer per 1000 (from 239 fewer to 52 more)

Laxative misuse	154 (1 study)	⊕⊕⊕⊖ LOW11,12 due to risk of bias, imprecision	RR 0.65 (0.34 to 1.23)	255 per 1000	89 fewer per 1000 (from 168 fewer to 59 more)
EDE - Shape concern	40 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - shape concern in the intervention groups was 2.44 standard deviations lower (3.28 to 1.6 lower)
EDE - Weight concern	40 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - weight concern in the intervention groups was 2.44 standard deviations lower (3.28 to 1.6 lower)
Bulimic episodes	154 (1 study)	⊕⊕⊕⊖ LOW11,12 due to risk of bias, imprecision	RR 0.81 (0.57 to 1.13)	529 per 1000	101 fewer per 1000 (from 228 fewer to 69 more)
EDE - Dietary Restraint	40 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - dietary restraint in the intervention groups was 1.52 standard deviations lower (2.24 to 0.81 lower)
Did not achieve remission ITT	81 (1 study)	⊕⊕⊕⊖ LOW3,11 due to risk of bias, imprecision	RR 0.90 (0.77 to 1.06)	74 per 1000	7 fewer per 1000 (from 17 fewer to 4 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

1 It was unclear if allocation concealment was performed or if participants were blind.

2 95% CI crossed 1 MID (-0.5)

3 It was unclear if allocation concealment was performed. Across studies it was unclear if either or all of the participants, investigators or assessors were blind. High drop outs were reported >20%.

4 Heterogeneity >80%

5 It was unclear if allocation concealment was performed. In Agras 1999, assessors were blind but it was unclear if either participants or investigators were blind. It was unclear in Treasure 1994 if any were blind. High drop outs were reported >20%.

6 It was unclear if allocation concealment was conducted or if either the participants, investigators or assessors were blind. High drop outs were reported >20%.

7 For a continuous outcome, there were fewer than 400 participants.

8 It was unclear how random sequence was generated or if allocation concealment was conducted. It was unclear if either participants, investigators or assessors were blind. High drop outs were reported >20%

9 It was unclear how random sequence was generated or if allocation concealment was conducted. Participants were blind but it was unclear if assessors or investigators were blind. High drop outs were reported >20%

10 It was unclear if allocation concealment was performed. Assessors were blind but it was unclear if either participants or investigators were blind. High drop outs were reported >20%.

11 95% CI Crossed 1 MID (0.75)

12 It was unclear if allocation concealment was conducted. Assessors and investigators were blind but it was unclear if participants were blind.

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Table 180: Summary of findings table for dialectical behaviour therapy (DBT) versus another other intervention at the end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN DBT (95% CI)
Negative mood regulation score	29 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean negative mood regulation score in the intervention groups was 0.33 standard deviations lower (1.07 lower to 0.4 higher)
Depression- Becks	29 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression- becks in the intervention groups was 0.91 standard deviations lower (1.68 to 0.14 lower)
Emotional eating - anger/anxiety/depression	29 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean emotional eating - anger/anxiety/depression in the intervention groups was 0.7 standard deviations lower (1.46 lower to 0.07 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 It was unclear if either participants, investigators or assessors were blind.					
2 95% CI crossed 1 MID (-0.5).					

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Table 181: Summary of findings table for psychodynamic therapy compared to another intervention at the end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BN Psychodynamic General (95% CI)
Binge eating (28/d)	116 (2 studies)	⊕⊕⊕⊕ VERY LOW _{1,2,3,4} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean binge eating (28/d) in the intervention groups was 1.02 standard deviations higher (0.60 lower to 2.65 higher)
Vomiting/purging episodes (28d)	120 (2 studies)	⊕⊕⊕⊕ VERY LOW _{1,2,3,5} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean vomiting/purging episodes (28d) in the intervention groups was 1.46 standard deviations higher (0.05 lower to 2.97 higher)
EDE - Attitudes towards weight	120 (2 studies)	⊕⊕⊕⊕ VERY LOW _{1,2,3,6} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - attitudes towards weight in the intervention groups was 0.02 standard deviations higher (1.25 lower to 1.30 higher)
EDE - Dietary restraint	120 (2 studies)	⊕⊕⊕⊕ LOW _{1,2,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - dietary restraint in the intervention groups was 0.75 standard deviations higher (0.38 to 1.12 higher)
EDE - Attitudes towards shape	120 (2 studies)	⊕⊕⊕⊕ VERY LOW _{1,2,3,4} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede - attitudes towards shape in the intervention groups was 0.71 standard deviations lower (3.56 lower to 2.13 higher)
EDI - Drive for thinness	50 (1 study)	⊕⊕⊕⊕ LOW _{1,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 0.53 standard deviations higher (0.04 lower to 1.09 higher)
EDI -Bulimia	49 (1 study)	⊕⊕⊕⊕ LOW _{1,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi -bulimia in the intervention groups was 0.61 standard deviations higher (0.03 to 1.18 higher)
EDI - Body dissatisfaction	49 (1 study)	⊕⊕⊕⊕ LOW _{1,4}		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was

		due to risk of bias, imprecision			0.24 standard deviations higher (0.33 lower to 0.8 higher)
Depression	70 (1 study)	⊕⊕⊕⊕ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.78 standard deviations lower (1.27 to 0.29 lower)
General psychopathology	70 (1 study)	⊕⊕⊕⊕ LOW2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.36 standard deviations higher (0.11 lower to 0.83 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 It was unclear if allocation concealment was performed. Participants or investigators were not blind and it was unclear if assessors were blind.					
2 In Poulsen, it was unclear if participants or investigators were blind. Low drop outs. There was also a large difference in the duration of therapy, CBT-ED was 5 months versus psychodynamic was 19 months.					
3 Heterogeneity detected >80%					
4 95% CI crossed 1 MID (-0.5)					
5 95% CI crossed 1 MID (0.5)					
6 95% CI crossed 2 MIDs (-0.5 and 0.5)					

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Table 182: Summary of findings table for group behavioural therapy versus an alternative group behavioural therapy at the end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with BT.2 (ED)	Risk difference with BN Group BT (ED) (95% CI)
Vomiting	23 (1 study)	⊕⊕⊕⊕ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.06 standard deviations lower (0.87 lower to 0.76 higher)
Depression	23 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.35 standard deviations higher (0.48 lower to 1.17 higher)

Remission_ITT	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 1.00 (0.31 to 3.28)	267 per 1000	0 fewer per 1000 (from 184 fewer to 608 more)
Vomiting FU	24 (1 study)	⊕⊕⊕⊕ LOW ^{1,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting fu in the intervention groups was 0.65 standard deviations lower (1.48 lower to 0.17 higher)
Depression FU	23 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.47 standard deviations higher (0.36 lower to 1.3 higher)
Remission_ITT FU	30 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 2.50 (0.57 to 10.93)	133 per 1000	200 more per 1000 (from 57 fewer to 1000 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how they randomised or if they performed allocation concealment. It was unclear if either the participants, investigators or assessors were blinded. High dropout rates were detected >20% and a difference of greater than 10% in dropout rates were detected between two of the groups.

2 95% CI crossed 2 MIDs (-0.5 and 0.5).

3 95% CI crossed 1 MID (0.5).

4 95% CI Crossed 2 MIDs (0.75 and 1.25).

5 95% CI crossed 1 MID (-0.5).

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Table 183: Summary of findings table for CBT-ED versus wait list controls at the end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Group CBT-ED (95% CI)
Binge eating frequency	54 (2 studies)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating frequency in the intervention groups was 0.43 standard deviations lower (0.97 lower to 0.12 higher)

Purges (per week)	28 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean purges (per week) in the intervention groups was 0.33 standard deviations lower (1.08 lower to 0.42 higher)
Vomiting	24 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.9 standard deviations lower (1.74 to 0.05 lower)
Depression	24 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 1.81 standard deviations lower (2.79 to 0.84 lower)
EDI- Drive for thinness	26 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- drive for thinness in the intervention groups was 0.66 standard deviations lower (1.46 lower to 0.15 higher)
EDI - Bulimia	26 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - bulimia in the intervention groups was 0.38 standard deviations lower (1.17 lower to 0.4 higher)
EDI- Body Dissatisfaction	26 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- body dissatisfaction in the intervention groups was 0.67 standard deviations lower (1.47 lower to 0.13 higher)
No_Remission_ITT	52 (2 studies)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision	RR 0.86 (0.72 to 1.04)	38 per 1000	5 fewer per 1000 (from 11 fewer to 2 more)
No_Remission_ITT FU	59 (2 studies)	⊕⊕⊕⊕ LOW1,5 due to risk of bias, imprecision	RR 0.72 (0.55 to 0.94)	69 per 1000	19 fewer per 1000 (from 4 fewer to 31 fewer)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how randomisation was performed or if allocation concealment was performed. Neither the participant's investigators nor assessors were blind. High dropout rates were detected >20% and a difference of >10% was detected between the two groups in Less 1986.
 2 95% CI crossed 1 MID (-0.5).
 3 For a continuous outcome, there were fewer than 400 participants.
 4 For a dichotomous outcome, there were fewer than 300 events.
 5 95% CI crossed 1 MID (0.75).

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Table 184: Summary of findings table for group CBT-ED versus any other intervention at the end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Intervention	Risk difference with BN Group CBT (ED) (95% CI)
Binge eating frequency	206 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating frequency in the intervention groups was 0.08 standard deviations higher (0.19 lower to 0.36 higher)
EDI- Drive for thinness	206 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- drive for thinness in the intervention groups was 0.15 standard deviations higher (0.13 lower to 0.42 higher)
EDI - Bulimia	206 (3 studies)	⊕⊖⊖⊖ VERY LOW1,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 0.14 standard deviations higher (0.44 lower to 0.72 higher)
EDI- Body Dissatisfaction	206 (3 studies)	⊕⊖⊖⊖ VERY LOW1,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi- body dissatisfaction in the intervention groups was 0.16 standard deviations higher (0.33 lower to 0.66 higher)
EDI-Global	145 (2 studies)	⊕⊖⊖⊖ VERY LOW3,4,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi-global in the intervention groups was 0.07 standard deviations lower (0.57 lower to 0.42 higher)
EDE-Total	120 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-total in the intervention groups was 0.13 standard deviations higher (0.23 lower to 0.49 higher)

Clinical impairment	0 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical impairment in the intervention groups was 1.02 standard deviations lower (1.54 to 0.51 lower)
Symptom checklist	120 (1 study)	⊕⊕⊕⊖ LOW2,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist in the intervention groups was 0.07 standard deviations higher (0.27 lower to 0.43 higher)
Depression	211 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.07 standard deviations higher (0.21 lower to 0.34 higher)
Anxiety	120 (1 study)	⊕⊕⊕⊖ LOW2,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean anxiety in the intervention groups was 0.11 standard deviations lower (0.47 lower to 0.25 higher)
Vomiting	91 (2 studies)	⊕⊕⊕⊖ LOW5,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.45 standard deviations higher (0.02 to 0.87 higher)
Laxatives	56 (1 study)	⊕⊕⊕⊖ LOW5,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxatives in the intervention groups was 0.55 standard deviations higher (0.02 to 1.09 higher)
No_Remission_ITT	81 (1 study)	⊕⊕⊕⊖ LOW9,10 due to risk of bias, imprecision	RR 0.95 (0.86 to 1.05)	25 per 1000	1 fewer per 1000 (from 3 fewer to 1 more)
Binging frequency FU	205 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binging frequency fu in the intervention groups was 0.07 standard deviations higher (0.21 lower to 0.34 higher)
EDI- Body Dissatisfaction FU	205 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- body dissatisfaction fu in the intervention groups was 0.25 standard deviations lower (0.53 lower to 0.02 higher)

EDI - Bulimia FU	205 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia fu in the intervention groups was 0.06 standard deviations lower (0.33 lower to 0.22 higher)
EDI-Global FU	74 (1 study)	⊕⊕⊕⊖ LOW7,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-global fu in the intervention groups was 0.1 standard deviations lower (0.15 to 0.05 lower)
EDI- Drive for thinness FU	205 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- drive for thinness fu in the intervention groups was 0.11 standard deviations lower (0.39 lower to 0.16 higher)
EDE-Total FU	120 (1 study)	⊕⊕⊕⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-total fu in the intervention groups was 0.03 standard deviations lower (0.39 lower to 0.32 higher)
Vomiting FU	91 (2 studies)	⊕⊕⊕⊖ LOW5,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting fu in the intervention groups was 0.38 standard deviations higher (0.05 lower to 0.81 higher)
Depression FU	210 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.04 standard deviations lower (0.31 lower to 0.24 higher)
Laxatives FU	55 (1 study)	⊕⊕⊕⊖ LOW5,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxatives fu in the intervention groups was 0.59 standard deviations higher (0.05 to 1.13 higher)
Anxiety FU	120 (1 study)	⊕⊕⊕⊖ LOW3,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean anxiety fu in the intervention groups was 0.41 standard deviations lower (0.78 to 0.05 lower)
Symptom checklist FU	120 (1 study)	⊕⊕⊕⊖ LOW2,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist fu in the intervention groups was 0.14 standard deviations lower (0.49 lower to 0.22 higher)

Remission_ITT FU	126 (2 studies)	⊕⊕⊖⊖ LOW9,11 due to risk of bias, imprecision	RR 0.70 (0.32 to 1.56)	200 per 1000	60 fewer per 1000 (from 136 fewer to 112 more)
Clinical impairment FU	74 (1 study)	⊕⊕⊖⊖ LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical impairment fu in the intervention groups was 2.29 standard deviations lower (3.43 to 1.15 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 In some studies was unclear how randomisation was performed and in all studies it was unclear if allocation concealment was performed. It was either unclear or the participants, investigators or assessors were blind. High dropout rates were detected >20%.

2 For a continuous outcome, there were fewer than 400 participants.

3 95% CI crossed 1 MID (-0.5)

4 Heterogeneity was detected, I² >50%

5 95% CI crossed 1 MID (0.5)

6 It was unclear if allocation concealment was performed. The participants were not blinded and it was unclear if the investigators and assessors were blind.

7 It was unclear if allocation concealment was performed. The participants were not blinded, however, the investigators and assessors were blinded. It was unclear what the number of completers were.

8 It was unclear if allocation concealment was performed. Participants were not blinded in Chen, and It was either unclear in Wolf. It was also unclear if the investigators or assessors were blind.

9 It was unclear if allocation concealment was performed. It was unclear if the participants, investigators and assessors were blind. High dropout rates were detected >20% and a difference in dropout rates of more than 10%.

10 For a dichotomous outcome, there were fewer than 300 events.

11 95% CI Crossed 2 MIDs (0.75 and 1.25)

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Group therapy

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Table 185: Summary of findings table for group behavioural therapy versus wait list control (WLC) at the end of treatment and follow up in adults with bulimia nervosa

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Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Group BT(ED) (95% CI)

Binge eating frequency	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating frequency in the intervention groups was 0.15 standard deviations higher (0.63 lower to 0.93 higher)
Vomiting	35 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 1.22 standard deviations lower (1.99 to 0.45 lower)
EDI- Drive for thinness	26 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- drive for thinness in the intervention groups was 0.39 standard deviations lower (1.17 lower to 0.4 higher)
EDI - Bulimia	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - bulimia in the intervention groups was 0.2 standard deviations higher (0.58 lower to 0.98 higher)
EDI- Body Dissatisfaction	26 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- body dissatisfaction in the intervention groups was 0.73 standard deviations lower (1.54 lower to 0.08 higher)
Depression	35 (1 study)	⊕⊕⊕⊕ LOW ^{1,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 1.37 standard deviations lower (2.17 to 0.58 lower)
Did not achieve remission_ITT	44 (1 study)	⊕⊕⊕⊕ LOW ^{1,5} due to risk of bias, imprecision	RR 0.77 (0.6 to 0.99)	0 per 1000	-
Remission_ITT FU	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,6} due to risk of bias, imprecision	RR 1.07 (0.73 to 1.58)	286 per 1000	20 more per 1000 (from 77 fewer to 166 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how they randomised or if they performed allocation concealment. It was unclear whether the participants, investigators or assessors were blinded. High dropout rates were detected >20%.
 2 95% CI crossed 2 MIDs (-0.5 and 0.5).
 3 95% CI crossed 1 MID (-0.5).
 4 For a continuous outcome, there were fewer than 400 participants.
 5 95% CI crossed 1 MID (0.75).
 6.95% CI crossed 2 MIDs (0.75 and 1.25)

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Table 186: Summary of findings table for group behavioural therapy versus another group intervention at the end of treatment in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BN Group BT (ED) (95% CI)
Binge eating frequency	30 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating frequency in the intervention groups was 0.33 standard deviations higher (0.39 lower to 1.06 higher)
Vomiting	36 (1 study)	⊕⊕⊕⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.27 standard deviations lower (0.97 lower to 0.43 higher)
Depression	35 (1 study)	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.16 standard deviations higher (0.54 lower to 0.86 higher)
EDI- Drive for thinness	30 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- drive for thinness in the intervention groups was 0.25 standard deviations higher (0.47 lower to 0.97 higher)
EDI - Bulimia	30 (1 study)	⊕⊖⊖⊖ VERY LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 0.51 standard deviations higher (0.22 lower to 1.24 higher)
EDI- Body Dissatisfaction	30 (1 study)	⊕⊖⊖⊖ VERY LOW1,5		Not calculable for SMD values	The mean edi- body dissatisfaction in the intervention groups was

		due to risk of bias, imprecision			0.08 standard deviations lower (0.79 lower to 0.64 higher)
Did not achieve remission	60 (1 study)	⊕⊕⊕⊕ LOW3,6 due to risk of bias, imprecision	RR 0.76 (0.61 to 0.96)	33 per 1000	8 fewer per 1000 (from 1 fewer to 13 fewer)
Binge eating frequency FU	58 (2 studies)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating frequency fu in the intervention groups was 0.01 standard deviations lower (0.53 lower to 0.52 higher)
Vomiting FU	36 (1 study)	⊕⊕⊕⊕ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting fu in the intervention groups was 0.38 standard deviations lower (1.08 lower to 0.33 higher)
Depression FU	63 (2 studies)	⊕⊕⊕⊕ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.13 standard deviations higher (0.39 lower to 0.65 higher)
EDI - Drive for thinness FU	30 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness fu in the intervention groups was 0.24 standard deviations higher (0.48 lower to 0.96 higher)
EDI - Bulimia FU	30 (1 study)	⊕⊕⊕⊕ VERY LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia fu in the intervention groups was 0.02 standard deviations higher (0.69 lower to 0.74 higher)
EDI- Body Dissatisfaction FU	30 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- body dissatisfaction fu in the intervention groups was 0.35 standard deviations higher (0.37 lower to 1.07 higher)
EDE- Shape concern FU	28 (1)	⊕⊕⊕⊕ VERY LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern fu in the intervention groups was 0 standard deviations higher (0.77 lower to 0.77 higher)
EDE- Weight concern FU	28 (1 study)	⊕⊕⊕⊕ LOW1,2		Not calculable for SMD values	The mean ede- weight concern fu in the intervention groups was

		due to risk of bias, imprecision			0.34 standard deviations higher (0.44 lower to 1.12 higher)
EDE- Eating concern FU	20 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern fu in the intervention groups was 0 standard deviations higher (0.88 lower to 0.88 higher)
EDE- Restraint FU	28 (1 study)	⊕⊖⊖⊖ VERY LOW ^{3,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint fu in the intervention groups was 0 standard deviations higher (0.77 lower to 0.77 higher)
Remission_ITT FU	73 (2 studies)	⊕⊕⊖⊖ LOW ^{3,7} due to risk of bias, imprecision	RR 0.85 (0.53 to 1.35)	576 per 1000	86 fewer per 1000 (from 271 fewer to 202 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear methods of randomisation and allocation concealment. Neither the participants, investigators nor assessors were blinded.

2 95% CI crossed 1 MID (0.5).

3 Unclear how randomisation was performed or if allocation concealment was conducted. It was unclear if either the participants, investigators or assessors were blind. High dropouts >20% were reported in some groups.

4 95% CI crossed 1 MID (-0.5).

5 95% CI crossed 2 MIDs (0.5 and -0.5).

6 95% CI crossed 1 MID (0.75).

7 95% CI crossed 2 MIDs (0.75 and 1.25).

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Table 187: Summary of findings table for group psychoeducation versus any other intervention at the end of treatment in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with BN Group psychoeducation vs. Other (95% CI)
Binge eating	54 (1 study)	⊕⊕⊖⊖ LOW ^{1,2}		Not calculable for SMD values	The mean binge eating in the intervention groups was

		due to risk of bias, imprecision			0.2 standard deviations higher (0.33 lower to 0.74 higher)
Vomiting	54 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.44 standard deviations higher (0.11 lower to 0.98 higher)
Remission_ITT	65 (1 study)	⊕⊖⊖⊖ VEY LOW1,3 due to risk of bias, imprecision	RR 0.57 (0.23 to 1.42)	300 per 1000	129 fewer per 1000 (from 231 fewer to 126 more)
EDI-Drive for thinness	54 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-drive for thinness in the intervention groups was 0.62 standard deviations higher (0.08 to 1.17 higher)
EDI-Bulimia	54 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-bulimia in the intervention groups was 0.5 standard deviations higher (0.05 lower to 1.04 higher)
EDI-Body dissatisfaction	54 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-body dissatisfaction in the intervention groups was 0.12 standard deviations higher (0.41 lower to 0.66 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Neither the participants, investigators nor assessors appear blinded. There were differences detected at baseline, however a correlations analysis suggested it had no impact on the outcomes.

2 95% CI crossed 1 MID (0.5).

3 95% CI crossed 2 MIDs (0.75 and 1.25).

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Table 188: Summary of findings table for group CBT-ED (varied intensity) versus CBT (control low intensity) at the end of treatment in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT (control low)	Risk difference with BN CBT (varied intensity and focus) (95% CI)

Binging episodes	143 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binging episodes in the intervention groups was 0.37 standard deviations lower (0.76 lower to 0.02 higher)
Laxative use	143 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use in the intervention groups was 0.10 standard deviations higher (0.29 lower to 0.49 higher)
Vomiting episodes	143 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting episodes in the intervention groups was 0.4 standard deviations lower (0.79 to 0.01 lower)
EDI - Drive for thinness	143 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - drive for thinness in the intervention groups was 0.49 standard deviations lower (0.88 to 0.1 lower)
EDI - Bulimia	143 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - bulimia in the intervention groups was 0.85 standard deviations lower (1.25 to 0.45 lower)
EDI - Body dissatisfaction	143 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi - body dissatisfaction in the intervention groups was 0.03 standard deviations lower (0.41 lower to 0.36 higher)
Depression	143 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.1 standard deviations higher (0.29 lower to 0.48 higher)
Anxiety	143 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean anxiety in the intervention groups was 0.11 standard deviations higher (0.27 lower to 0.5 higher)
Did not achieve remission_ITT	143 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision	RR 0.42 (0.3 to 0.57)		106 fewer per 1000 (from 78 fewer to 127 fewer)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear method of randomisation and if allocation concealment was performed. Neither the participants, investigators nor assessors were blind.

2 95% CI crossed 1 MID (-0.5)

3 For a continuous variable, there were fewer than 400 participants.

4 For a dichotomous outcome, there were fewer than 300 participants.

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Table 189: Summary of findings table for group emotional and mind training versus any other intervention at end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Group Emotional and Mind Training (95% CI)
EDE-Global	74 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-global in the intervention groups was 0.1 standard deviations lower (0.59 lower to 0.39 higher)
EDE-Global FU	74 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-global fu in the intervention groups was 0.1 standard deviations higher (0.05 to 0.15 higher)
Clinical impairment	74 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical impairment in the intervention groups was 1.02 standard deviations higher (0.51 to 1.54 higher)
Clinical impairment FU	74 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical impairment fu in the intervention groups was 2.29 standard deviations higher (1.15 to 3.43 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Unclear if allocation concealment was performed. The participants were not blinded, however the investigators and assessors were blind. It was unclear how many participants dropped out of the study.

2 95% CI crossed 1 MID (-0.5).

3 For a continuous outcome, there were fewer than 400 participants.
4 95% CI crossed 1 MID (0.5).

1 **Table 190: Summary of findings table for group support versus any other intervention at end of treatment in adults with bulimia**
2 **nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Group Support (95% CI)
Change in depression scores	100 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean change in depression scores in the intervention groups was 0.06 standard deviations higher (0.4 lower to 0.52 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 It was unclear how random sequence was generated or if allocation concealment was performed. It was unclear if either the participants, investigators or assessors were blind. High dropouts were detected >20%.
2 95% CI crossed 1 MID (0.5).

3 **Self Help**

4 **Table 191: Summary of findings table for guided self-help (ED) (or self-help with support) versus any other intervention at end of**
5 **treatment and follow up in adults with bulimia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Guided SH (ED) (95% CI)
Binge eating	388 (6 studies)	⊕⊖⊖⊖ VERY LOW1,2,3,4 due to risk of bias, inconsistency, indirectness		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.18 standard deviations lower (0.38 lower to 0.02 higher)
Purging	80 (1 study)	⊕⊖⊖⊖ VERY LOW5,6,7 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.34 standard deviations higher (0.1 lower to 0.78 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Guided SH (ED) (95% CI)
Excessive exercising	187 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,8} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean excessive exercising in the intervention groups was 0.02 standard deviations higher (0.27 lower to 0.31 higher)
Vomiting	190 (5 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.18 standard deviations lower (0.4 lower to 0.05 higher)
Laxative use	243 (5 studies)	⊕⊕⊕⊕ LOW ^{1,3,9} due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use in the intervention groups was 0.33 standard deviations lower (0.58 to 0.07 lower)
Bulimic Inventory Index	112 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,7,10} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean bulimic inventory index in the intervention groups was 0.29 standard deviations higher (0.09 lower to 0.67 higher)
EDE- Eating concern	145 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,11} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.02 standard deviations higher (0.31 lower to 0.35 higher)
EDE- Shape concern	192 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,11} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.00 standard deviations lower (0.29 lower to 0.28 higher)
EDE- Weight concern	192 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,11} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.12 standard deviations lower (0.41 lower to 0.16 higher)
EDE- Restraint	192 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,11} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.03 standard deviations higher (0.25 lower to 0.32 higher)
EDE-Global	159 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{2,4,6,11}		Not calculable	The mean ede-global in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Guided SH (ED) (95% CI)
		due to risk of bias, inconsistency, indirectness, imprecision		for SMD values	0.10 standard deviations lower (0.41 lower to 0.22 higher)
EDI Body dissatisfaction	55 (1 study)	⊕⊕⊕⊖ LOW9,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.62 standard deviations lower (1.16 to 0.09 lower)
EDI Drive for thinness	56 (1 study)	⊕⊕⊕⊖ LOW4,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.48 standard deviations lower (1.01 lower to 0.06 higher)
EDI Bulimia	56 (1 study)	⊕⊕⊕⊖ LOW9,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia in the intervention groups was 0.71 standard deviations lower (1.25 to 0.17 lower)
Depression	280 (5 studies)	⊕⊖⊖⊖ VERY LOW2,3,4,13 due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.25 standard deviations higher (0.01 to 0.49 higher)
Remission - Adults_ITT	454 (4 studies)	⊕⊖⊖⊖ VERY LOW3,11,14 due to risk of bias, indirectness, imprecision	RR 1.01 (0.66 to 1.53)	162 per 1000	2 more per 1000 (from 55 fewer to 86 more)
Bulimic Inventory Index FU	47 (1 study)	⊕⊕⊕⊖ LOW14,15 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic inventory index fu in the intervention groups was 0.77 standard deviations higher (0.18 to 1.37 higher)
Bingeing FU	270 (4 studies)	⊕⊖⊖⊖ VERY LOW3,4,16 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean bingeing fu in the intervention groups was 0.04 standard deviations higher (0.2 lower to 0.28 higher)
Purging FU	52 (1 study)	⊕⊖⊖⊖ VERY LOW5,6,7 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean purging fu in the intervention groups was 0.40 standard deviations higher (0.15 lower to 0.95 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Guided SH (ED) (95% CI)
Vomiting FU	95 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,9,16} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean vomiting fu in the intervention groups was 0.25 standard deviations lower (0.66 lower to 0.16 higher)
Excessive Exercising FU	159 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,17} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean excessive exercising fu in the intervention groups was 0.02 standard deviations lower (0.33 lower to 0.3 higher)
Laxative use FU	216 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,9,16} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean laxative use fu in the intervention groups was 0.29 standard deviations lower (0.56 lower to 0.02 higher)
Depression FU	154 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,9,18} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.19 standard deviations lower (0.5 lower to 0.13 higher)
EDE- Eating concern FU	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{4,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- eating concern fu in the intervention groups was 0.25 standard deviations higher (0.29 lower to 0.8 higher)
EDE- Shape concern FU	99 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,19} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- shape concern fu in the intervention groups was 0.08 standard deviations lower (0.48 lower to 0.32 higher)
EDE- Weight concern FU	99 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,19} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- weight concern fu in the intervention groups was 0.09 standard deviations higher (0.31 lower to 0.48 higher)
EDE- Restraint FU	99 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,19} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- restraint fu in the intervention groups was 0.04 standard deviations higher (0.36 lower to 0.43 higher)
Satisfaction with life FU	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{5,6,9}		Not calculable	The mean satisfaction with life fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Guided SH (ED) (95% CI)
		due to risk of bias, indirectness, imprecision		for SMD values	0.08 standard deviations lower (0.62 lower to 0.47 higher)
EDI Body dissatisfaction FU	55 (1 study)	⊕⊕⊕⊖ LOW7,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction fu in the intervention groups was 0.1 standard deviations higher (0.43 lower to 0.63 higher)
EDI Drive for thinness FU	55 (1 study)	⊕⊕⊕⊖ LOW7,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu in the intervention groups was 0.23 standard deviations higher (0.3 lower to 0.77 higher)
EDI Bulimia FU	55 (1 study)	⊕⊕⊕⊖ LOW9,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia fu in the intervention groups was 0.23 standard deviations lower (0.76 lower to 0.31 higher)
Remission FU - Adults	454 (4 studies)	⊕⊖⊖⊖ VERY LOW3,11,20 due to risk of bias, indirectness, imprecision	RR 0.85 (0.59 to 1.14)	225 per 1000	34 fewer per 1000 (from 92 fewer to 32 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

1 It was unclear in all studies except Schmidt 2006 (where it was performed) if allocation concealment was performed. Across all studies it was unclear if patients were blind to treatment allocation, and in most studies it was unclear if the assessors and investigators were blind. High drop out rates were reported across studies.

2 Heterogeneity was detected I² >50%.

3 A mixed population of BN and EDNOS was used for a majority of the included studies, however, the BN made up the higher number.

4 For a continuous outcome, there were fewer than 400 participants.

5 It was unclear if they performed allocation concealment. It was unclear if participants or investigators were blind, however, assessors were blind. High drop outs were reported >20%.

6 A mixed population of BN and EDNOS was used, however, the BN made up the higher number.

7 95% CI crossed 1 MID (0.5).

8 It was unclear in all studies, except Schmidt 2006 if allocation concealment was performed. It was unclear across studies if participants and investigators were blind, assessors were blind in all studies but Schmidt. High drop outs were reported >20%.

9 95% CI crossed 1 MID (-0.5).

10 It was unclear in Durand 2003 if allocation concealment was performed, in Thiels it was not performed. Neither the investigators or assessors were blind

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Guided SH (ED) (95% CI)
<p>in Durand 2003, but it was unclear if participants were blind. In Thiels it was unclear if any were blind. High drop outs were reported >20%,</p> <p>11 Across studies it was unclear if allocation concealment was performed and if either or all of the participants, investigators, and assessors were blind. High drop out rates were reported >20</p> <p>12 It was unclear in Bailer 2004 how the randomisation sequence was generated and if allocation concealment was conducted. It was also unclear if either the participant, investigator or assessor was performed. High drop outs were detected >20%.</p> <p>13 It was unclear in all studies except Thiels 1998 (where it was not performed) if allocation concealment was performed. Across all studies it was unclear if patients were blind to treatment allocation, and in most studies it was unclear if the assessors and investigators were blind. High drop out rates were reported across studies >20%.</p> <p>14 95% CI crossed 2 MIDs (0.75 and 1.25)</p> <p>15 Allocation concealment was not performed and it was unclear if either the participants, investigators or assessors were blind. High drop out rates were detected >20%.</p> <p>16 It was unclear in Bailer 2004 how the randomised sequence was generated and it was unclear across all studies except Schmidt 2006 if allocation concealment was performed. In Mitchell 2008 and Wagner 2013 assessors were blind, but it was unclear if participants or investigators were blind. High drop outs were reported >20%.</p> <p>17 It was unclear if in Wagner 2013 if allocation concealment was performed, but it was in Schmidt 2006. It was unclear if participants or investigators were blind in both studies. In Schmidt the assessors were not blind at follow-up, yet in Wagner 2013 the assessors were blind. High drop outs were reported >20%.</p> <p>18 It was unclear in Bailer and Mitchell if allocation concealment was conducted but it was not performed in Thiels 1988. It was unclear across all studies if the participants, investigators or assessors were blind, except Mitchell 2008 the assessors were blind. High drop outs were reported >20%.</p> <p>19 It was unclear in Mitchell if allocation concealment was conducted but it was not performed in Thiels 1988. It was unclear if the participants, investigators or assessors were blind, except Mitchell 2008 the assessors were blind. High drop outs were reported >20%.</p> <p>20 95% CI crossed 1 MID (0.75).</p>					

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Table 192: Summary of findings table for guided self-help (ED) (or self-help with support) versus wait list control (WLC) at end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Guided SH (ED) (95% CI)
Bingeing	111 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for	The mean bingeing in the intervention groups was 0.46 standard deviations lower (0.84 to 0.08 lower)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Guided SH (ED) (95% CI)
				SMD values	
Vomiting	151 (2 studies)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.32 standard deviations lower (0.64 lower to 0.01 higher)
Use of laxatives	151 (2 studies)	⊕⊕⊕⊕ VERY LOW1,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean use of laxatives in the intervention groups was 0.55 standard deviations lower (1.80 lower to 0.69 higher)
Depression	220 (3 studies)	⊕⊕⊕⊕ VERY LOW1,2,3 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.53 standard deviations lower (0.8 to 0.26 lower)
Purging	178 (2 studies)	⊕⊕⊕⊕ VERY LOW1,2,3,4 due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.95 standard deviations lower (1.27 to 0.63 lower)
EDI Drive for thinness	178 (2 studies)	⊕⊕⊕⊕ VERY LOW2,3,5,6 due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.80 standard deviations lower (1.1 to 0.49 lower)
EDI Body dissatisfaction	178 (2 studies)	⊕⊕⊕⊕ VERY LOW2,3,5 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.81 standard deviations lower (1.12 to 0.51 lower)
EDI - Bulimia	69 (1 study)	⊕⊕⊕⊕ VERY LOW2,3,5		Not calculable for	The mean edi - bulimia in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Guided SH (ED) (95% CI)
		due to risk of bias, indirectness, imprecision		SMD values	0.15 standard deviations lower (0.62 lower to 0.32 higher)
EDE- Weight concern	178 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,5,6,7} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.82 standard deviations lower (1.13 to 0.51 lower)
EDE-Restraint	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede-restraint in the intervention groups was 0.31 standard deviations lower (0.78 lower to 0.17 higher)
EDE - Eating concern	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,8} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede - eating concern in the intervention groups was 1.19 standard deviations lower (1.71 to 0.68 lower)
EDE- Shape concern	178 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,5,6} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.70 standard deviations lower (1.01 to 0.4 lower)
EDE-Global	178 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,9} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede-global in the intervention groups was 1.31 standard deviations lower (1.64 to 0.99 lower)
Quality of life	178 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.59 standard deviations higher (0.29 to 0.89 higher)
Clinical Symptom Index	151 (2 studies)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for	The mean clinical symptom index in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Guided SH (ED) (95% CI)
				SMD values	0.38 standard deviations lower (0.71 to 0.06 lower)
Did not achieve remission_ITT	198 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{10,11,12} due to risk of bias, indirectness, imprecision	RR 0.86 (0.77 to 0.96)	70 per 1000	10 fewer per 1000 (from 3 fewer to 16 fewer)
Remission FU_ITT	89 (1 study)	⊕⊕⊕⊕ VERY LOW ^{11,13,14} due to risk of bias, indirectness, imprecision	RR 0.99 (0.44 to 2.23)	226 per 1000	2 fewer per 1000 (from 126 fewer to 278 more)
Purging <18 binges month	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean purging <18 binges month in the intervention groups was 2.07 standard deviations lower (2.66 to 1.47 lower)
Purging >18 binge month	88 (1 study)	⊕⊕⊕⊕ LOW ^{1,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean purging <18 binge month in the intervention groups was 0.49 standard deviations lower (0.87 to 0.11 lower)
EDE- Shape concern <18 binges month	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,7,8} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- shape concern <18 binges month in the intervention groups was 1.05 standard deviations lower (1.56 to 0.54 lower)
EDE- Shape concern >18 binges month	109 (1 study)	⊕⊕⊕⊕ LOW ^{3,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern >18 binges month in the intervention groups was 0.51 standard deviations lower (0.89 to 0.13 lower)
EDE- Weight concern <18 binges month	69 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,7,8} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede- weight concern <18 binges month in the intervention groups was 1.29 standard deviations lower (1.81 to 0.77 lower)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Guided SH (ED) (95% CI)
EDE- Weight concern >18 binges month	109 (1 study)	⊕⊕⊖⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern >18 binges month in the intervention groups was 0.56 standard deviations lower (0.95 to 0.18 lower)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio;</p> <p>1 It was unclear in all studies if allocation concealment was performed. How the randomisation sequence was generated in Walsh 2004 was unclear. Across the studies it was unclear if either or all the participants, investigators or assessors were blind. High dropout rates were reported >20%.</p> <p>2 Ljotsson 2007 contained a mixture of BED (52%) and BN (48%)</p> <p>3 95% CI crossed 1 MID (-0.5).</p> <p>4 Heterogeneity was detected I² >80%.</p> <p>5 It was unclear in all studies if allocation concealment was performed. In Banasiask 2005 the assessors were blind, but participants and investigators were not blind. In Ljotsson 2007 the participants were not blind but it was unclear if investigators and assessors were blind. High dropout rates were reported >20%.</p> <p>6 Heterogeneity was detected I² >50%.</p> <p>7 For a continuous outcome, there were fewer than 400 participants.</p> <p>8 It was unclear in all studies if allocation concealment was performed. In Ljotsson 2007 the participants were not blind but it was unclear if investigators and assessors were blind. High dropout rates were reported >20%.</p> <p>9 It was unclear in all studies if allocation concealment was performed. Across the studies it was unclear if either or all the participants, investigators or assessors were blind. High dropout rates were reported >20%.</p> <p>10 It was unclear in all studies if allocation concealment was performed. In Banasiask 2005 the assessors were blind, but participants and investigators were not blind. In Palmer 2002, it was unclear if participants, investigators and assessors were blind. High dropout rates were reported >20%.</p> <p>11 Palmer 2002 contained a mixed population of EDNOS (20%) and BN (80%)</p> <p>12 For a dichotomous outcome, there were fewer than 300 events.</p> <p>13 It was unclear if allocation concealment was performed. It was unclear if assessors, investigators or participants were blind. High drop outs were detected >20%.</p> <p>14 95% CI crossed 1 MID (1.25).</p>					

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Table 193: Summary of findings table for general self-help (or self-help without support) versus any other intervention at end of treatment in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Self-help (95% CI)
Depression	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision			The mean depression in the intervention groups was 0.52 standard deviations lower (1.05 lower to 0.01 higher)
EDE Global	32 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision			The mean ede global in the intervention groups was 0.82 standard deviations lower (1.55 to 0.1 lower)
EDE Restraint	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision			The mean ede restraint in the intervention groups was 0.20 standard deviations lower (0.73 lower to 0.32 higher)
EDE Eating concern	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision			The mean ede eating concern in the intervention groups was 0.45 standard deviations lower (0.98 lower to 0.08 higher)
EDE Shape Concern	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision			The mean ede shape concern in the intervention groups was 0.39 standard deviations higher (0.14 lower to 0.92 higher)
EDE Weight Concern	56 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision			The mean ede weight concern in the intervention groups was 0.47 standard deviations lower (1 lower to 0.06 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 In Carter 2003, the participants were not blinded, it was unclear if investigators were blind and the assessors were blind. Again, high drop outs were reported >20%					
2 95% CI crossed 1 MID (-0.5)					

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Table 194: Summary of findings table for general self-help (or self-help without support) versus wait list controls (WLC) at end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Self-help (95% CI)
Depression	56 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.02 standard deviations higher (0.5 lower to 0.54 higher)
EDE- Restraint	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.07 standard deviations lower (0.59 lower to 0.45 higher)
EDE-Shape concern	56 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern in the intervention groups was 0.08 standard deviations lower (0.6 lower to 0.44 higher)
EDE-Weight concern	56 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.00 standard deviations higher (0.52 lower to 0.52 higher)
EDE- Eating concern	56 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.0 standard deviations higher (0.52 lower to 0.52 higher)
Did not achieve remission_ITT	63 (1 study)	⊕⊕⊕⊕ VERY LOW ^{4,5,6} due to risk of bias, indirectness, imprecision	RR 0.94 (0.84 to 1.04)		-

Remission_ITT_FU	63 (1 study)	⊕⊕⊕⊕ VERY LOW ^{4,5,7} due to risk of bias, indirectness, imprecision	RR 0.97 (0.38 to 2.44)	226 per 1000	7 fewer per 1000 (from 140 fewer to 325 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 In Carter 2003, the participants were not blinded, it was unclear if investigators were blind and the assessors were blind. Again, high dropouts were reported >20%					
2 95% CI crossed 2 MIDs (-0.5 and 0.5)					
3 95% CI crossed 1 MID (-0.5)					
4 It was unclear if allocation concealment was performed. It was unclear if participants, assessors and investigators were blinded. High dropouts were reported >20%,					
5 Palmer 2002 contained a mixed population of EDNOS (20%) and BN (80%)					
6 For a dichotomous outcome, there were fewer than 300 events					
7 95% CI crossed 2 MIDs (0.75 and 1.25)					

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Table 195: Summary of findings table for self-help (ED) (or self-help without support) versus any other intervention at end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Self-help (ED) (95% CI)
Binge eating	162 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.49 standard deviations higher (0.17 to 0.81 higher)
Purging	70 (1 study)	⊕⊕⊕⊕ LOW ^{5,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.49 standard deviations higher (0.02 to 0.97 higher)
Use of laxatives	33 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean use of laxatives in the intervention groups was 0.10 standard deviations higher (0.58 lower to 0.78 higher)

Vomiting	96 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,8,9} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.85 standard deviations higher (0.41 to 1.29 higher)
Depression	56 (1 study)	⊕⊕⊕⊕ LOW ^{9,10} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.52 standard deviations higher (0.01 lower to 1.05 higher)
Exercising	33 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,7,11} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean exercising in the intervention groups was 0.1 standard deviations higher (0.58 lower to 0.79 higher)
Remission_ITT	173 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{12,13,14} due to risk of bias, indirectness, imprecision	RR 0.74 (0.32 to 1.7)	140 per 1000	36 fewer per 1000 (from 95 fewer to 98 more)
EDE-Global	132 (2 studies)	⊕⊕⊕⊕ LOW ^{5,9} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-global in the intervention groups was 0.2 standard deviations higher (0.15 lower to 0.55 higher)
EDE- Weight concern	118 (2 studies)	⊕⊕⊕⊕ LOW ^{9,15} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.23 standard deviations higher (0.14 lower to 0.61 higher)
EDE- Eating concern	56 (1 study)	⊕⊕⊕⊕ LOW ^{9,16} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.45 standard deviations higher (0.08 lower to 0.98 higher)
EDE- Shape concern	118 (2 studies)	⊕⊕⊕⊕ LOW ^{9,15} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.2 standard deviations higher (0.18 lower to 0.57 higher)
EDE- Restraint	118 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{8,9,15} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.71 standard deviations higher (0.32 to 1.1 higher)

Purging FU	70 (1 study)	⊕⊕⊕⊕ LOW4,17 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging fu in the intervention groups was 0 standard deviations higher (0.47 lower to 0.47 higher)
Binge eating FU	111 (2 studies)	⊕⊕⊕⊕ VERY LOW1,3,9 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.23 standard deviations higher (0.14 lower to 0.61 higher)
Vomiting FU	40 (1 study)	⊕⊕⊕⊕ VERY LOW3,7,11 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean vomiting fu in the intervention groups was 0.07 standard deviations higher (0.55 lower to 0.69 higher)
Excessive exercising FU	37 (1 study)	⊕⊕⊕⊕ VERY LOW3,7,11 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean excessive exercising fu in the intervention groups was 0.09 standard deviations higher (0.55 lower to 0.74 higher)
Use of laxatives FU	39 (1 study)	⊕⊕⊕⊕ VERY LOW3,7,9 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean use of laxatives fu in the intervention groups was 0.22 standard deviations higher (0.41 lower to 0.85 higher)
EDE-Global FU	70 (1 study)	⊕⊕⊕⊕ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-global fu in the intervention groups was 0.14 standard deviations lower (0.61 lower to 0.33 higher)
Remission FU	90 (1 study)	⊕⊕⊕⊕ VERY LOW11,12,13 due to risk of bias, indirectness, imprecision	RR 0.98 (0.43 to 2.2)	224 per 1000	4 fewer per 1000 (from 128 fewer to 269 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Whilst in Schmidt 2006, allocation concealment was performed it was unclear in the other studies. It was unclear in all studies if participants, investigators or assessors were blind. High dropouts were reported.>20%.

2 Heterogeneity detected I2 >50%.

3 Schmidt 2006 included a mixed population of BN and EDNOS

4 For a continuous outcome there were fewer than 400 participants.

- 5 It was unclear if allocation concealment was performed. It was also unclear if participants, investigators and assessors were blind. High dropouts were detected >20%.
- 6 95% CI crossed 1 MID (-0.5).
- 7 In Schmidt 2006, allocation concealment was performed. It was unclear in all studies if participants, investigators were blind. Assessors were blind at baseline but not at follow up. High dropouts were reported.>20%.
- 8 Heterogeneity was detected I2>80%
- 9 95% CI crossed 1 MID (0.5).
- 10 Allocation concealment was performed and assessors were blind. However, participants were not blind and it was unclear if investigators were. High dropouts were detected >20%.
- 11 95% CI crossed 2 MIDs (-0.5 and 0.5).
- 12 It was unclear if allocation concealment was performed. It was also unclear if either the participants, assessors or investigators were blind. High dropouts were reported >20%.
- 13 Palmer 2002 contained a mixed population of EDNOS (20%) and BN (80%)
- 14 95% CI crossed 2 MIDs (0.75 and 1.25).
- 15 Allocation concealment was performed in Carter 2003, however it was unclear if it was in the other study. In Carter, the participants were not blind but the assessors were. It was unclear in the other study/ies if either the participants, assessors or investigators were blind. High dropouts were reported >20%.
- 16 Allocation concealment was performed in Carter 2003. The participants were not blind but the assessors were. High dropouts were reported >20%.
- 17 it was unclear if allocation concealment was conducted. Assessors were blind but it was unclear if participants or participants were blind

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Table 196: Summary of findings table for internet self-help versus any other intervention at end of treatment and follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BN Internet SH (ED) (95% CI)
Binge eating	192 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.26 standard deviations lower (0.55 lower to 0.03 higher)
Purging	70 (1 study)	⊕⊕⊖⊖ LOW ^{4,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.49 standard deviations lower (0.97 to 0.02 lower)
Vomiting	122 (1 study)	⊕⊕⊖⊖ LOW ^{5,6} due to risk of bias, imprecision		Not calculable	The mean vomiting in the intervention groups was

				for SMD values	0.14 standard deviations higher (0.22 lower to 0.5 higher)
EDE-Q	70 (1 study)	⊕⊕⊕⊕ LOW4,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q in the intervention groups was 0.36 standard deviations lower (0.84 lower to 0.11 higher)
Laxative use	122 (1 study)	⊕⊕⊕⊕ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use in the intervention groups was 0.16 standard deviations higher (0.2 lower to 0.52 higher)
Excessive exercise	122 (1 study)	⊕⊕⊕⊕ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean excessive exercise in the intervention groups was 0.08 standard deviations higher (0.28 lower to 0.44 higher)
Remission_ITT	155 (1 study)	⊕⊕⊕⊕ LOW4,8 due to risk of bias, imprecision	RR 0.95 (0.44 to 2.01)	153 per 1000	8 fewer per 1000 (from 86 fewer to 154 more)
Binging FU	192 (2 studies)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binging fu in the intervention groups was 0.21 standard deviations lower (0.49 lower to 0.08 higher)
Remission FU_ITT	155 (1 study)	⊕⊕⊕⊕ VERY LOW1,8 due to risk of bias, imprecision	RR 1.66 (0.86 to 3.2)	153 per 1000	101 more per 1000 (from 21 fewer to 336 more)
EDE-Q FU	70 (1 study)	⊕⊕⊕⊕ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q fu in the intervention groups was 0.14 standard deviations higher (0.33 lower to 0.61 higher)
Purging FU	70 (1 study)	⊕⊕⊕⊕ LOW3,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging fu in the intervention groups was 0 standard deviations higher (0.47 lower to 0.47 higher)
Vomiting FU	122 (1 study)	⊕⊕⊕⊕ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting fu in the intervention groups was 0.04 standard deviations lower (0.4 lower to 0.32 higher)

Laxative use FU	122 (1 study)	⊕⊕⊕⊕ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use fu in the intervention groups was 0.18 standard deviations higher (0.18 lower to 0.54 higher)
Excessive exercise FU	122 (1 study)	⊕⊕⊕⊕ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean excessive exercise fu in the intervention groups was 0.01 standard deviations lower (0.37 lower to 0.35 higher)
Binge eating <18 per month	192 (1 study)	⊕⊕⊕⊕ LOW6,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating <18 per month in the intervention groups was 0.69 standard deviations lower (1.17 to 0.2 lower)
Bingeing >18 month	122 (1 study)	⊕⊕⊕⊕ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating >18 month in the intervention groups was 0.03 standard deviations lower (0.3 lower to 0.33 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; FU: Follow up

- 1 It was unclear allocation concealment was conducted. In Wagner 2013 assessors were blind but it was unclear if either the participants or investigators were blind. In Ruwaard 2013 it was unclear if either the participants, investigators or assessors were blind. High dropouts were reported >20%.
- 2 Heterogeneity was detected >50%
- 3 For a continuous outcome, there were fewer than 400 participants.
- 4 In Wagner 2013, it was unclear allocation concealment was conducted, or if either the participants, assessors or investigators were blind. High drop outs were reported >20%.
- 5 95% CI crossed 1 MID (0.5)
- 6 In Ruwaard 2013, it was unclear allocation concealment was conducted. Assessors were blind but it was unclear if either the participants or investigators were blind. High dropouts were reported >20%.
- 7 95% CI crossed 1 MID (-0.5)
- 8 95% CI crossed 2 MIDs (0.75 and 1.25).

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Table 197: Summary of findings table for internet self-help versus wait list control at end of treatment in adults with bulimia nervosa

Outcomes	No of Participants	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Internet SH (ED) (95% CI)

	(studies) Follow up				
Binge eating	137 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean binge eating in the intervention groups was 0.41 standard deviations lower (0.75 to 0.07 lower)
Purging	137 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean purging in the intervention groups was 0.37 standard deviations lower (0.71 to 0.04 lower)
Vomiting	137 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4} due to risk of bias, inconsistency, indirectness, imprecision		Not calculabl e for SMD values	The mean vomiting in the intervention groups was 0.09 standard deviations higher (0.25 lower to 0.43 higher)
Depression	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,6} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean depression in the intervention groups was 1.09 standard deviations lower (1.6 to 0.57 lower)
Quality of life	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,7} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean quality of life in the intervention groups was 0.7 standard deviations higher (0.19 to 1.2 higher)
Remission Not Achieved	76 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,8} due to risk of bias, indirectness, imprecision	RR 0.84 (0.71 to 0.98)	26 per 1000	4 fewer per 1000 (from 1 fewer to 8 fewer)
EDE-Q	137 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean ede-q in the intervention groups was 0.71 standard deviations lower (1.05 to 0.36 lower)

EDE- Restraint	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,6} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean ede- restraint in the intervention groups was 0.88 standard deviations lower (1.38 to 0.38 lower)
EDE- Shape concern	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,6} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean ede- shape concern in the intervention groups was 1.18 standard deviations lower (1.7 to 0.66 lower)
EDE- Weight concern	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,6} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean ede- weight concern in the intervention groups was 0.88 standard deviations lower (1.38 to 0.38 lower)
EDE- Eating concern	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,6} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean ede- eating concern in the intervention groups was 0.94 standard deviations lower (1.45 to 0.43 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was conducted. In Sanchez-Ortiz, the assessors were blind but it was unclear if either the investigators or participants were blind. In the other study, it was unclear if any were blind. High dropouts were reported >20%.

2 Sanchez-Ortiz 2011 included a mixed population of BN (51.3%) and EDNOS (48.7%)

3 For a continuous outcome, there were fewer than 400 participants.

4 Heterogeneity was detected, I² >80%

5 In Sanchez-Ortiz, it was unclear if allocation concealment was conducted. The assessors were blind but it was unclear if either the investigators or participants were blind. High dropouts were reported >20%.

6 95% CI crossed 1 MID (-0.5).

7 95% CI crossed 1 MID (0.5).

8 95% CI crossed 1 MID (0.75).

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Table 198: Summary of findings table for self-help (ED) (or self-help without support) versus wait list control at end of treatment in adults with bulimia nervosa

Outcomes			Anticipated absolute effects
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	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Risk with WLC	Risk difference with BN Self-help (ED) (95% CI)
Binge eating	130 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 1.23 standard deviations lower (3.95 lower to 1.49 higher)
Purging	70 (1 study)	⊕⊕⊕⊕ LOW ^{4,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.2 standard deviations higher (0.27 lower to 0.67 higher)
Vomiting	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,5,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.00 standard deviations higher (0.54 lower to 0.54 higher)
EDE-Q	130 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-q in the intervention groups was 1.25 standard deviations lower (3.41 lower to 0.92 higher)
Depression	57 (1 study)	⊕⊕⊕⊕ LOW ^{5,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.47 standard deviations higher (0.06 lower to 1 higher)
Remission_ITT	82 (1 study)	⊕⊕⊕⊕ VERY LOW ^{8,9} due to risk of bias, imprecision	RR 2.21 (0.51 to 9.52)	74 per 1000	90 more per 1000 (from 36 fewer to 631 more)
EDE- Restraint	117 (2 studies)	⊕⊕⊕⊕ LOW ^{8,10} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.07 standard deviations higher (0.31 lower to 0.44 higher)
EDE- Shape concern	117 (2 studies)	⊕⊕⊕⊕ LOW ^{6,8} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.74 standard deviations lower (1.18 to 0.29 lower)

EDE- Weight concern	117 (2 studies)	⊕⊕⊕⊖ LOW8,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.55 standard deviations lower (0.97 to 0.13 lower)
EDE- Eating concern	57 (1 study)	⊕⊕⊕⊖ LOW5,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.42 standard deviations higher (0.1 lower to 0.95 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was conducted. It was unclear if participants, investigators or assessors were blind, except in Mitchell 2008 assessors were not blind. High drop outs were reported >20%.

2 Heterogeneity was detected, I² >80%.

3 95% CI crossed 2 MIDs (-0.5 and 0.5).

4 It was unclear if allocation concealment was conducted. It was unclear if participants, investigators or assessors were blind. High dropouts were reported >20%.

5 95% CI crossed 1 MID (0.5).

6 95% CI crossed 1 MID (-0.5).

7 In Carter 2003, allocation concealment was conducted. Assessors were blind, but participants were not. It was unclear if investigators were blind. High dropouts were detected >20%.

8 In Carter 2003, allocation concealment was conducted, but it was unclear if it was conducted in Treasure. In Carter, assessors were blind, but participants were not. It was unclear if investigators were blind. It was unclear if any were blind in Treasure. High dropouts were detected >20%.

9 95% CI crossed 2 MIDs (0.75 and 1.25)

10 For a continuous outcome, there were fewer than 400 participants.

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Table 199: Summary of findings table for text messaging versus wait list control at end of treatment in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BN Text messaging (95% CI)
Remission_ITT	165 (1 study)	⊕⊖⊖⊖ VERY LOW1,2,3 due to risk of bias, indirectness, imprecision	RR 1.42 (0.99 to 2.02)	361 per 1000	152 more per 1000 (from 4 fewer to 369 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 it was unclear how the randomisation sequence was generated or if allocation concealment was conducted. It was unclear if either the participants, investigators or assessors were blind.

2 Included a mixed population of BN 60% and EDNOS 40%.

3 95% CI crossed 1 MID (1.25).

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Family therapy

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Table 200: Summary of findings table for family therapy for eating disorders versus any individual therapy at end of treatment in young people with bulimia nervosa

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Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Family therapy-ED (95% CI)
Remission	295 (3 studies) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4,5} due to risk of bias, indirectness, imprecision	RR 1.27 (0.87 to 1.86)	248 per 1000	67 more per 1000 (from 32 fewer to 214 more)
Binge Frequency	157 (2 studies) 12 months	⊕⊕⊕⊕ LOW ^{1,2,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.09 standard deviations lower (0.4 lower to 0.23 higher)
Abstinence from vomiting EATATE	63 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias, indirectness, imprecision	RR 0.87 (0.41 to 1.85)	323 per 1000	42 fewer per 1000 (from 190 fewer to 274 more)
Purge Frequency	86 (1 study) 12 months	⊕⊕⊕⊕ LOW ^{2,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean purge frequency in the intervention groups was 0.33 standard deviations lower (0.75 lower to 0.1 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Family therapy-ED (95% CI)
Vomit Frequency EDE	71 (1 study) 6 months	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomit frequency in the intervention groups was 0.64 standard deviations lower (1.12 to 0.16 lower)
EDE Global	155 (2 studies) 12 weeks	⊕⊕⊖⊖ LOW1,2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.38 standard deviations lower (0.69 to 0.06 lower)
EDE Restraint	71 (1 study) 6 months	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint in the intervention groups was 0.51 standard deviations lower (0.98 to 0.04 lower)
EDE Shape Concern	71 (1 study) 6 months	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.54 standard deviations lower (1.01 to 0.07 lower)
EDE Weight Concern	71 (1 study) 6 weeks	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.48 standard deviations lower (0.95 to 0.01 lower)
Yale-Brown-Cornell Eating Disorder Scale	86 (1 study) 12 weeks	⊕⊕⊖⊖ LOW2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean yale-brown-cornell eating disorder scale in the intervention groups was 0.36 standard deviations lower (0.78 lower to 0.07 higher)
Depression BDI	157 (2 studies) 12 months	⊕⊕⊖⊖ LOW1,2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.28 standard deviations lower (0.6 lower to 0.03 higher)
Hospitalized during treatment phase	109 (1 study) 12 months	⊕⊕⊖⊖ LOW2,5 due to risk of bias, imprecision	RR 0.09 (0.01 to 0.7)	207 per 1000	188 fewer per 1000 (from 62 fewer to 205 fewer)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Family therapy-ED (95% CI)
Service User Experience Helping Relationship Questionnaire	68 (1 study) 6 months	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean service user experience in the intervention groups was 0.06 standard deviations higher (0.42 lower to 0.53 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Le Grange 2007: Unclear randomization method and allocation concealment, no participant, investigator nor assessor blinding.					
2 Le Grange 2015: Unclear randomization method and allocation concealment, no participant nor investigator blinding.					
3 Schmidt 2007: Unclear randomization and allocation concealment, No participant nor investigator blinding.					
4 Schmidt 2007: Sample consists of 61 bulimia nervosa and 24 EDNOS.					
5 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
6 <300 events (dichotomous outcome) or <400 participants (continuous outcome).					
7 CI crosses both 0.75 and 1.25 (Risk Ratio).					

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Table 201: Summary of findings table for family therapy for eating disorders versus any individual therapy at follow up in young people with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Family Therapy-ED (95% CI)
Remission FU	215 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,3,4 due to risk of bias, indirectness, imprecision	RR 1.69 (1.11 to 2.57)	254 per 1000	175 more per 1000 (from 28 more to 399 more)
Binge Frequency FU	137 (2 studies)	⊕⊕⊖⊖ LOW1,5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0.1 standard deviations lower (0.44 lower to 0.24 higher)
Abstinence from vomiting FU EATATE	54 (1 study)	⊕⊖⊖⊖ VERY LOW4,7	RR 0.92 (0.56 to 1.51)	560 per 1000	45 fewer per 1000 (from 246 fewer to 286 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Family Therapy-ED (95% CI)
		due to risk of bias, imprecision			
Purge Frequency FU	69 (1 study)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean purge frequency fu in the intervention groups was 0 standard deviations higher (0.48 lower to 0.48 higher)
Vomit Frequency FU EDE	68 (1 study)	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomit frequency fu in the intervention groups was 0.17 standard deviations lower (0.65 lower to 0.3 higher)
EDE Global FU	137 (2 studies)	⊕⊕⊕⊖ LOW1,3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.38 standard deviations lower (0.72 to 0.04 lower)
EDE Restraint FU	68 (1 study) 6 weeks	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint fu in the intervention groups was 0.38 standard deviations lower (0.86 lower to 0.1 higher)
EDE Shape Concern FU	68 (1 study) 6 months	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern fu in the intervention groups was 0.58 standard deviations lower (1.06 to 0.09 lower)
EDE Weight Concern FU	68 (1 study) 6 months	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern fu in the intervention groups was 0.46 standard deviations lower (0.94 lower to 0.02 higher)
Yale-Brown-Cornell Eating Disorder Scale FU	69 (1 study) 12 months	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean yale-brown-cornell eating disorder scale fu in the intervention groups was 0.37 standard deviations lower (0.85 lower to 0.11 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other intervention	Risk difference with Family Therapy-ED (95% CI)
Depression FU	137 (2 studies) 12 months	⊕⊕⊖⊖ LOW1,5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.1 standard deviations lower (0.43 lower to 0.24 higher)
Service User Experience FU Helping Relationship Questionnaire	71 (1 study) 6 months	⊕⊕⊖⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean service user experience fu in the intervention groups was 0.41 standard deviations lower (0.88 lower to 0.06 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Le Grange 2015: Unclear randomization method and allocation concealment, no participant nor investigator blinding.					
2 Schmidt 2007: Sample consists of 61 bulimia nervosa and 24 EDNOS					
3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
4 Schmidt 2007: Unclear randomization and allocation concealment, No participant nor investigator blinding.					
5 Le Grange 2007: Unclear randomization method and allocation concealment, no participant, investigator nor assessor blinding.					
6 <300 events (dichotomous outcome) or <400 participants (continuous outcome).					
7 CI crosses both 0.75 and 1.25 (Risk Ratio).					

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1 7.2.3 Economic evidence

2 7.2.3.1 Systematic literature review

3 The systematic search of the economic literature undertaken for the guideline identified:

- 4 • One US study on the cost effectiveness of CBT-ED in adults with bulimia nervosa or
5 EDNOS subsyndromal variants of bulimia nervosa (Crow et al., 2009);
- 6 • One UK study on the cost effectiveness of family therapy (FT) compared with CBT ED in
7 young people (13-20 years) with bulimia nervosa and EDNOS (Schmidt et al., 2007a).

8 References to included studies and evidence tables for all economic evaluations included in
9 the systematic literature review are provided in Appendix P. Completed methodology
10 checklists of the studies are provided in Appendix O. Economic evidence profiles of studies
11 considered during guideline development (that is, studies that fully or partly met the
12 applicability and quality criteria) are presented in Appendix Q.

13 Crow (2009) evaluated the cost effectiveness of a CBT-ED compared with guided self-help
14 ED in adults with bulimia nervosa or EDNOS subsyndromal variants of bulimia nervosa in the
15 US. The economic analysis was conducted alongside an RCT (Mitchell 2008) (N=128). CBT
16 comprised 20 sessions of treatment over 16 weeks. The analysis was conducted from the
17 intervention provider (plus travel costs) perspective. The study considered a range of costs
18 including treatment (initial evaluation, laboratory evaluation and psychotherapy visits) and
19 travel time for therapists and participants (time and fuel). The resource use estimates were
20 based on the RCT (N=128). The unit costs were obtained from national sources (Medicare
21 and Medicaid reimbursement rates). The measure of outcome for the economic analysis was
22 remission, defined as abstinence from binge eating and purging. The time horizon of the
23 analysis was 12 months.

24 CBT-ED resulted in a greater proportion of people achieving full remission at 12 months
25 compared with guided self-help ED (28.8% versus 22.6%, respectively; a difference of 6.2%).
26 The mean total costs per participant over 12 months were \$2,684 for the CBT-ED and
27 \$1,648 for guided self-help ED, a difference of \$1,036 in 2005 US dollars. Statistical
28 significance levels were not reported for differences in costs and outcomes. The incremental
29 cost-effectiveness ratio (ICER) of CBT-ED when compared with guided self-help ED was
30 \$16,708 per additional participant in remission. Bootstrapping indicated that in 78.9% of
31 iterations guided self-help ED was less effective but also less costly than CBT-ED while in
32 the 21.1% iterations guided self-help ED was both more effective and less costly (that is,
33 guided self-help ED was dominant).

34 Deterministic sensitivity analysis showed that the results were robust to the assumptions.
35 Assuming full clinical prices for treatments (as opposed to the reimbursement rates) CBT-ED
36 resulted in an ICER of \$16,155 per additional remitter when compared with guided self-help
37 ED; assuming 2008 gasoline prices (as opposed to 2005 prices) the ICER increased to
38 \$17,547; and assuming built in video camera for guided self-help ED (no additional charges
39 for the telemedicine component) the ICER increased to \$19,308.

40 The analysis was judged by the committee to be partially applicable to the NICE decision-
41 making context, as it has been conducted in the US. The authors did not attempt to estimate
42 quality adjusted life years (QALYs) which made it difficult for the committee to interpret the
43 cost-effectiveness results and to compare the findings with other studies. However, overall,
44 given the data limitations in this area, this was a well conducted study and was judged by the
45 committee to have only minor methodological limitations.

1 Schmidt and colleagues (2007a) evaluated the cost effectiveness of a family therapy (FT)
2 compared with CBT-ED in young people (13-20 years) with bulimia nervosa and EDNOS
3 alongside an RCT (Schmidt 2007) (N=85 at baseline, N=63 at 6 months, N=54 at 12 months)
4 conducted in the UK. In the study CBT-ED was referred to as 'CBT-ED guided self-care' but
5 was classified by the committee as a form of CBT-ED. The FT involved up to 13 sessions
6 with family members and two individual sessions over a six month period and CBT-ED
7 involved 10 weekly sessions, three monthly follow up sessions and 2 optional sessions with a
8 close other (such as, parent or guardian). The main analysis was conducted from a societal
9 perspective (health care, social care, education, productivity costs and out-of-pocket
10 expenses). The costs were stratified and could be estimated from the NHS and personal
11 social services (PSS) perspective only. The study considered a range of educational costs
12 (home tuition, individual help in classes, classes in a special unit, contacts with school nurse,
13 educational psychologist and educational welfare officer, additional meetings with tutors and
14 other educational supports), hospital services (inpatient care, A&E department visits,
15 outpatient appointments and day hospital attendances), primary care (health visitor, GP,
16 dentist and optician), specialist services (child development or guidance centre, dietitian,
17 family or individual therapy and contacts with a psychiatrist or psychologist), medication,
18 social care (social work, after-school clubs and other social care supports), family member's
19 service use (GP, outpatient appointments and psychiatrist and psychologist), lost
20 employment and out-of-pocket expenses. The resource use estimates were based on the
21 RCT (N=83, N=61 at 6 month follow up and N=53 at 12 month follow up). The unit costs
22 were obtained from national sources. The measures of outcome for the economic analysis
23 included the proportion of participants abstinent from binge eating, abstinent from vomiting
24 and abstinent from binge eating and purging combined. The time horizon of the analysis was
25 12 months. The results were reported at the end of treatment (6 months) and at 12 months.

26 CBT-ED resulted in a greater proportion of participants abstinent from binge eating at the
27 end of treatment (0.42 versus 0.25, respectively; a difference of 0.17, $p=0.03$). At 12 months
28 CBT-ED resulted in fewer participants abstinent from binge eating (0.52 versus 0.55; a
29 difference of 0.03; p -value was not significant). CBT-ED also resulted in a greater proportion
30 of participants abstinent from vomiting at six months (0.32 versus 0.28; a difference of 0.04,
31 p -value was not significant) and at 12 months (0.56 versus 0.52; a difference of 0.04, p -value
32 was not significant). When looking at the proportion abstinent from binge eating and vomiting
33 combined CBT-ED resulted in a greater proportion of participants abstinent at six months
34 (0.19 versus 0.13, a difference of 0.07, p -value was not significant), but not at 12 months
35 (0.36 versus 0.41; a difference of 0.05, p -value was not significant).

36 The mean NHS and PSS costs at the end of treatment (six months) were £319 for FT and
37 £849 for CBT-ED, a difference of £530 (in favour of FT) in likely 2006 prices. The mean NHS
38 and PSS costs at 12 months were £691 for FT and £1,286 for CBT-ED, a difference of £595
39 (in favour of FT). Significance levels were not reported.

40 When considering costs from a societal perspective the mean costs at the end of treatment
41 were £720 for FT and £1,096 for CBT-ED, a difference of £377 (in favour of FT) and at 12
42 months the mean costs per participant were £1,269 for FT and £1,657 for CBT-ED, a
43 difference of £388 (in favour of FT), p -values were not significant.

44 Using the proportion of participants abstinent from binge eating at the end of treatment (6
45 months) from the NHS and PSS perspective CBT-ED results in an ICER of £3,120 per
46 additional abstinent person. At six months from a societal perspective CBT-ED results in an
47 ICER of £2,216 per additional abstinent person. At 12 month follow up FT dominates CBT-
48 ED (that is, it results in lower costs and also greater proportion abstinent from binge eating
49 and purging combined).

1 The analysis was judged by the committee to be partially applicable to the NICE decision-
2 making context. The authors did not attempt to estimate quality adjusted life years (QALYs)
3 which made it difficult to interpret the cost-effectiveness results and to compare the findings
4 with other studies. However, overall, given the data limitations in this area, this was a well
5 conducted study and was judged by the committee to have only minor methodological
6 limitations.

7 **7.2.3.2 Economic modelling**

8 A decision-analytical model was developed to assess the relative cost effectiveness of
9 interventions for adults with BN. The rationale for economic modelling, the methodology
10 adopted, the results and the conclusions from this economic analysis are described in detail
11 in Appendix S. This section provides a summary of the methods employed and the results of
12 the economic analysis.

13 **137.2.3.2.1 Overview of methods**

14 A decision-analytic model in the form of a decision-tree was constructed to evaluate the
15 relative cost effectiveness of psychological interventions over 1.4 years. The psychological
16 interventions assessed were self-help with support (referred to as guided self-help ED in
17 clinical evidence) and CBT-ED individual. The model also considered no treatment (wait list)
18 as a comparator. The choice of treatments assessed in the economic analysis was
19 determined by the availability of respective clinical data (full remission at the end of
20 treatment) included in the guideline systematic literature review. The economic analysis
21 considered effective treatments, as demonstrated by the systematic review of clinical
22 evidence, that were deemed appropriate by the committee as treatment options for people
23 with BN in the UK. The study population comprised of adults with BN.

24 Clinical data were derived from studies included in the guideline systematic review of clinical
25 evidence and other published literature. Clinical data (that is, full remission at the end of
26 treatment) were analysed using mixed treatment comparison technique. Full remission was
27 defined as cessation of BN-related symptoms over and above two weeks. The inconsistency
28 checks were also undertaken. Details on the methods and clinical data utilised in the NMA
29 that was undertaken to estimate full remission for each treatment option considered in the
30 economic analysis are presented in Appendix R. Results of inconsistency checks are
31 presented in the Appendix N.

32 The measure of outcome in the economic analysis was the number of QALYs gained. The
33 perspective of the analysis was that of NHS and PSS. Resource use was based on the
34 published literature and the committee expert opinion. National UK unit costs were used. The
35 cost year was 2015. Two methods were employed for the analysis of input parameter data
36 and presentation of the results. First, a deterministic analysis was undertaken, where data
37 were analysed as point estimates and results were presented in the form of ICERs following
38 the principles of incremental analysis. A probabilistic analysis was subsequently performed in
39 which most of the model input parameters were assigned probability distributions.
40 Subsequently, 10,000 iterations were performed, each drawing random values out of the
41 distributions fitted onto the model input parameters. Mean costs and QALYs for each
42 treatment option were calculated by averaging across the 10,000 iterations. This approach
43 allowed more comprehensive consideration of the uncertainty characterising the input
44 parameters and captured the non-linearity characterising the economic model structure.
45 Results of probabilistic analysis were also summarised in the form of cost effectiveness
46 acceptability curves, which express the probability of each intervention being cost effective at
47 various levels of willingness-to-pay per QALY gained (that is, at various cost-effectiveness

1 thresholds). As part of the sensitivity analyses two different bias adjustment scenarios were
2 tested pertaining to the estimation of treatment effects in the network meta-analysis. The
3 scenarios tested included: in trials of active treatments versus waitlist, active treatments were
4 favoured; all active treatments were favoured against wait list and CBT was favoured against
5 other active treatments. Results of bias adjustment analyses are presented in the Appendix
6 T.

7 The committee expressed the opinion that CBT is associated with long-term benefits, as the
8 effect is sustained over a longer period of time than the time horizon of the analysis. As the
9 longer-term benefits of CBT were not fully captured by the base-case analysis, a secondary
10 analysis was undertaken, in which the time horizon of the analysis was extended to five
11 years. The secondary analysis also included the scenario where the relapse rate associated
12 with CBT-ED individual was assumed to be zero (that is, all people sustained treatment
13 effect and no-one relapse) whereas the relapse rate for self-help with support and wait list
14 was assumed to be equivalent to the annual relapse rate of 0.27 (this rate was applied during
15 each year of the long-term follow-up).

167.2.3.2.2 **Findings of the NMA and base-case economic analysis**

17 The results of the NMA indicated that wait list had the lowest probability of full remission at
18 16 weeks (mean 0.10), followed by self-help with support (0.32) and CBT-ED individual
19 (0.32). Both CBT-ED individual and self-help with support showed a significant effect
20 compared with wait list. There was no significant difference between CBT-ED individual and
21 self-help with support. The odds ratio of CBT-ED individual versus self-help with support was
22 1.14 (95% CrI: 0.36 to 2.81). The inconsistency checks did not identify any significant
23 inconsistency in the direct and indirect evidence included in the NMA. The bias adjustment
24 sensitivity analysis suggested that bias due to small study effects may be exaggerating the
25 treatment effects in this network. However, as the bias coefficient included 0 in all scenarios
26 and there was no reduction in heterogeneity as a result of the bias adjustment, no strong
27 conclusions about the presence of bias could be made. This strengthens the conclusions
28 from the base-case analysis.

29 According to deterministic analysis, self-help with support was the most cost-effective option
30 with a cost per QALY of £8,822 versus wait list that is well below lower NICE cost-
31 effectiveness threshold of £20,000 per QALY. CBT-ED individual was not cost effective as its
32 ICER versus self-help with support was more than £1 million per QALY. According to
33 sensitivity analysis the results were sensitive to the probability of remission associated with
34 the self-help with support, the utility value for remission, and intervention costs. The results
35 were robust under all scenarios examined in bias adjustment analyses. Conclusions of
36 probabilistic analysis were similar to those of deterministic analysis. At the lower NICE cost-
37 effectiveness threshold of £20,000 per QALY (NICE, 2008b) the probability of self-help with
38 support being cost effective was 0.80 and it increased to 0.89 at the upper threshold of
39 £30,000 per QALY.

407.2.3.2.3 **Findings of the secondary economic analysis**

41 According to the secondary analysis, where the impact of extending the time horizon of the
42 analysis to five years was explored, the ICER of CBT-ED individual versus self-help with
43 support always remained above upper NICE threshold of £30,000 per QALY. However, the
44 ICER of CBT-ED individual versus wait list at five years was reduced to £8,171 per QALY
45 (from £55,100 per QALY at 1 year follow up). The ICER associated with CBT-ED individual
46 was reduced to the lower NICE cost-effectiveness threshold by approximately 2.5 years
47 follow up. At five years the conclusions of probabilistic analysis were similar to those of
48 deterministic analysis (that is, self-help with support remained the preferred treatment

1 option). At lower NICE cost-effectiveness threshold of £20,000 per QALY the probability of
2 self-help with support and CBT-ED individual being cost effective was 0.60 and 0.37,
3 respectively. When comparing only CBT-ED individual with wait list the probability of CBT-ED
4 individual and wait list being cost effective at lower NICE cost-effectiveness threshold of
5 £20,000 per QALY was 0.60 and 0.40, respectively. The probability of CBT-ED individual
6 being cost effective increased to 0.65 at upper NICE cost-effectiveness threshold of £30,000
7 per QALY.

8 Similarly, in the scenario where the relapse rate associated with CBT-ED individual was
9 assumed to be zero (that is, everyone sustains the treatment effect) and the annual relapse
10 rate associated with self-help with support and wait list was assumed to be equivalent to the
11 baseline rate of 0.27 (which was applied every year during the long term follow-up) the ICER
12 of CBT-ED individual versus self-help with support was reduced to £35,578. However, it was
13 still above upper NICE cost-effectiveness threshold (that is, self-help with support was still
14 the preferred treatment option). The ICER of CBT-ED individual versus wait list was reduced
15 to £3,788.

16 At the long-term follow up self-help with support remained the cost-effective option. Only,
17 when CBT-ED individual was compared with wait list the ICER of CBT-ED individual was
18 reduced below lower NICE cost-effectiveness threshold and supported the committee's view
19 that CBT-ED individual has potentially more favourable cost effectiveness in the long run.

207.2.3.2.4 **Strengths and limitations**

21 Clinical data on remission were synthesised using network meta-analytic techniques. Such
22 methods enabled evidence synthesis from both direct and indirect comparisons between
23 treatments. The base-case economic analysis considered only data on remission at the end
24 of treatment. However, the secondary analysis was undertaken where the time horizon of the
25 analysis was extended to five years. Due to the lack of suitable data the cost estimates
26 during the follow up were based on the committee expert opinion.

27 **7.2.4 Clinical evidence statements for people with bulimia nervosa**

28 **7.2.4.1 Individual Therapy**

29 **CBT-ED versus another intervention in adults with bulimia nervosa at end of** 30 **treatment.**

31 Very low quality evidence from five RCTs (n=359) showed CBT-ED is more effective on
32 purging compared with any other intervention.

33 Low quality evidence from ten RCTs (n=387) showed CBT-ED is more effective on binge
34 eating compared with any other intervention.

35 Very low quality evidence from seven RCTs (n=484) showed CBT-ED is more effective on
36 vomiting compared with any other intervention.

37 Very low quality evidence from two RCTs (n=238) showed no difference in the effect of CBT-
38 ED on laxative use compared with any other intervention.

39 Low quality evidence from three RCTs (n=261) showed CBT-ED is more effective on
40 symptom checklist compared with any other intervention.

- 1 Low quality evidence from one RCT (n=62) showed no difference in the effect of CBT-ED on
2 symptom checklist compared with any other intervention in people who had bulimia nervosa
3 less than five years.
- 4 Low quality evidence from three RCTs (n=197) showed no difference in the effect of CBT-ED
5 on symptom checklist compared with any other intervention in people who had bulimia
6 nervosa more than five years.
- 7 Low quality evidence from one RCT (n=80) showed no difference in the effect of CBT-ED on
8 quality of life compared with any other intervention.
- 9 Very low quality evidence from 10 RCTs (n=632) showed CBT-ED is more effective on
10 depression compared with any other intervention.
- 11 Very low quality evidence from five RCTs (n=419) showed CBT-ED is more effective on
12 EDE-global compared with any other intervention.
- 13 Very low quality evidence from 10 RCTs (n=725) showed CBT-ED is more effective on EDE-
14 dietary restraint compared with any other intervention.
- 15 Very low quality evidence from 10 RCTs (n= 725) showed CBT-ED is more effective on EDE-
16 weight concern compared with any other intervention but there was some uncertainty.
- 17 Low quality evidence from five RCTs (n=477) showed CBT-ED is more effective on EDE-
18 eating concern compared with any other intervention but there is some uncertainty.
- 19 Very low quality evidence from 10 RCTs (n=725) showed no difference in the effect of CBT-
20 ED on EDE- shape concern compared with any other intervention.
- 21 Very low to low quality evidence from four RCTs (n=242) showed CBT-ED is more effective
22 on EDI- bulimia compared with any other intervention.
- 23 Very low quality evidence from four RCTs (n=200 to 243) showed no difference in the effect
24 of CBT-ED on EDI- body dissatisfaction and EDI-drive for thinness compared with any other
25 intervention.
- 26 Low quality evidence from three RCTs (n=111) showed no difference in the effect of CBT-ED
27 on global clinical score compared with any other intervention.
- 28 Low quality evidence from one RCT (n=22) showed no difference in the effect of CBT-ED on
29 general psychopathology compared with any other intervention.
- 30 Low quality evidence from one RCT (n=45) showed CBT-ED is more effective on bulimic
31 inventory test edinburgh compared with any other intervention.
- 32 Low quality evidence from eight RCTs (n=807) showed CBT-ED is more effective on
33 remission compared with any other intervention.
- 34 **CBT-ED versus another intervention in adults with bulimia nervosa at follow up**
- 35 Very low quality evidence from five RCTs (n=294) showed no difference in the effect of CBT-
36 ED on frequency of binge eating compared with any other intervention.
- 37 Low quality evidence from three RCTs (n=208) showed no difference in the effect of CBT-
38 frequency of purges compared with any other intervention.

- 1 Low quality evidence from one RCTs (n=98) showed no difference in the effect of CBT-ED
2 on laxative use compared with any other intervention.
- 3 Low quality evidence from three RCTs (n=162) showed no difference in the effect of CBT-ED
4 on frequency of vomiting compared with any other intervention.
- 5 Very low quality evidence from three RCTs (n=236) showed CBT-ED is more effective on
6 symptom checklist compared with any other intervention.
- 7 Low quality evidence from one RCT (n=52) showed no difference in the effect of CBT-ED on
8 quality of life compared with any other intervention. Moderate quality evidence from nine
9 RCTs (n=410) showed no difference in the effect of CBT-ED on depression compared with
10 any other intervention.
- 11 Low quality evidence from three RCTs (n=307) showed no difference in the effect of CBT-ED
12 on EDE- total compared with any other intervention.
- 13 Low quality evidence from three RCTs (n=126) showed no difference in the effect of CBT-ED
14 on EDE-dietary restraint, EDE- shape concern and EDE- weight concern compared with any
15 other intervention. Low quality evidence from one RCT (n=52) showed no difference in the
16 effect of CBT-ED on EDE-eating concerns compared with any other intervention.
- 17 Low quality evidence from one RCT (n=22) showed CBT-ED is more effective on global
18 clinical score compared with any other intervention, but there was some uncertainty. Low
19 quality evidence from two RCTs (n=49) showed CBT-ED is more effective on general
20 psychopathology compared with any other intervention but there was some uncertainty.
- 21 Low quality evidence from one RCTs (n=27 to 47) showed no difference in the effect of CBT-
22 ED on EDI-drive for thinness, EDI-body dissatisfaction and EDI- bulimia compared with any
23 other intervention.
- 24 Low quality evidence from one RCT (n=47) showed no difference in the effect of CBT-ED
25 bulimic inventory test edinburgh compared with any other intervention.
- 26 Low quality evidence from five RCTs (n=629) showed CBT-ED is more effective on remission
27 compared with any other intervention.
- 28 CBT-ED versus another intervention in young people with bulimia nervosa at end of
29 treatment. Low quality evidence from one RCT (n=86) showed no difference in the effect of
30 CBT-ED effective on purging, binge eating, compared with any other intervention.
- 31 Low quality evidence from one RCT (n=110) showed CBT-ED may be less effective on
32 depression compared with any other intervention, though there is some uncertainty.
- 33 Low quality evidence from one RCT (n=110) showed no difference in the effect of CBT-ED
34 on EDE-global compared with any other intervention.
- 35 Very low quality evidence from two RCTs (n=215) showed that CBT-ED may be more
36 effective on remission compare with any other intervention, though there is some uncertainty.
- 37 **CBT-ED versus another intervention in young people with bulimia nervosa at follow up**
- 38 Low quality evidence from one RCT (n=69) showed no difference in the effect of CBT-ED on
39 purging and binge eating compared with any other intervention.

1 Very low quality evidence from two RCTs (n=215) showed no difference in the effect of CBT-
2 ED on remission compared with any other intervention.

3 **IPT versus another intervention in adults with bulimia nervosa at end of treatment.**

4 Low quality evidence from two RCTs (n=247) showed IPT is less effective on EDE- total
5 compared with any other intervention.

6 Very low quality evidence from three RCTs (n=303) showed IPT is less effective on EDE-
7 restraint compared with any other intervention but there was some uncertainty.

8 Very low quality evidence from three RCTs (n=303) showed no difference in the effect of IPT
9 on EDE-weight concern and EDE-shape concern compared with any other intervention.

10 Low quality evidence from two RCTs (n=247) showed IPT is less effective on EDE-eating
11 concern compared with any other intervention.

12 Low quality evidence from two RCTs (n=247) showed IPT is less effective on EDE-eating
13 concern compared with any other intervention.

14 Very low quality evidence from three RCTs (n=303) showed no difference in the effect of IPT
15 on EDE-weight concern and EDE-shape concern compared with any other intervention.

16 Low quality evidence from two RCTs (n=191) showed no difference in the effect of IPT on
17 symptom checklist compared with any other intervention.

18 Low quality evidence from three RCTs (n=215) showed IPT is less effective on social
19 adjustment scale compared with any other intervention, but there was some uncertainty.

20 Low quality evidence from one RCT (n=131) showed IPT is less effective on purging
21 compared with any other intervention.

22 Low quality evidence from two RCTs (n=178) showed IPT is less effective on vomiting
23 compared with any other intervention.

24 Low quality evidence from two RCTs (n=98) showed IPT is less effective on binge eating
25 compared with any other intervention but there was some uncertainty.

26 Very low quality evidence from three RCTs (n=202) showed no difference in the effect of IPT
27 on depression compared with any other intervention.

28 Very low quality evidence from one RCT (n=116) showed IPT is more effective on laxative
29 use compared with any other intervention.

30 Low quality evidence from three RCTs (n=425) showed IPT is less effective on remission
31 compared with any other intervention.

32 Low quality evidence from one RCT (n=22) showed IPT is less effective on global clinical
33 scores compared with any other intervention.

34 **IPT versus another intervention in adults with bulimia nervosa at follow up.**

35 Low quality evidence from two RCTs (n=227) showed IPT is less effective on EDE-total
36 compared with any other intervention but there was some uncertainty.

37 Low quality evidence from three RCTs (n=264) showed IPT is less effective on EDE-restraint
38 compared with any other intervention.

- 1 Low quality evidence from three RCTs (n=264) showed no difference in the effect of IPT on
2 EDE-weight concern and EDE-shape concern compared with any other intervention.
- 3 Low quality evidence from two RCTs (n=227) showed no difference in the effect of IPT on
4 EDE-eating concern compared with any other intervention.
- 5 Low quality evidence from two RCTs (n=166) showed no difference in the effect of IPT on the
6 symptom checklist compared with any other intervention.
- 7 Low quality evidence from two RCTs (n=166) showed no difference in the effect of IPT on the
8 social adjustment scale compared with any other intervention.
- 9 Low quality evidence from one RCT (n=129) showed no difference in the effect of IPT on
10 purging compared with any other intervention.
- 11 Low quality evidence from one RCT (n=98) showed no difference in the effect of IPT on
12 bulimic episodes and laxative use compared with any other intervention.
- 13 Low quality evidence from two RCTs (n=135) showed no difference in the effect of IPT on
14 vomiting compared with any other intervention.
- 15 Very low quality evidence from three RCTs (n=135) showed no difference in the effect of IPT
16 on depression compared with any other intervention.
- 17 Low quality evidence from three RCTs (n=425) showed no difference in the effect of IPT on
18 remission compared with any other intervention.
- 19 Low quality evidence from one RCT (n=75) showed no difference in the effect of IPT on
20 remission compared with any other intervention in those who had bulimia for less than 5
21 years.
- 22 Low quality evidence from two RCTs (n=350) showed IPT is less effective on remission
23 compared with any other intervention in those who had bulimia for more than 5 years but
24 there was some uncertainty.
- 25 **ICAT versus another intervention in adults with bulimia nervosa at end of treatment.**
- 26 Low quality evidence from one RCT (n=80) showed no difference in the effect of ICAT on the
27 EDE-global, purges, binge eating and depression compared with any other intervention.
- 28 **ICAT versus another intervention in adults with bulimia nervosa at follow up.**
- 29 Low quality evidence from one RCT (n=80) showed no difference in the effect of ICAT on the
30 EDE-global, purges, binge eating and depression compared with any other intervention.
- 31 **CBT-ED versus CBT-ED in adults with bulimia nervosa at end of treatment.**
- 32 Very low quality evidence from three RCTs (n=291) showed no difference in the effect of
33 CBT-ED on symptom check-list compared with alternative type of CBT-ED.
- 34 Very low quality evidence from five RCTs (n=306) showed no difference in the effect of CBT-
35 ED on depression compared with alternative type of CBT-ED.
- 36 Low quality evidence from two RCTs (n=142) showed no difference in the effect of CBT-ED
37 on social adjustment score compared with alternative type of CBT-ED.

- 1 Low quality evidence from four RCTs (n=242) showed one type of CBT-ED is more effective
2 on bulimic episodes compared with alternative type of CBT-ED but there was some
3 uncertainty.
- 4 Low quality evidence from two RCTs (n=122) showed no difference in the effect of CBT-ED
5 on vomiting compared with alternative type of CBT-ED.
- 6 Very low quality evidence from one RCT (n=72) showed no difference in the effect of CBT-
7 ED laxative use compared with alternative type of CBT-ED.
- 8 Low quality evidence from two RCT (n=114) showed no difference in the effect of CBT-ED on
9 purges compared with alternative type of CBT-ED.
- 10 Low quality evidence from four RCTs (n=321) showed no difference in the effect of CBT-ED
11 on remission compared with alternative type of CBT-ED.
- 12 Low quality evidence from one RCT (n=72) showed no difference in the effect of CBT-ED on
13 EDI- drive for thinness compared with alternative type of CBT-ED.
- 14 Low quality evidence from two RCTs (n=122) showed no difference in the effect of CBT-ED
15 on EDI- bulimia and EDI-body dissatisfaction compared with alternative type of CBT-ED.
- 16 Low quality evidence from three RCTs (n=319) showed no difference in the effect of CBT-ED
17 on EDI- total compared with alternative type of CBT-ED.
- 18 Low quality evidence from four RCTs (n=361) showed no difference in the effect of CBT-ED
19 on EDE-total compared with alternative type of CBT-ED.
- 20 Low quality evidence from one RCT (n=72) showed no difference in the effect of CBT-ED on
21 global function compared with alternative type of CBT-ED but there was some uncertainty.
- 22 Low to very low quality evidence from one RCT (n=149) showed no difference in the effect of
23 CBT-ED on general psychiatric features, bulimic episodes, vomiting episodes, purging and
24 laxative misuse compared with alternative type of CBT-ED
- 25 Very low quality evidence from one RCT (n=50) showed CBT-ED is less effective on
26 depression compared with alternative type of CBT-ED but there was some uncertainty in
27 those who binged less than 18 times per month.
- 28 Very low quality evidence from four RCTs (n=256) showed CBT-ED is more effective on
29 depression compared with alternative type of CBT-ED but there was some uncertainty in
30 those who binged more than 18 times per month.
- 31 **CBT-ED versus CBT-ED in adults with bulimia nervosa at follow up.**
- 32 Low to very low quality evidence from four RCTs (n=280) showed no difference in the effect
33 of CBT-ED on binge eating and depression compared with alternative type of CBT-ED.
- 34 Low quality evidence from two RCTs (n=269) showed no difference in the effect of CBT-ED
35 on symptom check-list compared with alternative type of CBT-ED.
- 36 Low quality evidence from one RCT (n=149) showed no difference in the effect of CBT-ED
37 on general psychiatric features, binge eating episodes, vomiting episodes, purging and
38 laxative use compared with alternative type of CBT-ED.

- 1 Low quality evidence from one RCT (n=72) showed no difference in the effect of CBT-ED on
2 laxative use compared with alternative type of CBT-ED.
- 3 Low quality evidence from three RCTs (n=232) showed no difference in the effect of CBT-ED
4 on vomiting compared with alternative type of CBT-ED.
- 5 Low to very low quality evidence from two RCTs (n=111) showed no difference in the effect
6 of CBT-ED on purges compared with alternative type of CBT-ED.
- 7 Low quality evidence from one RCT (n=72) showed CBT-ED was more effective on global
8 function compared with an alternative type of CBT-ED.
- 9 Low quality evidence from two RCTs (n=170) showed CBT-ED was more effective on social
10 adjustment score compared with an alternative type of CBT-ED.
- 11 Low quality evidence from two RCTs (n=122) showed no difference in the effect of CBT-ED
12 on EDI- bulimia and EDI-body dissatisfaction compared with alternative type of CBT-ED.
- 13 Low quality evidence from one RCT (n=72) showed no difference in the effect of CBT-ED on
14 EDI- drive for thinness compared with alternative type of CBT-ED.
- 15 Low quality evidence from three RCTs (n= 319) showed no difference in the effect of CBT-
16 ED on EDI- total compared with alternative type of CBT-ED.
- 17 Low quality evidence from two RCTs (n=199) showed no difference in the effect of CBT-ED
18 on EDE-total compared with alternative type of CBT-ED.
- 19 Low to very low quality evidence from three RCTs (n=144) showed no difference in the effect
20 of CBT-ED on remission compared with alternative type of CBT-ED.
- 21 **Behavioural therapy versus any other intervention in adults with bulimia nervosa at**
22 **the end of treatment.**
- 23 Low quality evidence from three RCTs (n=183) showed no difference in the effect of
24 behavioural therapy on bulimic episodes compared with any other intervention.
- 25 Very low quality evidence from five RCTs (n=185) showed no difference in the effect of
26 behavioural therapy on depression compared with any other intervention.
- 27 Low quality evidence from one RCT (n=92) showed no difference in the effect of behavioural
28 therapy laxative use compared with any other intervention.
- 29 Low quality evidence from three RCTs (n=160) showed behavioural therapy is more effective
30 on vomiting compared with any other intervention.
- 31 Low quality evidence from one RCTs (n=62) showed no difference in the effect of
32 behavioural therapy on the symptom check list compared with any other intervention.
- 33 Very low quality evidence from two RCTs (n=89) showed no difference in the effect of
34 behavioural therapy on EDE-dietary restraint, EDE-attitudes to weight and EDE-attitudes to
35 shape compared with any other intervention.
- 36 Low quality evidence from three RCTs (n=139 to 139) showed behavioural therapy is more
37 effective on the EDI- bulimia, EDI- drive for thinness and EDE-body dissatisfaction compared
38 with any other intervention.

1 Low quality evidence from one RCT (n=62) showed no difference in the effect of behavioural
2 therapy on the social adjustment scale compared with any other intervention.

3 Low quality evidence from three RCTs (n=106) showed no difference in the effect of
4 behavioural therapy on remission compared with any other intervention.

5 Low quality evidence from one RCT (n=41) showed behavioural therapy is more effective on
6 vomiting compared with any other intervention in people who had BN less than 5 years or
7 binged less than 18 times per month.

8 Low quality evidence from two RCTs (n=119) showed no difference in the effect of
9 behavioural therapy on vomiting compared with any other intervention in people who had BN
10 more than five years or binged more than 18 times per month.

11 **Behavioural therapy versus any other intervention in adults with bulimia nervosa at**
12 **follow up.**

13 Low quality evidence from one RCT (n=27) showed behavioural therapy is less effective on
14 purging and vomiting compared with any other intervention.

15 Low quality evidence from one RCT (n=27) showed behavioural therapy is less effective on
16 bulimic episodes compared with any other intervention.

17 Low quality evidence from one RCT (n=27) showed no difference in the effect of behavioural
18 therapy on EDE-dietary restraint, EDE-attitudes to shape and EDE-attitudes to weight
19 compared with any other intervention.

20 Low quality evidence from two RCTs (n=74) showed no difference in the effect of behavioural
21 therapy on depression compared with any other intervention.

22 Low quality evidence from one RCT (n=47) showed behavioural therapy is more effective on
23 EDI- drive for thinness compared with any other intervention.

24 Low quality evidence from one RCT (n=27) showed no difference in the effect of behavioural
25 therapy on EDI- body dissatisfaction and EDI- bulimia compared with any other intervention.

26 Low quality evidence from one RCT (n=75) showed no difference in the effect of behavioural
27 therapy on remission compared with any other intervention.

28 **Behavioural therapy (BT) versus wait list controls in adults with bulimia nervosa at the**
29 **end of treatment**

30 Low quality evidence from one RCT (n=50) showed BT is more effective on binge frequency,
31 self-induced vomiting, laxative use compared with wait list controls.

32 Low quality evidence from one RCT (n=50) showed no difference in the effect of BT on
33 depression compared with wait list controls.

34 **Hybrid therapy versus any other intervention in adults with bulimia nervosa at end of**
35 **treatment.**

36 Low quality evidence from one RCT (n=86) showed no difference in the effect a hybrid
37 therapy on binge eating, symptom check list, depression and EDI- symptoms compared with
38 any other intervention.

- 1 **Hybrid therapy versus any other intervention in adults with bulimia nervosa at follow**
2 **up.**
- 3 Low quality evidence from one RCT (n=86) showed hybrid therapy is more effective on binge
4 eating compared with any other intervention but there was some uncertainty.
- 5 Low quality evidence from one RCT (n=86) showed no difference in the effect a hybrid
6 therapy on symptom check list, depression and EDI- symptoms compared with any other
7 intervention.
- 8 **CBT-ED versus wait list controls in adults with bulimia nervosa at end of treatment.**
- 9 Low quality evidence from one RCT (n=52) showed CBT-ED is more effective on laxative
10 use compared with wait list controls.
- 11 Very low quality evidence from three RCTs (n=113) showed CBT-ED is more effective on
12 binge episodes compared with wait list controls.
- 13 Low quality evidence from one RCT (n=21) showed CBT-ED is more effective on purge
14 frequency compared with wait list controls.
- 15 Low quality evidence from two RCTs (n=92) showed CBT-ED is more effective on vomiting
16 compared with wait list controls.
- 17 Low quality evidence from two RCTs (n=194) showed CBT-ED is more effective on overall
18 severity compared with wait list controls.
- 19 Low quality evidence from one RCT (n=41) showed no difference in the effect of CBT-ED on
20 body dissatisfaction compared with wait list controls.
- 21 Low quality evidence from one RCT (n=41) showed CBT-ED is more effective on EDI-drive
22 for thinness, EDE-shape concern, EDE-weight concern and EDE-dietary restraint compared
23 with wait list controls.
- 24 Low quality evidence from one RCT (n=41) showed CBT-ED is less effective on EDI-bulimia
25 compared with wait list controls.
- 26 Low quality evidence from one RCT (n=154) showed CBT-ED is more effective on symptom
27 check list compared with wait list controls.
- 28 Low quality evidence from one RCT (n=122) showed CBT-ED is more effective on general
29 psychiatric features compared with wait list controls.
- 30 Low quality evidence from one RCT (n=35) showed CBT-ED is more effective on depression
31 compared with wait list controls.
- 32 Low quality evidence from one RCT (n=153 to 154) showed no difference in the effect of
33 CBT-ED on vomiting episodes, purging, laxative use and bulimic episodes compared with
34 wait list controls.
- 35 Low quality evidence from one RCT (n=81) showed CBT-ED is more effective on remission
36 compared with wait list controls, but there was some uncertainty.

1 **DBT versus any other intervention in adults with bulimia nervosa at end of treatment.**

2 Low quality evidence from one RCT (n=29) showed no difference in the effect of DBT on
3 negative mood regulation compared with any other intervention.

4 Low quality evidence from one RCT (n=29) showed DBT is more effective on compared with
5 any other intervention.

6 Low quality evidence from one RCT (n=29) showed DBT is more effective on emotional
7 eating compared with any other intervention but there was some uncertainty.

8 **Psychodynamic general therapy versus any other intervention in adults with bulimia
9 nervosa at end of treatment.**

10 Very low evidence from two RCTs (n=116) showed no difference in the effect of
11 psychodynamic general therapy on binge eating compared with any other intervention.

12 Very low evidence from two RCTs (n=120) showed psychodynamic general therapy is less
13 effective on vomiting/purging episodes compared with any other intervention but there was
14 some uncertainty.

15 Very low evidence from two RCTs (n=120) showed psychodynamic general therapy is less
16 effective on EDE-dietary restraint compared with any other intervention, but there was some
17 uncertainty.

18 Very low evidence from two RCTs (n=120) showed no difference in the effect of
19 psychodynamic general therapy on EDE-attitudes of weight and EDE-attitude to shape
20 compared with any other intervention.

21 Very low evidence from one RCT (n=50) showed psychodynamic general therapy is less
22 effective on EDE-dietary restraint and EDI- bulimia compared with any other intervention.

23 Very low evidence from one RCT (n=50) showed psychodynamic general therapy is less
24 effective on EDI-drive for thinness compared with any other intervention bu there was some
25 uncertainty.

26 Very low evidence from one RCT (n=50) showed no difference in the effect of
27 psychodynamic general therapy on EDI-body dissatisfaction compared with any other
28 intervention.

29 Very low evidence from one RCT (n=50) showed psychodynamic general therapy is more
30 effective on depression compared with any other intervention.

31 Very low evidence from one RCT (n=50) showed no difference in the effect of
32 psychodynamic general therapy on general psychopathology compared with any other
33 intervention.

34 **7.2.4.2 Group Therapy**

35 **Group behavioural therapy versus another group behavioural therapy in adults with
36 bulimia nervosa at end of treatment.**

37 Very low to low quality evidence from one RCT (n=23) showed no difference in the effect of
38 group behavioural therapy on vomiting and depression compared with another group
39 behavioural therapy.

1 Low quality evidence from one RCT (n=30) showed no difference in the effect of group
2 behavioural therapy on remission compared with another group behavioural therapy.

3 **Group behavioural therapy versus another group behavioural therapy in adults with**
4 **bulimia nervosa at follow up.**

5 Low quality evidence from one RCT (n=23 to 24) showed no difference in the effect of group
6 behavioural therapy on vomiting and depression compared with another group behavioural
7 therapy.

8 Low quality evidence from one RCT (n=30) showed no difference in the effect of group
9 behavioural therapy on remission compared with another group behavioural therapy.

10 **Group CBT-ED versus wait list controls in adults with bulimia nervosa at end of**
11 **treatment.**

12 Low quality evidence from two RCTs (n=54) showed no difference in the effect of group CBT-
13 ED on binge eating compared with wait list controls.

14 Low quality evidence from one RCTs (n=24) showed no difference in the effect of group
15 CBT-ED on purging compared with wait list controls.

16 Low quality evidence from one RCT (n=24) showed a benefit of CBT-ED on vomiting and
17 depression compared with wait list controls.

18 Low quality evidence from one RCT (n=26) showed no difference in the effect of group CBT-
19 ED on EDI- body dissatisfaction, EDI-bulimia and EDI-drive for thinness compared with wait
20 list controls.

21 Low quality evidence from two RCTs (n=52) showed a benefit of CBT-ED on remission,
22 compared with wait list controls however there was some uncertainty.

23 **Group CBT-ED versus wait list controls in adults with bulimia nervosa at follow up**

24 Low quality evidence from two RCTs (n=59) showed a benefit of CBT-ED on remission,
25 compared with wait list controls.

26 **Group CBT-ED versus any other intervention in adults with bulimia nervosa at end of**
27 **treatment.**

28 Low quality evidence from three RCTs (n=206) showed no difference in the effect of group
29 CBT-ED on binge eating, EDI-drive for thinness, EDI-bulimia and EDI-body dissatisfaction,
30 compared with any other intervention.

31 Low quality evidence from two RCTs (n=145) showed no difference in the effect of group
32 CBT-ED on EDI-global compared with any other intervention controls.

33 Low quality evidence from one RCT (n=120) showed no difference in the effect of group
34 CBT-ED on EDE-total, symptom check-list and anxiety compared with any other intervention.

35 Low quality evidence from three RCTs (n=211) showed no difference in the effect of group
36 CBT-ED on depression compared with any other intervention.

37 Low quality evidence from one RCT (n=74) showed a benefit of group CBT-ED on clinical
38 impairment compared with any other intervention.

1 Low quality evidence from two RCTs (n=91) showed a potentially harmful effect of group
2 CBT-ED on vomiting compared with any other intervention.

3 Low quality evidence from one RCT (n=56) showed a potentially harmful effect of group
4 CBT-ED on laxative use compared with any other intervention.

5 Low quality evidence from one RCT (n=81) showed no difference in the effect of group CBT-
6 ED on remission compared with any other intervention

7 **Group CBT-ED versus any other intervention in adults with bulimia nervosa at follow**
8 **up**

9 Low quality evidence from three RCTs (n=205) showed no difference in the effect of group
10 CBT-ED on binge eating, EDI-drive for thinness and EDI-bulimia compared with any other
11 intervention.

12 Low quality evidence from three RCTs (n=205) showed a benefit of group CBT-ED on EDI-
13 body dissatisfaction compared with any other intervention but there was some uncertainty.

14 Low quality evidence from one RCT (n=74) showed no difference in the effect of group CBT-
15 ED on EDI-global compared with any other intervention.

16 Low quality evidence from one RCT (n=120) showed no difference in the effect of group
17 CBT-ED on EDE-total compared with any other intervention.

18 Low quality evidence from two RCTs (n=91) showed a potentially harmful effect of group
19 CBT-ED on vomiting compared with any other intervention, but there was some uncertainty.

20 Low quality evidence from three RCTs (n=210) showed no difference in the effect of group
21 CBT-ED on depression compared with any other intervention.

22 Low quality evidence from one RCT (n=56) showed a potentially harmful effect of group
23 CBT-ED on laxative use compared with any other intervention.

24 Low quality evidence from three RCTs (n=205) showed a benefit of group CBT-ED on
25 anxiety compared with any other intervention.

26 Low quality evidence from one RCT (n=120) showed no difference in the effect of group
27 CBT-ED on symptom checklist compared with any other intervention.

28 Low quality evidence from two RCTs (n=126) showed no difference in the effect of group
29 CBT-ED on remission compared with any other intervention.

30 Low quality evidence from one RCT (n=74) showed a benefit of group CBT-ED on clinical
31 impairment compared with any other intervention.

32 **Group BT-ED versus wait list control in adults with bulimia nervosa at end of**
33 **treatment**

34 Low to very low quality evidence from one RCT (n=26) showed no difference in the effect of
35 group behavioural therapy on binge eating, EDI-drive for thinness and EDI-bulimia compared
36 with wait list control.

37 Low quality evidence from one RCT (n=35) showed group behavioural therapy is more
38 effective on vomiting and depression compared with wait list controls.

1 Low quality evidence from one RCT (n=26) showed group behavioural therapy is more
2 effective on EDI-body dissatisfaction compared with wait list controls, but there was some
3 uncertainty.

4 Low quality evidence from one RCT (n=44) showed group behavioural therapy is more
5 effective on remission compared with wait list controls.

6 **Group BT-ED versus wait list control in adults with bulimia nervosa at follow up**

7 Very low quality evidence from one RCT (n=44) showed no difference in the effect of group
8 behavioural therapy on remission compared with wait list control

9 **Group BT-ED versus another group intervention in adults with bulimia nervosa at end** 10 **of treatment**

11 Low to very low quality evidence from one RCT (n=30 to 36) showed no difference in the
12 effect of group behavioural therapy on binge eating, vomiting, depression, EDI-drive for
13 thinness, EDI-bulimia and EDI-body dissatisfaction compared with another group
14 intervention.

15 Low quality evidence from one RCT (n=60) showed group behavioural therapy is more
16 effective on remission compared *with* another group intervention.

17 **Group BT-ED versus another group intervention in adults with bulimia nervosa at** 18 **follow up.**

19 Low to very low quality evidence from one RCT (n=20 to 36) showed no difference in the
20 effect of group behavioural therapy on vomiting, EDI-drive for thinness, EDI-bulimia, EDI-
21 body dissatisfaction, EDE-shape concern, EDE-weight concern, EDE-eating concern and
22 EDE-restraint compared with another group intervention.

23 Low quality evidence from two RCTs (n=58 to 63) showed no difference in the effect of group
24 behavioural therapy on binge eating and depression with compared another group
25 intervention.

26 Low quality evidence from two RCTs (n=73) showed no difference in the effect of group
27 behavioural therapy on remission compared with another group intervention.

28 **Group psychoeducation versus another intervention in adults with bulimia nervosa at** 29 **end of treatment.**

30 Low quality evidence from one RCT (n=54 to 65) showed no difference in the effect of group
31 psychoeducation on binge eating, vomiting and EDI-body dissatisfaction compared another
32 intervention.

33 Very low quality evidence from one RCT (n= 65) showed no difference in the effect of group
34 psychoeducation on remission compared with another intervention.

35 Low quality evidence from one RCT (n=54) showed group psychoeducation is less effective
36 on EDI-drive for thinness compared with another group intervention.

37 Low quality evidence from one RCT (n=54) showed group psychoeducation is less effective
38 on EDI-bulimia compared with another intervention, but there was some uncertainty.

1 **Group CBT-ED of varying intensity versus control CBT-ED in adults with bulimia**
2 **nervosa at end of treatment.**

3 Low quality evidence from one RCT (n=143) showed a benefit of group CBT-ED of varying
4 intensity on vomiting, EDI-drive for thinness, EDI- bulimia and remission compared with a
5 control CBT-ED group.

6 Low quality evidence from one RCT (n=143) showed a benefit of group CBT-ED of varying
7 intensity on binge eating compared with a control CBT-ED group, but there was some
8 uncertainty.

9 Low quality evidence from one RCT (n=143) showed no difference in the effect of group
10 CBT-ED of varying intensity on laxative use, EDI-body dissatisfaction, depression and
11 anxiety compared with a control CBT-ED group.

12 **Group emotional and mind training versus another intervention in adults with bulimia**
13 **nervosa at end of treatment.**

14 Low quality evidence from one RCT (n=74) showed no difference in the effect of group
15 emotional and mind training on EDE-global compared with another intervention.

16 Low quality evidence from one RCT (n=74) showed group emotional and mind training is less
17 effective on clinical impairment compared with another intervention.

18 **Group emotional and mind training versus another intervention in adults with bulimia**
19 **nervosa at follow up.**

20 Low quality evidence from one RCT (n=74) showed group emotional and mind training is less
21 effective on EDE-global and clinical impairment compared with another intervention.

22 **Group support versus another intervention in adults with bulimia nervosa at end of**
23 **treatment.**

24 Low quality evidence from one RCT (n=100) showed no difference in the effect of group
25 support on depression scores compared with another intervention.

26 **7.2.4.3 Self-help**

27 **Guided self-help (ED) versus another intervention in adults with bulimia nervosa at**
28 **end of treatment**

29 Very low quality evidence from six RCTs (n=388) showed guided self-help (ED) is more
30 effective on binge eating compared with another intervention but there was some uncertainty.

31 Very low quality evidence from five RCTs (n=190) showed no difference in the effect of
32 guided self-help (ED) on vomiting compared with another intervention.

33 Very low quality evidence from five RCTs (n=243) showed guided self-help (ED) is more
34 effective on the use of laxatives compared with another intervention but there was some
35 uncertainty.

36 Very low quality evidence from five RCTs (n=280) showed no difference in the effect of
37 guided self-help (ED) on depression compared with any other intervention.

- 1 Low quality evidence from one RCT (n= 56) showed guided self-help (ED) is more effective
2 on ED-drive for thinness compared with another intervention but there was some uncertainty.
- 3 Low quality evidence from one RCT (n=55 to 56) showed guided self-help (ED) is more
4 effective on EDI-bulimia and EDI-body dissatisfaction compared with another intervention.
- 5 Very low quality evidence from four RCTs (n=454) showed no difference in the effect of
6 guided self-help (ED) on remission compared with any other intervention.
- 7 Very low quality evidence from three RCTs (n=159 to 192) showed no difference in the effect
8 of guided self-help (ED) on EDE-global, EDE-restraint, EDE-weight concern, EDE-shape
9 concern and excessive exercise compared with any other intervention.
- 10 Very low quality evidence from two RCTs (n=145) showed no difference in the effect of
11 guided self-help (ED) on EDE-eating concern compared with any other intervention.
- 12 Very low quality evidence from one RCT (n=80) showed no difference in the effect of guided
13 self-help (ED) on purging and satisfaction with life compared with any other intervention.
- 14 Very low quality evidence from two RCTs (n=112) showed guided self-help (ED) is less
15 effective on bulimia inventory index with life compared with any other intervention, but there
16 was some uncertainty.
- 17 **Guided self-help (ED) versus another intervention in adults with bulimia nervosa at**
18 **follow up.**
- 19 Very low quality evidence from four RCTs (n=270) showed no difference in the effect of
20 guided self-help (ED) on binge eating compared with any other intervention.
- 21 Very low quality evidence from three RCTs (n=95) showed no difference in the effect of
22 guided self-help (ED) on vomiting compared with any other intervention.
- 23 Very low quality evidence from three RCTs (n=154) showed no difference in the effect of
24 guided self-help (ED) on depression compared with any other intervention.
- 25 Very low quality evidence from three RCTs (n=216) showed guided self-help (ED) is more
26 effective on the use of laxatives compared with any other intervention but there was some
27 uncertainty.
- 28 Very low quality evidence from two RCTs (n=99) showed no difference in the effect of guided
29 self-help (ED) on EDE-restraint, EDE-weight concern and EDE-shape concern compared
30 with any other intervention.
- 31 Very low quality evidence from one RCT (n=52 to 55) showed no difference in the effect of
32 guided self-help (ED) on purging, EDE eating concern and satisfaction with life, EDI-body
33 dissatisfaction and EDI-bulimia and EDI- drive for thinness compared with any other
34 intervention.
- 35 Very low quality evidence from two RCTs (n=159) showed no difference in the effect of
36 guided self-help (ED) on excessive exercise compared with any other intervention.
- 37 Low quality evidence from one RCT (n=47) showed guided self-help (ED) is less effective on
38 bulimic inventory index compared with any other intervention.
- 39 Very low quality evidence from four RCTs (n=454) showed no difference in the effect of
40 guided self-help (ED) on remission compared with any other intervention.

1 **Guided self-help (ED) versus wait list controls in adults with bulimia nervosa at end of**
2 **treatment.**

3 Very low quality evidence from two RCTs (n=111) showed guided self-help (ED) is more
4 effective on binge eating compared with wait list controls, but there was some uncertainty.

5 Low quality evidence from two RCTs (n=151) showed guided self-help (ED) is more effective
6 on vomiting compared with wait list controls, but there was some uncertainty.

7 Very low quality evidence from two RCTs (n= 151) showed no difference in the effect of
8 guided self-help (ED) on laxative use compared with wait list controls.

9 Very low quality evidence from three RCTs (n= 220) showed guided self-help (ED) is more
10 effective on depression compared with wait list controls.

11 Very low quality evidence from two RCTs (n= 178) showed guided self-help (ED) is more
12 effective on the purging compared with wait list controls. A subgroup analysis showed the
13 effect is greater in those with a less severe case of BN who binge less than 18 times per
14 month compared with those who binge more than 18 times per month.

15 Very low quality evidence from two RCTs (n= 178) showed guided self-help (ED) is more
16 effective on EDI- drive for thinness, EDI-body dissatisfaction, EDE weight concern, EDE
17 shape concern, EDE-global and quality of life compared with wait list controls.

18 A subgroup analysis showed the effect of guided self-help on EDE-shape concern and EDE-
19 weight concern is greater in those with a less severe case of BN who binge less than 18
20 times per month compared with those who binge more than 18 times per month.

21 Very low quality evidence from one RCT (n= 69) showed guided self-help (ED) is more
22 effective on EDE-eating concern compared with wait list controls.

23 Very low quality evidence from two RCTs (n= 151) showed guided self-help (ED) is more
24 effective on the clinical symptom index compared with wait list controls.

25 Very low quality evidence from one RCT (n= 69) showed no difference in the effect of guided
26 self-help (ED) on EDI-bulimia and EDE-restraint compared with wait list controls.

27 Very low quality evidence from two RCTs (n=198) showed guided self-help (ED) is more
28 effective on remission compared with wait list controls.

29 **Guided self-help (ED) versus wait list controls in adults with bulimia nervosa at follow**
30 **up.**

31 Very low quality evidence from one RCT (n=78) showed no difference in the effect of guided
32 self-help (ED) on remission compared with wait list controls.

33 **General self-help versus another intervention in adults with bulimia nervosa at end of**
34 **treatment.**

35 Low quality evidence from one RCT (n= 56) showed general self-help is more effective on
36 depression, EDE-eating concern and EDE-weight concern compared with another
37 intervention but there was some uncertainty.

38 Low quality evidence from one RCT (n= 32) showed general self-help is more effective on
39 EDE-global compared with another intervention.

1 Low quality evidence from one RCT (n= 56) showed no difference in the effect of general
2 self-help on EDE-restraint and EDE-shape concern compared with another intervention.

3 **General self-help versus wait list controls in adults with bulimia nervosa at end of**
4 **treatment.**

5 Low quality evidence from one RCT (n= 56) showed no difference in the effect of general
6 self-help on depression, EDE-restraint, EDE-shape concern, EDE-eating concern and EDE-
7 weight concern compared with wait list controls.

8 Low quality evidence from one RCT (n= 63) showed no difference in the effect of general
9 self-help on remission compared with wait list controls.

10 **General self-help versus wait list controls in adults with bulimia nervosa at follow up.**

11 Low quality evidence from one RCT (n= 63) showed no difference in the effect of general
12 self-help remission compared with wait list controls.

13 **Self-help (ED) versus another intervention in adults with bulimia nervosa at end of**
14 **treatment.**

15 Very low quality evidence from three RCTs (n= 162) showed self-help (ED) was less effective
16 on binge eating compared with another intervention.

17 Low quality evidence from one RCT (n= 70) showed self-help (ED) was less effective on
18 purging compared with another intervention.

19 Very low quality evidence from one RCT (n= 33) showed no difference in the effect of self-
20 help (ED) on the use of laxatives or exercising compared with another intervention.

21 Very low quality evidence from two RCTs (n= 96) showed self-help (ED) is less effective on
22 vomiting compared with another intervention.

23 Low quality evidence from one RCT (n= 56) showed self-help (ED) is less effective on
24 depression compared with another intervention but there was some uncertainty.

25 Very low quality evidence from two RCTs (n= 173) showed no difference in the effect of self-
26 help (ED) on remission compared with another intervention.

27 Low quality evidence from two RCTs (n= 118 to 132) showed no difference in the effect of
28 self-help (ED) on EDE-global, EDE-weight concern and EDE-shape concern compared with
29 another intervention.

30 Very low quality evidence from two RCTs (n= 118) showed self-help (ED) is less effective on
31 EDE-restraint compared with another intervention.

32 Very low quality evidence from one RCT (n= 56) showed self-help (ED) is less effective on
33 EDE-eating concern compared with another intervention but there was some uncertainty.

34 **Self-help (ED) versus another intervention in adults with bulimia nervosa at follow up.**

35 Low quality evidence from one RCT (n= 70) showed no difference in the effect of self-help
36 (ED) on purging and EDE-global compared with another intervention.

- 1 Very low to low quality evidence from one RCT (n=37 to 40) showed no difference in the
2 effect of self-help (ED) on vomiting, use of laxatives and excessive exercise compared with
3 another intervention.
- 4 Very low quality evidence from two RCTs (n= 111) showed no difference in the effect of self-
5 help (ED) on binge eating compared with another intervention.
- 6 Very low quality evidence from one RCT (n= 90) showed no difference in the effect of self-
7 help (ED) on remission compared with another intervention.
- 8 **Internet self-help (ED) versus another intervention in adults with bulimia nervosa at**
9 **end of treatment.**
- 10 Very low quality evidence from two RCTs (n= 192) showed internet self-help (ED) is more
11 effective on binge eating compared with another intervention, although there was some
12 uncertainty.
- 13 Very low quality evidence from one RCT (n= 70) internet self-help (ED) is more effective on
14 purging compared with another intervention.
- 15 Low quality evidence from one RCT (n= 122) showed no difference in the effect of internet
16 self-help (ED) on vomiting, laxative use and excessive exercise compared with another
17 intervention.
- 18 Low quality evidence from one RCT (n= 70) showed no difference in the effect of internet
19 self-help (ED) on EDE-global compared with another intervention.
- 20 Low quality evidence from one RCT (n= 155) showed no difference in the effect of internet
21 self-help (ED) on remission compared with another intervention.
- 22 Low quality evidence from one RCT (n= 192) showed internet self-help (ED) is more effective
23 on binge eating compared with another intervention in people who binge ≤ 18 times per
24 month.
- 25 Low quality evidence from one RCT (n= 122) showed no difference in the effect of internet
26 self-help (ED) on binge eating compared with another intervention in people who binge more
27 than 18 times per month.
- 28 **Internet self-help (ED) versus another intervention in adults with bulimia nervosa at**
29 **follow up.**
- 30 Low quality evidence from two RCTs (n= 192) showed a benefit of internet self-help (ED) on
31 binge eating compared with another intervention.
- 32 Low quality evidence from one RCT (n= 70) showed no difference in the effect of internet
33 self-help (ED) on purging and EDE-global compared with another intervention.
- 34 Low quality evidence from one RCT (n= 122) showed no difference in the effect of internet
35 self-help (ED) on vomiting, laxative use and excessive exercise compared with another
36 intervention.
- 37 Low quality evidence from one RCT (n= 155) showed no difference in the effect of internet
38 self-help (ED) on remission compared with another intervention.
- 39 **Internet self-help (ED) versus wait list controls in adults with bulimia nervosa at end of**
40 **treatment.**

- 1 Very low quality evidence from two RCTs (n= 137) showed internet self-help (ED) is more
2 effective on purging and binge eating compared with wait list controls.
- 3 Very low quality evidence from two RCTs (n= 137) showed no difference in the effect of
4 internet self-help (ED) on vomiting compared with wait list controls.
- 5 Very low quality evidence from one RCT (n=67) showed a benefit of internet self-help (ED)
6 on depression, quality of life, EDE-restraint, EDE-shape concern, EDE-weight concern and
7 EDE-eating concern compared with wait list controls.
- 8 Very low quality evidence from two RCTs (n=137) showed a benefit of internet self-help (ED)
9 on EDE-global compared with wait list controls.
- 10 Very low quality evidence from one RCT (n=76) showed a benefit of internet self-help (ED)
11 on remission compared with wait list controls.

12 **Self-help (ED) versus wait list controls in adults with bulimia nervosa at end of**
13 **treatment**

- 14 Very low quality evidence from two RCTs (n=130) showed no difference in the effect of self-
15 help (ED) on binge eating compared with wait list controls.
- 16 Very low quality evidence from two RCTs (n=130) showed there may be a benefit of self-help
17 (ED) on EDE-global compared with wait list controls.
- 18 Low quality evidence from two RCTs (n=117) showed a benefit of self-help (ED) on EDE-
19 shape concern and EDE-weight concern compared with wait list controls.
- 20 Very low quality evidence from one RCT (n=82) showed no difference in the effect of self-
21 help (ED) on remission compared with wait list controls.
- 22 Low to very low quality evidence from two RCTs (n=55 to 117) showed no difference in the
23 effect of self-help (ED) on purging, vomiting, depression, EDE-restraint and EDE-eating
24 concern compared with wait list controls.

25 **Text messaging versus wait list controls in adults with bulimia nervosa at end of**
26 **treatment.**

- 27 Very low quality evidence from one RCT (n=165) showed text messaging is less effective on
28 remission compared with wait list controls but there was some uncertainty.

29 **7.2.4.4 Family therapy**

30 **Family therapy versus any individual therapy in young people with bulimia nervosa at**
31 **end of treatment.**

- 32 Very low quality evidence from three RCTs (n=295) showed no difference in the effect of
33 family therapy on improving remission compared with any individual therapy.
- 34 Low quality evidence from two RCTs (n=157) showed no difference in the effect of family
35 therapy on binge frequency compared with any individual therapy.
- 36 Very low quality evidence from one RCT (n=63) showed no difference in the effect of family
37 therapy in the number of people abstaining from vomiting compared with any individual
38 therapy.

- 1 Low quality evidence from one RCT (n=155) showed that family therapy is more effective on
2 reducing EDE–global scores compared with any individual therapy.
- 3 Low quality evidence from one RCT (n=71) showed that family therapy is more effective on
4 reducing scores on EDE-vomiting, EDE-all compensatory behaviours, EDE-restraint, EDE-
5 shape concern and EDE-weight concern, and on reducing the number of participants
6 hospitalized during treatment compared with any individual therapy.
- 7 Low quality evidence from two RCTs (n=157) showed family therapy may be effective on
8 reducing depression compared with any individual therapy, although there was some
9 uncertainty.
- 10 Low quality evidence from one RCT (n=86) showed family therapy may be more effective on
11 YBC-EDS compared with any individual therapy, although there was some uncertainty.
- 12 Low quality evidence from one RCT (n=86) showed no difference in the effect of family
13 therapy on frequency of purging compared with any individual therapy.
- 14 Low quality evidence from one RCT (n=71) showed no difference in the effect of family
15 therapy on EDE–objective binge eating compared with any individual therapy.
- 16 Low quality evidence from one RCT (n=68) showed no difference in the effect of family
17 therapy on service user experience compared with any individual therapy.
- 18 **Family therapy versus any individual therapy in young people with bulimia nervosa at**
19 **follow up.**
- 20 Very low quality evidence from two RCTs (n=215) showed family therapy is more effective on
21 improving remission compared with any individual therapy.
- 22 Low quality evidence from one RCT (n=137) showed that family therapy is more effective on
23 reducing scores on EDE–global compared with any individual therapy.
- 24 Low quality evidence from one RCT (n=68) showed that family therapy is more effective on
25 reducing scores on EDE–shape concern compared with any individual therapy.
- 26 Low quality evidence from two RCTs (n=137) showed no difference in the effect of family
27 therapy on binge frequency and depression compared with any individual therapy.
- 28 Low quality evidence from one RCT (n=68) showed family therapy may be more effective on
29 reducing scores on EDE–weight concern compared with any individual therapy, although
30 there was some uncertainty.
- 31 Low quality evidence from one RCT (n=69) showed no difference in the effect of family
32 therapy on frequency of purging and YBC-EDS compared with any individual therapy.
- 33 Very low quality evidence from one RCT (n=54) showed no difference in the effect of family
34 therapy on the number of people abstaining from vomiting compared with any individual
35 therapy.
- 36 Low quality evidence from one RCT (n=68) showed no difference in the effect of family
37 therapy on frequency of vomiting and EDE-dietary restraint compared with any individual
38 therapy.

1 Low quality evidence from one RCT (n=71) showed family therapy may be less effective on
2 service user experience compared with any individual therapy, although there was some
3 uncertainty.

4 **7.2.5 Economic evidence statements**

5 There was existing economic evidence from 1 US study (N=128) comparing CBT-ED and
6 guided self-help ED in people with ED. However, due to the lack of QALYs the committee
7 could not judge the cost effectiveness of CBT-ED versus guided self-help ED. This evidence
8 was partially applicable and characterised by minor methodological limitations.

9 In the economic analysis conducted for this guideline, self-help with support appeared to be
10 the most cost-effective option for adults with bulimia nervosa when compared with CBT-ED
11 individual and wait list using end of treatment effectiveness data. These results were overall
12 robust to alternative scenarios considered in sensitivity analysis. At the lower NICE cost-
13 effectiveness threshold of £20,000 per QALY (NICE, 2008b) the probability of self-help with
14 support being cost effective was 0.80 and it increased to 0.89 at the upper threshold of
15 £30,000 per QALY. The secondary analysis where the time horizon of the analysis was
16 extended to five years indicated that the ICER of CBT-ED individual when compared with
17 wait list was below lower NICE cost-effectiveness threshold of £20,000 per QALY by
18 approximately 2.5 years follow up. At 5 years the probability of CBT-ED individual (when
19 compared with wait list) being cost effective was 0.60 at lower NICE cost-effectiveness
20 threshold of £20,000 per QALY. The evidence from the guideline economic analysis was
21 directly applicable to the UK context and was characterised by potentially serious
22 methodological limitations.

23 There evidence from one UK study (N=85) suggested that family therapy may be a cost-
24 effective treatment option when compared with CBT-ED in young people with bulimia
25 nervosa or EDNOS. This evidence was from one partially applicable study that was
26 characterised by minor methodological limitations. There was no evidence on the cost
27 effectiveness of other psychological therapies for the treatment of young people with bulimia
28 nervosa.

29 **7.2.6 Recommendations and link to evidence**

30 **Psychological treatment for adults with bulimia nervosa**

108. Explain to all people with bulimia nervosa that psychological treatments have a limited effect on body weight.

First-line psychological treatment for adults

109. Consider bulimia-nervosa-focused guided self-help for adults with bulimia nervosa.

110. Bulimia-nervosa-focused guided self-help programmes for adults with bulimia nervosa should:

- use cognitive behavioural self-help materials for eating disorders
- supplement the self-help programme with brief supportive sessions (for example 4 to 9 sessions)

	<p>lasting 20 minutes each over 16 weeks, running weekly at first).</p> <p>111. If bulimia-nervosa-focused guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks of treatment, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED).</p> <p>Second-line psychological treatment for adults</p> <p>112. Individual CBT-ED for adults with bulimia nervosa should:</p> <ul style="list-style-type: none"> • typically consist of up to 20 sessions over 20 weeks, and consider twice-weekly sessions in the first phase • in the first phase focus on: <ul style="list-style-type: none"> ○ engagement and education ○ establishing a pattern of regular eating, and providing encouragement, advice and support while people do this • follow by addressing the eating disorder psychopathology (for example, the extreme dietary restraint, the concerns about body shape and weight, and the tendency to binge eat in response to difficult thoughts and feelings) • towards the end of treatment, spread appointments further apart and focus on maintaining positive changes and minimising the risk of relapse • if appropriate, involve significant others to help with one-to-one treatment.
<p>Relative value of different outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychological therapies for treating bulimia nervosa in children, young people and adults. For this population, binge eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with bulimia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p> <p>The committee discussed whether to include weight/BMI as an outcome in the reviews on people with bulimia nervosa. They acknowledged that it was not clear whether ideally, either should be higher, lower or show no change at the end of treatment because it is not a priority of treatment as it is for anorexia nervosa. The</p>

	<p>committee considered whether weight or BMI should still be an important outcome because a number of people would want to know if they are going to gain weight in response to treatment. They also discussed whether the results on weight and BMI may lead to a research recommendation or them not recommending the treatment. Overall, due to the uncertainty surrounding the importance of weight/BMI and how to interpret the data, they decided to exclude it from the reviews.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>First-line psychological treatment for adults</p> <p>Guided self-help compared with wait list controls improved rates of remission and reduced the frequency of binge eating in adults with bulimia nervosa. There was a reduced frequency of purging and other outcomes were improved in response to guided self-help, including depression, quality of life and eating disorder psychopathology (EDE-global, EDE subscales [except EDE-restraint and EDI-bulimia], EDI subscales and clinical symptom index). Laxative use was not significantly different and vomiting showed a trend to be reduced in the guided self-help group. A subgroup analysis showed severity of illness may influence the responsiveness to treatment. Those who are more severely ill (>18 binges per month vs. <18 binges per month) may show a reduced response to guided self-help when considering the following outcomes: purging, EDE-shape concern, EDE-weight concern.</p> <p>At 12 months follow up, the benefits on remission were inconclusive (depending on what the comparison arm was). No other outcomes were reported. At no time point was data reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience</p> <p>Comparing guided self-help with any other intervention in adults showed there was no difference in remission rates at the end of treatment. Binge eating, use of laxatives and EDI drive for thinness were reduced but there was some uncertainty, only EDI-bulimia and EDI-body dissatisfaction showed a meaningful reduction compared with any other intervention at the end of treatment. All other outcomes showed no difference between the two groups at the end of the intervention (including vomiting, depression, EDI and EDE subscales, purging, exercising, and satisfaction with life). Bulimic Inventory Index showed poorer scores in the guided self-help group but there was some uncertainty.</p> <p>Six to twelve months follow up mostly showed no difference between guided self-help and any other treatment, and for the critical outcomes of binge eating and remission there was no difference (one of the studies in the “other treatment” arm included CBT-ED and in this study remission at follow up was not different between guided self-help and CBT-ED). Use of laxatives was lower in the guided self-help group but there was some uncertainty, and bulimic inventory index was poorer in the guided self-help group. At no time point was data reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning or service user experience</p> <p>Second-line psychological treatment for adults</p> <p>Individual cognitive behavioural therapy with a focus on the eating disorder (CBT-ED) improved rates of remission and binge eating frequency in adults with bulimia nervosa compared with any other intervention at the end of treatment.</p> <p>Benefits were also found on EDE-dietary restraint, bulimic inventory test (Edinburgh) and depression. Some benefits were found on EDE-bulimia, symptom check-list but there was some uncertainty. A number of outcomes showed no difference between the two arms including vomiting, general psychopathology,</p>

global clinical Impressions score, quality of life, laxative use, EDE-total score, EDE-eating concern, EDI-drive for thinness, EDI-body dissatisfaction and EDE-attitude to shape.

CBT-ED had long-term benefits ranging from 4 months to 3 years on remission but no significant effect on binge eating. Other outcomes continued to favour CBT-ED at follow up including depression, global clinical impressions and general psychopathology but there was some uncertainty. Other outcomes showed no difference between CBT-ED individual and any other treatment. No data was reported at any time point on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.

CBT-ED was not only more effective on binge eating compared with any other intervention but also compared with waitlist controls. A number of other outcomes were also largely improved in the CBT-ED arm compared with the wait list controls, including purging, vomiting, depression and most of the EDE and EDI sub-scales. One study reported on whether compensatory behaviours were present or absent at the end of treatment and showed no difference between CBT-ED and wait list control on binge eating, vomiting, laxative misuse and purging. No data was available for follow up nor on all-cause mortality, adverse events, quality of life, resource use, relapse, general functioning, family functioning and service user experience.

Other psychological treatments for adults

Other individual treatments considered by the committee for this review included interpersonal psychotherapy (IPT), integrative cognitive-affective therapy (ICAT), variations in CBT-ED, behavioural therapy (BT), dialectical behaviour therapy (DBT) and psychodynamic therapy. Group therapies included group behavioural therapy, group CBT-ED, group behavioural therapy (ED), group psychoeducation, group CBT-ED of varying intensity, group emotional and mind training and group support. Self-help therapies (besides guided self-help as discussed in other LETR) were also considered, they included: general self-help; self-help (ED); internet self-help (ED); and text messaging.

Of all these comparisons, the therapies that showed positive results on the critical outcomes of remission or binge eating included: CBT-ED versus another CBT-ED (for binge eating at the end of treatment); group CBT-ED versus wait list controls (for remission at the end of treatment and follow up); group BT versus wait list controls (for remission at the end of treatment); group BT-ED versus another group intervention (for remission at the end of treatment); group CBT-ED versus another group CBT-ED of varying intensity (on remission at the end of treatment) and internet self-help (ED) versus another intervention (for binge eating at the end of treatment but there was some uncertainty).

Conversely, the therapies that showed negative results on remission or binge eating included: IPT versus another intervention (for remission and binge eating at the end of treatment) and psychodynamic therapy versus another intervention (for binge eating at the end of treatment; and self-help (ED) versus another intervention (for binge eating at the end of treatment and at follow up).

No difference on one or both of the critical outcomes was found in the following comparisons: IPT versus another comparison (for remission and binge eating at follow up); ICAT versus another intervention (for binge eating at the end of treatment and follow up); CBT (ED) versus another CBT (ED) (for remission at the end of treatment and binge eating and remission at follow up); BT versus another

	<p>intervention (for binge eating and remission at end of treatment and follow up); hybrid versus another intervention (for binge eating at the end of treatment and follow up); group BT versus another intervention (for remission at the end of treatment and follow up); group CBT-ED versus wait list controls (for binge eating at the end of treatment); group CBT-ED versus another intervention (for binge eating and remission at the end of treatment and follow up); group BT versus wait list controls (for binge eating at the end of treatment and remission at follow up); group BT-ED versus another group intervention (for binge eating at the end of treatment and binge eating and remission at follow up); group psychoeducation versus another intervention (for binge eating and remission at the end of treatment); group CBT-ED versus another group CBT-ED of varying intensity (on binge eating at the end of treatment but there was some uncertainty); general self-help versus wait list controls (for remission at end of treatment and follow up); self-help (ED) versus another intervention (for remission at end of treatment and binge eating and remission at follow up); internet self-help (ED) versus another intervention (for remission at the end of treatment and at follow up); and self-help (ED) versus wait list controls (for remission and binge eating at the end of treatment);</p> <p>A less effective result on remission was found in response to text messaging compared with wait list controls (at the end of treatment) but there was some uncertainty.</p> <p>Studies of DBT, group emotional and mind training, group support, general self-help (versus another intervention), did not report any critical outcomes.</p> <p>At no time point, for any comparison, was data reported on the important outcomes: all-cause mortality, adverse events, resource use, relapse, family functioning or service user experience.</p> <p>Refer to the LETR on young people with bulimia nervosa for a summary of the finding on guided self-help in young people.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>Existing economic evidence pertaining to the psychological therapies for adults with bulimia nervosa was very limited and the committee could not draw any conclusions from it.</p> <p>The network meta-analysis that was undertaken to inform the guideline economic analysis demonstrated that after excluding treatments with pooled number of participants less than 150 across all RCTs, CBT-ED individual had the highest probability of full remission (using the end of treatment data) followed by self-help with support (or guided self-help) in adults with bulimia nervosa. There was high heterogeneity and uncertainty surrounding the results as indicated by very wide credible intervals and high model standard deviation. There were no significant differences between active treatments. CBT-ED individual and self-help with support were significantly better than wait list in achieving remission. The inconsistency checks did not identify any significant inconsistency in the direct and indirect evidence included in the NMA. This strengthens the conclusions from the base case analysis.</p> <p>The bias adjustment sensitivity analysis suggested that bias due to small study effects may be exaggerating the treatment effects in the NMA. However, as the bias coefficient included 0 in all scenarios and there was no reduction in heterogeneity as a result of the bias adjustment, no strong conclusions about the presence of bias could be made.</p>

	<p>Although individual CBT-ED was the intervention with the highest probability of full remission, it was also associated with the highest healthcare costs due to high intervention costs. The guideline economic analysis demonstrated that self-help with support is the most cost effective first-line treatment option for people with bulimia nervosa. The probability of it being cost effective ranged from 0.80 to 0.89 at a willingness-to-pay of £20,000-£30,000 per quality-adjusted life year (QALY) (NICE, 2008b). Results were sensitive to the estimate of the probability of remission associated with self-help with support and utility value associated with the remission health state.</p> <p>However, the committee expressed the view that CBT-ED individual is better at sustaining response and may have more favourable cost effectiveness when considering the long-term follow up. There was no suitable data to populate the economic model looking at the cost effectiveness of treatments for people with bulimia nervosa during the long-term follow up. Given the lack of long-term cost-effectiveness data the committee agreed that the economic analysis does not provide a complete picture and CBT-ED individual together with self-help with support should be available treatment options for people with bulimia nervosa. The secondary analysis indicated that when extending the time horizon of the analysis to five years the ICER of CBT-ED individual versus self-help with support remains above upper NICE cost-effectiveness threshold of £30,000 per QALY. However, the ICER of CBT-ED individual when compared with wait list is well below lower NICE cost-effectiveness threshold of £20,000 per QALY by approximately 2.5 years follow up. The ICER of CBT-ED individual versus wait list represents the cost effectiveness of CBT-ED individual in people where self-help is not effective or is unacceptable.</p> <p>According to the secondary analysis, where the impact of extending the time horizon of the analysis to 5 years was explored, self-help with support remained the cost-effective option. At five years the probability of CBT-ED individual (when compared with wait list) being cost effective was 0.60 at lower NICE cost-effectiveness threshold of £20,000 per QALY and increased to 0.65 at upper NICE cost-effectiveness threshold. In the scenario where the relapse rate associated with CBT-ED individual was assumed to be zero (that is, everyone sustains the treatment effect) and the annual relapse rate associated with self-help with support and wait list was assumed to be equivalent to the baseline rate the ICER of CBT-ED individual versus wait list was reduced to £3,788.</p> <p>This supports the view that CBT-ED individual may have more favourable cost effectiveness in the long run and could be considered as a second-line option where self-help with support is ineffective or unacceptable.</p>
Quality of evidence	<p>The quality of the evidence was mostly considered very low quality. The evidence was downgraded for indirectness, imprecision and risk of bias for reasons such as it was unclear how the randomisation sequence was generated and if allocation concealment was not performed, if either or all of the participants, investigators or assessors were blinded and high dropouts were detected >20%. To account for high dropout rates, intention-to-treat analysis was used for remission results, with the assumption that any dropouts did not recover from the eating disorder.</p> <p>For indirectness, a number of RCTs in both the guided self-help and self-help arms included a mixture of people with EDNOS and bulimia nervosa and in one study binge eating disorder. Nevertheless, the majority of people who contributed to the</p>

	<p>overall result for each outcome were those with bulimia nervosa (ranging from an estimated 66% to 100%).</p> <p>As previously discussed a sensitivity analysis could not be conducted with only two studies and duration of illness, chronicity and severity of illness could not explain the results since they were all similar.</p> <p>For purging, EDE-shape concern and EDE-weight concern, duration of illness, chronicity were similar between the studies but severity of illness may explain the heterogeneity detected. One study by Ljotsson 2007 included people with a low number of binges per month (<18), and compared with Banasiask 2005 who studied people with a higher number of binges per month (>18), they showed a greater response to treatment. This suggests that severity of illness may influence how well people respond to guided self-help.</p>
<p>Other considerations</p>	<p>The committee agreed that guided self-help was a good first line treatment because of the benefit it showed on remission and binge eating compared with no treatment (wait list controls), particularly in less severe bulimia nervosa. The committee were also confident in the results for individual CBT-ED in adults given the large number of participants and the strength of the evidence that showed CBT-ED was effective across a number of outcomes including binge eating and remission at the end of treatment and importantly on remission at follow up. For this reason, they felt it was important that if people are not responding early (approximately four weeks) to guided self-help, then they should be offered CBT-ED.</p> <p>Details of the guided self-help (ED) and CBT-ED interventions in the recommendation were based on manuals used in the studies that were included in the meta-analysis. The majority of the studies referred to the same published manuals and are considered the best treatment programmes available to date.</p> <p>The committee also acknowledged that the economic evidence showed guided self-help to be more cost effective than CBT-ED. This was based on the analysis that showed the additional benefit of CBT-ED compared with guided self-help was too small to justify its additional cost according to NICE cost effectiveness criteria. Also, guided self-help remained the most cost effective treatment option when the time horizon of the economic analysis was extended to 5 years.</p> <p>The committee agreed that one of the key benefits of guided self-help is that it can be easily accessed and delivered arrange of competent practitioners in primary care and other settings. The consequent reduce waiting times for treating people with bulimia nervosa could be helpful as there is some indication that early treatment is associated with improved response.</p> <p>A subgroup analysis showed that guided self-help may be less effective in people with a more severe case of bulimia nervosa compared with those with a mild case. Although this could only be explored in a few (important) outcomes and only in a few studies, it does suggest that guided self-help may be less effective in those with a severe case of bulimia nervosa. This finding was supported by the experience of the committee members. Nevertheless, they agreed that it was important for the practitioners to assess as early as possible (e.g. four weeks) whether the person is responding to treatment and if not, they should be offered CBT-ED</p>

One study that examined the long term effects of guided self-help suggesting remission is not different compared with wait list controls (Palmer 2002, n=78). In this study, the authors appear to have provided limited information on additional treatments in the wait list control group. Participants who had shown little or no improvement were offered CBT or IPT therapy during the follow-up period. The paper reports that 39% of the wait list controls group and 28% of guided self-help group received full therapy (CBT or IPT) during the follow-up period (after the end of treatment, between 4 and 12 months). Thus, guided self-help vs. wait list control group at follow-up is actually comparing guided self-help vs. delayed treatment, or stepped care vs. stepped care. The wait list control group does not reflect what would happen to people if they had no treatment at all over a 12 month period.

There was no difference in remission rates between guided self-help and any other intervention or active treatment (four studies, n=454) at long-term follow-up. One study in the other intervention arm included CBT-ED and examining this comparison more closely showed there was no significant difference in remission rates at follow-up between CBT-ED and guided self-help (29% versus 23% respectively). Thus, both guided self-help and CBT may have similar benefits long-term in one small study (n=128).

The committee agreed that remission at follow up is the most important outcome and ideally should have been modelled in the economic analysis. However, because of the lack of follow up data it was not possible to model long term cost effectiveness of interventions for people with BN (Nevertheless, in the secondary economic analysis where the time horizon of the economic analysis was extrapolated to 5 years, guided self-help remained the cost-effective option. CBT-ED was only cost effective when compared with wait list control. However, individual CBT-ED compared with other interventions (interpersonal psychotherapy, behavioural therapy and guided self-help) appeared to show the most convincing results on remission at follow up. Thus, this supported the committee in recommending CBT-ED individual as a second-line treatment.

The impact of severity of illness (average number of binges per month) and duration of illness on responsiveness to CBT-ED was difficult to decipher because of the limited number of published studies, there was a lot of overlap in the populations severity of illness, variation in reporting binge frequency, data was not always reported and no clear definition in the field on what is mild, moderate or severe bulimia nervosa. Nevertheless, there was a subgroup analysis (that showed people with a more severe case of bulimia nervosa may be less responsive to guided self-help. This provided further support for the committee to recommend CBT-ED as a second line treatment for people who do not respond to guided self-help.

In addition the NMA of interventions for people with BN found that CBT-ED and guided self-help had a very similar effectiveness at the end of treatment and the economic analysis (found that guided self-help is the most cost-effective option when compared with CBT-ED and wait list.

The committee were aware that the duration of CBT-ED may be reduced in the future based on the preliminary evidence that 20 sessions of CBT-ED may not be needed for benefits to be seen. People may only need as few as 10 sessions. To further explore this, the committee developed a research recommendation to examine treatments of reduced duration or reduced intensity can be just as effective as standard treatment.

Other interventions for adults

In contrast individual CBT-ED, and guided self-help few treatments showed any benefit on remission at the end of treatment they included: group CBT-ED versus wait list controls; group BT versus wait list controls; group BT-ED versus another group intervention; group CBT-ED versus another group; CBT-ED of varying intensity versus another CBT-ED. None of these treatments showed a positive effect on remission at follow up compared with another treatment or wait list controls. And therefore the committee decided not to recommend any of these treatments.

The committee considered the possibility of delivering individual CBT-ED in a group format. The evidence, however, was limited and based on small numbers (critical outcomes n=52 to 126). Group CBT-ED showed no difference in binge eating or remission compared with other interventions at the end of treatment or at follow up. Compared with wait list controls, benefits from group CBT-ED were found for remission at the end of treatment (14%) and at follow up (28%). However, the results were from only two studies with 59 participants. Thus, the committee did not have confidence in recommending group CBT-ED over individual CBT-ED.

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16. Research recommendation: What is the comparative effectiveness of psychological treatments for eating disorders of reduced duration and reduced intensity compared to standard treatment?

Psychological treatment for children and young people with bulimia nervosa

First-line psychological treatment for children and young people

113. Offer bulimia-nervosa-focused family therapy (FT-BN) to children and young people with bulimia nervosa

114. FT-BN for children and young people with bulimia nervosa should:

- typically consist of 18–20 sessions over 6 months
- establish a good therapeutic relationship with the person and their family members or carers
- support and encourage the family to help the person recover
- not blame the person, their family members or carers
- include information about:
 - regulating body weight
 - dieting
 - the adverse effects of attempting to control weight with self-induced vomiting, laxatives or other compensatory behaviours

- use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours
- include regular meetings with the person on their own throughout the treatment
- include self-monitoring of bulimic behaviours and discussions with family members or carers
- in later phases of treatment, support the person and their family members or carers to establish a level of independence appropriate for their level of development
- in the final phase of treatment, focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention.

115. Consider support for family members who are not involved in the family therapy, to help them to cope with distress caused by the condition.

116. If FT-BN is unacceptable, contraindicated or ineffective, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) for children and young people with bulimia nervosa.

Second-line psychological treatment for children and young people

117. Individual CBT-ED for children and young people with bulimia nervosa should:

- typically consist of 18 sessions over 6 months, with more frequent sessions early in treatment
- include up to 4 additional sessions with parents or carers
- initially focus on the role bulimia nervosa plays in the person's life and on building motivation to change
- provide psychoeducation about eating disorders and how symptoms are maintained, while encouraging the person to gradually establish regular eating habits
- develop a case formulation with the person
- teach the person to monitor their thoughts, feelings and behaviours
- set goals and encourage the person to address problematic thoughts, beliefs and behaviours with problem-solving
- use relapse prevention strategies to prepare for and mitigate potential future setbacks

	<ul style="list-style-type: none"> • in sessions with parents and carers, provide education about eating disorders, identify family factors that stop the person from changing their behaviour, and discuss how the family can support the person's recovery.
<p>Relative value of different outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating bulimia nervosa in children and young people. For this population, binge eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with bulimia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>Family therapy</p> <p>Three RCTs were identified on the effects of family therapy on young people with bulimia nervosa. Overall, the studies showed family therapy has a positive effect on remission but has a similar effect on binge frequency compared with any other individual intervention (CBT-ED, supportive psychotherapy).</p> <p>Other outcomes generally showed positive results for family therapy compared with any other individual intervention. The following outcomes favoured family therapy: EDE-global, EDE-restraint, EDE-shape concern, EDE-weight concern and reduced hospitalisation rates. The Yale-Brown Cornell eating disorder scale and depression showed a trend to favour family therapy. One outcome, mean objective binge eating episodes, favoured the other intervention. The following outcomes were not different between the two arms: purging episodes, vomiting episodes, service user experience.</p> <p>At follow up, remission rates in young people with bulimia nervosa still favoured family therapy compared with any other intervention. Most other outcomes were similar between the two treatment arms, including: binge episodes, purging episodes, vomiting episodes, EDE-restraint, Yale-Brown Cornell eating disorder scale and depression. Two outcomes, EDE-weight concern and service user experience, showed a trend to favour family therapy although there was some uncertainty. Family therapy did however show a benefit on EDE-shape concern and EDE-global.</p> <p>No evidence was found on the important outcomes of general functioning, family functioning, adverse events, quality of life, all-cause mortality or relapse.</p> <p>CBT-ED</p> <p>The evidence on individual CBT-ED in young people with bulimia nervosa was less convincing and only one or two small studies were available per outcome. One RCT compared a form of CBT-ED for adults adapted for use in young people (CBT-A) with two active interventions (supportive psychotherapy and family therapy). One RCT (Schmidt 2007) compared what it called 'guided self-care CBT-ED' with family therapy. The committee considered this to be a form of CBT-ED</p>

	<p>since there were regular weekly meetings with a therapist, and problem solving with behavioural experiments and goal setting,</p> <p>CBT-ED was more effective than any other intervention (family therapy and supportive psychotherapy) on remission though favoured any other on binge eating. There was also no difference between CBT-ED and any other intervention on other compensatory behaviours, EDE-global and depression though there was a trend against CBT-ED.</p> <p>However, at 12 months follow up, there was no difference between CBT-ED and any other intervention on remission, binge eating and other compensatory behaviours.</p> <p>No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning or service user experience.</p> <p>Other treatments</p> <p>Two studies compared supportive psychotherapy with family therapy and showed that supportive therapy was less effective on remission and EDE-global at end of treatment. No difference between the two treatments was found on binge frequency. At follow up, supportive therapy was less effective on remission and showed no difference on binge frequency and EDE-global. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning or service user experience.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>The existing economic evidence in young people with bulimia nervosa is very limited. Existing evidence from UK-study is only partially applicable and is characterised by minor methodological limitations.</p> <p>The committee considered the existing economic evidence which indicated that family therapy may potentially be cost effective when compared with CBT-ED. The committee also took into account the physical consequences of eating disorders and high costs associated with managing these; psychological and financial burden associated with eating disorders both for children and young people and for their families, as well as the clinical benefits associated with treatment and the benefits of involving parents or carers in the recovery process. The committee also considered the intervention costs and concluded that offering treatment, such as family treatment, would represent good value for money.</p> <p>The committee noted that there is a lack of evidence on the effectiveness and cost effectiveness of interventions for young people with BN. The committee also noted that because treatment options are very limited CBT-ED should be an option where family therapy is ineffective or unacceptable. Also, the committee considered that over the long-term CBT-ED was potentially a cost effective second line treatment for adults with bulimia nervosa and given the lack of data for young people the committee extrapolated the cost effectiveness of interventions (to young people with bulimia nervosa) from the economic analysis conducted for this guideline for adults with bulimia nervosa.</p>
<p>Quality of evidence</p>	<p>The evidence for family therapy was all low or very low quality. The evidence was downgraded for imprecision and risk of bias for reasons such as it was unclear how they randomised or if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded.</p> <p>Imprecision was often detected because the 95% confidence interval crossed one or two MIDs or the outcome did not meet the optimal information size of 300 events or 400 participants. One study (Schmidt 2007) was downgraded for indirectness because it included over 28% EDNOS participants.</p>

Other considerations	<p>Few studies on psychological therapies for young people with bulimia nervosa were identified and none on children. The most convincing evidence was on family therapy where three studies were found with 295 participants. The 69% greater increase in the number who achieved remission at follow up compared with other treatments convinced the committee that family therapy should be recommended as a first-line treatment.</p> <p>The other evidence considered by the committee when refining the recommendations was on CBT-ED. Only two studies on CBT-ED with a total of 195 participants were identified which reported. There was no difference between CBT-ED and family therapy on remission and a trend favouring family-based therapy on binge frequency. Despite the uncertainty about the difference in outcomes the committee agreed to not recommend CBT-ED as a first line treatment based on the costings for CBT-ED in adults. However, the committee recognised that it was important to recommend an alternative to family-therapy if it was unacceptable, contraindicated or ineffective.</p> <p>More generally, the committee recognised that given the recommendation to use family therapies for children and young people with anorexia nervosa or bulimia nervosa as first-line treatments, with CBT-ED as a second-line treatment. As few studies that have directly compared the two interventions, a research recommendation was made to assess comparative efficacy,</p> <p>The committee drew on their knowledge and experience to identify the importance of including siblings and other family members in the treatment because of the distress bulimia nervosa may cause to other family members.</p>
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1 **17. Research recommendation: How effective are family therapies compared with**
2 **CBT-ED in children and young people with eating disorders?**

3 **7.3 Carer interventions**

4 **7.3.1 Review question: Does any psychological intervention produce benefits/harms**
5 **in the parents or carers of children or young people with an eating disorder**
6 **compared with any other intervention or controls?**

7 The review protocol summary, including the review question and the eligibility criteria used
8 for this section of the guideline, can be found in Table 202. Further information about the
9 search strategy can be found in Appendix H; the full review protocols can be found in
10 Appendix J.

11 This review considers all psychological interventions for the parents or carers of children or
12 young people with bulimia nervosa. The interventions were categorised according to their
13 mode of delivery (e.g. group, self-help), the age of the people with the eating disorder, and
14 the type of eating disorder and were compared to wait list controls, TAU or any other
15 intervention.

1

Table 202: Clinical review protocol summary

Component	Description
Review question(s)	<ul style="list-style-type: none"> Does any psychological intervention produce benefits/harms in the parents or carers of children or young people with an eating disorder compared with any other intervention or controls?
Population	<ul style="list-style-type: none"> Family or carers of people with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder)
Intervention(s)	<p>Psychological interventions may include:</p> <ul style="list-style-type: none"> Family-based Parent only (not necessarily focussed on eating disorder) Parent-focused therapy (PFT) Group Parent-Training (GPT) Separated family therapy Parents with person with ED (greater focus on eating disorder) Behavioural Family Therapy (BFT) Behavioural family systems therapy (BFST). Family-Based Treatment (FBT) Family Day Workshops (FDW) Family Therapy (FT) Family therapy for anorexia nervosa (FT-AN) Multi-Family Group Day Treatment (MFGDT) Multi-Family Group Therapy (MFGT) Systemic Family Therapy (SFT) Systemic Family Therapy for AN (SFT-AN) Multifamily therapy (MFT) is synonymous with (MFGT; MFGDT). Uniting couples in the treatment of AN (UCAN) Conjoint family therapy
Comparison	<ul style="list-style-type: none"> Wait list control Treatment as usual Another intervention
Critical outcomes	<ul style="list-style-type: none"> Parent's or carer's general psychopathology (including mood/depression/anxiety) Family functioning Quality of life Other primary outcomes commonly reported in studies that just target the family/carer The following outcomes will be included if the family or carer intervention includes the child or person with an eating disorder: Remission and long-term recovery (if symptoms were measured over a minimum two week period) Binge eating for BN and BED Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> General functioning

Component	Description
	<ul style="list-style-type: none"> • Resource use. • Service user experience • All-cause mortality. • Adverse events • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 7.3.2 Clinical evidence

2 No studies in parents or carers of children or young people with bulimia nervosa were found
3 that met the eligibility criteria for this review. Further information about excluded studies can
4 found in Appendix J.

5 7.3.3 Economic evidence

6 No economic evidence on the cost effectiveness of interventions for the parents or carers of
7 children or young people with bulimia nervosa was identified by the systematic search of the
8 economic literature undertaken for this guideline.

9 7.3.4 Clinical evidence statements

10 No studies in parents or carers of children or young people with bulimia nervosa were found
11 that met the eligibility criteria for this review

12 7.3.5 Economic evidence statements

13 No economic evidence on the cost effectiveness of interventions for the parents or carers of
14 children or young people with bulimia nervosa was available.

15 7.3.6 Recommendations and link to evidence

16 Working with family members and carers

See Section 6.3.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing whether any interventions help the parents and carers of children and young people with an eating disorder. The critical outcomes for the parents and carers were: general psychopathology, family functioning, quality of life, and other primary outcomes reported by the study.</p> <p>Other outcomes that are critical for the child or young person with the eating disorder include remission and binge eating or body weight, depending on the eating disorder.</p>

	Other outcomes that are of lesser importance but clearly important outcomes include, general functioning, service user experience, all-cause mortality, adverse events and eating disorder psychopathology.
Trade-off between clinical benefits and harms	No relevant published evidence was found on the families or carers of children and young people with bulimia nervosa. For discussion of carer interventions for other eating disorders, see the LETRs in the relevant chapters.
	The committee expressed the view that offering family members and carers an assessment of their own needs may incur additional healthcare resources (that is, time required to perform such assessment and the delivery of any subsequent interventions). However, the committee considered the cost of providing such to be limited, taking into account the potential reduction in family and carers' burden, potential depression and other health vulnerabilities which may be costly to other parts of the healthcare system, especially considering that the burden on family and carers can last for many years and increase their morbidity and stress. Consequently, the committee judged that assessment and any subsequent that aim to improve family and carers' experience are likely to represent good value for money.
Quality of evidence	No evidence was identified for carer interventions in the families or carers of people with bulimia nervosa.
Other considerations	Given the very low quality of the data with very few positive findings favouring one arm over the other, the committee concluded that there was not enough evidence to support a recommendation on any specific interventions for parents or carers of people with an eating disorder. They made a number of general recommendations which have application across all eating disorders. (See the LETR in Section 6.3 for further discussion of carer interventions).

1 7.4 Pharmacological interventions

2 7.4.1 Review question: Does any pharmacological intervention produce 3 benefits/harms on specified outcomes in people with eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 203 **Error! Reference source not**
6 **found.** Further information about the search strategy can be found in Appendix H; the full
7 review protocols can be found in Appendix F.

8 This review considers all pharmacological interventions that may be delivered to children,
9 young people and adults with an eating disorder. The interventions were categorised
10 according to type of physical intervention, the age of the participants and the type of eating
11 disorder and were compared to wait list controls, placebo, treatment as usual or any other
12 intervention.

1

Table 203: Clinical review protocol summary

Topic	Interventions to treat eating disorders in children, young people and adults
Review question	<ul style="list-style-type: none"> Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Strata: <ul style="list-style-type: none"> Children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years Eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical eating disorder)
Intervention	Pharmacological intervention Pharmacological interventions may include: <ul style="list-style-type: none"> Anti-depressants i.e. SSRIs, Fluoxetine – Prozac Anxiolytic (antianxiety) Antipsychotic Anti-emetic medication. i.e. Ondansetron Anticonvulsant topiramate/antiepileptic (Topomax) Appetite suppressant (i.e. lisdexamfetamine dimesylate) Pharmacological + psychological:
Control	<ul style="list-style-type: none"> Placebo Wait list control Treatment as usual Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes for decision making	<ul style="list-style-type: none"> Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED. Body weight / BMI for AN. Adverse events
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs

2

3 7.4.2 Clinical evidence

4 In total 28 RCTs were identified that met the criteria for this review. Some of these studies
 5 included the follow up data. Of these studies, 17 (n=1556) compared a single
 6 pharmacological intervention with another active arm or placebo (Carruba et al., 2001; Faris
 7 et al., 2000; Fluoxetine Bulimia Nervosa Collaborative Study Group, 1992; Hedges et al.,
 8 2003; Hoopes et al., 2003; Kaneva et al., 1995; Leombruni et al., 2006; Milano et al., 2004;
 9 McCann and Agras, 1990; Mitchell et al., 1990b; Nickel et al., 2005; Pope et al., 1989;
 10 Romano et al., 2002; Schmidt et al., 2004; Walsh et al., 1991; Walsh et al., 1987; Walsh et
 11 al., 2004). All of the studies were conducted in adults.

1 Of all the relevant studies identified, 10 RCTs (n=732) compared a combined
2 pharmacological therapy with another treatment (mostly psychological) and compared it with
3 another active arm or placebo (Beumont et al., 1997; Agras et al., 1992; Agras et al., 1994a;
4 Goldbloom et al., 1997; Jacobi et al., 2002; Mitchell et al., 1990b; Keel et al., 2002; Mitchell
5 et al., 2001; Walsh et al., 2004; Walsh et al., 1997).

6 An overview of the trials included in this review can be found in Table 204. Summary of
7 findings for the studies on bulimia nervosa can be found in Table 205, Table 206, Table 207,
8 Table 208, Table 209, Table 210, Table 211, and Table 212.

9 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
10 evidence tables in Appendix L and exclusion list in Appendix J.

Table 204: Study information for trials included in the meta-analysis of pharmacological versus any other intervention, placebo or wait list controls for people with bulimia nervosa.

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N	Intervention Category	Comparison Arm Category	Treatment Length
Bulimia Nervosa								
Single Pharmacotherapy								
Carruba 2001	25.7 (0.8)	20.4 (0.4)	100%	Not reported	77	Moclobemide - 400-600 mg/day. MAOI	Placebo	42 days
Faris 2000	29.1 (6)	21.6 (2.5)	100%	Duration of BN 11-8 years	26	Ondansetron -4 mg/day. Antiemetics	Placebo	4 weeks
FBNCSSG 1992	27.4 (7.2)	22.7 (4.2)	100%	At least 6 months	387	Fluoxetine hydrochloride -20 mg/d. SSRI Fluoxetine hydrochloride 60 mg/d. SSRI	Placebo	8 weeks
Hoopes 2003/ Hedges 2003	29.0 (9.7)	61.3 (10.3) kg	99%	At least 2 binge eating episodes per week for a min of 1 year	69	Topiramate 25 to 400 mg/day. Anticonvulsant	Placebo	50 weeks
Kanerva 1995	25.2 (16-22)	62.2 (15.4) (kg)	100%	Duration of BN 5.7 (0.5-20) years	50	Fluoxetine 60 mg/day. SSRI	Placebo	8 weeks
Leombruni 2006	28.7 (8.2)	20.7 (5.0)	100%	Duration of ED 7 years	37	Citalopram 20 mg to 40 mg. SSRI	Fluoxetine SSRI	3 months
Milano 2004	24 to 36 years	NR	100%	Not reported	20	Sertraline 100 mg/day. SSRI	Placebo	12 weeks

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N	Intervention Category	Comparison Arm Category	Treatment Length
McCann 1990	20 (14-36)	31.7 (4.7) kg	100%	Not reported	30	Desipramine 50 mg to 300 mg. TCA	Placebo	84 days
Mitchell 1990	24.1 (4.4)	106.4 (12.8)% ideal body weight	100%	Duration of BN: 6.5 (2.9) years	171	Imipramine Hydrochloride 50 to 300 mg/day. TCA TCA and Group therapy Group therapy + Placebo	Placebo	12 weeks
Nickel 2005	21.5 (3.1)	64.9 (5.8) kg	100%	Duration of illness at least 6 months	60	Topiramate 25 to 200 mg/day. anticonvulsant	Placebo	10 weeks
Pope 1989	26 (18-55)	Not reported	100%	Not reported	46	Trazodone -355 mg (max 400 mg). Other	Placebo	26 days
Romano 2002* (prevent relapse)	29.5 (7.0)	22.5 (3.9)	93%	Responders to 8 weeks of treatment were randomised to treatment or placebo	150	Fluoxetine 60 mg/day. SSRI	Placebo	12 months
Schmidt 2004	18-50 years	85% and 115% of ideal body weight	100%	Not reported	200	Fluvoxamine 50 to 300 mg/day. SSRI	Placebo	52 weeks.
Walsh 1991	24.8 (4.5)	136.2 (16.1)	100%	6.7 (3.6) years	80	Desipramine.200 to 300 mg/day. (TCA).	Placebo	42 days
Walsh 1987	26.9 (4.3)	NR	100%	Duration of BN: 9.0 (4.4) years	62	Phenelzine 30-90 mg/day. (MAOI)	Placebo	56 days

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N	Intervention Category	Comparison Arm Category	Treatment Length
Walsh 2004	30.6 (7.8)	BMI > 17.5 kg/m ²	100%	Duration of BN: 12.0 (7.9) years	91	Fluoxetine (60 mg/day). SSRI Self-help + SSRI. Combination Guided Self-help	Placebo	4 months
Bulimia Nervosa Combined Therapy								
Beumont 1997	24.2 (4.5)	22.0 (2.0)	100%	Not reported	67	Nutrition + Fluoxetine (SSRI, 60 mg/day)	Nutritional counselling	8 weeks + 12 weeks FU
Agras 1992 (Agras 1994 FU)	29.6 (8.9)	59.9 (9.1) ideal weight: 53.7 (5.8) kg	100%	Duration of BN: 10 years	71	Desipramine hydrochloride (TCA, 25-350mg) Combination Medication and CBT	CBT	16 or 24 weeks. 8, 12 weeks FU
Goldbloom 1997	25.8 (5.5)	23.0 (2.5)	100%	Minimum 6-month duration of illness;	76	Fluoxetine (SSRI, 60 mg/day) Combination Medication and CBT	CBT-ED	12 weeks (4 weeks FU)
Jacobi 2002	26.0 (5.8)	20.6 (2.0)	100%	Binge eating had begun 7.9 (5.2) years and vomiting 7.4 (4.8) years before the start of the study	53	Fluoxetine (SSRI, 20 to 60 mg/day) Combination Medication and CBT	CBT-ED	4 months (6 mo and 1 year FU)
Mitchell 1990 (Keel 2002 FU)	24.1 (4.4)	% Ideal BW 106.5 (12.8)	100%	Duration of BN: 6.5 (2.9) years	171	Imipramine hydrochloride (TCA, 50 to 300 mg/day)	Placebo	10 weeks (10 year FU)

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N	Intervention Category	Comparison Arm Category	Treatment Length
						Group-CBT-ED (placebo) Combined TCA + Group therapy		
Mitchell 2001	26.6 (7.1)	59.5 (13.9) kg	100%	Duration of illness at least 6 months	91	Fluoxetine (SSRI, 60 mg/day) Fluoxetine + Self-help manual Placebo + Self-help	Placebo	16 weeks
Walsh 2004	24.3 (5.5)	21.9 (3.4)	100%	Duration of BN: 12.0 (7.9) years	91	Fluoxetine (SSRI, 60mg/day) Guided self-help Guided self-help+fluorextine (SSRI)	Placebo	4 months
Walsh 1997	26.1 (4.9)	21.9 (2.2)	100%	Duration of BN: 8.0 (4.0)	112	CBT + Placebo CBT+ Desipramine TCA Supportive Psychotherapy + Medication	Supportive Psychotherapy + Placebo	112 days

Abbreviations: CBT, cognitive behavioural therapy; FU, follow up; TCA, tricyclic antidepressant; SSRI, selective serotonin reuptake inhibitor.

Table 205: Summary of findings table for an antidepressant versus placebo at end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with Antidepressant (95% CI)

Binge frequency, Adults - SSRIs	42 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency, adults - ssris in the intervention groups was 0.13 standard deviations lower (0.73 lower to 0.48 higher)
Purge frequency. Adults - TCAs	78 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency. adults - tcas in the intervention groups was 0.34 standard deviations lower (0.79 lower to 0.11 higher)
Vomiting frequency. Adults - SSRI	42 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting frequency. adults - ssri in the intervention groups was 0.20 standard deviations lower (0.8 lower to 0.41 higher)
EDI Adults	123 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi adults in the intervention groups was 1.19 standard deviations higher (0.74 to 1.64 higher)
EDI Adults - SSRI	46 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi adults - ssri in the intervention groups was 0.29 standard deviations lower (0.87 lower to 0.29 higher)
EDI Adults - MAOI	77 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi adults - maoui in the intervention groups was 3.34 standard deviations higher (2.64 to 4.04 higher)
EDI - Drive for thinness. Adults - SSRI	46 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - drive for thinness. adults - ssri in the intervention groups was 0.44 standard deviations lower (1.02 lower to 0.15 higher)
EDI- Body dissatisfaction. Adults - SSRI	46 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi- body dissatisfaction. adults - ssri in the intervention groups was 0.48 standard deviations lower (1.07 lower to 0.1 higher)
EDI- Bulimia. Adults - SSRI	46 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6}		Not calculable	The mean edi- bulimia. adults - ssri in the intervention groups was

		due to risk of bias, imprecision, publication bias		for SMD values	0.15 standard deviations lower (0.73 lower to 0.43 higher)
Depression TCA	101 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression tca in the intervention groups was 0.35 standard deviations lower (0.74 lower to 0.04 higher)
Depression scores. Adults - SSRIs	88 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,9} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression scores. adults - ssris in the intervention groups was 0.39 standard deviations lower (0.81 to 0.03 lower)
Depression scores. Adults - MAOIs	127 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression scores. adults - maois in the intervention groups was 0.06 standard deviations lower (0.4 lower to 0.29 higher)
Depression change score - SSRI	146 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression change score - ssri in the intervention groups was 0.19 standard deviations lower (0.52 lower to 0.13 higher)
Global clinical score. Adults	312 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean global clinical score. adults in the intervention groups was 0.33 standard deviations lower (0.55 to 0.1 lower)
Global clinical score. Adults - TCA	78 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean global clinical score. adults - tca in the intervention groups was 0.33 standard deviations lower (0.77 lower to 0.12 higher)
Global clinical score. Adults - SSRI	234 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean global clinical score. adults - ssri in the intervention groups was 0.32 standard deviations lower (0.58 to 0.07 lower)
Did not have adverse event. Adults	960 (11 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,12} due to risk of bias, imprecision, publication bias	RR 0.95 (0.92 to 0.99)	49 per 1000	2 fewer per 1000 (from 0 fewer to 4 fewer)

Did not have adverse event. Adults - TCAs	165 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,9} due to risk of bias, imprecision, publication bias	RR 0.94 (0.87 to 1.01)	14 per 1000	1 fewer per 1000 (from 2 fewer to 0 more)
Did not have adverse event. Adults- SSRIs	610 (5 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,9,13} due to risk of bias, imprecision, publication bias	RR 0.97 (0.93 to 1.01)	49 per 1000	1 fewer per 1000 (from 3 fewer to 0 more)
Did not have adverse event. Adults - MAOIs	139 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,6,14,15} due to risk of bias, inconsistency, imprecision, publication bias	RR 0.87 (0.75 to 1)	86 per 1000	11 fewer per 1000 (from 21 fewer to 0 more)
Drop out due to adverse events. Adults - Other	46 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,15} due to risk of bias, imprecision, publication bias	RR 1 (0.88 to 1.13)	43 per 1000	0 fewer per 1000 (from 5 fewer to 6 more)
Did not achieve remission Adults Other_ITT	46 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,15} due to risk of bias, imprecision, publication bias	RR 0.91 (0.79 to 1.06)	0 per 1000	-
Binge frequency Adults TCA FU	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency adults tca fu in the intervention groups was 0.39 standard deviations lower (1.04 lower to 0.25 higher)
Laxative use Adults TCA FU	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,16} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative use adults tca fu in the intervention groups was 0.08 standard deviations higher (0.56 lower to 0.72 higher)
Vomit frequency Adults TCA FU	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomit frequency adults tca fu in the intervention groups was 0.46 standard deviations lower (1.1 lower to 0.19 higher)
Depression Adults TCA FU	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6}		Not calculable	The mean depression adults tca fu in the intervention groups was

		due to risk of bias, imprecision, publication bias		for SMD values	0.27 standard deviations higher (0.37 lower to 0.91 higher)
EDI - Body dissatisfaction Adults TCA FU	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - body dissatisfaction adults tca fu in the intervention groups was 0.24 standard deviations lower (0.88 lower to 0.4 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 It was unclear how the random sequence was generated or if allocation concealment was conducted. It was unclear if either the participants, investigators or assessors were blind. High dropouts were reported in one arm >20%.
- 2 For continuous outcome, there were fewer than 400 participants.
- 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
- 4 It was unclear how patients were randomised and if allocation concealment was performed. Studies were double-blind but unclear if assessors were blind.
- 5 95% Crossed 1 MID (-0.5).
- 6 It was unclear how randomised sequence was generated and if allocation concealment was conducted. Study was double-blind but it was unclear if assessors were blind. High dropouts were reported.
- 7 It was unclear in one study how randomised sequence was generated and if allocation concealment was conducted in both studies. Studies were double-blind but it was unclear if investigators were blind. High dropouts were reported in Romano.
- 8 It was unclear how randomised sequence was generated and if allocation concealment was conducted in both studies. Studies were double-blind but it was unclear if assessors were blind.
- 9 It was unclear in one study how random sequence was generated and in all studies if allocation concealment was performed. In was unclear if assessors were blind. High dropouts were reported >20%.
- 10 It was unclear if allocation concealment was performed. It was a double-blind study but it was unclear if assessors were blind. High dropouts were reported >20%.
- 11 It was unclear in all but one study how the randomised sequence was generated and if allocation concealment was conducted. It was unclear in one study if investigator was blind and in all studies if assessors were blind. High dropout rates were reported >20%.
- 12 In most studies it was unclear how patients were randomised and if allocation concealment was performed. Most studies were double-blind but unclear if assessors were blind. High dropouts were reported >20%.
- 13 It was unclear how the random sequence was generated or if allocation concealment was conducted. It was unclear if either the participants, investigators or assessors were blind.
- 14 Heterogeneity was detected I² >80%.
- 15 For a dichotomous outcome, there were fewer than 300 events.
- 16 95% CI crossed 2 MIDs (-0.5 to 0.5).

Table 206: Summary of findings table for an antidepressant versus another antidepressant at end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another Antidepressant	Risk difference with Antidepressant (95% CI)
Depression - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression - ssri (citalopram) vs. ssri (fluoxetine). adults in the intervention groups was 0.22 standard deviations lower (0.97 lower to 0.52 higher)
EDI - Drive for thinness - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - drive for thinness - ssri (citalopram) vs. ssri (fluoxetine). adults in the intervention groups was 0.34 standard deviations higher (0.4 lower to 1.09 higher)
EDI- Body dissatisfaction - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi- body dissatisfaction - ssri (citalopram) vs. ssri (fluoxetine). adults in the intervention groups was 0 standard deviations higher (0.74 lower to 0.74 higher)
EDI - Bulimia - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - bulimia - ssri (citalopram) vs. ssri (fluoxetine). adults in the intervention groups was 0.04 standard deviations lower (0.78 lower to 0.7 higher)
Exercise - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean exercise - ssri (citalopram) vs. ssri (fluoxetine). adults in the intervention groups was 1.23 standard deviations higher (0.41 to 2.05 higher)
Clinical Global Impression - Adverse effect - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias,		Not calculable for SMD values	The mean clinical global impression - adverse effect - ssri (citalopram) vs. ssri (fluoxetine). adults in the intervention groups was

		imprecision, publication bias			0.27 standard deviations lower (1.02 lower to 0.47 higher)
Drop outs due to any reason - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,6} due to risk of bias, imprecision, publication bias	RR 1.18 (0.38 to 3.72)	222 per 1000	40 more per 1000 (from 138 fewer to 604 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Unclear how random sequence was generated and if allocation concealment was conducted. Single-blind study but patients were not blinded. High dropouts were reported >20%.					
2 95% CI crossed 2 MIDs (-0.5 and 0.5).					
3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.					
4 95% CI crossed 1 MID (0.5).					
5 95% CI crossed 1 MID (-0.5).					
6 95% CI crossed 2 MIDs (0.75 and 1.25).					

Table 207: Summary of findings table for an antidepressant versus a combined antidepressant and psychotherapy at end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
Laxative use. Adults - Self-help	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative use. adults - self-help in the intervention groups was 0.04 standard deviations lower (0.64 lower to 0.55 higher)
Vomiting frequency. Adults	102 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,5}		Not calculable for SMD values	The mean vomiting frequency. adults in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
		due to risk of bias, imprecision, publication bias			0.19 standard deviations higher (0.21 lower to 0.58 higher)
Vomiting frequency. Adults - Self-help	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting frequency. adults - self-help in the intervention groups was 0.02 standard deviations lower (0.62 lower to 0.57 higher)
Vomiting frequency. Adults - CBT	58 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting frequency. adults - cbt in the intervention groups was 0.35 standard deviations higher (0.17 lower to 0.87 higher)
Binge frequency- Adults	203 (5 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency- adults in the intervention groups was 0.26 standard deviations higher (0.02 lower to 0.547 higher)
Binge frequency. Adults - CBT	109 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency. adults - cbt in the intervention groups was 0.63 standard deviations higher (0.24 to 1.02 higher)
Binge frequency. Adults - Self-help	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,9} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency. adults - self-help in the intervention groups was 0.02 standard deviations higher (0.58 lower to 0.61 higher)
Binge frequency. Adults - Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency. adults - focal/ supportive psychotherapy in the intervention groups was 0.29 standard deviations lower (0.85 lower to 0.27 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
Purge frequency Total Adults	159 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency total adults in the intervention groups was 0.22 standard deviations higher (0.1 lower to 0.54 higher)
Purge frequency, Adults - CBT	109 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency, adults - cbt in the intervention groups was 0.49 standard deviations higher (0.1 to 0.87 higher)
Purge frequency, Adults - Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ LOW ^{3,10,11} due to risk of bias, imprecision		Not calculable for SMD values	The mean purge frequency, adults - focal/supportive psychotherapy in the intervention groups was 0.35 standard deviations lower (0.92 lower to 0.21 higher)
General psychiatric features - Total Adults	179 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,7,12} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric features - total adults in the intervention groups was 0.04 standard deviations lower (0.33 lower to 0.26 higher)
General psychiatric symptoms, Adults - CBT	85 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,13} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric symptoms, adults - cbt in the intervention groups was 0.1 standard deviations higher (0.33 lower to 0.53 higher)
General psychiatric symptoms, Adults - Self-help	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,11,14} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric symptoms, adults - self-help in the intervention groups was 0.09 standard deviations lower (0.69 lower to 0.5 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
General psychiatric symptoms, Adults - Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric symptoms, adults - focal/ supportive psychotherapy in the intervention groups was 0.22 standard deviations lower (0.78 lower to 0.34 higher)
Depression. Adults - CBT	125 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,15} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression. adults - cbt in the intervention groups was 0.29 standard deviations higher (0.06 lower to 0.65 higher)
Depression. Adults - Self-help	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,14} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression. adults - self-help in the intervention groups was 0.02 standard deviations lower (0.62 lower to 0.57 higher)
Depression. Adults - supportive psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression. adults - focal/ supportive psychotherapy in the intervention groups was 0.26 standard deviations higher (0.3 lower to 0.83 higher)
EDE-Shape concern. Adults - CBT	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,16} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-shape concern. adults - cbt in the intervention groups was 0.26 standard deviations higher (0.54 lower to 1.07 higher)
EDE-Weight concern. Adults - CBT	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,16} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-weight concern. adults - cbt in the intervention groups was 0.19 standard deviations higher (0.62 lower to 0.99 higher)
EDE-Global score, Adults - CBT	51 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,16}		Not calculable for SMD values	The mean ede-global score, adults - cbt in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
		due to risk of bias, imprecision, publication bias			0.54 standard deviations higher (0.03 lower to 1.1 higher)
EDI-Drive for thinness. Adults - CBT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-drive for thinness. adults - cbt in the intervention groups was 0.24 standard deviations higher (0.44 lower to 0.92 higher)
EDI-Bulimia. Adults - CBT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-bulimia. adults - cbt in the intervention groups was 0.6 standard deviations higher (0.09 lower to 1.29 higher)
EDI-Body dissatisfaction. Adults - CBT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-body dissatisfaction. adults - cbt in the intervention groups was 0.34 standard deviations higher (0.34 lower to 1.02 higher)
Drop out due to adverse events. Adults - CBT	140 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,15,18} due to risk of bias, imprecision, publication bias	RR 0.8 (0.31 to 2.07)	114 per 1000	23 fewer per 1000 (from 79 fewer to 122 more)
Remission (100% binge free). Adults - Supportive psychotherapy	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,18} due to risk of bias, imprecision, publication bias	RR 1.10 (0.4 to 3)	294 per 1000	29 more per 1000 (from 176 fewer to 588 more)
Remission (100% binge free). Adults - CBT ITT	155 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,19,20} due to risk of bias, imprecision, publication bias	RR 0.56 (0.3 to 1.06)	222 per 1000	98 fewer per 1000 (from 156 fewer to 13 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
Did not achieve Remission (100% binge free) FU Adults - CBT ITT	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,17,20} due to risk of bias, imprecision, publication bias	RR 0.99 (0.89 to 1.11)	34 per 1000	0 fewer per 1000 (from 4 fewer to 4 more)
Remission (100% purge free). Adults - CBT ITT	155 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,19,21} due to risk of bias, imprecision, publication bias	RR 1.15 (0.44 to 3.06)	86 per 1000	13 more per 1000 (from 48 fewer to 178 more)
Remission (100% purge free). Adults - Supportive Psychotherapy ITT	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,18} due to risk of bias, imprecision, publication bias	RR 1.31 (0.35 to 4.89)	136 per 1000	42 more per 1000 (from 89 fewer to 530 more)
Did not achieve Remission (100% purge free) FU Adults - CBT ITT (Copy)	52 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,17,20} due to risk of bias, imprecision, publication bias	RR 0.90 (0.76 to 1.07)	34 per 1000	3 fewer per 1000 (from 8 fewer to 2 more)
Quality of life. Adults - CBT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean quality of life. adults - cbt in the intervention groups was 0.17 standard deviations higher (0.5 lower to 0.85 higher)
EDI Body dissatisfaction FU. Adults - CBT	53 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,24} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi body dissatisfaction fu. adults - cbt in the intervention groups was 0.11 standard deviations higher (0.44 lower to 0.67 higher)
Vomit frequency FU. Adults - CBT	53 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,11,24} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomit frequency fu. adults - cbt in the intervention groups was 0.09 standard deviations lower (0.65 lower to 0.46 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
Depression FU. Adults - CBT	92 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,20,23} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression fu. adults - cbt in the intervention groups was 0.07 standard deviations higher (0.35 lower to 0.48 higher)
Laxative FU abuse - CBT	53 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,17,24} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative fu abuse - cbt in the intervention groups was 0.18 standard deviations higher (0.38 lower to 0.73 higher)
Binge frequency FU. Adults - CBT	53 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,12,24} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency fu. adults - cbt in the intervention groups was 0.00 standard deviations higher (0.55 lower to 0.55 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 Unclear how random sequence was generated and if allocation concealment was conducted. Unclear if it were blinded, although placebo pills were used. High dropouts were reported >20%.
- 2 95% CI crossed 2 MIDs (-0.5 and 0.5).
- 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
- 4 It was unclear how randomised sequence was generated and if allocation concealment was conducted. It was unclear if patients, investigators or assessors were blind. High dropouts were reported.
- 5 95% CI crossed 1 MID (0.5).
- 6 Unclear how random sequence was generated or if allocation concealment was performed. In one study patients were not blinded. Unclear in either study if assessors were blind. High dropouts were reported >20%.
- 7 In most studies it is unclear how random sequence was generated and if allocation concealment were conducted. It is unclear if assessors were blind in all studies, High dropouts were reported.
- 8 Unclear how random sequence was generated or if allocation concealment was performed. Unclear in most studies if participants, investigators or

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Antidepressant + Psychotherapy (BN)	Risk difference with Antidepressant (95% CI)
<p>assessors were blind. High dropouts were reported >20%.</p> <p>9 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were blind but unclear if assessors were blind, one study investigators were not blind. High dropouts were reported.</p> <p>10 Unclear how random sequence was generated and if allocation concealment was conducted. It is unclear if assessors were blind, High dropouts were reported.</p> <p>11 95% CI crossed 1 MID (-0.5).</p> <p>12 For continuous variable, there were fewer than 400 participants.</p> <p>13 It was unclear how randomised sequence was generated and if allocation concealment was conducted. Participants were not blind in one study and it was unclear if assessors were blind in all studies. High dropouts were reported.</p> <p>14 It was unclear how randomised sequence was generated and if allocation concealment was conducted. Participants were blind, but it was unclear if investigators or assessors were blind. High dropouts were reported.</p> <p>15 It was unclear how randomised sequence was generated and if allocation concealment was conducted. Participants were not blind in one study and it was unclear if investigators were blind or assessors were blind in all studies. High dropouts were reported.</p> <p>16 Unclear how random sequence was generated and if allocation concealment was conducted. It is unclear if participants, investigator or assessors were blind, High dropouts were reported.</p> <p>17 It was unclear how randomised sequence was generated and if allocation concealment was conducted. Participants were not blind and it was unclear if investigators or assessors were blind. High dropouts were reported.</p> <p>18 95% CI crossed 2 MIDs (0.75 and 1.25).</p> <p>19 Unclear how random sequence was generated and if allocation concealment was conducted. It is unclear if participants, investigators or assessors were blind across different studies, High dropouts were reported.</p> <p>20 For a dichotomous outcome, there were fewer than 300 events.</p> <p>21 95% CI crossed 1 MID (0.75).</p> <p>22 Unclear how random sequence was generated and if allocation concealment was conducted. Investigators were not blind and it was unclear if either participants or assessors were blind. High dropouts were reported >20%.</p> <p>23 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind in one study but not the investigators and it was unclear if the assessors were blind. In the other it was unclear if they were blind, along with the investigators and assessors. High dropouts were reported >20%.</p> <p>24 It was unclear how random sequence was generated and if allocation concealment was performed. Participants were blind to drug treatment, assessors were blind but investigators were not blind. High dropouts were reported >20%.</p>					

Table 208: Summary of findings table for an antidepressant and nutritional therapy versus placebo and nutritional therapy at end of treatment and follow up in adults with bulimia nervosa

.Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+Nutrition	Risk difference with Antidepressant+Nutrition (95% CI)
EDE- Weight concern FU. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede- weight concern fu. adults - ssri in the intervention groups was 0.12 standard deviations lower (0.6 lower to 0.36 higher)
EDE- Weight . Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede- weight . adults - ssri in the intervention groups was 0.94 standard deviations lower (1.45 to 0.44 lower)
EDE-Eating concern. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-eating concern. adults - ssri in the intervention groups was 0.04 standard deviations lower (0.51 lower to 0.44 higher)
EDE-Eating concern FU. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-eating concern fu. adults - ssri in the intervention groups was 0.12 standard deviations higher (0.36 lower to 0.6 higher)
EDE-Shape concern. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-shape concern. adults - ssri in the intervention groups was 0.63 standard deviations lower (1.13 to 0.14 lower)
EDE-Shape concern FU. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-shape concern fu. adults - ssri in the intervention groups was 0.26 standard deviations higher (0.23 lower to 0.74 higher)

Drop out due to any reason. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, imprecision, publication bias	RR 1.53 (0.67 to 3.45)	212 per 1000	112 more per 1000 (from 70 fewer to 520 more)
Drop out due to adverse events. Adults - SSRI	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,6} due to risk of bias, imprecision, publication bias	RR 0.88 (0.77 to 1.01)	0 per 1000	-

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 It was unclear how the randomised sequence was generated and if allocation concealment was performed. It was unclear if either the participants or investigators were blinded. Assessors were blind. High dropouts were reported >20%
- 2 95% CI crossed 1 MID (-0.5)
- 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
- 4 95% CI crossed 1 MID (0.5)
- 5 95% CI crossed 2 MIDs (0.75 and 1.25)
- 6 95% CI crossed 1 MID (0.75)

Table 209: Summary of findings table for psychotherapy versus an antidepressant at the end of treatment in adults and at follow up with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant	Risk difference with Psychotherapy (95% CI)
Laxative use. Adults - Self-help (Guided)	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative use. adults - self-help (guided) in the intervention groups was 0.56 standard deviations higher (0.04 lower to 1.16 higher)

Vomiting. Adults	183 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults in the intervention groups was 0.51 standard deviations higher (0.21 to 0.8 higher)
Vomiting. Adults - Self-help (Guided)	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults - self-help (guided) in the intervention groups was 0.82 standard deviations higher (0.21 to 1.44 higher)
Vomiting. Adults - CBT	88 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults - cbt in the intervention groups was 0.36 standard deviations higher (0.06 lower to 0.78 higher)
Vomiting. Adults - Focal psychoeducation	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults - focal psychoeducation in the intervention groups was 0.49 standard deviations higher (0.08 lower to 1.06 higher)
Binge frequency Total Adult	183 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency total adult in the intervention groups was 0.09 standard deviations higher (0.2 lower to 0.38 higher)
Binge frequency. Adults - CBT	88 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency. adults - cbt in the intervention groups was 0.10 standard deviations lower (0.52 lower to 0.32 higher)
Binge frequency. Adults - Focal/ Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency. adults - focal/ supportive psychotherapy in the intervention groups was 0.19 standard deviations higher (0.37 lower to 0.75 higher)

Binge frequency. Adults - Self-help (Guided)	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency. adults - self-help (guided) in the intervention groups was 0.37 standard deviations higher (0.22 lower to 0.97 higher)
Binge frequency (follow up). Adults - CBT	106 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency (follow up). adults - cbt in the intervention groups was 0.13 standard deviations lower (0.51 lower to 0.26 higher)
Purge frequency Total Adults	138 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency total adults in the intervention groups was 0.28 standard deviations higher (0.05 lower to 0.62 higher)
Purge frequency. Adults - CBT	88 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency. adults - cbt in the intervention groups was 0.17 standard deviations higher (0.25 lower to 0.59 higher)
Purge frequency. Adults - Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency. adults - focal/ supportive psychotherapy in the intervention groups was 0.49 standard deviations higher (0.08 lower to 1.06 higher)
Purge frequency (follow up). Adults - CBT	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,8,9} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean purge frequency (follow up). adults - cbt in the intervention groups was 0.36 standard deviations lower (1.14 lower to 0.42 higher)
General psychiatric symptoms. Adults - CBT	88 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,5,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric symptoms. adults - cbt in the intervention groups was 0.11 standard deviations lower (0.53 lower to 0.31 higher)

General psychiatric symptoms. Adults - Self-help (Guided)	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric symptoms. adults - self-help (guided) in the intervention groups was 0.48 standard deviations higher (0.11 lower to 1.08 higher)
General psychiatric symptoms. Adults - Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general psychiatric symptoms. adults - focal/ supportive psychotherapy in the intervention groups was 0.22 standard deviations higher (0.34 lower to 0.78 higher)
EDI-Drive for thinness. Adults - CBT	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,8,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-drive for thinness. adults - cbt in the intervention groups was 0.39 standard deviations lower (1.06 lower to 0.28 higher)
EDI-Weight concern. Adults - CBT	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-weight concern. adults - cbt in the intervention groups was 0.15 standard deviations lower (0.93 lower to 0.62 higher)
EDI-Shape concern. Adults - CBT	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,11,12} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-shape concern. adults - cbt in the intervention groups was 0.25 standard deviations lower (1.03 lower to 0.52 higher)
Depression scores. Adults - CBT	141 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression scores. adults - cbt in the intervention groups was 0.14 standard deviations lower (0.48 lower to 0.2 higher)
Depression scores. Adults - Self-help (guided)	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression scores. adults - self-help (guided) in the intervention groups was 0.45 standard deviations higher (0.14 lower to 1.05 higher)

Depression scores. Adults - Supportive Psychotherapy	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression scores. adults - focal/ supportive psychotherapy in the intervention groups was 0.2 standard deviations higher (0.36 lower to 0.76 higher)
Depression scores (follow up). Adults - CBT	76 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,7,13} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression scores (follow up). adults - cbt in the intervention groups was 0 standard deviations higher (0.47 lower to 0.47 higher)
EDE-Global Adults - CBT	53 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,8} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-global adults - cbt in the intervention groups was 0.39 standard deviations lower (0.94 lower to 0.15 higher)
EDE-Bulimia. Adults - CBT	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,8,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-bulimia. adults - cbt in the intervention groups was 0.51 standard deviations lower (1.19 lower to 0.17 higher)
EDE-Body dissatisfaction. Adults - CBT	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,8,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-body dissatisfaction. adults - cbt in the intervention groups was 0.44 standard deviations lower (1.11 lower to 0.24 higher)
Did not achieve remission (100% purge free). Adults - CBT ITT	145 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,14} due to risk of bias, imprecision, publication bias	RR 0.84 (0.71 to 0.98)	108 per 1000	17 fewer per 1000 (from 2 fewer to 31 fewer)
Did not achieve remission (100% purge free). Adults Supportive Psychotherapy ITT	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,15} due to risk of bias, imprecision, publication bias	RR 1.11 (0.89 to 1.38)	179 per 1000	20 more per 1000 (from 20 fewer to 68 more)

Did not achieve remission (100% purge free) FU Adults - CBT ITT	47 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,15} due to risk of bias, imprecision, publication bias	RR 1.05 (0.86 to 1.29)	130 per 1000	7 more per 1000 (from 18 fewer to 38 more)
Did not achieve remission (100% binge free). Adults - CBT ITT	233 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,4,14} due to risk of bias, imprecision, publication bias	RR 0.78 (0.67 to 0.92)	156 per 1000	34 fewer per 1000 (from 12 fewer to 52 fewer)
Did not achieve remission (100% binge free). Adults - Focal/ Supportive Psychotherapy ITT	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,16} due to risk of bias, imprecision, publication bias	RR 1.03 (0.75 to 1.41)	250 per 1000	7 more per 1000 (from 62 fewer to 102 more)
Did not achieve remission (100% binge free) FU. Adults - CBT ITT	47 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,15,17} due to risk of bias, imprecision, publication bias	RR 0.87 (0.71 to 1.06)	43 per 1000	6 fewer per 1000 (from 13 fewer to 3 more)
No adverse events. Adults - CBT	123 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,18,19} due to risk of bias, imprecision, publication bias	RR 1.09 (0.99 to 1.2)	86 per 1000	8 more per 1000 (from 1 fewer to 17 more)
Quality of life - CBT	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,7,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean quality of life - cbt in the intervention groups was 0.49 standard deviations lower (1.17 lower to 0.19 higher)
Laxative FU abuse - CBT	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,7,20} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative fu abuse - cbt in the intervention groups was 0.41 standard deviations lower (1 lower to 0.18 higher)

Vomit frequency FU. Adults - CBT	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,12,20} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomit frequency fu. adults - cbt in the intervention groups was 0.05 standard deviations lower (0.64 lower to 0.54 higher)
EDI Body dissatisfaction FU. Adults - CBT	45 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,8,20} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi body dissatisfaction fu. adults - cbt in the intervention groups was 0.49 standard deviations lower (1.09 lower to 0.1 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind, but it was unclear if either investigators or assessors were blind. High dropouts were reported >20%.
- 2 95% CI crossed 1 MID (0.5).
- 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
- 4 Unclear how random sequence was generated and if allocation concealment was conducted. It was unclear if either participants, investigators or assessors were blind. High dropouts were reported >20%.
- 5 Unclear how random sequence was generated and if allocation concealment was conducted. In one study it was unclear if participants, investigators or assessors were blind. The other study was double blind but it was unclear if assessors were blind. High dropouts were reported >20%.
- 6 Unclear how random sequence was generated and if allocation concealment was conducted. Study was double-blind but it was unclear if assessors were blind. High dropouts were reported >20%.
- 7 For a continuous outcome there were fewer than 400 participants.
- 8 95% CI crossed 1 MID (-0.5)
- 9 Unclear how random sequence was generated and if allocation concealment was conducted. It was unclear if investigators, investigators or assessors were blind. High dropouts were reported >20%.
- 10 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind and it was unclear if investigators or assessors were blind. High dropouts were reported >20%.
- 11 Unclear how random sequence was generated and if allocation concealment was conducted. It was unclear if participants, investigators or assessors were blind. High dropouts were reported >20%.
- 12 95% CI crossed 2 MIDs (-0.5 and 0.5).
- 13 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were blind but not investigators in one study and it was unclear if assessors were blind. In the other study it was unclear if any were blind. High dropouts were reported >20%.
- 14 95% CI crossed 1 MID (0.75).

15 95% CI crossed 1 MID (1.25).
 16 95% CI crossed 2 MIDs (0.75 and 1.25).
 17 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind in one study and it was unclear if they were in the other study. It was unclear in both studies if either investigators or assessors were blind. High dropouts were reported >20%.
 18 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were blind but not investigators in one study and it was unclear if assessors were blind. In the other study participants were not blind and it was unclear if investigators or assessors were blind. High dropouts were reported >20%.
 19 For a dichotomous outcome there were fewer than 300 participants.
 20 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were blind, investigators were not. It was unclear if assessors were blind.

Table 210: Summary of findings table for psychotherapy versus psychotherapy and antidepressant at end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Combined Psychotherapy+Antidepressant	Risk difference with Psychotherapy (95% CI)
Binges. Adults - CBT	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binges. adults - cbt in the intervention groups was 0.46 standard deviations higher (0.19 lower to 1.12 higher)
Binges. Adults - Guided SH	49 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,7} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binges. adults - guided sh in the intervention groups was 0.39 standard deviations higher (0.18 lower to 0.95 higher)
Vomiting. Total Adults	204 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,8,9} due to risk of bias, inconsistency, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. total adults in the intervention groups was 0.74 standard deviations higher (0.45 to 1.04 higher)

Vomiting. Adults - CBT	111 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,8} due to risk of bias, inconsistency, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults - cbt in the intervention groups was 0.98 standard deviations higher (0.56 to 1.4 higher)
Vomiting. Adults - Guided SH	49 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults - guided sh in the intervention groups was 0.75 standard deviations higher (0.16 to 1.33 higher)
Vomiting. Adults - Focal psychoeducation	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomiting. adults - focal psychoeducation in the intervention groups was 0.25 standard deviations higher (0.35 lower to 0.84 higher)
Objective purgers. Adults - CBT	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean objective purgers. adults - cbt in the intervention groups was 0.44 standard deviations higher (0.35 lower to 1.22 higher)
Laxative use - Adults - CBT	49 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,12} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative use - adults - cbt in the intervention groups was 0.55 standard deviations higher (0.02 lower to 1.12 higher)
EDE-Global score. Adults - CBT	48 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,10} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-global score. adults - cbt in the intervention groups was 0.14 standard deviations higher (0.42 lower to 0.71 higher)

EDE - Shape concern. Adults - CBT	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede - shape concern. adults - cbt in the intervention groups was 0 standard deviations higher (0.77 lower to 0.77 higher)
EDE-Body dissatisfaction, Adults - CBT	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-body dissatisfaction, adults - cbt in the intervention groups was 0.04 standard deviations lower (0.68 lower to 0.61 higher)
EDE-Weight concern, Adults - CBT	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,11} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean ede-weight concern, adults - cbt in the intervention groups was 0 standard deviations higher (0.77 lower to 0.77 higher)
EDI-Drive for thinness. Adults - CBT	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,9} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-drive for thinness. adults - cbt in the intervention groups was 0.16 standard deviations lower (0.8 lower to 0.49 higher)
EDI-Bulimia. Adults - CBT	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi-bulimia. adults - cbt in the intervention groups was 0.01 standard deviations higher (0.63 lower to 0.66 higher)
Depression, Adults - CBT	108 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression, adults - cbt in the intervention groups was 0.18 standard deviations higher (0.2 lower to 0.56 higher)
Depression, Adults - Focal psychoeducation	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,10}		Not calculable for SMD values	The mean depression, adults - focal psychoeducation in

		due to risk of bias, imprecision, publication bias			the intervention groups was 0.37 standard deviations higher (0.22 lower to 0.97 higher)
Remission. Adults - CBT_ITT	152 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,13,14} due to risk of bias, inconsistency, imprecision, publication bias	RR 1.14 (0.32 to 4.13)	185 per 1000	26 more per 1000 (from 126 fewer to 580 more)
Remission. Adults - Focal/psychoeducation_ITT	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,10,14} due to risk of bias, imprecision, publication bias	RR 0.67 (0.12 to 3.61)	136 per 1000	45 fewer per 1000 (from 120 fewer to 356 more)
Quality of life - Adults - CBT	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,6,9} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean quality of life - adults - cbt in the intervention groups was 0.43 standard deviations lower (1.08 lower to 0.22 higher)
General symptoms - Guided SH	49 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,6} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general symptoms - guided sh in the intervention groups was 0.37 standard deviations higher (0.2 lower to 0.93 higher)
General symptoms - CBT	48 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,12} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general symptoms - cbt in the intervention groups was 0.18 standard deviations higher (0.23 lower to 0.59 higher)
General symptoms - Focal psychoeducation	44 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,5,10} due to risk of bias,		Not calculable for SMD values	The mean general symptoms - focal psychoeducation in the intervention groups was

		imprecision, publication bias			0 standard deviations higher (0.59 lower to 0.59 higher)
No side-effects. Adults - CBT	123 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{3,15,16} due to risk of bias, imprecision, publication bias	RR 1.12 (1.01 to 1.25)	114 per 1000	14 more per 1000 (from 1 more to 29 more)
Binge frequency FU. Adults - CBT	56 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,9,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean binge frequency fu. adults - cbt in the intervention groups was 0.05 standard deviations lower (0.58 lower to 0.48 higher)
Laxative FU abuse - CBT	87 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,9,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean laxative fu abuse - cbt in the intervention groups was 0.06 standard deviations lower (0.5 lower to 0.38 higher)
Vomit frequency FU. Adults - CBT	56 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,9,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean vomit frequency fu. adults - cbt in the intervention groups was 0.13 standard deviations lower (0.66 lower to 0.4 higher)
Depression FU. Adults - CBT	87 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,3,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression fu. adults - cbt in the intervention groups was 0.18 standard deviations higher (0.25 lower to 0.62 higher)
EDI Body dissatisfaction FU. Adults - CBT	56 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,9,17} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi body dissatisfaction fu. adults - cbt in the intervention groups was 0.36 standard deviations

					lower (0.89 lower to 0.18 higher)
Did not achieve Remission-FU. Adults - CBT_ITT	53 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,3,19} due to risk of bias, imprecision, publication bias	RR 0.86 (0.71 to 1.05)	34 per 1000	5 fewer per 1000 (from 10 fewer to 2 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

- 1 Unclear how random sequence was generated and if allocation concealment was conducted. Across studies, it was unclear if either participants, investigators or assessors were blind. High dropouts were reported >20%,
- 2 95% CI crossed 1 MID (0.5)
- 3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.
- 4 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind in one study and it was unclear if investigators or assessors were blind. In the other study it was unclear if any were blind. High dropouts were reported >20%,
- 5 95% CI crossed 2 MIDs (-0.5 and 0.5)
- 6 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind but it was unclear if investigators or assessors were blind. High dropouts were reported >20%,
- 7 For a continuous outcome there were fewer than 400 participants.
- 8 Heterogeneity detected I² >80%
- 9 95% CI crossed 1 MID (-0.5).
- 10 Unclear how random sequence was generated and if allocation concealment was conducted. Participants and investigators were blind but it was unclear if assessors were blind. High dropouts were reported >20%,
- 11 Unclear how random sequence was generated and if allocation concealment was conducted. It was unclear if participants, investigators or assessors were blind. High dropouts were reported >20%,
- 12 Unclear how random sequence was generated and if allocation concealment was conducted. Participants may have been blind to pills taken, but it was unclear if investigators or assessors were blind. High dropouts were reported >20%,
- 13 Heterogeneity was detected I²>50%
- 14 95% CI crossed 2 MIDs (0.75 and 1.25)
- 15 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were not blind in one study but it was unclear if investigators or assessors were blind. In the other study, the participants were blind but it was unclear if either the investigators or assessors were blind, High dropouts were reported >20%,
- 16 For a dichotomous outcome there were fewer than 300 events.
- 17 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were blind in one study and it was unclear if

investigators or assessors were blind. In the other study it was unclear if any were blind. High drop outs were reported >20%, 18 Unclear how random sequence was generated and if allocation concealment was conducted. Participants were blind in one study, and investigators were not blind. But it was unclear if assessors were blind.
19 95% CI crossed 1 MID (0.75)

Table 211: Summary of findings table for an anticonvulsant versus placebo at end of treatment in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with placebo	Risk difference with Anticonvulsant (95% CI)
Clinical Global Impressions-Severity of Illness Scale (CGI-S). Adults	64 (1 study)	⊕⊕⊕⊕ VERY LOW 2,3,4 due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean clinical global impressions-severity of illness scale (cgi-s). adults in the intervention groups was 0.47 standard deviations lower (0.97 lower to 0.02 higher)
Clinical Global Impressions-Improvement Scale (CGI-I). Adults	64 (1 study)	⊕⊕⊕⊕ VERY LOW 2,3,4 due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean clinical global impressions-improvement scale (cgi-i). adults in the intervention groups was 0.68 standard deviations lower (1.19 to 0.18 lower)
EDI - Drive for thinness. Adults	64 (1 study)	⊕⊕⊕⊕ VERY LOW 2,3,4 due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - drive for thinness. adults in the intervention groups was 0.86 standard deviations lower (1.37 to 0.34 lower)
EDI - Bulimia. Adults	64 (1 study)	⊕⊕⊕⊕ VERY LOW 2,3,4 due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - bulimia. adults in the intervention groups was 0.66 standard deviations lower (1.17 to 0.16 lower)
EDI - Body dissatisfaction. Adults	64 (1 study)	⊕⊕⊕⊕ VERY LOW 2,3,4 due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean edi - body dissatisfaction. adults in the intervention groups was 0.7 standard deviations lower (1.21 to 0.19 lower)

General health perceptions - SF-36. Adults	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean general health perceptions - sf-36. adults in the intervention groups was 1.22 standard deviations higher (0.67 to 1.78 higher)
No side-effects. Adults	67 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4,6} due to risk of bias, imprecision, publication bias	RR 1.03 (0.93 to 1.15)	61 per 1000	2 more per 1000 (from 4 fewer to 9 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 95% CI crossed 1 MID (0.5).

2 95% CI crossed 1 MID (-0.5).

3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.

4 Unclear how random sequence was generated and if allocation concealment was conducted. Study was an open trial and it was unclear if investigators or assessors were blind. High dropouts were reported >20%.

5 Unclear how random sequence was generated and if allocation concealment was conducted. Participants and investigators were blind but it was unclear if assessors were blind.

6 For a dichotomous outcome there were fewer than 300 events.

Table 212: Summary of findings table for an antiemetics versus placebo at end of treatment in adults with bulimia nervosa.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Other medication (not antidepressants) vs, placebo (95% CI)
Did not drop out due to adverse events. Adults - Antiemetics	26 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias	RR 1.00 (0.87 to 1.15)	Not calculable for SMD values	Not estimable because of zero events in raw data.

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if assessors were blind.

2 For a dichotomous outcome there were fewer than 300 events.

3 High risk of publication bias from studies sponsored by the pharmaceutical industry. There is a risk in the 1980's, 1990's and early 2000's that only positive findings are being published, there is selective outcome reporting and outliers are being excluded.

1

2 **7.4.3 Economic evidence**

3 No economic evidence on the cost effectiveness of pharmacological interventions for the
4 treatment of bulimia nervosa was identified by the systematic search of the economic
5 literature undertaken for this guideline. Pharmacological interventions showed no benefit in
6 the NMA conducted for this guideline and they were not considered as options in the
7 economic model. Details on the methods used for the systematic search of the economic
8 literature are described in Chapter 3. Details and findings of the NMA are provided in the
9 Appendix R.

10 **7.4.4 Clinical evidence statements**

11 **7.4.4.1 Antidepressant versus placebo in adults with bulimia nervosa at the end of treatment**

12 **SSRIs**

13 Very low quality evidence from one RCT (n=42 to 46) showed no difference in the effect of
14 SSRI's on bingeing, vomiting, EDI-total, EDI-drive for thinness, EDI-body dissatisfaction and
15 EDI-bulimia compared with placebo.

16 Very low quality evidence from two RCTs (n=88) showed SSRI's are more effective on
17 depression compared with placebo.

18 Very low quality evidence from three RCTs (n=234) showed SSRI's are more effective on
19 global clinical scores compared with placebo.

20 Very low quality evidence from five RCTs (n=610) showed no difference in the effect of
21 SSRIs on adverse events compared with placebo.

22 Very low quality evidence from one RCT (n=46) showed no difference in the effect of SSRI's
23 on drop-out rates and remission compared with placebo.

24 **TCA's**

25 Very low quality evidence from one RCT (n=78) showed no difference in the effect of TCA's
26 on purging and global clinical score compared with placebo.

27 Very low quality evidence from two RCTs (n=101) showed TCA's are more effective on
28 depression compared with placebo but there was some uncertainty.

29 Very low quality evidence from two RCTs (n=165) showed no difference in the effect of
30 TCA's on adverse events compared with placebo.

31 **MAOIs**

32 Very low quality evidence from one RCT (n=77) showed MAOI's is less effective on EDI-total
33 compared with placebo.

34 Very low quality evidence from two RCTs (n=127) showed no difference in the effect of
35 MAOI's on depression compared with placebo.

1 Very low quality evidence from two RCTs (n=139) showed MAOI's lead to more adverse
2 events compared with placebo.

3 **7.4.4.2 Antidepressant versus placebo in adults with bulimia nervosa at follow up**

4 **TCA**

5 Very low quality evidence from one RCT (n=38) showed no difference in the effect of TCA's
6 on binge eating, laxative use, vomiting, depression and EDI-body dissatisfaction compared
7 with placebo.

8 **7.4.4.3 Antidepressant versus another antidepressant in adults with bulimia nervosa at end of 9 treatment.**

10 Very low quality evidence from one RCT (n=28) showed no difference in the effect of SSRIs
11 (Citalopram) on depression, EDI-drive for thinness, EDI-body dissatisfaction, EDI-bulimia and
12 clinical global impression (adverse events) compared with another SSRI (Fluoxetine).

13 Very low quality evidence from one RCT (n=37) showed no difference in the effect of SSRIs
14 (Citalopram) on drop-outs compared with another SSRI (Fluoxetine).

15 Very low quality evidence from one RCT (n=28) showed a harm of SSRIs (Citalopram) on
16 excessive exercise compared with another SSRI (Fluoxetine).

17 **7.4.4.4 Antidepressant versus combined antidepressant and psychotherapy in adults with 18 bulimia nervosa at end of treatment.**

19 **Antidepressant and self-help**

20 Very low quality evidence from one RCT (n=44) showed no difference in the effect of
21 antidepressants on laxative use, binge eating, depression, vomiting, general psychiatric
22 symptoms compared with combined self-help and antidepressant.

23 **Antidepressant and CBT**

24 Very low quality evidence from one RCT (n=44) showed no difference in the effect of
25 antidepressants on vomiting compared with combined CBT and antidepressant.

26 Very low quality evidence from one RCT (n=34 to 51) showed antidepressants are less
27 effective on binge eating, EDI-bulimia and EDI body dissatisfaction compared with combined
28 CBT and antidepressant.

29 Very low quality evidence from one RCT (n=34) showed antidepressants are less effective
30 on EDE-global and EDI-bulimia compared with combined CBT and antidepressant but there
31 was some uncertainty.

32 Very low quality evidence from three RCTs (n=109) showed antidepressants are less
33 effective on purging compared with combined CBT and antidepressant.

34 Very low quality evidence from four RCTs (n=126) showed antidepressants are less effective
35 on depression compared with combined CBT and antidepressant but there was some
36 uncertainty.

1 Very low quality evidence from two RCTs (n=85) showed no difference in the effect of
2 antidepressants on general psychiatric symptoms compared with combined CBT and
3 antidepressant.

4 Very low quality evidence from one RCT (n=24 to 34) showed no difference in the effect of
5 antidepressants on EDE-shape concerns, EDE-weight concerns, EDE-drive for thinness and
6 quality of life compared with combined CBT and antidepressant.

7 Very low quality evidence from two RCTs (n=140) showed no difference in the number of
8 dropouts in those treated with antidepressants compared with combined CBT and
9 antidepressant.

10 Very low quality evidence from three RCTs (n=155) showed antidepressants are less
11 effective on remission (binge free) compared with combined CBT and antidepressant but
12 there was some uncertainty.

13 Very low quality evidence from three RCTs (n=155) showed no difference in the effect of
14 antidepressants on remission (purge free) compared with combined CBT and
15 antidepressant.

16 **Antidepressant and supportive psychotherapy**

17 Very low quality evidence from one RCT (n=50) showed no difference in the effect of
18 antidepressants on purging, depression and general psychiatric symptoms compared with
19 combined supportive psychotherapy and antidepressant.

20 Very low quality evidence from one RCT (n=45) showed no difference in the effect of
21 antidepressants on remission (binge and purge free) compared with combined supportive
22 psychotherapy and antidepressant.

23 **7.4.4.5 Antidepressant versus combined antidepressant and psychotherapy in adults with 24 bulimia nervosa at follow up.**

25 **Antidepressant and CBT**

26 Very low quality evidence from one RCT (n=52) showed no difference in the effect of
27 antidepressants on binge eating, EDI-body dissatisfaction, vomiting, laxative use and
28 remission (either binge or purge free) compared with combined CBT and antidepressant.

29 Very low quality evidence from two RCTs (n=92) showed no difference in the effect of
30 antidepressants on depression compared with combined CBT and antidepressant.

31 **Antidepressant and supportive psychotherapy**

32 Very low quality evidence from one RCT (n=52) showed antidepressants have no effect on
33 remission compared with combined supportive psychotherapy and antidepressant.

34 **7.4.4.6 Antidepressant and nutritional counselling versus combined placebo and nutritional 35 counselling in adults with bulimia nervosa at end of treatment**

36 Very low quality evidence from one RCT (n=67) showed antidepressants and nutritional
37 counselling have no effect on EDE-eating concern or dropouts due to any reason compared
38 with combined placebo and nutritional counselling.

1 Very low quality evidence from one RCT (n=67) showed antidepressants and nutritional
2 counselling are more effective on EDE-weight concern and EDE-shape concern compared
3 with combined placebo and nutritional counselling.

4 Very low quality evidence from one RCT (n=67) showed antidepressants and nutritional
5 counselling have fewer drop-outs due to adverse events than combined placebo and
6 nutritional counselling but there was some uncertainty.

7 **7.4.4.7 Antidepressant and nutritional counselling versus combined placebo and nutritional** 8 **counselling in adults with bulimia nervosa at follow up**

9 Very low quality evidence from one RCT (n=67) showed antidepressants and nutritional
10 counselling have no effect on EDE-weight concern, EDE-eating concern and EDE-shape
11 concern compared with combined placebo and nutritional counselling.

12 **7.4.4.8 Psychotherapy versus antidepressant in adults with bulimia nervosa at end of** 13 **treatment**

14 **Guided self-help**

15 Very low quality evidence from one RCT (n=45) showed guided self-help is less effective on
16 laxative use compared with an antidepressant but there was some uncertainty.

17 Very low quality evidence from one RCT (n=45) showed guided self-help is less effective on
18 vomiting compared with an antidepressant.

19 Very low quality evidence from one RCT (n=45) showed no difference in the effect of guided
20 self-help on binge eating, depression and general psychiatric symptoms compared with an
21 antidepressant.

22 **CBT**

23 Very low quality evidence from two RCTs (n=88 to 123) showed CBT is less effective on
24 vomiting and adverse events compared with an antidepressant, but there was some
25 uncertainty.

26 Very low quality evidence from two RCTs (n=88) showed no difference in the effect of CBT
27 on binge eating, purging and general psychiatric symptoms compared with an
28 antidepressant.

29 Very low quality evidence from two RCTs (n=141) showed no difference in the effect of CBT
30 on depression compared with an antidepressant.

31 Very low quality evidence from one RCT (n=26 to 35) showed no difference in the effect of
32 CBT on EDI-drive for thinness, EDI-weight concern, EDI-shape concern, EDE-global, EDE-
33 bulimia, EDE-body dissatisfaction and quality of life compared with an antidepressant.

34 Very low quality evidence from three RCTs (n=145) showed CBT is more effective on
35 remission (purge free) compared with an antidepressant.

36 Very low quality evidence from four RCTs (n=233) showed CBT is more effective on
37 remission (binge free) compared with an antidepressant.

1 **Focal psychoeducation/supportive psychotherapy**

2 Very low quality evidence from one RCT (n=50) showed focal psychoeducation/supportive
3 psychotherapy is less effective on vomiting and purging compared with an antidepressant,
4 but there was some uncertainty.

5 Very low quality evidence from one RCT (n=45 to 50) showed no difference in the effect of
6 focal psychoeducation/supportive psychotherapy on binge eating, depression, general
7 psychiatric symptoms and remission (binge and purge free) compared with an
8 antidepressant.

9 **7.4.4.9 Psychotherapy versus antidepressant in adults with bulimia nervosa at follow up**

10 Very low quality evidence from two RCTs (n=76) showed no difference in the effect of CBT
11 on depression compared with an antidepressant.

12 Very low quality evidence from one RCT (n=45 to 47) showed no difference in the effect of
13 CBT on laxative use, vomiting, EDI-body dissatisfaction and remission (purge and binge free)
14 compared with an antidepressant.

15 **7.4.4.10 Psychotherapy versus combined psychotherapy and antidepressant in adults with**
16 **bulimia nervosa at end of treatment**

17 **Guided self-help**

18 Very low quality evidence from one RCT (n=49) showed guided self-help is less effective on
19 vomiting compared with combined guided self-help and antidepressant.

20 Very low quality evidence from one RCT (n=49) showed no difference in the effect of guided
21 self-help on general symptoms compared with combined guided self-help and
22 antidepressant.

23 **CBT**

24 Very low quality evidence from three studies (n=111) showed CBT is less effective on
25 vomiting compared with combined CBT and antidepressant.

26 Very low quality evidence from one RCT (n=26 to 49) showed no difference in the effect of
27 CBT on binge eating, purging, laxative use, EDE-global, EDE-shape concern, EDI-body
28 dissatisfaction, EDE-weight concern, EDI-drive for thinness, EDI-bulimia, general symptoms
29 and quality of life compared with combined CBT and antidepressant.

30 Very low quality evidence from three RCTs (n=108 to 152) showed no difference in the effect
31 of CBT on depression and remission compared with combined CBT and antidepressant.

32 Very low quality evidence from two RCTs (n=123) showed CBT has fewer side-effects
33 compared with combined CBT and antidepressant.

34 **Focal psychoeducation**

35 Very low quality evidence from 1 RCT (n=44) showed no difference in the effect of focal
36 psychoeducation self-help on vomiting, depression, general symptoms and remission
37 compared with an antidepressant.

1 **7.4.4.11 Psychotherapy versus combined psychotherapy and antidepressant in adults with**
2 **bulimia nervosa at follow up**

3 Very low quality evidence from one RCT (n=56) showed no difference in the effect of CBT on
4 binge eating, vomiting and EDI body dissatisfaction compared with combined CBT and
5 antidepressant.

6 Very low quality evidence from two RCTs (n=87) showed no difference in the effect of CBT
7 on laxative use and depression compared with combined CBT and antidepressant.

8 Very low quality evidence from one RCT (n=53) showed CBT is more effective on remission
9 compared with combined CBT and antidepressant, but there was some uncertainty.

10 **7.4.4.12 Anticonvulsant versus placebo in adults with bulimia nervosa at end of treatment**

11 Very low quality evidence from one RCT (n=64) showed an anticonvulsant is more effective
12 on global clinical score (CGI-S) compared with placebo but there was some uncertainty.

13 Very low quality evidence from one RCT (n=60 to 64) showed an anticonvulsant is more
14 effective on global clinical score (CGI-I), EDI-drive for thinness, EDI-bulimia, EDI-body
15 dissatisfaction and general health perceptions (SF-36) compared with placebo.

16 Very low quality evidence from one RCT (n=67) showed no difference in the number of side
17 effects in the anticonvulsant group compared with placebo.

18 **7.4.4.13 Antiemetics versus placebo in adults with bulimia nervosa at end of treatment**

19 Very low quality evidence from one RCT (n=26) showed no difference in the number of drop
20 outs due to side effects in the antiemetics group compared with placebo.

21 **7.4.5 Economic evidence statements**

22 No economic evidence on the cost effectiveness of pharmacological interventions for people
23 with bulimia nervosa was available.

24 **7.4.6 Recommendations and link to evidence**

25 **Medication for bulimia nervosa**

118. Do not offer medication as the sole treatment for bulimia nervosa.	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of pharmacotherapy for treating bulimia nervosa in children, young people and adults. For this population, binge eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with bulimia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology,</p>

	<p>general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>When considering whether to recommend a pharmacological agent for treating bulimia nervosa, it is important to firstly establish whether the agent is more effective compared with placebo and then consider its effectiveness head-to-head trials with other active agents.</p> <p>Two studies were found comparing tricyclic antidepressants (TCAs) with placebo in adults with bulimia nervosa. There was no difference at the end of treatment between the groups in purge frequency, global clinical score and adverse events. However, depression scores were lower in the TCA-treated group (though there was some uncertainty).</p> <p>At 10 years follow up, none of the outcomes were different between the TCA- and placebo-treated groups. The outcomes included: binge frequency, laxative use, vomit frequency, depression and EDI- body dissatisfaction (showed a trend only to be improved). At both time points, no data was reported on remission, all-cause mortality, adverse events, quality of life, resource use, relapse general psychopathology, general functioning, family functioning or service user experience</p> <p>A few studies were identified that compared SSRIs with placebo and showed at the end of treatment that depression improved in the SSRI-treated group, but not global clinical scores. No difference in binge frequency or vomiting frequency, EDI-global, EDI-drive for thinness, EDI-body dissatisfaction or EDI-bulimia were detected. Data on remission, all-cause mortality, adverse events, quality of life, resource use, relapse, general functioning, family functioning and service user experience was not available.</p> <p>Evidence comparing monoamine oxidase inhibitors (MAOIs) with placebo showed no difference at the end of treatment on depression or EDI-global scores. There were, however, more adverse events reported in the MAOI-treated group. Data on remission, all-cause mortality, quality of life, resource use, relapse, general functioning, family functioning and service user experience was not available.</p> <p>A head-to-head trial of two selective serotonin re-uptake inhibitors (SSRIs), citalopram and fluoxetine, showed excessive exercise was higher in the citalopram arm but that there was no difference on depression, global clinical score, EDI-drive for thinness, EDI-body dissatisfaction, EDI-bulimia and the number of dropouts. Data on remission, all-cause mortality, quality of life, resource use, relapse, general functioning, family functioning and service user experience was not reported.</p> <p>Adding CBT-ED to an antidepressant showed favourable results on binge and purge frequency, and a trend to improve depression, remission, EDI-bulimia, and EDE-global scores compared with an antidepressant only. All other outcomes were similar between the two groups including: vomiting frequency, adverse events, EDE and EDI subscales, quality of life and general psychiatric features. At 6 months to 1 year follow up, there was no difference on remission rates nor on any other outcome. All-cause mortality, quality of life, resource use, relapse, general functioning, family functioning and service user experience were not reported.</p> <p>When adding self-help to an antidepressant, there was no difference in binge frequency, laxative use, vomiting frequency, depression and general psychiatric</p>

features compared with an antidepressant only. Similar results on outcomes (including remission) were found when supportive psychotherapy was added to an antidepressant compared with an antidepressant only. All-cause mortality, quality of life, resource use, relapse, adverse events, general functioning, family functioning and service user experience were not reported.

Adding an antidepressant to nutritional therapy compared to nutritional therapy only appeared to have some benefit on EDE-weight, EDE-shape concern. However no difference was found in EDE eating concern and dropouts due to adverse events or for any reason. At 12 weeks follow up, whilst there was no difference found on EDE-weight concern or EDE-shape concern, there was a trend to favour EDE-eating concern in the combined treatment group. No data was available on remission, nor all-cause mortality, quality of life, resource use, relapse, general functioning, family functioning and service user experience.

A head-to-head comparison of self-help versus an antidepressant showed some favourable results for the latter group on vomiting frequency and a trend to reduce laxative use. No differences were found for depression, binge frequency, purges and general psychiatric features. No data was available on remission, nor all-cause mortality, quality of life, resource use, relapse, adverse events, general functioning, family functioning and service user experience.

CBT-ED compared with an antidepressant showed some benefit of therapy on remission, but no benefits on depression, vomiting frequency (where there was a trend for a negative effect), binge frequency, purges, general psychiatric features, quality of life, and subscales of the EDI and EDE questionnaires. No difference in harms were detected. The benefit of CBT-ED on remission was no longer evident at follow up. No data was available on all-cause mortality, resource use, relapse, adverse events, general functioning, family functioning and service user experience.

Supportive psychotherapy or focal psychoeducation compared with an antidepressant showed no difference in the effect of the two treatments on vomiting frequency (with a trend for a negative effect), binge frequency, purges (with a trend for a negative effect), general psychiatric features or remission rates. No data was available on all-cause mortality, resource use, relapse, adverse events, general functioning, family functioning and service user experience.

Adding an antidepressant to guided self-help compared to guided self-help only showed that there was no additional benefit to the combination therapy on binge frequency and general psychiatric features. There was a greater reduction in vomiting frequency in the guided self-help group compared with the combination treatment. No data was available on remission, all-cause mortality, quality of life, resource use, relapse, adverse events, general functioning, family functioning and service user experience.

Adding an antidepressant to CBT-ED showed a greater benefit on vomiting frequency compared with CBT-ED only, and a trend for improving laxative use. However there was no additional benefit on depression, binge frequency, quality of life, EDE and EDI subscales and general psychiatric features. Fewer adverse events were detected in the CBT-ED only group. No long-term benefits were observed combined treatment group. No data was available on remission, all-cause mortality, resource use, relapse, adverse events, general functioning, family functioning and service user experience.

	<p>Adding an antidepressant to supportive psychotherapy/focal psychoeducation showed no difference at the end of treatment on remission, depression, vomit frequency, laxative use, general psychiatric features compared with supportive psychotherapy/focal psychoeducation only. No data was available on remission, all-cause mortality, resource use, relapse, adverse events, general functioning, family functioning and service user experience.</p> <p>Anticonvulsants appeared to show positive effects on EDI subscales, clinical global impressions and general health perceptions compared with placebo. No difference was found on adverse events. No data was available on remission, all-cause mortality, resource use, relapse, general functioning, family functioning and service user experience.</p> <p>Finally, one small study reported no difference in adverse events in a group treated with antiemetics compared with placebo, but no other relevant outcomes were reported.</p> <p>The committee highlighted the fact that there are risks associated with prescribing medication to people with bulimia nervosa and a comorbidity because of potential physical problems. Depending on the severity and duration of the eating disorder, they may also have cardiovascular and renal problems, gastrointestinal disturbance, fluid and electrolyte abnormalities and dental abnormalities. For this reason, the committee wanted to emphasise that caution should be exercised when prescribing or discontinuing antidepressants such as SSRIs. See the LETR on medication risk management in Section 5.2.6 for further discussion.</p> <p>The network meta-analysis showed pharmacological interventions were not effective at treating people with bulimia nervosa. For this reason, the committee agreed not to recommend any of the medications for treating bulimia nervosa. There was some discussion that the development of new drugs in the future may be effective, but they are a long way off and may be more effective for treating binge eating disorder.</p>
Trade-off between net health benefits and resource use	<p>The network meta-analysis found no evidence for the effectiveness of pharmacological interventions for the management of people with bulimia nervosa. As a result, such treatments are also likely to be not cost effective.</p>
Quality of evidence	<p>The quality of the evidence was considered very low quality. The evidence was downgraded for imprecision and risk of bias for reasons including lack of detail about randomisation, allocation concealment and blinding, as well as a high proportion (>20%) of dropouts in the studies.</p> <p>All outcomes were downgraded for risk of publication bias since the studies were sponsored by pharmaceutical companies and in the 1980s to early 2000s there is a risk that mostly positive findings were being published (Lexchin et al., 2003).</p> <p>Imprecision was often detected because the 95% confidence interval crossed one to two MIDDs or the outcome did not meet the optimal information size.</p> <p>Remission was not often reported for the studies that compared a medication with placebo or directly compared one medication with another.</p>

Other considerations	<p>The committee agreed that the evidence was too low quality to be fully confident in the results and that there were few benefits found that would justify recommending a medication for treating bulimia nervosa. However, they agreed that medication may be needed for treating comorbidities such as major depressive disorder and anxiety disorder given the high prevalence rates reported in people with bulimia nervosa. None of the evidence in this review included people with a comorbidity.</p> <p>The committee decided to exclude two TCAs from the network meta-analysis: desipramine (because it is not available in the UK) and imipramine (because it is not licensed in the UK for the treatment of eating disorders). Despite this, these medications were included in the pharmacological review to assess whether they are effective and if so, whether a research recommendation would be warranted and whether their licencing status should be reconsidered. The results of the review suggest neither.</p> <p>The committee also wanted to include these drugs in the review in case they wanted to make a recommendation about TCAs for people with an eating disorder and a mental health comorbidity. Unfortunately, people with comorbidities were not included in the studies, so it was not possible to make a specific recommendation about TCAs or any other medication for this population.</p>
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1 7.5 Nutritional interventions

2 7.5.1 Review question: Does any nutritional intervention produce benefits/harms on 3 specified outcomes in people with eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 213. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all nutritional interventions that may be delivered to children, young
9 people and adults with an eating disorder with or without a pharmacological intervention.
10 The interventions were categorised according to type of nutritional intervention, the age of
11 the participants and the type of eating disorder. In addition, the interventions were grouped
12 according to their type of therapy and were compared to wait list controls, placebo, TAU or
13 any other intervention.

14 **Table 213: Clinical review protocol summary**

Component	Description
Review question(s)	Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> Children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years. Eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder).
Intervention(s)	<ul style="list-style-type: none"> Nutritional intervention Method of feeding

Component	Description
	<ul style="list-style-type: none"> • Nutritional in combination with any pharmacological intervention • Examples of nutritional interventions are nutritional counselling (with or without educational and supportive groups) and supplements (e.g. zinc)
Comparison	<ul style="list-style-type: none"> • Placebo • Wait list control • Treatment as usual • Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 7.5.2 Clinical evidence

2 Six RCTs (n=295) met the eligibility criteria for this review for people with bulimia nervosa, all
3 of which were for adult females (Beumont et al., 1997), (Burton and Stice, 2006; Hsu et al.,
4 2001; Laessle et al., 1991; Sundgot-Borgen et al., 2002; Ventura and Bauer, 1999). An
5 overview of the trials included in the meta-analysis can be found in Table 214. Further
6 information about both included and excluded studies can found in Appendix J.

7 Summary of findings for those on bulimia nervosa can be found in Table 215, Table 216,
8 Table 217, Table 218, Table 219 and Table 220. See also the study selection flow chart in
9 Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and exclusion
10 list in Appendix J.

1 **Table 214: Study information for trials included in the meta-analysis of nutritional interventions versus any other intervention or**
2 **wait list control for adult female bulimia nervosa.**

Study ID	N Randomized	Sample	Type of nutritional intervention	Intervention Age at onset and/or duration of illness (years)	Comparison(s) Age at onset and/or duration of illness (years)	Duration
Beumont 1997	67	Adult BN	Nutritional counselling	Nutritional counselling + Fluoxetine	Nutritional Counselling + Placebo	8 weeks + 3-mo FU
Burton 2006	85	Adult Full- and Sub-threshold BN	Healthy Weight Program	Healthy Weight Program	WLC	8 weeks + 3-mo FU
Hsu 2001	100	Adult BN	Nutritional counselling	Nutritional therapy + Cognitive therapy Duration of BN: 5.9 (3.7)	1. Nutritional therapy Duration of BN: 5 (4.4) 2. Cognitive therapy Duration of BN: 5.5 (3.2)	14 weeks
Laessle 1991	55	Adult BN	Nutritional counselling	Nutritional Management Duration of bulimic symptoms for sample=7.5 (3.8)	Stress Management Duration of bulimic symptoms for sample=7.5 years (3.8)	3 months + 12-mo FU
Sundgot-Borgen 2002	64	Adult BN	Nutritional counselling	Nutritional counselling Duration of BN=5 (2.3)	1. Exercise Duration of BN=7 (3.7) 2. CBT Duration of BN=5 (1.6) 3. WLC Duration of BN=6 (3.8)	16 weeks + 18-mo FU
Ventura 1999	40	Adult BN-P	Nutritional counselling	Psychobiological Nutritional Rehabilitation + CBT Duration of BN: 8.6 (4.9)	Traditional Nutritional Rehabilitation + CBT Duration of BN 6.5 (4.6)	24 weeks

3 Abbreviations: BN, Bulimia Nervosa; BN-P, Bulimia Nervosa – Purging subtype; CBT, Cognitive Behavioural Therapy; FU, follow up; WLC, wait list control.

1 **Table 215: Summary table of findings for nutritional counselling versus any other intervention at the end of treatment in adult females**
2 **with bulimia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Nutritional Counselling (95% CI)
Meal Frequency meals/week	100 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean meal frequency in the intervention groups was 0.34 standard deviations higher (0.11 lower to 0.78 higher)
Calories/day (kcal)	48 (1 study) 12 months	⊕⊕⊕⊕ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean calories/day (kcal) in the intervention groups was 0.21 standard deviations higher (0.36 lower to 0.78 higher)
EDI Bulimia	48 (1 study) 12 months	⊕⊕⊕⊕ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia in the intervention groups was 0.21 standard deviations lower (0.78 lower to 0.36 higher)
EDI Body Dissatisfaction	79 (2 studies) 12 months	⊕⊕⊕⊕ LOW2,3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.54 standard deviations higher (0.09 to 0.99 higher)
EDI Drive for Thinness	48 (1 study) 12 months	⊕⊕⊕⊕ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.19 standard deviations higher (0.38 lower to 0.76 higher)
Depression - raw scores BDI	48 (1 study) 12 months	⊕⊕⊕⊕ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - raw scores in the intervention groups was 0.22 standard deviations lower (0.79 lower to 0.35 higher)
Depression - Change scores HDRS	100 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - change scores in the intervention groups was 0.4 standard deviations lower (0.85 lower to 0.04 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Nutritional Counselling (95% CI)
CI: Confidence interval;					
1 Hsu 2001: Allocation concealment unclear. No participant nor investigator blinding. Dropout rate of Nutritional therapy group=46%; dropout rate of Cognitive therapy group 39%. Difference between Nutritional and Cognitive Therapy group, Nutritional Therapy group and Cognitive Therapy group>20%. 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD). 3 Laessle 1991: No details provided regarding randomization method nor allocation concealment. Participant, investigator and assessor blinding unclear. 4 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group dropout rate=20%.					

1 **Table 216: Summary table of findings for nutritional counselling versus any other intervention at follow up in adult females with bulimia nervosa.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Nutritional Counselling (95% CI)
Recovered from Bulimia Nervosa FU	43 (1 study) 18 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.1 (0.02 to 0.71)	500 per 1000	450 fewer per 1000 (from 145 fewer to 490 fewer)
Satisfying EDNOS criteria FU	43 (1 study) 18 months	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision	RR 0.53 (0.2 to 1.36)	423 per 1000	199 fewer per 1000 (from 338 fewer to 152 more)
Calories/day (kcal) FU	42 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean calories/day (kcal) fu in the intervention groups was 0.1 standard deviations higher (0.51 lower to 0.71 higher)
EDI Bulimia FU	73 (2 studies) 18 months	⊕⊖⊖⊖ VERY LOW1,3,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean edi bulimia fu in the intervention groups was 1.28 standard deviations higher (2.15 lower to 4.72 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Nutritional Counselling (95% CI)
EDI Body Dissatisfaction FU	73 (2 studies) 18 months	⊕⊕⊖⊖ LOW ^{1,4,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction fu in the intervention groups was 0.25 standard deviations higher (0.22 lower to 0.71 higher)
EDI Drive for Thinness FU	42 (1 study) 12 months	⊕⊕⊖⊖ LOW ^{4,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu in the intervention groups was 0.16 standard deviations lower (0.77 lower to 0.46 higher)
Depression FU Beck Depression Inventory. Scale from: 0 to 63.	42 (1 study) 12 months	⊕⊕⊖⊖ LOW ^{4,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.35 standard deviations lower (0.96 lower to 0.27 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio;</p> <p>1 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group dropout rate=20%. 2 <300 events. 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD). 4 Laessle 1991: No details provided regarding randomization method nor allocation concealment. Participant, investigator and assessor blinding unclear. 5 I²>80%. 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).</p>					

1 **Table 217: Summary table of findings for nutritional counselling versus wait list control at follow up in adult females with bulimia**
2 **nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Nutritional Counselling (95% CI)
Does not satisfy EDNOS criteria FU	32 (1 study) 18 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.77 (0.58 to 1.03)	1000 per 1000	230 fewer per 1000 (from 420 fewer to 30 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group dropout rate=20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio).					

3 **Table 218: Summary table of findings for nutritional therapy versus any other intervention in adult females with bulimia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Nutritional Therapy (95% CI)
Meal Frequency meals/week	73 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean meal frequency in the intervention groups was 0.021 standard deviations higher (0.47 lower to 0.52 higher)
Depression – change scores HDRS	73 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.17 standard deviations lower (0.66 lower to 0.33 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Nutritional Therapy (95% CI)
<p>1 Hsu 2001: Allocation concealment unclear. No participant nor investigator blinding. Dropout rate of Nutritional therapy group=46%; dropout rate of Cognitive therapy group 39%. 2 CI crosses either 0.5 or -0.5 (SMD).</p>					

1 **Table 219: Summary table of findings for healthy weight program versus wait list control at end of treatment in adult females with bulimia nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Healthy Weight Program (95% CI)
Remission	85 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision	RR 6.84 (0.88 to 53.2)	24 per 1000	139 more per 1000 (from 3 fewer to 1000 more)
Binge Frequency binge episodes/month	85 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.95 standard deviations lower (1.4 to 0.5 lower)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p> <p>1 Burton 2006: No details of randomization method nor allocation concealment provided. No participant blinding, unclear investigator blinding. Dropout rate of 3 of 4 groups>25%. Reasons for dropout not stated. 2 Sample is participants with Full- and Sub-Threshold Bulimia Nervosa. Participants classified as Full Threshold BN if they have (i) >=8 binge eating episodes or compensatory behaviour episodes in month prior to study and (ii) overvalue weight and shape. Participants classified as Sub Threshold BN if they are not classified as Full Threshold (minimum of 4 binge eating and 4 compensatory episodes in past month). 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD). 4 <300 events (dichotomous outcome) or <400 participants (continuous outcome).</p>					

1 **Table 220: Summary table of findings for healthy weight program versus wait list control follow up for adult females with bulimia**
2 **nervosa.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Healthy Weight Program (95% CI)
Remission FU	85 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision	RR 3.66 (1.32 to 10.13)	95 per 1000	253 more per 1000 (from 30 more to 870 more)
Binge Frequency FU binge episodes/month	85 (1 study) 3 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean binge frequency fu in the intervention groups was 0.86 standard deviations lower (1.3 to 0.41 lower)
General functioning FU Social Adjustment Scale (adapted)	85 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean social adjustment scale (adapted) fu in the intervention groups was 0.31 standard deviations lower (0.74 lower to 0.12 higher)
Resource use FU Health Survey Utilization Scale	85 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculabl e for SMD values	The mean health survey utilization scale fu in the intervention groups was 0.16 standard deviations lower (0.58 lower to 0.27 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Burton 2006: No details of randomization method nor allocation concealment provided. No participant blinding, unclear investigator blinding. Dropout rate of 3 of 4 groups >25%. Reasons for dropout not stated.

2 Sample is participants with Full- and Sub-Threshold Bulimia Nervosa. Participants classified as Full Threshold BN if they have (i) ≥8 binge eating episodes or compensatory behaviour episodes in month prior to study and (ii) overvalue weight and shape. Participants classified as Sub Threshold BN if they are not classified as Full Threshold (minimum of 4 binge eating and 4 compensatory episodes in past month).

3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1

2

1 **7.5.3 Economic evidence**

2 No economic evidence on the cost effectiveness of nutritional interventions for people with
3 bulimia nervosa was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **7.5.4 Clinical evidence statements**

7 **7.5.4.1 Nutritional counselling versus any other intervention at end of treatment in adults with** 8 **bulimia nervosa**

9 Low quality evidence from one RCT (n=100) showed no difference in the effect of nutritional
10 counselling on improving weekly meal frequency compared with any other intervention.

11 Low quality evidence from one RCT (n=48) showed no difference in the effect of nutritional
12 counselling on increasing daily calorie intake, EDI-bulimia, EDI-drive for thinness and
13 depression compared with any other intervention.

14 Low quality evidence from one RCT (n=79) showed nutritional counselling may be less
15 effective on improving scores on EDI-body dissatisfaction compared with any other
16 intervention.

17 Low quality evidence form one RCT (n=100) showed nutritional counselling is more effective
18 on change in depression compared with any other intervention, but there was some
19 uncertainty.

20 **7.5.4.2 Nutritional counselling versus any other intervention at follow up in adults with** 21 **bulimia nervosa**

22 Low quality evidence from one RCT (n=43) showed that nutritional counselling is less
23 effective on the number of people who recovered from bulimia nervosa compared to any
24 other intervention.

25 Very low quality evidence from one RCT (n=43) showed no difference in the effect of
26 nutritional counselling on the number of people who satisfied EDNOS criteria compared with
27 any other intervention.

28 Very low quality evidence from one RCT (n=42) showed no difference in the effect of
29 nutritional counselling on daily calorie intake, EDI-drive for thinness and reducing depression
30 compared with any other intervention.

31 Low to very low quality evidence from 2 RCTs (n=73) showed no difference in the effect of
32 nutritional counselling on improving scores on EDI-body dissatisfaction and EDI-bulimia
33 compared with any other intervention.

34 **7.5.4.3 Nutritional counselling versus wait list control at follow up in adults with bulimia** 35 **nervosa**

36 Low quality evidence from one RCT (n=32) showed nutritional counselling is more effective
37 on the number of people not satisfying EDNOS criteria compared with any other intervention,
38 although there was some uncertainty.

39 **7.5.4.4 Nutritional therapy versus any other intervention in adults with bulimia nervosa**

40 Low quality evidence from one RCT (n=73) showed no difference in the effect of nutritional
41 therapy on meal frequency and change in depression compared with any other intervention.

1 **7.5.4.5 Healthy Weight Program versus wait list control at end of treatment in adults with**
2 **bulimia nervosa**

3 Very low quality evidence from one RCT (n=85) showed Healthy Weight Program may be
4 more effective on in remission compared with wait list control, although there was some
5 uncertainty.

6 Very low quality evidence from one RCT (n=85) showed Healthy Weight Program is more
7 effective on binge frequency compared with wait list control.

8 **7.5.4.6 Healthy Weight Program versus wait list control at follow up in adults with bulimia**
9 **nervosa**

10 Very low quality evidence from one RCT (n=85) showed Healthy Weight Program is more
11 effective on remission and reducing binge frequency than wait list control.

12 Very low quality evidence from one RCT (n=85) showed no difference in the effect of Healthy
13 Weight Program on general functioning and resource use than wait list control.

14 **7.5.5 Economic evidence statements**

15 No economic evidence on the cost effectiveness of nutritional interventions for people with
16 bulimia nervosa was available.

17 **7.5.6 Recommendations and link to evidence**

18 **Nutritional counselling**

	The committee expressed the view that nutritional counselling is an integral part of most eating disorder specific psychological interventions so they did not make a recommendation about this for people with bulimia nervosa.
Critical and important outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of nutritional interventions for treating bulimia nervosa in children, young people and adults. For this population, binge eating and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with bulimia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, eating disorder psychopathology, general functioning, family functioning and service user experience.</p>
Trade off benefits and harms	<p>Compared with any other intervention, nutritional counselling showed no difference on meal frequency, calories consumed per day, EDI-bulimia, EDI-drive for thinness, depression, and a trend to have a negative effect on EDI-body dissatisfaction but a more positive effect on depression.</p> <p>At 12 to 18 months follow up, fewer people recovered from bulimia nervosa in the nutritional counselling group compared with any other intervention. No differences were found in the number who satisfied the EDNOS criteria, EDI scores, depression or calorie intake. No evidence was found on the important outcomes of adverse events, quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, or service user experience.</p>

	<p>Compared with wait list controls, nutritional counselling showed some long-term benefits at 12 months follow up on the number who satisfied the EDNOS criteria but there was some uncertainty. No evidence was found on remission, binge eating, adverse events, quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, or service user experience.</p> <p>Nutritional therapy had a similar effect on meal frequency and change in depression scores at the end of treatment compared with any other intervention. No other outcomes were reported.</p> <p>A healthy weight programme showed a benefit on binge eating and a trend to improve remission compared with wait list controls at the end of the treatment. At 3 months follow up, benefits were found on binge eating and remission, but no difference on general functioning or resource use. No evidence was found on the important outcomes of adverse events, quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, family functioning, cost effectiveness or service user experience.</p>
Trade-off between net health benefits and resource use	The committee expressed the view that dietary advice is an integral part of most eating disorder specific psychological interventions and providing such supplementary advice would not incur significant extra resource implications to the healthcare system.
Quality of the evidence	<p>The quality of the evidence very low quality. It was unclear how randomisation was conducted and if allocation concealment was performed. It was unclear if either the participants or investigators were blind. In one nutritional study the assessors were blinded. High dropouts were also reported >20%. Imprecision was also detected because the 95% confidence interval crossed one or two MIDs or the numbers did not meet the optimum information size (300 events or 400 participants).</p> <p>Heterogeneity was not detected in any of the outcomes.</p>
Other considerations	The committee agreed that the evidence was not strong enough to recommend nutritional counselling or a healthy weight programme as the sole treatment for adults with bulimia nervosa. They highlighted that dietary advice and counselling (dietetics) are an integral part of CBT-ED, SSCM, MANTRA and family therapy and so decided not to make a specific recommendation for bulimia nervosa.

1 7.6 Physical interventions

2 7.6.1 Review question: Do physical interventions, such as transcranial magnetic 3 stimulation or physiotherapy, produce benefits/harms in people with eating 4 disorders?

5 The review protocol summary, including the review question and the eligibility criteria used
6 for this section of the guideline, can be found in Table 221. Further information about the
7 search strategy can be found in Appendix H; the full review protocols can be found in
8 Appendix F.

9 This review considers all physical interventions that may be delivered to children, young
10 people and adults with an eating disorder. The interventions were categorised according to
11 type of physical intervention, the age of the participants and the type of eating disorder and
12 were compared to wait list controls, placebo, TAU or any other intervention.

1

Table 221: Clinical review protocol summary

Component	Description
Review question(s)	Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> Children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years Eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	Physical interventions may include: <ul style="list-style-type: none"> transcranial magnetic stimulation deep brain stimulation physiotherapy yoga physical exercise acupuncture mandometer massage
Comparison	<ul style="list-style-type: none"> Placebo Wait list control Treatment as usual Another intervention
Critical outcomes	<ul style="list-style-type: none"> Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> Adverse events All-cause mortality Cost effectiveness Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) Family functioning General psychopathology (including mood/depression/anxiety) General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) Quality of life Relapse Resource use Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs

2 7.6.2 Clinical evidence

3 Three RCTs (n=213) met the eligibility criteria for this review, which were all for adults (Bulik
4 et al., 1998; Sundgot-Borgen et al., 2002; Van den Eynde et al., 2010). An overview of the

- 1 trials included in the analysis can be found in Table 222. Further information about both
- 2 included and excluded studies can found in Appendix J.
- 3 No studies were identified that compared a combined physical intervention and a
- 4 pharmacological agent with any other intervention or wait list controls.

1 **Table 222: Study information for trials included in the analysis of physical interventions versus any other intervention or wait list**
2 **control for people with bulimia nervosa.**

Study ID	N Randomized	Female (%)	Mean BMI, kg/m2 (SD)	Intervention	Comparison(s)	Duration
				Age at onset and/or duration of illness (years)	Age at onset and/or duration of illness (years)	
Bulik 1998	111	100	22.4 (2.5)	Relaxation training	Exposure with response prevention to pre-binge cues Exposure with response prevention to pre-purge cues	6 weeks
Sundgot-Borgen 2002	64	100	21 (2.21)	Physical Exercise Duration of illness=7 (3.7)	1. Nutritional Counselling Duration of illness=5 (2.3) 2. CBT-ED Duration of illness=5 (1.6) 3. WLC Duration of illness=6 (3.8)	16 weeks
van den Eynde 2010*	38	86	25.4 (9.9)	Real rTMS Duration of illness (years): 0-5=6, 5-10=5, 10-15=3, >15=3	Sham rTMS Duration of illness (years): 0-5=12, 5-10=2, 10-15=4, >15=2	20 trains of 5 sec with 55 sec intertrain intervals.

3 *Note: *All participants received 8 sessions of CBT-ED over 8 weeks before randomisation to groups. Intervention group includes 10 participants diagnosed with bulimia nervosa*
4 *and 7 participants diagnosed with an eating disorder not otherwise specified-bulimic type; comparison group includes 10 participants with bulimia nervosa and 10 participants*
5 *diagnosed with an eating disorder not otherwise specified*
6 *Abbreviations: CBT-ED, Cognitive Behavioural Therapy for eating disorders; rTMS, Repetitive Transcranial Magnetic Stimulation; WLC, wait list control.*

7 **Table 223: Summary of findings table for real repetitive transcranial magnetic stimulation (rTMS) versus ‘sham’ rTMS (placebo) at end**
8 **of treatment in adults with bulimia nervosa**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with (Sham) rTMS	Risk difference with (Real) rTMS (95% CI)
Food Craving Questionnaire-State (raw scores)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable for SMD values	The mean food craving questionnaire-state (raw scores) in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with (Sham) rTMS	Risk difference with (Real) rTMS (95% CI)
		due to risk of bias, indirectness, imprecision			0.33 standard deviations lower (0.98 lower to 0.32 higher)
Food Craving Questionnaire-State (change scores)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean food craving questionnaire-state (change scores) in the intervention groups was 0.41 standard deviations lower (1.06 lower to 0.25 higher)
Not Withdrawn due to Adverse Events	38 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision	RR 0.94 (0.81 to 1.09)	1000 per 1000	60 fewer per 1000 (from 190 fewer to 90 more)
Urge To Eat (Visual Analogue Scale)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean urge to eat (visual analogue scale) in the intervention groups was 0.44 standard deviations lower (1.09 lower to 0.22 higher)
Mood (Visual Analogue Scale)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean mood (visual analogue scale) in the intervention groups was 0.38 standard deviations higher (0.27 lower to 1.03 higher)
Tension (Visual Analogue Scale)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean tension (visual analogue scale) in the intervention groups was 0.04 standard deviations higher (0.6 lower to 0.69 higher)
Hunger (Visual Analogue Scale)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean hunger (visual analogue scale) in the intervention groups was 0.58 standard deviations lower (1.25 lower to 0.08 higher)
Urge To Binge Eat (Visual Analogue Scale)	37 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean urge to binge eat (visual analogue scale) in the intervention groups was 0.03 standard deviations lower (0.68 lower to 0.61 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with (Sham) rTMS	Risk difference with (Real) rTMS (95% CI)
# patients NOT binged in 24 hours after treatment	34 (1 study) 1 days	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision	RR 1.27 (0.98 to 1.66)	778 per 1000	210 more per 1000 (from 16 fewer to 513 more)
<p>1 van den Eynde 2010: unclear randomization method and allocation concealment. No investigator blinding. Blinding only partially successful with 15/18 participants in real rTMS group correctly guessed treatment group; 11/20 participants in sham rTMS incorrectly guessed treatment group. 2 Sample consists of 20 BN participants and 17 EDNOS participants. EDNOS subgroup includes participants diagnosed with Binge Eating Disorder. 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD). 4 <300 events. 5 CI crosses both 0.5 and -0.5 (SMD).</p>					

1 Table 224: Summary table of findings for aerobic exercise versus any other intervention in adults with bulimia nervosa at follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Exercise (95% CI)
Recovery from Bulimia Nervosa FU	43 (1 study) 18 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 5.04 (0.3 to 83.76)	161 per 1000	652 more per 1000 (from 113 fewer to 1000 more)
Satisfied EDNOS criteria FU	43 (1 study) 18 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.57 (0.11 to 3.06)	194 per 1000	83 fewer per 1000 (from 172 fewer to 399 more)
EDI Drive for Thinness FU	26 (1 study) 18 months	⊕⊕⊕⊕ LOW ^{1,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu in the intervention groups was 1.36 standard deviations higher (0.47 to 2.25 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p>					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with Exercise (95% CI)
1 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group dropout rate=20%. 2 CI crosses both 0.75 and 1.25 (Risk Ratio). 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 Table 225: Summary table of findings for aerobic exercise versus wait list control at follow up in adults with bulimia nervosa

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Exercise (95% CI)
Not recovered from Bulimia Nervosa FU	27 (1 study) 18 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.36 (0.17 to 0.76)	1000 per 1000	640 fewer per 1000 (from 240 fewer to 830 fewer)
Does not satisfy EDNOS criteria FU	27 (1 study) 18 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.91 (0.74 to 1.13)	1000 per 1000	90 fewer per 1000 (from 260 fewer to 130 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI). CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group dropout rate=20%. 2 CI crosses either 0.75 or 1.25 (Risk Ratio).					

1 **Table 226: Summary of findings for relaxation training versus any other intervention in adults with bulimia nervosa at end of**
2 **treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with other intervention for adult BN	Risk difference with Relaxation training (95% CI)
Binge frequency	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.09 standard deviations higher (0.3 lower to 0.48 higher)
Vomiting frequency	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean vomiting frequency in the intervention groups was 0.33 standard deviations higher (0.07 lower to 0.72 higher)
Laxative use frequency	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean laxative use frequency in the intervention groups was 0.37 standard deviations higher (0.03 lower to 0.76 higher)
Purge frequency	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean purge frequency in the intervention groups was 0.42 standard deviations higher (0.03 to 0.82 higher)
No binge or purge episodes/2 weeks	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision	RR 0.85 (0.57 to 1.27)	542 per 1000	81 fewer per 1000 (from 233 fewer to 146 more)
EDI Drive for Thinness	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.09 standard deviations higher (0.3 lower to 0.48 higher)
EDI Bulimia	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi bulimia in the intervention groups was 0.55 standard deviations higher (0.15 to 0.94 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with other intervention for adult BN	Risk difference with Relaxation training (95% CI)
EDI Body dissatisfaction	111 (1 study) 12 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.1 standard deviations higher (0.29 lower to 0.49 higher)
Depression	111 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4, 6} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.61 standard deviations higher (0.21 to 1.01 higher)
Global Functioning GAFS	111 (1 study) 12 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean global functioning in the intervention groups was 0.3 standard deviations lower (0.69 lower to 0.09 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Bulik 1998: unclear randomisation method and allocation concealment. Unclear participant and investigator blinding. Seventeen participants discontinued treatment during prior CBT-ED, whilst 2 were withdrawn by investigators. Five participants discontinued treatment prior to randomization.					
2 All participants received 8 sessions of CBT-ED over 8 week period prior to randomisation to intervention groups.					
3 <400 participants.					
4 CI crosses either 0.5 or -0.5 (SMD).					
5 CI crosses both 0.75 and 1.25 (Risk Ratio).					
6 I ² >50%.					

1 Table 227: Summary of findings for relaxation training versus any other intervention in adults with bulimia nervosa at follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with other intervention for adult BN 12-mo FU	Risk difference with Relaxation training (95% CI)
Binge frequency	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable for SMD values	The mean binge frequency in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with other intervention for adult BN 12-mo FU	Risk difference with Relaxation training (95% CI)
		due to risk of bias, indirectness, imprecision			0.08 standard deviations lower (0.47 lower to 0.31 higher)
Vomiting frequency	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean vomiting frequency in the intervention groups was 0.16 standard deviations higher (0.23 lower to 0.56 higher)
Laxative use frequency	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean laxative use frequency in the intervention groups was 0.4 standard deviations higher (0.01 to 0.79 higher)
Purge frequency	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean purge frequency in the intervention groups was 0.27 standard deviations higher (0.13 lower to 0.66 higher)
No binge or purge episodes/2 weeks	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4,5} due to risk of bias, inconsistency, indirectness, imprecision	RR 0.78 (0.52 to 1.19)	556 per 1000	122 fewer per 1000 (from 267 fewer to 106 more)
EDI Drive for Thinness	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.05 standard deviations higher (0.34 lower to 0.44 higher)
EDI Bulimia	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi bulimia in the intervention groups was 0.05 standard deviations higher (0.34 lower to 0.44 higher)
EDI Body dissatisfaction	111 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.17 standard deviations higher (0.22 lower to 0.56 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with other intervention for adult BN 12-mo FU	Risk difference with Relaxation training (95% CI)
Depression	111 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.47 standard deviations higher (0.08 to 0.87 higher)
Global Functioning GAFS	111 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean global functioning in the intervention groups was 0.44 standard deviations lower (0.84 to 0.05 lower)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p> <p>1 Bulik 1998: unclear randomisation method and allocation concealment. Unclear participant and investigator blinding. Seventeen participants discontinued treatment during prior CBT-ED, whilst 2 were withdrawn by investigators. Five participants discontinued treatment prior to randomization.</p> <p>2 All participants received 8 sessions of CBT-ED over 8 week period prior to randomisation to intervention groups.</p> <p>3 <400 participants.</p> <p>4 CI crosses either 0.75 or 1.25 (SMD), or either 0.5 or -0.5 (SMD).</p> <p>5 I²>50%.</p>					

1

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1 **7.6.3 Economic evidence**

2 No economic evidence on the cost effectiveness of physical interventions for people with
3 bulimia nervosa was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **7.6.4 Clinical evidence statements**

7 **7.6.4.1 Repetitive transcranial magnetic stimulation (rTMS) versus placebo in adults with** 8 **bulimia nervosa**

9 Very low quality evidence from one RCT (n=37) showed rTMS may be more effective on
10 hunger and binge eating within 24 hours of treatment compared with placebo (sham rTMS),
11 although there was some uncertainty.

12 Very low quality evidence from one RCT (n=37) showed no difference in the effect of rTMS
13 on food craving, the urge to eat, urge to binge eat, mood, and tension compared with
14 placebo (sham rTMS).

15 Very low quality evidence from one RCT (n=37) showed rTMS may be less effective on the
16 number of people who withdraw due to adverse events compared with placebo (sham rTMS),
17 although there was some uncertainty.

18 **7.6.4.2 Aerobic exercise versus any other intervention at follow up in adults with bulimia** 19 **nervosa**

20 Very low quality evidence from one RCT (n=43) showed no difference in the effect of aerobic
21 exercise on the number of people who recovered from bulimia nervosa nor on the number of
22 people who satisfied the EDNOS criteria compared with any other intervention.

23 Low quality evidence from one RCT (n=26) showed exercise is less effective on scores for
24 EDI-drive for thinness compared with any other intervention.

25 **7.6.4.3 Aerobic exercise versus wait list control at follow up in adults with bulimia nervosa**

26 Low quality evidence from one RCT (n=27) showed no difference in the effect of exercise on
27 the number of people not recovered from bulimia nervosa nor the number of people not
28 satisfying EDNOS criteria compared with wait list control.

29 **7.6.4.4 Relaxation training versus any other intervention in adults with bulimia nervosa at end** 30 **of treatment**

31 Very low quality evidence from one RCT (n=111) showed no difference in the effect of
32 relaxation training on binge frequency, the number of people not binge eating nor purging for
33 2 weeks, EDI-drive for thinness and EDI-body dissatisfaction compared with any other
34 intervention.

35 Very low quality evidence from one RCT (n=111) showed relaxation training may be less
36 effective on vomiting frequency, laxative use, and global functioning compared with any other
37 intervention, although there was some uncertainty.

38 Very low quality evidence from one RCT (n=111) showed relaxation training is less effective
39 on purge frequency, EDI-bulimia and depression compared with any other intervention.

1 **7.6.4.5 Relaxation training versus any other intervention in adults with bulimia nervosa at**
2 **follow up**

3 Very low quality evidence from one RCT (n=111) showed no difference in the effect of
4 relaxation training on binge frequency, vomiting frequency, purge frequency, the number of
5 people not binge eating nor purging for two weeks, EDI-drive for thinness, EDI-bulimia, EDI-
6 body dissatisfaction compared with any other intervention.

7 Very low quality evidence from one RCT (n=111) showed relaxation training is less effective
8 on laxative use, depression and global functioning compared with any other intervention.

9 **7.6.5 Economic evidence statements**

10 No economic evidence on the cost effectiveness of physical interventions for people with
11 bulimia nervosa was available.

12 **7.6.6 Recommendations and link to evidence**

13 **Physical therapy for any eating disorder**

See Section 6.6.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes for the review on the effectiveness of physical interventions, such as transcranial magnetic stimulation or physiotherapy in people with eating disorders and it was agreed that for any eating disorder remission is of greatest concern. The other critical outcomes for bulimia nervosa is binge eating.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in randomised controlled trials for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse, thus they were extracted where possible, but did not factor strongly in the decision making.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>Repetitive transcranial magnetic stimulation (rTMS) versus sham rTMS ('placebo') showed no difference in the effect on binge eating and food cravings within 24 hours of treatment, nor on the urge to eat o adults with bulimia nervosa. There was a trend for hunger and the number of people who binged to be reduced and the number of people who withdrew due to adverse events to be increased. However, there was some uncertainty. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, resource use or service user experience.</p> <p>Aerobic exercise appeared to be less effective on EDI-drive for thinness. No difference was found on the number of people who recovered from bulimia nervosa nor who satisfied the EDNOS criteria.</p> <p>Compared with wait list control, aerobic exercise was less effective on the number who had recovered (unclear definition) from bulimia nervosa but showed no difference on the number who satisfied the criteria for EDNOS. No evidence was found on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, resource use or service user experience.</p>

See Section 6.6.6 for relevant recommendations	
	For discussion of physical interventions for other eating disorders, see the LETRs in the relevant chapters.
Trade-off between net health benefits and resource use	There was no evidence for the effectiveness of physical interventions in people with bulimia nervosa. As a result, such interventions are likely to be not cost effective.
Quality of evidence	<p>The evidence for physical interventions was mostly very low quality. The evidence was downgraded for imprecision and risk of bias for reasons such as unclear methods of randomisation or if allocation concealment was performed, if either or all of the participants, investigators or assessors were blinded. High dropout rates were also detected, with more than 20% dropping out in each arm.</p> <p>Most of the outcomes were the result of a single study with a very low number of participants. Imprecision was detected in most outcomes because the 95% confidence interval crossed one or two MIDs or it did not meet the optimal information size.</p> <p>Also, few studies measured remission and/or compensatory behaviours relevant to that eating disorder. Some outcomes were excluded from the study because it was either unclear over what duration they measured the symptoms or it was less than the two week minimum required by the committee.</p>
Other considerations	<p>The committee agreed that the evidence presented was not strong enough or of sufficient quality to offer a physical intervention to people with bulimia nervosa.</p> <p>See LETR in Section 6.6 for further discussion of physical interventions.</p>

1 **7.7 Management of long- and short-term complications**

2 **7.7.1 Review question: What interventions are effective at managing or reducing** 3 **short and long-term physical complications of eating disorders?**

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 228. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all interventions that may be delivered to manage or reduce the short-
9 or long-term physical complications of eating disorders in children, young people and adults
10 and includes recovered as well as current service users. The interventions were categorised
11 according to type of physical complication and intervention, the age of the participants and
12 the type of eating disorder, and were compared to the control arm as reported in the relevant
13 studies.

14 **Table 228: Clinical review protocol summary**

Component	Description
Review question(s)	What interventions are effective at managing or reducing short and long-term physical complications of eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder)

Component	Description
	<ul style="list-style-type: none"> recovered or current service users <p>Strata:</p> <ul style="list-style-type: none"> Children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years. Eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder).
Intervention(s)	<p>Interventions to address the following:</p> <ul style="list-style-type: none"> Low bone mineral density (risk of fracture) Growth (physical development) Pubertal development Tooth wear Low body weight <p>Interventions to address the long-term physical complications may include:</p> <ul style="list-style-type: none"> GH/IGF-I Calcium with and without Vitamin D Bisphosphonates (age dependent and exclude pregnancy) Exercise (low impact)/Physiotherapy Oestrogen (patches/exogenous/pills other) Testosterone (males/females) Weight gain vs. Weight restoration (brain size) <p>Interventions to address the short-term physical complications may include</p> <ul style="list-style-type: none"> Phosphates supplementation (refeeding) Potassium Thiamine (refeeding) Laxatives (for when underweight patients are constipated) Salbutamol (reduce food intake)
Comparison	<ul style="list-style-type: none"> Control arm as defined by study
Critical outcomes	<ul style="list-style-type: none"> Primary outcome as reported by study
Important outcomes	<ul style="list-style-type: none"> Secondary outcome as reported by study
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs Observational studies: including prospective or retrospective cohort studies, (if no RCTs) (if no RCTs)

1 7.7.2 Clinical evidence

2 No studies in people with bulimia nervosa were found that met the eligibility criteria for this
3 review.

4 7.7.3 Economic evidence

5 No economic evidence on the cost effectiveness of interventions for the management of
6 short and long-term physical complications of bulimia nervosa was identified by the
7 systematic search of the economic literature undertaken for this guideline. Details on the
8 methods used for the systematic search of the economic literature are described in Chapter
9 3.

1 7.7.4 Clinical evidence statements

2 No studies in people with bulimia nervosa were found that met the eligibility criteria for this
3 review.

4 7.7.5 Economic evidence statements

5 No economic evidence on the cost effectiveness of interventions for the management of
6 short and long-term physical complications of bulimia nervosa was available.

7 7.7.6 Recommendations and link to evidence

The committee agreed no recommendation was needed for this review question on those with bulimia nervosa.	
Relative value of different outcomes	The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of nutritional interventions for treating bulimia nervosa in children, young people and adults. For this population, binge eating and remission are of greatest concern. Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making. Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, family functioning and service user experience.
Trade-off between clinical benefits and harms	No relevant clinical evidence was identified.
Trade-off between net health benefits and resource use	No relevant existing economic evidence was identified.
Quality of evidence	No relevant clinical evidence was identified.
Other considerations	The committee agreed that no recommendation was needed on how to treat or manage people with bulimia nervosa who have short or long-term physical complications.

8 7.8 Management of comorbidities

9 7.8.1 Review question: Does any intervention for an eating disorder need to be 10 modified in the presence of common long-term health conditions?

11 The review protocol summary, including the review question and the eligibility criteria used
12 for this section of the guideline, can be found in Table 229. Further information about the
13 search strategy can be found in Appendix H; the full review protocols can be found in
14 Appendix F.

15 This review considers whether any intervention used to treat eating disorders in children,
16 young people and adults needs to be modified in the presence of a common long-term health
17 condition (i.e. comorbidity). The interventions were categorised according to their type, the

1 type of eating disorder and comorbidity examined and the age of the participants. The
2 comparison arm was the same intervention delivered to participants with the relevant eating
3 disorder but without the relevant comorbidity.

4 **Table 229: Clinical review protocol summary**

Component	Description
Review question(s)	Does any intervention for an eating disorder need to be modified in the presence of common long-term health conditions?
Population	<ul style="list-style-type: none"> • Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) and a common comorbidity (e.g. diabetes, hypothyroidism). • Mental comorbidities may include: <ul style="list-style-type: none"> • Depression • Anxiety • Social anxiety • Autism • Obsessive Compulsive Disorder • Personality Disorder • Learning disability • ADHD (Bulimia) • Self-harm • Substance misuse • Physical comorbidities may include: <ul style="list-style-type: none"> • Coeliac disease • Diabetes (type II – relevant to obesity) • Bowel disease • Cystic Fibrosis <p>Strata:</p> <ul style="list-style-type: none"> • Children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years. • Eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder).
Intervention(s)	<p>Trials will be included that address the ED as primary or secondary aim to treating the comorbidity. Interventions may include:</p> <p>Psychotherapy (including psychoeducation)</p> <ul style="list-style-type: none"> • Pharmacological • Nutritional • Physical • Combination of any listed above
Comparison	<ul style="list-style-type: none"> • The same intervention but delivered to people with an eating disorder without a comorbidity.
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness

Component	Description
	<ul style="list-style-type: none"> • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs • Observational studies: including prospective or retrospective cohort studies, (if no RCTs)

1 7.8.2 Clinical evidence

2 Diabetes

3 One observational study in people with bulimia nervosa and type I diabetes was found that
4 compared the effectiveness of an integrated inpatient care programme versus treatment as
5 usual inpatient care (n=18) (Takii et al., 2003). An overview of the trial can be found in Table
6 230.

7 History of substance misuse

8 One observational study in people with bulimia nervosa (n=100) who had a history of
9 substance misuse met the eligibility criteria for this review (Mitchell et al., 1990a).

10 Although this review question includes people with any eating disorder (anorexia nervosa,
11 bulimia nervosa, binge eating disorder, EDNOS), the committee wanted to firstly consider the
12 evidence for individual eating disorders to see if specific recommendations could be made. If
13 none was available, or it was deemed insufficient, then they agreed to make a general
14 recommendation for treating people with any eating disorder and a common long-term health
15 condition.

16 Summary of findings for those on bulimia nervosa can be found in Table 233. See also the
17 study selection flow chart in Appendix K, forest plots in Appendix M, study evidence tables in
18 Appendix L and exclusion list in Appendix J.

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1 **Table 230: Study information of the observational study that compared different inpatient care for adults with bulimia nervosa and**
2 **type I diabetes.**

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
Takii 2003 Japan	Bulimia Nervosa + Type I Diabetes	23.8 (5)	21.4 (3.1)	19	Binge Eating duration=4.9 (3.9) years Diabetes T1DM duration=7.6 (5.1) years	Integrated Inpatient Therapy – CBT + addressed diabetes + family relationships	No integrated inpatient care	Variable

3 Abbreviations: T1DM, type I diabetes mellitus; CBT, cognitive behavioural therapy

4 **Table 231: Study information of the observational study included in the review of interventions in young people with bulimia nervosa**
5 **and common long-term health condition at follow up.**

Study ID	N	Mean age	Female	Setting	Group 1	Group 2	Intervention	Duration
Mitchell 1990	100	17.5	not reported	OP	BN + History of chemical dependence	BN only	Group CBT	12 weeks

6 Abbreviations: BN, bulimia nervosa; CBT, cognitive behavioural therapy; OP, outpatients

7 **Table 232: Summary of findings table on the effective of integrated inpatient care versus inpatient care for adults with bulimia**
8 **nervosa and type I diabetes.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with IP therapy v No IP Therapy for BN+Diabetes1 (95% CI)
Did not achieve remission (no diagnosis of BN)	18 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,3 due to risk of bias, imprecision	RR 0.13 (0.02 to 0.8)	111 per 1000	97 fewer per 1000 (from 22 fewer to 109 fewer)
Depression	17 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,4		Not calculable	The mean depression in the intervention groups was

		due to risk of bias, imprecision		for SMD values	1.42 standard deviations lower (2.52 to 0.32 lower)
General Psychopathology	17 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 1.25 standard deviations lower (2.31 to 0.18 lower)
Inappropriate Compensatory Behaviours to prevent weight gain past 3 months	18 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision	RR 4 (1.15 to 13.88)	778 per 1000	1000 more per 1000 (from 117 more to 1000 more)
Insulin Omission	18 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision	RR 2 (0.93 to 4.3)	556 per 1000	556 more per 1000 (from 39 fewer to 1000 more)
Calorific Value of Binge Episodes (Kcal)	18 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean calorific value of binge episodes (kcal) in the intervention groups was 1.52 standard deviations lower (2.6 to 0.44 lower)
EDI Total	17 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total in the intervention groups was 1.16 standard deviations lower (2.21 to 0.11 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 The patients were selected from the same recruitment site and showed no difference in their characteristics, except for binge frequency that was significantly higher in the inpatient group. The follow up was different for the two groups: 36 months for IP group and 24 months for non-IP group. Investigators were not blind to treatment allocation.

2 There were fewer than 10 per arm.

3 For a dichotomous outcome, there were fewer than 300 events.

4 95% CI crossed 1 MID (-0.5)

5 For a continuous outcome, there were fewer than 400 participants.

1 **Table 233: Summary of findings table for Group CBT in young people with bulimia nervosa and history of substance misuse**
2 **compared with those who had no history of substance misuse at follow-up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Group CBT (95% CI)
Remission FU	87 (1 study) 3.5 years	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision	RR 1.01 (0.72 to 1.4)	677 per 1000	7 more per 1000 (from 190 fewer to 271 more)
Treatment Failures FU	87 (1 study) 3.5 years	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision	RR 1.11 (0.5 to 2.48)	246 per 1000	27 more per 1000 (from 123 fewer to 364 more)
Hospitalised for substance abuse FU	87 (1 study) 3.5 years	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision	RR 0.98 (0.11 to 8.99)	46 per 1000	1 fewer per 1000 (from 41 fewer to 369 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Mitchell 1990: Sample is those with and without history of substance abuse; current substance abuse comorbidity not included; selection bias (history of substance abuse group significantly older); performance bias (no info about intervention etc.); attrition bias (insufficient info about intervention); high detection bias.

2 CI crosses both 0.75 and 1.25.

3

4

1 **7.8.3 Economic evidence**

2 No economic evidence on the cost effectiveness of interventions for bulimia nervosa in the
3 presence of common long-term conditions was identified by the systematic search of the
4 economic literature undertaken for this guideline. Details on the methods used for the
5 systematic search of the economic literature are described in Chapter 3.

6 **7.8.4 Clinical evidence statements**

7 **7.8.4.1 Diabetes and eating disorder treatment (integrated care) in hospital in adults with
8 bulimia nervosa**

9 Very low quality evidence from one observational study (n=17 to 18) showed integrated
10 inpatient care is more effective on remission, depression, general psychopathology, calorie
11 intake with binge eating and EDI-total compared with treatment as usual inpatient care.

12 Very low quality evidence from one observational study (n= 18) showed integrated inpatient
13 care is more effective on inappropriate compensatory behaviours to prevent weight gain
14 compared with treatment as usual inpatient care.

15 Very low quality evidence from one observational study (n= 18) showed integrated inpatient
16 care may be more effective on insulin omission compared with treatment as usual inpatient
17 care but there is some uncertainty.

18 **7.8.4.2 Substance misuse in young people with bulimia nervosa**

19 Very low quality evidence from one observational study (n=87) showed no difference in the
20 effect of group CBT-general in people with bulimia nervosa and a history of substance
21 misuse on remission and treatment failures compared with those with bulimia and no history
22 of substance abuse.

23 Very low quality evidence from one observational study (n=87) showed no difference in the
24 effect of group CBT-general in people with bulimia nervosa and a history of substance
25 misuse on the number of people were hospitalised for substance abuse during the follow up
26 period compared with those with bulimia and no history of substance abuse.

27 **7.8.5 Economic evidence statements**

28 No economic evidence on the cost effectiveness of interventions for bulimia nervosa in the
29 presence of common long-term conditions was available.

30 **7.8.6 Recommendations and link to evidence**

31 **Physical and mental health comorbidities**

See Section 6.8.6 for relevant recommendations	
Relative value of different outcomes	The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for OSFED, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.

	<p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>No relevant published evidence was identified in people with bulimia nervosa.</p> <p>For discussion of interventions for treatment of other eating disorders with a comorbidity, see the LETRs in the relevant chapters.</p>
Trade-off between net health benefits and resource use	<p>The committee considered that providing care for people with eating disorders who have comorbid physical or mental health problems may have resource implications in terms of the extra time required to provide such a collaborative approach to care. However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate subsequent treatment and management of underlying health problems at an earlier stage (including eating disorder and comorbid mental health problem), before individuals require more resource intensive management, then the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>No evidence was identified for interventions in people with anorexia nervosa and a physical or mental health comorbidity.</p>
Other considerations	<p>The committee generated recommendations based on the limited data found and from their own knowledge and experience using informal consensus methods which had application all eating disorders. (See the LETR in section 6.8.6 for further discussion on the treatment of an eating disorders with a physical or mental health comorbidity).</p>

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Diabetes

<p>119. For people with an eating disorder and diabetes, the eating disorder and diabetes teams should:</p> <ul style="list-style-type: none"> • collaborate to explain the importance of physical health monitoring to the person • agree who has responsibility for monitoring physical health • collaborate on managing mental and physical health comorbidities • use a low threshold for monitoring blood glucose and blood ketones • use outcome measurements to monitor the effectiveness of treatments for each condition and the potential impact they have on each other. <p>120. When treating eating disorders in people with diabetes:</p>	
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- explain to the person (and if needed their diabetes team) that they may need to monitor their blood glucose and blood ketones more closely during treatment
- consider involving their family members and carers (as appropriate) in treatment to help them with blood glucose control.

121. Address insulin misuse as part of any psychological treatment for eating disorders in people with diabetes.

122. Offer people with an eating disorder who are misusing insulin the following treatment plan:

- a gradual increase in the amount of carbohydrates in their diet (if medically safe), so that insulin can be started at a lower dose
- a gradual increase in insulin doses to avoid a rapid drop in blood glucose levels, which can increase risk of retinopathy and neuropathy
- adjusted total glycaemic load and carbohydrate distribution to meet their individual needs and prevent rapid weight gain
- psychoeducation about the problems caused by misuse of diabetes medication
- diabetes educational interventions, if the person has any gaps in their knowledge.

123. For people with suspected hypoglycaemia, test for blood glucose:

- before all supervised meals and snacks
- when using the hypoglycaemia treatment algorithm
- after correction doses.

124. For people with suspected hyperglycaemia or hypoglycaemia, and people with normal blood glucose levels who are misusing insulin, healthcare professionals should test for blood ketones:

- when using the hypoglycaemia treatment algorithm
- after correction doses.

125. For people with bulimia nervosa and diabetes, consider monitoring of:

- glucose toxicity
- insulin resistance
- ketoacidosis
- oedema.

126. When diabetes control is challenging:

	<ul style="list-style-type: none"> do not attempt to rapidly treat hyperglycaemia (for example with increased insulin doses), because this increases the risk of retinopathy and neuropathy regularly monitor blood potassium levels do not stop insulin altogether, because this puts the person at high risk of ketoacidosis. <p>127. For more guidance on managing diabetes, including that for fluid replacement in young people, refer to the NICE guidelines on type 1 and type 2 diabetes in children and young people, type 1 diabetes in adults, and type 2 diabetes in adults.</p>
Relative value of different outcomes	The committee discussed the importance and relevance of various outcomes when assessing whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem. In the case of diabetes, HbA1c levels and insulin omission days were considered critical outcomes. The other critical outcomes depended on the eating disorder included in the study. The committee noted for Type 1 diabetes, severity should be measured or informed by HbA1c since HbA1c/ DKA frequency is the immediate risk factor; furthermore, BMI is less of a risk factor for death in those with Type 1 diabetes than HbA1c.
Trade-off between clinical benefits and harms	One observational study compared the effectiveness of inpatient integrated care with treatment as usual in adults with bulimia nervosa and type I diabetes. The integrated care provided CBT-ED, family therapy and addressed control of diabetes. Whilst treatment as usual included outpatient counselling sessions on diabetes but not inpatient care or treatment for the eating disorder. This study showed better outcomes for the integrated care including, remission, general psychopathology, depression, EDI-total, volume of the binges, few compensatory behaviours but no difference in insulin omission. However, no data was available on HbA1c scores (a critical outcome) , all-cause mortality, quality of life, resource use, relapse, general functioning, family functioning or service user experience.
Trade-off between net health benefits and resource use	The committee considered that providing care for eating disorders and diabetes, may have resource implications in terms of extra time required to provide fully integrated care. However, the committee expressed the view that if such care arrangements (that is, multidisciplinary approach, involvement of family members and carers, and the use of treatment plans) lead to better and appropriate treatment and management of diabetes, a long-term illness with very significant health care associated with it then the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.
Quality of evidence	<p>In the observational study where they compared inpatient integrated care with treatment as usual, the people were selected from the same recruitment site and showed no difference in their characteristics, except that binge frequency was significantly higher in the inpatient group. The duration of follow up was different for the two groups: 36 months versus 24 months in the inpatient care and treatment as usual groups, respectively. Investigators were not blind to treatment allocation and only 18 participants were included. No diabetic outcomes were reported</p> <p>Overall discussion</p> <p>No RCT or observational study fully met inclusion criteria for inclusion. One RCT compared the effectiveness of an intervention that addressed both the eating disorder and diabetes, but the other arm addressed just the diabetes. In another RCT, one intervention was modified but it was compared with a control therapy.</p>

	In the observational studies, one study compared the same intervention but in those with either an eating disorder and diabetes or just the eating disorder alone. So it only provided insight into whether one group was more responsive to treatment than the other. In the other observational study, inpatient integrated care was compared with treatment as usual, but the treatment as usual only addressed the diabetes not the eating disorder. Thus, it did not provide insight into whether a modified eating disorder treatment was needed for those with a comorbidity.
Other considerations	Overall, it was difficult for the committee to draw conclusions from these studies on whether treatment for an eating disorders should be modified in the presence of comorbid diabetes. The committee therefore drew on their experience and knowledge and used informal consensus to generate a series of recommendations on the management of diabetes. The recommendations reflected three key concerns of the committee; first, that there be effective multi-disciplinary working between the diabetes and mental health teams, secondly that the particular problems faced by people with diabetes and an eating disorder including compliance with diet medication and potential misuse of medication were known and thirdly that specific problems with the management of diabetes were effectively addressed, for example, problems with refeeding syndrome or the management of potassium levels in diabetes.

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Substance and medication misuse

	<p>128. For people with an eating disorder who are misusing substances, or over the counter or prescribed medication, provide treatment for the eating disorder unless the substance misuse is interfering with this treatment.</p> <p>129. If substance misuse or medication is interfering with treatment, consider a multidisciplinary approach with substance misuse services.</p>
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and substance misuse. For binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for EDNOS, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to substance misuse.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	An observational study compared the long-term outcomes (2 to 5 years) of women with bulimia nervosa who had a history of substance abuse with those who no history of substance abuse (or chemical dependency). Both groups had received outpatient group cognitive behavioural psychotherapy and showed no difference in long-term remission rates or being hospitalised for substance abuse. No evidence

	<p>was found on the critical outcome of binge eating, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p>
Trade-off between net health benefits and resource use	<p>The committee considered that providing care for people with an eating disorder who are misusing substances or medication may have resource implications in terms of the extra time required to facilitate care for such people (in particular the use of a multi-disciplinary approach). However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate subsequent treatment and management of health problems (including eating disorder and substance and medication misuse) at an earlier stage, before individuals require more resource intensive management, then the additional costs associated with facilitating a multi-disciplinary care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>The evidence used to generate these recommendations was very low quality. The evidence was observational and in of very low quality</p> <p>In one study a reasonable number of participants were included (n=119) and they underwent a currently recommended CBT-ED programme, however, there were few outcomes reported and no remission data. In the other study, again there was a reasonable number of participants included (n=81), but there was no data at the end of treatment (only at follow up) and again few outcomes were reported. However, they did measure remission.</p> <p>The evidence suggested that those with a low or high alcohol intake may be equally responsive to an eating disorder treatment. Also, in the long-term, a positive response to treatment may be found in both those with a history of substance misuse and those with no history. Thus, the committee drew on their experience and used informal consensus to recommend that for people with an eating disorder who are misusing substances, provide treatment for the eating disorder unless the substance misuse is demonstrably interfering with this treatment. If substance misuse is interfering with treatment, the committee recommended considering a multidisciplinary approach, where the person first receives treatment for their substance misuse problem. A multidisciplinary approach will ensure once the person is in a better cognitive state, they can begin treatment for their eating disorder.</p>
Other considerations	<p>The committee also noted that there is evidence to suggest that patients may benefit from treatment not only with respect to their eating disorder but also in terms of their alcohol intake. In the study by Karacic 2011, over half the high alcohol intake group were no longer drinking excessively (52.8%, n=19) at the end of treatment, however, 12.5% (n=10) of the low alcohol intake group were now drinking above the safe limit (this data was not extracted because change scores were not presented).</p> <p>For these reasons, the committee were confident recommending that people with an eating disorder and comorbid substance misuse should have the same treatment for the relevant eating disorder as those with the eating disorder only, unless the substance misuse interferes with the treatment. In such cases, a multidisciplinary approach may be needed to treat the comorbidity separately.</p> <p>Although the evidence for this recommendation was based on a study that used a mixed sample of people with bulimia nervosa or EDNOS, the committee were confident that the findings could translate to those with any eating disorder. For this reason, they did not specify the type of eating disorder in the recommendation.</p>

8 Treatment and management of binge eating disorder

8.1 Introduction

Individuals with BED regularly binge on large amounts of food in a discrete period with accompanying loss of control. Binge eating is accompanied by significant distress and may involve high levels of guilt and shame, eating in secret and eating despite not being hungry or until feeling uncomfortably full. Recurrent binges may occur against a background of a general tendency to overeat, or people with BED may eat normally between binges, but do not fast or use other compensatory behaviours to a significant degree. As a result, many people with BED are overweight or obese. The demographic distribution of BED is distinctive in that the majority of patients are middle-aged and about a third are male. The course of BED is also quite different from other eating disorders. Rather than being persistent, it tends to remit and recur, with extended periods, often lasting many months, free from the eating disorder (Beat 2015, Fairburn 2003). It is generally recognised that treatment should be focused around reducing or eliminating binge eating rather than on weight loss.

8.2 Psychological interventions

8.2.1 Review question: Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with binge eating disorder compared with any other intervention or controls?

The review protocol summary, including the review question and the eligibility criteria used for this section of the guideline, can be found in Table 234. Further information about the search strategy can be found in Appendix H; the full review protocols can be found in Appendix F.

This review considers all psychological interventions that may be delivered to children, young people and adults with binge eating disorder with or without a pharmacological intervention. The interventions were categorised according to their mode of delivery, i.e. individual, group or self-help, the age of the participants and the type of eating disorder. In addition, the interventions were grouped according to their type of therapy and were compared to any other intervention or to wait list controls.

Table 234: Clinical review protocol summary

Component	Description
Review question(s)	Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with eating disorders compared with any other intervention or controls?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Strata: <ul style="list-style-type: none"> children (≤ 12), young people (13-17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder) mode of delivery (i. individual ii. family iii. group iv. self-help)
Intervention(s)	Psychological intervention including: <ul style="list-style-type: none"> Dialectical behaviour therapy (DBT) Counselling (Nutritional/Other)

Component	Description
	<ul style="list-style-type: none"> • Integrative Cognitive-Affective Therapy for Binge Eating (ICAT) • Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) • Cognitive remediation therapy (CRT) • Specialist supportive clinical management for anorexia nervosa (SSCM) • Behavioural therapy (BT) • CBT (General or ED specific) • Dynamic (IPT, Psychodynamic General or ED specific) • Guided Self Help w therapist guidance • Pure self-help • E-therapies Psychological in combination with any pharmacological intervention.
Comparison	<ul style="list-style-type: none"> • wait list control • treatment as usual • another other intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for bulimia nervosa and binge eating disorder; and weight/body mass index (Appropriate adjustment for age) for anorexia nervosa
Important outcomes	<ul style="list-style-type: none"> • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF). • Family functioning. • Service user experience • Quality of life. • All-cause mortality. • Relapse. • Adverse events • Resource use.
Study design	<ul style="list-style-type: none"> • Systematic reviews • RCTs

1 8.2.2 Clinical evidence

2 8.2.2.1 Individual psychotherapy versus any other intervention or wait list control

3 Eight RCTs (n=760) met the eligibility criteria for this review on individual therapies for those
 4 with binge eating disorder. The majority of those found were on adults (Castelnuovo et al.,
 5 2011; DeBar et al., 2013; Fischer et al., 2014; Hill et al., 2011; Kristeller et al., 2014;
 6 McIntosh et al., 2016; Ricca et al., 2010; Wilson et al., 2010). The study by DeBar 2013 was
 7 conducted on young people.

8 An overview of the trials included in the meta-analysis can be found in Table 235. Further
 9 information about both included and excluded studies can be found in Appendix J.

1 No studies were identified that compared a combined individual psychotherapy with a
2 pharmacological agent with any other intervention or wait list controls.

3 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
4 evidence tables in Appendix L and exclusion list in Appendix J.

5 **8.2.2.2 Group therapy versus any other intervention or wait list control**

6 15 RCTs (n=1504) met the eligibility criteria for this review all of which were on adults (Agras
7 et al., 1994b; Alfonsson et al., 2015; Grilo et al., 2011; Hilbert and Tuschen-Caffier, 2004;
8 Kristeller et al., 2014; Munsch et al., 2007; Nauta et al., 2000; Peterson et al., 2009; Peterson
9 et al., 2001; Ricca et al., 2010; Safer et al., 2010; Shapiro et al., 2007; Telch et al., 1990;
10 Wilfley et al., 1993; Wilfley et al., 2002). Further information about both included and
11 excluded studies can be found in Appendix J.

12 **8.2.2.3 Self-help versus any other intervention or wait list control**

13 16 RCTs (n=1605) met the eligibility criteria for this review, the majority of which were on
14 adults (Carrard et al., 2011; Carter and Fairburn, 1998; Cassin et al., 2008; DeBar et al.,
15 2011; Dunn et al., 2006; Ghaderi and Scott, 2003; Grilo and Masheb, 2005; Grilo et al., 2013;
16 Jones et al., 2008; Loeb et al., 2000; Masson et al., 2013; Peterson et al., 2009; Peterson et
17 al., 2001; Shapiro et al., 2007; Striegel-Moore et al., 2010; Wilson et al., 2010). One study
18 (Jones 2008) was on young people. Further information about both included and excluded
19 studies can be found in Appendix J.

20 **8.2.2.4 Family therapy versus any other intervention or wait list control**

21 One RCT (n=94), which was on adults, met the eligibility criteria for this review (Gorin et al.,
22 2003). The study compared group CBT-ED with spouse involvement, group CBT-ED without
23 spouse involvement and wait list control. An overview of this trial can be found in Table 238.

1 **Table 235: Study information for trials included in the meta-analysis of individual psychotherapy versus any other intervention or wait**
2 **list controls.**

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison Arm	Sessions N	Treatment length	Long-term FU
Castellnuovo 2011	46.2 (10.5)	mean weight: 107 ± 6.9 kg	100%	Admission to hospital	60	Hybrid 1 (CBT-ED and weight loss diet, exercise, counselling) group. Inpatient and outpatient treatment.	Hybrid 2 (brief strategic thinking and weight loss group) Inpatient and outpatient treatment.	16	7 months	None reported
DeBar 2013	15.1 (1.9)	26.6 (5.7)	100%	At least 3 months	26	CBT-ED	Treatment as usual	8	6 months	None reported
Fischer 2014	45.6 (11.2).	34.3 (8.2)	88%	NR	41	CBT-ED	Wait list control	8 + 5 =13	8 weeks (active treatment) and 12 month	12 months FU
Hill 2011	22.7 (5.9)	23.2 (5.2)	100%	At least one binge eating and one vomit episode per week/3 month	32	Dialectical behaviour therapy	Wait list control	12	12 weeks	None reported
Kristeller 2014	46.6 (20–74)	40.3 (26–78)	88%	20 years of BED	140	Mindfulness	Wait list control CBT-ED	12	12 weeks	4 months FU
McIntosh 2016	35.3 (12.0)	29.9 (7.8)	100%	Mean duration of illness 14.6 (13.2) years	112	CBT-ED	CBT-general Behavioural therapy	32	12 months	12 months FU
Ricca 2010	46.5 (12.4)	NR	86%	Minimum duration of	144	CBT-ED	CBT-ED Group	22	24 weeks	3 year FU

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N randomised	Intervention	Comparison Arm	Sessions N	Treatment length	Long-term FU
				six consecutive months						
Wilson 2010	50.3 (14.6)	36.2 (4.3)	85%	NR	205	IPT	Guided SH-ED Behavioural weight loss	20	24 weeks	None

1 Abbreviations: BED - binge eating disorder; BN - bulimia nervosa; BMI - body mass index; BT - behavioural therapy; CBT-ED -cognitive behavioural therapy with eating
2 disorder focus; ED -eating disorder; EDNOS - eating disorder not otherwise specified; FU - follow up; IPT - interpersonal patient therapy; N - number; NR - not reported; SD -
3 standard deviation; SH-ED - self-help with eating disorder focus.

4 **Table 236: Study information for trials included in the meta-analysis of group psychotherapy versus any other intervention or wait list**
5 **controls.**

Study_ID	Mean age (SD) years	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention	Comparison Arm	Sessions N	Treatment Length	Long-term FU
Agras 1994	45.0 (10)	38.6 (6.6)	100%	Average duration of binge eating was 26 years	108	CBT-ED Group	Self-help with Group therapy CBT-ED Group + Pharmacotherapy	30	30 weeks	None reported
Alfonsson 2015	44.3 (10.7)	41.2 (5.3)	94%	NR	100	BT Group	Wait list controls	10	10 weeks	None reported
Grilo 2011	44.9 (9.5)	38.7 (5.7)	62%	20 years of BED	125	CBT-ED Group	BT (Group) CBT- ED + BT	16	6 months	12 months FU
Hilbert 2004	42.1 (12.1)	34.0 (10.2)	100%	Mix of BED and Binge eaters. Duration mean 13 years	28	CBT-ED Group (Body exposure)	CBT-ED Group (cognitive)	24	5 months + 9 weeks	4 months FU
Kristeller 2014	46.6, range of 20–74	39.6 (8.0)	88%	20 years of BED	140	Nutritional Group	Wait list controls	12	12 weeks	4 months FU

Study_ID	Mean age (SD) years	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention	Comparison Arm	Sessions N	Treatment Length	Long-term FU
						Mindfulness Group				
Munsch 2007	44.4 (11.5)	33.7 (4.3)	91%	NR	80	CBT-ED Group	BT Group	16	16 weeks + 6 months	12 months FU
Nauta 2000	38.3 (7.1)	33.1 (4.3)	100%	NR	37	CBT-ED Group	BT Group	15	15 weeks	6 months FU
Peterson 2009	47.1 (10.4)	39.0 (7.8)	88%	NR	259	Group psychoeducation	Group guided self-help Wait list controls Group self-help	15	20 weeks	12 mo FU
Peterson 2001	42.9 (10.1)	34.1 (7.4)	100%	NR	51	Group psychoeducation	Group guided self-help Group self-help	14	8 weeks	12 mo FU
Ricca 2010	46.5 (12.4)	NR	86%	Minimum duration of six consecutive months	144	CBT-ED Group	CBT-ED	22	24 weeks	3 year FU
Safer 2010	51.9 (11.6)	35.8 (9.4)	86%	Duration of binge eating 32.8 years	101	BT - ED	Counselling (Group)	20	21 weeks	12 months FU
Shapiro 2007	39.1 (11.4)	37.7 (11.4)	93%	NR	66	CBT-ED Group	Wait list controls Guided self-help (ED)	10	10 weeks	2 months FU
Telch 1990	42.6 (8.4)	32.6 (5.1)	100%	Subjects reported binge eating for 22.9 years (11.9)	44	CBT-ED Group	Wait list controls	10	10 weeks	None reported
Wilfley 1993	44.3 (8.3)	32.8 (5.2)	100%	Subjects reported binge eating	56	IPT Group	CBT-ED Group Wait list controls	16	16 weeks	None reported

Study_ID	Mean age (SD) years	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention	Comparison Arm	Sessions N	Treatment Length	Long-term FU
				for an average of 23.7 years (13.4)						
Wilfley 2002	45.6 (9.6)	NR	83%	Duration of disorder approximately 21 years	162	CBT-ED Group	Guided Group IPT (ED)	20	20 weeks	12 months FU

- 1 Abbreviations: BED - binge eating disorder; BN - bulimia nervosa; BMI - body mass index; BT - behavioural therapy; CBT-ED -cognitive behavioural therapy with eating disorder focus; ED -eating disorder; EDNOS - eating disorder not otherwise specified; FU - follow up; IPT - interpersonal patient therapy; N - number; NR - not reported; SD - standard deviation; SH-ED - self-help with eating disorder focus

4 Table 237: Study information for trials included in the meta-analysis of self-help versus any other intervention or wait list controls.

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention	Comparison Arm	Sessions N	Treatment Length	Long-term FU
Carrard 2011	34.4 (11.0)	29.8 (5.9)	100%	Binge eating for at least 3 months	74	Guided Self-help-ED	Wait list controls	26	6 months	6 months FU
Carter 1988	39.7 (10.0)	31.6 (6.6)	100%	Approximately 16 years of BED	93	Guided Self-help ED	Self-help ED Wait list controls	6 to 8	12 weeks	6 months FU
Cassin 2008	42.5 (12.7)	33.2 (7.8)	100%	Duration of illness 15.1 (11.6)	108	Guided Self-help ED	Self-help ED	1	16 weeks	None reported
DeBar 2011	39.1 (6.7)	31.5 (5.9)	100%	NR	160	Guided Self-help ED	Treatment as usual	8	3 months	None reported
Dunn 2006	19.0 (2.6)	23.8 (4.1)	89%	NR BN (23.3%) and BED (27.8%), subthreshold BN (6.7%)	90	Guided Self-help ED	Self-help ED	1	4 months	None reported

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention	Comparison Arm	Sessions N	Treatment Length	Long-term FU
				subthreshold BED (8.9%) and partial criteria for BN or BED and						
Ghaderi 2003	29 (10.7)	24.7 (5.5)	NR	Approximately 9 years of BED. Sub-threshold BN (n=11, BN (n=9) and BED (n=11)	31	Guided Self-help ED	Self-help ED	6 to 8	16 weeks	None reported
Grilo 2005	46.3 (9.0)	35.5 (6.7)	79%	Duration of BED: 17.1 years	90	Guided Self-help ED	Guided Self-help ED 2. Control	6	12 weeks	None reported
Grilo 2013	45.8 (11.0)	37.6 (4.8)	79%	Duration approximately 20 years. Age of onset, 25.8	48	Self-help ED	Usual care		4 months	None reported
Jones 2008	15.1 (1.0)	30.58 (4.9)	73%	Binge eating at least 3 months	105	Internet Self-help ED	Wait list controls		16 weeks	9 months FU
Loeb 2000	41.5 (9.4)	35.8 (9.0)	100%	Sub-threshold BN n=2; BN=2; subthreshold BED n=3, full criteria BED n=33; ;	40	Guided Self-help ED	Self-help ED	6	10 weeks	None reported
Masson 2013	42.8 (10.5)	37.1 (8.8)	88%	NR	60	Guided Self-help ED	Wait list controls	6	13 weeks	12 months FU

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention	Comparison Arm	Sessions N	Treatment Length	Long-term FU
Peterson 2009	47.1 (10.4)	39.0 (7.8)	88%	NR	259	Group Guided Self-help ED	Wait list controls Group Psychoeducation Group Self-help ED	15	20 weeks	12 months FU
Peterson 2001	42.9 (10.1)	34.1 (7.4)	100%	NR	51	Group Guided Self-help ED	Group Self-help ED Group Psychoeducation	14	8 weeks	12 months FU
Shapiro 2007	40.4 (10.6)	39.6 (7.9)	92%	NR BED 71%; no BED 29%	66	Guided Self-help (ED) CD-ROM	Group CBT Wait list controls	10	10 weeks	2 months FU
Striegel-Moore 2010	37.2 (7.8)	31.3 (6.2)	92%	NR BED (53%) and BN	123	Guided Self-help ED	Usual care	8	12 weeks	40 weeks FU
Wilson 2010	50.3 (14.6)	36.2 (4.3)	85%	NR	205	Guided Self-help ED	IPT Behavioural weight loss	20	24 weeks	None reported

1 Abbreviations: BED - binge eating disorder; BN - bulimia nervosa; BMI - body mass index; BT - behavioural therapy; CBT-ED -cognitive behavioural therapy with eating disorder focus; ED -eating disorder; EDNOS - eating disorder not otherwise specified; FU - follow up; IPT - interpersonal patient therapy; N - number; NR - not reported; SD - standard deviation; SH-ED - self-help with eating disorder focus.

4 **Table 238: Study information for trials included in the analysis of family therapy versus another intervention or wait list control.**

Study_ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Sample	N Initially Randomised	Intervention	Comparison	Sessions N	Treatment Length	Long-term FU
Gorin 2003	45.2 (10.0)	39.4 (7.7)	NR	Satisfies DSM-IV criteria BED.	94	Group CBT-ED with Spouse	Group CBT-ED without Spouse Wait list controls	12	12 weeks	6 months

5 Abbreviations: BED - binge eating disorder; CBT-ED -cognitive behavioural therapy for eating disorders; NR – not reported

1 **Table 239: Summary table of findings for hybrid therapy (CBT-ED and weight loss) compared to another hybrid therapy (brief strategic thinking and weight loss) at the end of treatment in adults with binge eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with other Hybrid 2	Risk difference with Binge Hybrid (95% CI)
Global clinical score	60 (1 study)	⊕⊕⊕⊕ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean global clinical score in the intervention groups was 1.09 standard deviations lower (1.64 to 0.55 lower)
% weight loss	60 (1 study)	⊕⊕⊕⊕ LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean % weight loss in the intervention groups was 0.34 standard deviations higher (0.17 lower to 0.85 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Unclear if allocation concealment was performed. Unclear if the participants, assessors or investigators were blind.

2 Fewer than 400 participants

3 95% CI crossed 1 MID (0.5).

3 **Table 240: Summary table of findings for CBT-ED compared to another intervention at the end of treatment in adults and young people with binge eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with Binge CBT-ED (95% CI)
BMI Young people	26 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi young people in the intervention groups was 0.02 standard deviations higher (0.75 lower to 0.79 higher)
Depression Young people	26 (1 study)	⊕⊕⊕⊕ LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression young people in the intervention groups was 1.08 standard deviations lower (1.91 to 0.25 lower)

Depression Adults	141 (1 study)	⊕⊕⊖⊖ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression adults in the intervention groups was 0.00 standard deviations higher (0.33 lower to 0.33 higher)
EDE - Dietary restraint Young people	26 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - dietary restraint young people in the intervention groups was 0.65 standard deviations lower (1.44 lower to 0.15 higher)
EDE- Dietary restraint Adults	253 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- dietary restraint adults in the intervention groups was 0.52 standard deviations lower (0.78 to 0.26 lower)
EDE - Eating concerns Young people	26 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - eating concerns young people in the intervention groups was 1.41 standard deviations lower (2.29 to 0.54 lower)
EDE- Eating concerns Adults	256 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concerns adults in the intervention groups was 0.51 standard deviations lower (0.76 to 0.25 lower)
EDE - Shape concerns Young people	26 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - shape concerns young people in the intervention groups was 0.11 standard deviations higher (0.66 lower to 0.88 higher)
EDE- Shape concerns Adults	256 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concerns adults in the intervention groups was 0.56 standard deviations lower (0.80 to 0.28 lower)
EDE-Weight concerns Adults	256 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concerns adults in the intervention groups was 0.07 standard deviations higher (0.18 lower to 0.32 higher)
EDE - Weight concerns Young people	26 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - weight concerns young people in the intervention groups was 0.30 standard deviations lower (1.07 lower to 0.48 higher)

EDE- Global score Adults	346 (2 studies)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- global score adults in the intervention groups was 0.99 standard deviations lower (1.24 to 0.74 lower)
Social adjustment - Young people	26 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean social adjustment - young people in the intervention groups was 0.52 standard deviations lower (1.3 lower to 0.27 higher)
Binge eating Adults	253 (2 studies)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating adults in the intervention groups was 0.05 standard deviations higher (0.20 lower to 0.30 higher)
Remission Young people_ITT	26 (1 study)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision	RR 2.00 (0.95 to 4.23)	385 per 1000	385 more per 1000 (from 19 fewer to 1000 more)
Remission Adults	112 (1 study)	⊕⊕⊕⊖ LOW1,7 due to risk of bias, imprecision	RR 0.63 (0.39 to 1.03)	541 per 1000	200 fewer per 1000 (from 330 fewer to 16 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was conducted. Assessors were blind but it was unclear if participants or investigators were blind.

2 95% CI crossed 2 MIDs (-0.5 and 0.5).

3 95% CI crossed 1 MID (-0.5)

4 It was unclear if allocation concealment was conducted. Assessors were blind but it was unclear if participants or investigators were blind. High drop outs were reported >20%

5 For a continuous outcome there were fewer than 400 participants.

6 95% CI crossed 1 MID (1.25).

7 95% CI crossed 1 MID (0.75)

1 **Table 241: Summary table of findings for CBT-ED compared to another intervention at follow up in adults with binge eating disorder.**

Outcomes	No of Participants	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention FU	Risk difference with Binge CBT-ED (95% CI)

	(studies) Follow up				
BMI FU	346 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi fu in the intervention groups was 0.19 standard deviations lower (0.41 lower to 0.03 higher)
Depression FU	141 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.00 standard deviations higher (0.33 lower to 0.33 higher)
Binge eating FU	258 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.10 standard deviations higher (0.15 lower to 0.34 higher)
EDE- Global scale FU	346 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- global scale fu in the intervention groups was 1.02 standard deviations lower (1.27 to 0.77 lower)
EDE- Dietary restraint FU	231 (2 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- dietary restraint fu in the intervention groups was 0.39 standard deviations lower (0.66 to 0.13 lower)
EDE- Weight concerns FU	231 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concerns fu in the intervention groups was 1.53 standard deviations lower (1.86 to 1.20 lower)
EDE- Shape concerns FU	231 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values Not calculable for SMD values	The mean ede- shape concerns fu in the intervention groups was 1.67 standard deviations lower (2.0 to 1.33 lower)
EDE- Eating concerns FU	231 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision			The mean ede- eating concerns fu in the intervention groups was 1.28 standard deviations lower (1.59 to 0.97 lower)
Remission FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4	RR 0.84 (0.57 to 1.24)	632 per 1000	101 fewer per 1000 (from 272 fewer to 152 more)

		due to risk of bias, imprecision			
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Across studies it was unclear if allocation concealment was conducted. In Wilson, it was unclear if either the participants or investigators were blind, assessors were blind. In Ricca participants were not blind and assessors were only blind at baseline. Investigators were not blind. High drop outs were reported in Ricca >20%.					
2 For a continuous outcome there were fewer than 400 participants.					
3 95% CI crossed 1 MID (-0.5).					
4 95% CI crossed 1 MID (0.75)					

1 **Table 242: Summary table of findings for interpersonal psychotherapy versus any other intervention at the end of treatment in adults**
2 **of binge eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Another intervention	Risk difference with Binge IPT (95% CI)
BMI	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.02 standard deviations higher (0.26 lower to 0.31 higher)
Binge eating	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.05 standard deviations lower (0.33 lower to 0.24 higher)
Remission ITT	205 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	RR 1.05 (0.94 to 1.2)	815 per 1000	41 more per 1000 (from 49 fewer to 163 more)
BMI FU	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.01 standard deviations higher (0.27 lower to 0.3 higher)

Binge eating FU	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.07 standard deviations lower (0.35 lower to 0.22 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 It was unclear how the random sequence was generated or if allocation concealment was performed. It was unclear if participants and investigators were blind to treatment, however, assessors were blind. High dropout rates were reported >20%					
2 For a continuous outcome, there were fewer than 400 participants.					
3 For a dichotomous outcome, there were fewer than 300 events.					

1 **Table 243: Summary table of findings for dialectical behaviour therapy versus wait list control at the end of treatment in adults with binge eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Wait list control	Risk difference with Binge DBT (95% CI)
Binge eating (objective)	32 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating (objective in the intervention groups was 0.14 standard deviations lower (1.2 lower to 0.22 higher)
Vomiting episodes	32 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting episodes in the intervention groups was 0.72 standard deviations lower (1.44 lower to 0 higher)
EDE-Global Score	32 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-global score in the intervention groups was 1.02 standard deviations lower (1.77 to 0.27 lower)
Depression	32 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.90 standard deviations lower (1.63 to 0.16 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 It was unclear if allocation concealment was performed. It was also unclear if participants and investigators were blind, however, assessors were.
2 95% CI crossed 1 MID (-0.5)

1 **Table 244: Summary of findings table for BT compared to another intervention at the end of treatment and follow up in adults with**
2 **BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with Binge BT (95% CI)
Bulimic episodes	112 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic episodes in the intervention groups was 0.03 standard deviations higher (0.37 lower to 0.42 higher)
Purging	112 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.19 standard deviations higher (0.21 lower to 0.58 higher)
Symptom checklist	112 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist in the intervention groups was 0.16 standard deviations higher (0.24 lower to 0.55 higher)
EDE-Dietary restraint	112 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-dietary restraint in the intervention groups was 0.01 standard deviations higher (0.38 lower to 0.41 higher)
EDE-weight concern	112 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.06 standard deviations lower (0.46 lower to 0.33 higher)
EDE-shape concern	112 (1 study)	⊕⊕⊕⊖ LOW1,2		Not calculable for SMD values	The mean ede-shape concern in the intervention groups was 0.06 standard deviations lower (0.46 lower to 0.33 higher)

		due to risk of bias, imprecision			
EDE-eating concern	112 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.26 standard deviations higher (0.14 lower to 0.65 higher)
EDI-bulimia	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-bulimia in the intervention groups was 0.18 standard deviations lower (0.57 lower to 0.22 higher)
EDI-body dissatisfaction	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-body dissatisfaction in the intervention groups was 0.16 standard deviations lower (0.55 lower to 0.24 higher)
EDI-drive for thinness	112 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-drive for thinness in the intervention groups was 0.18 standard deviations lower (0.58 lower to 0.22 higher)
Remission	148 (1 study)	⊕⊕⊖⊖ LOW1 due to risk of bias, imprecision	RR 0.64 (0.41 to 1.01)	434 per 1000	156 fewer per 1000 (from 256 fewer to 4 more)
Bulimic episodes FU	86 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean bulimic episodes fu in the intervention groups was 0.11 standard deviations lower (0.56 lower to 0.34 higher)
Purging FU	87 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging fu in the intervention groups was 0.34 standard deviations higher (0.12 lower to 0.79 higher)
Symptom checklist FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean symptom checklist fu in the intervention groups was 0.29 standard deviations higher (0.16 lower to 0.74 higher)
EDE-Dietary restraint FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4		Not calculable for SMD values	The mean ede-dietary restraint fu in the intervention groups was

		due to risk of bias, imprecision			0.07 standard deviations lower (0.52 lower to 0.38 higher)
EDE-weight concern FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern fu in the intervention groups was 0.08 standard deviations lower (0.53 lower to 0.37 higher)
EDE-shape concern FU	87 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern fu in the intervention groups was 0.03 standard deviations higher (0.42 lower to 0.49 higher)
EDE-eating concern FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern fu in the intervention groups was 0.16 standard deviations lower (0.61 lower to 0.29 higher)
EDI-bulimia FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-bulimia fu in the intervention groups was 0.29 standard deviations lower (0.74 lower to 0.17 higher)
EDI-body dissatisfaction FU	87 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-body dissatisfaction fu in the intervention groups was 0.05 standard deviations lower (0.50 lower to 0.40 higher)
EDI-drive for thinness FU	87 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-drive for thinness fu in the intervention groups was 0.20 standard deviations lower (0.65 lower to 0.25 higher)
Remission FU	112 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision	RR 1.22 (0.81 to 1.82)	434 per 1000	96 more per 1000 (from 82 fewer to 356 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how randomisation was conducted or if allocation concealment was performed. Assessors were blind but it was unclear if investigators or participants were blind. High drop outs were reported >20%.

2 For a continuous outcome there were fewer than 400 participants

3 95% CI crossed 1 MID (0.5)
4 95% CI crossed 1 MID (-0.5)
5 95% CI crossed 1 MID (1.25)

1 **Table 245: Summary of findings table for CBT-general compared to another intervention at the end of treatment and follow up in**
2 **adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with CBT-General vs another intervention (95% CI)
Purging	112 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean purging in the intervention groups was 0.16 standard deviations lower (0.56 lower to 0.23 higher)
Binge eating	112 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.14 standard deviations lower (0.53 lower to 0.25 higher)
EDE-Weight concern	112 (1 study)	⊕⊕⊕⊖ LOW1 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.22 standard deviations higher (0.17 lower to 0.61 higher)
EDE-Shape concern	112 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern in the intervention groups was 0.21 standard deviations higher (0.18 lower to 0.50 higher)
EDE-Eating concern	112 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.11 standard deviations lower (0.51 lower to 0.28 higher)

EDE- Restraint	112 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean ede- restraint in the intervention groups was 0.01 standard deviations higher (0.38 lower to 0.40 higher)
EDI-Body dissatisfaction	112 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi-body dissatisfaction in the intervention groups was 0.33 standard deviations higher (0.06 lower to 0.72 higher)
EDI-Drive for thinness	112 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi-drive for thinness in the intervention groups was 0.74 standard deviations higher (0.15 lower to 0.64 higher)
EDI- Bulimia	112 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean edi- bulimia in the intervention groups was 0.07 standard deviations higher (0.33 lower to 0.46 higher)
SCL-90-R Global severity index	112 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean scl-90-r global severity index in the intervention groups was 0.07 standard deviations lower (0.46 lower to 0.32 higher)
Remission ITT	112 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision	RR 1.28 (0.87 to 1.89)	434 per 1000	122 more per 1000 (from 56 fewer to 386 more)
Purging FU	87 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculabl e for SMD values	The mean purging fu in the intervention groups was 0.23 standard deviations lower (0.68 lower to 0.22 higher)
Binge eating FU	87 (1 study)	⊕⊕⊕⊖ LOW1,3		Not calculabl e for	The mean binge eating fu in the intervention groups was

		due to risk of bias, imprecision		SMD values	0.05 standard deviations lower (0.50 lower to 0.40 higher)
EDE-Weight concern FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern fu in the intervention groups was 0.24 standard deviations higher (0.20 lower to 0.69 higher)
EDE-Shape concern FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern fu in the intervention groups was 0.34 standard deviations higher (0.11 lower to 0.78 higher)
EDE-Eating concern FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern fu in the intervention groups was 0.16 standard deviations higher (0.29 lower to 0.60 higher)
EDE- Restraint FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint fu in the intervention groups was 0.14 standard deviations higher (0.58 lower to 0.57 higher)
EDI-Body dissatisfaction FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-body dissatisfaction fu in the intervention groups was 0.32 standard deviations higher (0.13 lower to 0.76 higher)
EDI-Drive for thinness FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-drive for thinness fu in the intervention groups was 0.32 standard deviations higher (0.13 lower to 0.77 higher)
EDI- Bulimia FU	87 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi- bulimia fu in the intervention groups was 0.29 standard deviations higher (0.16 lower to 0.74 higher)

SCL-90-R Global severity index FU	87 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean scl-90-r global severity index fu in the intervention groups was 0.00 standard deviations higher (0.64 lower to 0.64 higher)
Remission IT FU	112 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision	RR 1.89 (1.45 to 2.46)	473 per 1000	421 more per 1000 (from 213 more to 691 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear how randomisation was conducted or if allocation concealment was performed. Assessors were blind but it was unclear if investigators or participants were blind. High dropouts were reported >20%.

2 95% CI crossed 1 MID (-0.5).

3 For a continuous outcome there were fewer than 400 participants.

4 95% CI crossed 1 MID (0.5).

5 95% CI Crossed 1 MID (1.25)

8.2.2.51 Group therapy

2 Table 246: Summary table of findings for group mindfulness versus another group intervention in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BED Group Mindfulness (95% CI)
BMI	103 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.07 standard deviations higher (0.32 lower to 0.45 higher)
Binge eating days	103 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating days in the intervention groups was 0.06 standard deviations lower (0.45 lower to 0.32 higher)
Depression	103 (1 study)	⊕⊕⊖⊖ LOW1,2		Not calculable for SMD values	The mean depression in the intervention groups was

		due to risk of bias, imprecision			0.1 standard deviations lower (0.49 lower to 0.29 higher)
BMI FU	103 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.12 standard deviations higher (0.26 lower to 0.51 higher)
Depression FU	103 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.06 standard deviations lower (0.45 lower to 0.32 higher)
Binge eating days FU	103 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating days fu in the intervention groups was 0.26 standard deviations lower (0.64 lower to 0.13 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Unclear if allocation concealment was performed. Participants were not blind, and it was unclear if investigators and assessors were blind. High dropouts were reported >20%.

2 For a continuous outcome, there were fewer than 400 participants.

3 95% CI crossed 1 MID (0.5).

4 95% CI crossed 1 MID (-0.5).

1 **Table 247: Summary table of group mindfulness compared to wait list controls in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Wait list control	Risk difference with BED Group Mindfulness (95% CI)
Binge eating days	100 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating days in the intervention groups was 1.08 standard deviations lower (1.5 to 0.66 lower)
Depression	100 (1 study)	⊕⊕⊖⊖ LOW1,3		Not calculable for SMD values	The mean depression in the intervention groups was

		due to risk of bias, imprecision			0.85 standard deviations lower (1.26 to 0.44 lower)
BMI	100 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.19 standard deviations higher (0.2 lower to 0.59 higher)
Binge eating scale	100 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 1.24 standard deviations lower (1.67 to 0.81 lower)
Binge eating days FU	100 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating days fu in the intervention groups was 1.02 standard deviations lower (1.44 to 0.6 lower)
Depression FU	100 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.44 standard deviations lower (0.83 to 0.04 lower)
BMI FU	100 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.2 standard deviations higher (0.19 lower to 0.59 higher)
Binge eating scale FU	100 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale fu in the intervention groups was 1.39 standard deviations lower (1.83 to 0.95 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Unclear if allocation concealment was performed. Participants were not blind, and it was unclear if investigators and assessors were blind. High dropouts were reported >20%.

2 For a continuous outcome, there were fewer than 400 participants.

3 95% CI crossed 1 MID (-0.5).

4 95% CI crossed 1 MID (0.5).

1 **Table 248: Summary table of group CBT (ED) compared to another intervention in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BED Group CBT (ED) (95% CI)
Weight	530 (6 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean weight in the intervention groups was 0.23 standard deviations higher (0.03 lower to 0.49 higher)
Binge eating	795 (9 studies)	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.13 standard deviations lower (0.27 lower to 0.01 higher)
Depression	588 (7 studies)	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		Not calculable for SMD values	The mean depression in the intervention groups was 0.03 standard deviations higher (0.13 lower to 0.19 higher)
Anxiety	53 (1 study)	⊕⊕⊕⊕ LOW ^{4,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean anxiety in the intervention groups was 0.13 standard deviations lower (0.69 lower to 0.42 higher)
EDE Global clinical score	266 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,6,7} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede global clinical score in the intervention groups was 1.08 standard deviations higher (0.79 to 1.37 higher)
EDE- Shape concerns	241 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{2,8,9} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- shape concerns in the intervention groups was 0.14 standard deviations lower (0.4 lower to 0.11 higher)
EDE-Dietary restraint	384 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8,9} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-dietary restraint in the intervention groups was 0.02 standard deviations higher (0.19 lower to 0.22 higher)
EDE-Weight concern	384 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{2,8,9} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.19 standard deviations lower (0.39 lower to 0.02 higher)

EDE-Eating concern	384 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8,9} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.18 standard deviations higher (0.03 lower to 0.38 higher)
Global symptom score	158 (1 study)	⊕⊕⊕⊕ LOW ^{9,10} due to risk of bias, imprecision		Not calculable for SMD values	The mean global symptom score in the intervention groups was 0.06 standard deviations higher (0.25 lower to 0.37 higher)
Remission_ITT	404 (4 studies)	⊕⊕⊕⊕ LOW ^{1,11} due to risk of bias, imprecision	RR 1.22 (1.03 to 1.45)	502 per 1000	111 more per 1000 (from 15 more to 226 more)
Weight FU	514 (6 studies)	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		Not calculable for SMD values	The mean weight fu in the intervention groups was 0.09 standard deviations higher (0.08 lower to 0.27 higher)
Binge eating FU	651 (7 studies)	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.03 standard deviations lower (0.19 lower to 0.12 higher)
Depression FU	587 (6 studies)	⊕⊕⊕⊕ MODERATE ¹ due to risk of bias		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.04 standard deviations higher (0.13 lower to 0.2 higher)
Anxiety FU	185 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{5,6,8} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean anxiety fu in the intervention groups was 0.86 standard deviations higher (0.55 to 1.17 higher)
EDE Global clinical score FU	266 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,3,6} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede global clinical score fu in the intervention groups was 1.01 standard deviations higher (0.73 to 1.3 higher)
EDE-Dietary restraint FU	350 (4 studies)	⊕⊕⊕⊕ LOW ^{2,8} due to risk of bias, inconsistency		Not calculable for SMD values	The mean ede-dietary restraint fu in the intervention groups was 0.16 standard deviations higher (0.05 lower to 0.37 higher)
EDE- Shape concerns FU	350 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{3,6,8}		Not calculable	The mean ede- shape concerns fu in the intervention groups was

		due to risk of bias, inconsistency, imprecision		for SMD values	0.74 standard deviations higher (0.5 to 0.98 higher)
EDE-Weight concern FU	540 (5 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8} due to risk of bias, inconsistency		Not calculable for SMD values	The mean ede-weight concern fu in the intervention groups was 0.24 standard deviations higher (0.05 to 0.43 higher)
EDE-Eating concern FU	540 (5 studies)	⊕⊕⊕⊕ VERY LOW ^{3,6,8} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-eating concern fu in the intervention groups was 0.26 standard deviations higher (0.08 to 0.45 higher)
Global symptom index FU	138 (1 study)	⊕⊕⊕⊕ LOW ^{9,10} due to risk of bias, imprecision		Not calculable for SMD values	The mean global symptom index fu in the intervention groups was 0.13 standard deviations higher (0.2 lower to 0.47 higher)
Remission FU_ITT	279 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,12} due to risk of bias, inconsistency, imprecision	RR 1.25 (0.85 to 1.85)	549 per 1000	137 more per 1000 (from 82 fewer to 467 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 Across studies, in some or all studies, it was unclear what methods were used for randomisation or if allocation concealment was performed. Across studies, in some or all, it was unclear if participants, investigators, and assessors were blind. High dropout rates were detected >20%.
- 2 Heterogeneity was detected I² >50%
- 3 95% CI crossed 1 MID (0.5)
- 4 Unclear what methods were used for randomisation or if allocation concealment was performed. Neither the participants nor investigators were blind. The assessors were not blinded. High dropouts were reported >20%.
- 5 95% CI crossed 1 MID (-0.5)
- 6 Heterogeneity was detected I² >80%.
- 7 95% CI crossed 2 MIDs (-0.5 and 0.5)
- 8 Across studies, in some or all studies, it was unclear what methods were used for randomisation or if allocation concealment was performed. Across studies, in some or all, it was unclear if participants, investigators, and assessors were blind. One study by Musch the assessors were blind. High dropout rates were detected >20%.
- 9 For a continuous outcome, there were fewer than 400 participants.
- 10 Unclear what methods were used for randomisation or if allocation concealment was performed. Neither the participants nor investigators were blind. The assessors were not blinded.

11 For a dichotomous outcomes, there were fewer than 300 events.
12 95% CI crossed 1 MID (1.25)

1 **Table 249: Summary table of group CBT (ED) compared with wait list controls in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Wait list control	Risk difference with BED Group CBT (ED) (95% CI)
Weight (BMI)	181 (3 studies)	⊕⊕⊖⊖ LOW1 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (bmi) in the intervention groups was 0.14 standard deviations higher (0.15 lower to 0.43 higher)
Binge eating days	141 (2 studies)	⊕⊖⊖⊖ VERY LOW2,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean binge eating days in the intervention groups was 0.36 standard deviations lower (1.45 lower to 0.72 higher)
Depression	160 (3 studies)	⊕⊖⊖⊖ VERY LOW2,3,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.19 standard deviations higher (0.5 lower to 0.11 higher)
BMI-FU	130 (2 studies)	⊕⊕⊖⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi-fu in the intervention groups was 0.12 standard deviations higher (0.22 lower to 0.47 higher)
Depression FU	137 (2 studies)	⊕⊖⊖⊖ VERY LOW3,4,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.04 standard deviations higher (1.06 lower to 1.15 higher)
Binge eating days FU	130 (2 studies)	⊕⊕⊖⊖ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating days fu in the intervention groups was 0.62 standard deviations lower (0.97 to 0.26 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; FU: Follow up

1 For a continuous outcome, there were fewer than 400 participants.
 2 It was unclear if allocation concealment was performed. Across the studies, either the participants, investigators and assessors were not blinded or it was unclear. High drop outs were reported >20% and greater than 10% difference in drop outs were detected between the two groups.
 3 Heterogeneity was detected, I² >80%
 4 95% CI crossed 2 MIDs (-0.5 and 0.5)
 5 95% CI crossed 1 MID (-0.5)
 6 It was unclear if allocation concealment was performed. The participants were not blind, however, it was unclear if the investigators and assessors were blinded. High drop outs were reported >20%.

1 Table 250: Summary table of group behavioural therapy (ED) compared with wait list controls in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BED Group BT(ED) (95% CI)
Binge eating frequency	72 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating frequency in the intervention groups was 0.24 standard deviations lower (0.7 lower to 0.23 higher)
EDE- Total	72 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- total in the intervention groups was 0.1 standard deviations higher (0.37 lower to 0.56 higher)
Anxiety	72 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean anxiety in the intervention groups was 0.03 standard deviations lower (0.49 lower to 0.44 higher)
Depression	72 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.5 standard deviations lower (0.97 to 0.03 lower)
Remission_ITT	100 (1 study)	⊕⊖⊖⊖ VERY LOW1,5 due to risk of bias, imprecision	RR 1.00 (0.46 to 2.19)	200 per 1000	0 fewer per 1000 (from 108 fewer to 238 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 It was unclear if allocation concealment was performed, Neither the participants, investigators or assessors were blind.

2 95% CI crossed 1 MID (-0.5).

3 95% CI crossed 1 MID (0.5).

4 For a continuous outcome, there were fewer than 400 participants.

5 95% CI crossed 2 MIDs (0.75 and 1.25).

1 **Table 251: Summary table of group behavioural therapy (ED) compared with another group intervention in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BED Group BT (ED) (95% CI)
Depression	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.21 standard deviations lower (0.61 lower to 0.19 higher)
BMI	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.18 standard deviations lower (0.58 lower to 0.22 higher)
Weight loss (pounds)	98 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (pounds) in the intervention groups was 0.18 standard deviations higher (0.22 lower to 0.57 higher)
Remission_ITT	101 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision	RR 1.81 (1.18 to 2.78)	353 per 1000	286 more per 1000 (from 64 more to 628 more)
EDE-Eating concern	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.54 standard deviations lower (0.95 to 0.14 lower)

EDE-Dietary restraint	98 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-dietary restraint in the intervention groups was 0.54 standard deviations lower (0.94 to 0.14 lower)
EDE- Shape concerns	98 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concerns in the intervention groups was 0.32 standard deviations lower (0.72 lower to 0.07 higher)
EDE-Weight concern	98 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.38 standard deviations lower (0.78 lower to 0.02 higher)
BMI FU	88 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.14 standard deviations lower (0.56 lower to 0.28 higher)
Weight loss (pounds) FU	88 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (pounds) fu in the intervention groups was 0.05 standard deviations higher (0.37 lower to 0.47 higher)
Depression FU	88 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.03 standard deviations higher (0.39 lower to 0.46 higher)
EDE-Dietary restraint FU	88 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-dietary restraint fu in the intervention groups was 0.6 standard deviations lower (1.03 to 0.17 lower)
EDE-Weight concern FU	88 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern fu in the intervention groups was 0.4 standard deviations lower (0.82 lower to 0.03 higher)
EDE- Shape concerns FU	88 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concerns fu in the intervention groups was 0.12 standard deviations lower (0.54 lower to 0.3 higher)

EDE-Eating concern FU	88 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern fu in the intervention groups was 0.18 standard deviations higher (0.24 lower to 0.6 higher)
Remission_ITT FU	101 (1 study)	⊕⊕⊖⊖ LOW1,6 due to risk of bias, imprecision	RR 1.44 (0.98 to 2.11)	431 per 1000	190 more per 1000 (from 9 fewer to 479 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear methods for randomisation or if allocation concealment was performed. It was unclear if participants and investigators were blind, however, assessors were blind. High dropouts were reported >20% and a greater than 10% difference in dropout rates were detected between the two groups.
2 95% CI crossed 1 MID (-0.5).
3 95% CI crossed 1 MID (0.5).
4 For a dichotomous outcome, there were fewer than 300 events.
5 For a continuous outcome, there were fewer than 400 participants.
6 95% CI crossed 1 MID (1.25).

1 **Table 252: Summary table of group CBT-ED (body exposure) compared with CBT-ED (cognitive) in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT (cognitive).	Risk difference with BED CBT (body exposure). (95% CI)
EDE- Restraint	24 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0 standard deviations higher (0.8 lower to 0.8 higher)
EDE- Eating concern	24 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.41 standard deviations lower (1.22 lower to 0.4 higher)
EDE- Weight concern	24 (1 study)	⊕⊖⊖⊖ VERY LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0 standard deviations higher (0.8 lower to 0.8 higher)

EDE- Shape concern	24 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.19 standard deviations higher (0.62 lower to 0.99 higher)
BMI	24 (1 study)	⊕⊕⊕⊕ LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi in the intervention groups was 0.38 standard deviations lower (1.19 lower to 0.43 higher)
Depression	24 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.01 standard deviations higher (0.79 lower to 0.81 higher)
Binge eating episodes	24 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating episodes in the intervention groups was 0.27 standard deviations lower (1.07 lower to 0.53 higher)
Remission_ITT	28 (1 study)	⊕⊕⊕⊕ LOW _{1,5} due to risk of bias, imprecision	RR 0.44 (0.18 to 1.11)	643 per 1000	360 fewer per 1000 (from 527 fewer to 71 more)
EDE- Restraint FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint fu in the intervention groups was 0.08 standard deviations lower (0.88 lower to 0.72 higher)
EDE- Eating concern FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern fu in the intervention groups was 0 standard deviations higher (0.8 lower to 0.8 higher)
EDE- Weight concern FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern fu in the intervention groups was 0.18 standard deviations higher (0.62 lower to 0.98 higher)
EDE- Shape concern FU	24 (1 study)	⊕⊕⊕⊕ LOW _{1,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern fu in the intervention groups was 0.45 standard deviations higher (0.37 lower to 1.26 higher)

BMI FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi fu in the intervention groups was 0.25 standard deviations lower (1.05 lower to 0.56 higher)
Depression FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.2 standard deviations higher (0.61 lower to 1 higher)
Binge eating episodes FU	24 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating episodes fu in the intervention groups was 0.43 standard deviations higher (0.38 lower to 1.24 higher)
Remission_ITT FU	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,7} due to risk of bias, imprecision	RR 0.75 (0.35 to 1.6)	571 per 1000	143 fewer per 1000 (from 371 fewer to 343 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 There was unclear methods of randomisation and allocation concealment. The participants, investigators and assessors were not blinded.
- 2 95% CI crossed 2 MIDs (-0.5 and 0.5)
- 3 95% CI crossed 1 MID (-0.5)
- 4 For a continuous outcome, there were fewer than 400 participants.
- 5 95% CI crossed 1 MID (0.75)
- 6 95% CI crossed 1 MID (0.5)
- 7 95% CI crossed 2 MIDs (0.75 and 1.25)

1 **Table 253: Summary table of group interpersonal psychotherapy (IPT) compared with another intervention in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BED Group IPT (ED) (95% CI)
Binge eating	158 (1 study)	⊕⊕⊕⊕ LOW ^{1,2}		Not calculable	The mean binge eating in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.16 standard deviations higher (0.15 lower to 0.48 higher)
Remission_ITT	162 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	RR 0.92 (0.77 to 1.1)	790 per 1000	63 fewer per 1000 (from 182 fewer to 79 more)
Depression	194 (2 studies)	⊕⊕⊕⊖ LOW4,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.22 standard deviations lower (0.5 lower to 0.06 higher)
EDE-Restraint	158 (1 study)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-restraint in the intervention groups was 0.59 standard deviations higher (0.27 to 0.91 higher)
EDE-Shape concern	158 (1 study)	⊕⊕⊕⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern in the intervention groups was 0.08 standard deviations higher (0.23 lower to 0.39 higher)
EDE-Eating concern	158 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.12 standard deviations higher (0.19 lower to 0.44 higher)
EDE-Weight concern	158 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.08 standard deviations higher (0.23 lower to 0.39 higher)
Global symptom index	158 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean global symptom index in the intervention groups was 0.06 standard deviations lower (0.37 lower to 0.25 higher)
BMI	158 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.06 standard deviations lower (0.37 lower to 0.26 higher)
Binge eating FU	138 (1 study)	⊕⊕⊕⊖ LOW1,2		Not calculable	The mean binge eating fu in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.14 standard deviations lower (0.48 lower to 0.19 higher)
EDE-Restraint FU	138 (1 study)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-restraint fu in the intervention groups was 0.25 standard deviations higher (0.09 lower to 0.58 higher)
EDE-Shape concern FU	138 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern fu in the intervention groups was 0 standard deviations higher (0.33 lower to 0.33 higher)
EDE-Eating concern FU	138 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern fu in the intervention groups was 0 standard deviations higher (0.33 lower to 0.33 higher)
EDE-Weight concern FU	138 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern fu in the intervention groups was 0 standard deviations higher (0.33 lower to 0.33 higher)
Global symptom index FU	138 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean global symptom index fu in the intervention groups was 0.13 standard deviations lower (0.47 lower to 0.2 higher)
Remission FU_ITT	162 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision	RR 1.04 (0.81 to 1.34)	593 per 1000	24 more per 1000 (from 113 fewer to 201 more)
Depression FU	138 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.1 standard deviations lower (0.43 lower to 0.24 higher)
BMI FU	138 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.17 standard deviations lower (0.5 lower to 0.16 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 There were unclear methods for randomisation and if allocation concealment was performed. It was unclear if participants, investigators and assessors were blind.
- 2 For a continuous outcome, there were fewer than 400 participants.
- 3 For a dichotomous outcome, there were fewer than 300 events.
- 4 There were unclear methods for randomisation and if allocation concealment was performed. The participants, investigators and assessors were either not blinded or it was unclear if they were. High dropouts were detected in Wilfley 1993 >20% and high difference in dropouts between the two groups >10%.
- 5 95% CI crossed 1 MID (-0.5).
- 6 95% CI crossed 1 MID (0.5).

1 **Table 254: Summary table of group counselling compared with another intervention in adults with BED at the end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention	Risk difference with BED Group Counselling (95% CI)
BMI	88 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.14 standard deviations higher (0.28 lower to 0.56 higher)
EDE - Dietary restraint	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - dietary restraint in the intervention groups was 0.54 standard deviations higher (0.14 to 0.94 higher)
EDE- Shape concerns	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concerns in the intervention groups was 0.32 standard deviations higher (0.07 lower to 0.72 higher)
EDE- Weight concerns	98 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concerns in the intervention groups was 0.38 standard deviations higher (0.02 lower to 0.78 higher)
EDE - Eating concerns	98 (1 study)	⊕⊕⊖⊖ LOW1,2		Not calculable for SMD values	The mean ede - eating concerns in the intervention groups was

		due to risk of bias, imprecision			0.54 standard deviations higher (0.14 to 0.95 higher)
Remission_ITT	101 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision	RR 8.33 (2.03 to 34.21)	40 per 1000	293 more per 1000 (from 41 more to 1000 more)
Depression	98 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.21 standard deviations higher (0.19 lower to 0.61 higher)
Weight loss	98 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss in the intervention groups was 0.18 standard deviations lower (0.57 lower to 0.22 higher)
Patient's preference for treatment	98 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean patient's preference for treatment in the intervention groups was 0.37 standard deviations lower (0.77 lower to 0.03 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 There were unclear methods for randomisation and if allocation concealment was performed. It was unclear if participants and investigators were blind, but the assessors were blind. High dropouts were reported in one arm >20% and a greater than 10% difference was detected for dropouts between the two groups.

2 95% CI crossed 1 MID (0.5).

3 95% CI crossed 1 MID (-0.5)

4. Fewer than 300 events

1 Table 255: Summary table of group counselling compared with another intervention in adults with BED at follow up.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention FU	Risk difference with BED Group Counselling (95% CI)
BMI FU	88 (1 study)	⊕⊕⊕⊕ LOW1,2		Not calculable for SMD values	The mean BMI fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention FU	Risk difference with BED Group Counselling (95% CI)
		due to risk of bias, imprecision			0.14 standard deviations higher (0.28 lower to 0.56 higher)
Depression FU	88 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.03 standard deviations lower (0.46 lower to 0.39 higher)
EDE - Dietary restraint FU	88 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - dietary restraint fu in the intervention groups was 0.6 standard deviations higher (0.17 to 1.03 higher)
EDE- Shape concerns FU	88 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concerns fu in the intervention groups was 0.12 standard deviations higher (0.3 lower to 0.54 higher)
EDE- Weight concerns FU	88 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concerns fu in the intervention groups was 0.4 standard deviations higher (0.03 lower to 0.82 higher)
EDE - Eating concerns FU	88 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede - eating concerns fu in the intervention groups was 0.18 standard deviations lower (0.6 lower to 0.24 higher)
Remission_ITT FU	101 (1 study)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision	RR 0.70 (0.47 to 1.02)	620 per 1000	186 fewer per 1000 (from 329 fewer to 12 more)
Weight loss FU	98 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss fu in the intervention groups was 0.18 standard deviations lower (0.57 lower to 0.22 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with another intervention FU	Risk difference with BED Group Counselling (95% CI)
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 There were unclear methods for randomisation and if allocation concealment was performed. It was unclear if participants and investigators were blind, but the assessors were blind. High dropouts were reported in one arm >20% and a greater than 10% difference was detected for dropouts between the two groups.					
2 95% CI crossed 1 MID (0.5).					
3 For a continuous outcome, there were fewer than 400 participants.					
4 95% CI crossed 1 MID (-0.5).					
5 95% CI crossed 1 MID (0.75).					

1 **Table 256: Summary table of group diet compared with another group intervention in adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BED Group Diet (95% CI)
Weight	242 (3 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight in the intervention groups was 0.54 standard deviations lower (0.81 to 0.28 lower)
Binge eating	241 (3 studies)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.24 standard deviations higher (0.02 lower to 0.5 higher)
EDE- Shape concern	85 (2 studies)	⊕⊖⊖⊖ VERY LOW1,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.26 standard deviations higher (0.17 lower to 0.7 higher)
EDE- Weight concern	85 (2 studies)	⊕⊖⊖⊖ VERY LOW1,3,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.19 standard deviations higher (0.24 lower to 0.63 higher)

EDE-Eating concern	85 (2 studies)	⊕⊕⊕⊖ LOW1,3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.26 standard deviations higher (0.17 lower to 0.7 higher)
EDE- Restraint	85 (2 studies)	⊕⊕⊕⊖ VERY LOW1,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.14 standard deviations higher (0.29 lower to 0.57 higher)
Depression	327 (4 studies)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.19 standard deviations higher (0.03 lower to 0.42 higher)
Global EDE	125 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean global ede in the intervention groups was 0.17 standard deviations higher (0.2 lower to 0.54 higher)
Remission_ITT	242 (3 studies)	⊕⊕⊕⊖ LOW1,8 due to risk of bias, imprecision	RR 0.64 (0.46 to 0.88)	503 per 1000	181 fewer per 1000 (from 60 fewer to 272 fewer)
Weight FU	229 (3 studies)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight fu in the intervention groups was 0.17 standard deviations lower (0.44 lower to 0.1 higher)
Binge eating FU	241 (3 studies)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.21 standard deviations higher (0.05 lower to 0.47 higher)
EDE- Shape concern FU	71 (2 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern fu in the intervention groups was 0.03 standard deviations lower (0.5 lower to 0.44 higher)
EDE- Weight concern FU	71 (2 studies)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern fu in the intervention groups was 0.11 standard deviations higher (0.36 lower to 0.59 higher)

EDE-Eating concern FU	71 (2 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern fu in the intervention groups was 0.06 standard deviations lower (0.53 lower to 0.41 higher)
EDE- Restraint FU	71 (2 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint fu in the intervention groups was 0.16 standard deviations lower (0.63 lower to 0.3 higher)
Global EDE FU	125 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean global ede fu in the intervention groups was 0.17 standard deviations higher (0.19 lower to 0.54 higher)
Depression FU	205 (3 studies)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.03 standard deviations lower (0.32 lower to 0.25 higher)
Remission-ITT FU	117 (2 studies)	⊕⊕⊕⊖ LOW1,8 due to risk of bias, imprecision	RR 0.67 (0.47 to 0.95)	662 per 1000	218 fewer per 1000 (from 33 fewer to 351 fewer)
EDE- Shape concern < 18 binges per month	48 (1 study)	⊕⊕⊕⊖ LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern < 18 binges per month in the intervention groups was 0.13 standard deviations lower (0.69 lower to 0.44 higher)
EDE- Shape concern > 18 binges per month	37 (1 study)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern > 18 binges per month in the intervention groups was 0.83 standard deviations higher (0.15 to 1.51 higher)
EDE- Restraint <18 binges per month	48 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint <18 binges per month in the intervention groups was 0.29 standard deviations lower (0.86 lower to 0.28 higher)
EDE- Restraint > 18 binges per month	37 (1 study)	⊕⊕⊕⊖ LOW3,4,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint > 18 binges per month in the intervention groups was 0.90 standard deviations higher (0.21 to 1.58 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Across studies it was unclear if randomisation was performed and in all studies if allocation concealment was performed. Across the studies, either it was unclear if the participants, investigators or assessors were not blinded. Only in Munsch 2007 were the assessors blind. High dropout rates were detected >20%.

2 95% CI crossed 1 MID (-0.5)

3 95% CI crossed 1 MID (0.5)

4 Heterogeneity was detected I² >50%

5 Heterogeneity was detected I² >80%

6 For a continuous outcome, there were fewer than 400 participants.

7 It was unclear how randomisation was performed and if allocation concealment was performed. The participants were not blinded, and it was unclear if investigators and assessors were blinded. High dropout rates were detected >20%.

8 95% CI crossed 1 MID (0.75)

1 **Table 257: Summary table of group self-help (ED) compared with another group in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BED Group SH(ED) (95% CI)
BMI	234 (2 studies)	⊕⊕⊖⊖ LOW1,2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.19 standard deviations lower (0.46 lower to 0.08 higher)
Binge eating	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.30 standard deviations higher (0.01 to 0.6 higher)
Depression	44 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.23 standard deviations higher (0.43 lower to 0.89 higher)
EDE Q Global Score	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q global score in the intervention groups was 0.33 standard deviations higher (0.03 to 0.62 higher)

EDE Q Restraint	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q restraint in the intervention groups was 0.46 standard deviations higher (0.16 to 0.76 higher)
EDE Q Eating Concern	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q eating concern in the intervention groups was 0.31 standard deviations higher (0.01 to 0.6 higher)
EDE Q Shape Concern	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q shape concern in the intervention groups was 0.22 standard deviations higher (0.08 lower to 0.52 higher)
EDE Q Weight Concern	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q weight concern in the intervention groups was 0.27 standard deviations higher (0.03 lower to 0.57 higher)
Quality of life	167 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.00 standard deviations lower (0.32 lower to 0.32 higher)
Remission_ITT	51 (1 study)	⊕⊕⊕⊕ LOW1,5 due to risk of bias, imprecision	RR 2.83 (1.29 to 6.23)	200 per 1000	366 more per 1000 (from 58 more to 1000 more)
BMI FU	231 (2 studies)	⊕⊕⊕⊕ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.08 standard deviations lower (0.35 lower to 0.2 higher)
Binge eating FU	190 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.10 standard deviations lower (0.4 lower to 0.19 higher)
Depression FU	44 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.23 standard deviations higher (0.43 lower to 0.89 higher)

EDE Q Restraint FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q restraint fu in the intervention groups was 0.46 standard deviations higher (0.16 to 0.76 higher)
EDE Q Eating Concern FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q eating concern fu in the intervention groups was 0.08 standard deviations lower (0.38 lower to 0.22 higher)
EDE Q Shape Concern FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q shape concern fu in the intervention groups was 0.07 standard deviations higher (0.23 lower to 0.37 higher)
EDE Q Weight Concern FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q weight concern fu in the intervention groups was 0.07 standard deviations higher (0.23 lower to 0.37 higher)
EDE Q Global Score FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q global score fu in the intervention groups was 0.06 standard deviations higher (0.24 lower to 0.35 higher)
Quality of life FU	167 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life fu in the intervention groups was 0.02 standard deviations higher (0.3 lower to 0.34 higher)
Remission_ITT FU	51 (1 study)	⊕⊕⊕⊕ VERY LOW1,7 due to risk of bias, imprecision	RR 0.67 (0.22 to 2.09)	286 per 1000	94 fewer per 1000 (from 223 fewer to 311 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear how they generated random sequence for randomisation and if allocation concealment was performed. It is unclear if either the participants, investigators or assessors were blind.

2 95% CI crossed 1 MID (-0.5).

3 For a continuous outcome, there were fewer than 400 participants.

4 95% CI crossed 1 MID (0.5).

5 For a dichotomous outcome, there were fewer than 300 events.
6 95% CI crossed 2 MIDs (-0.5 and 0.5).
7 95% CI crossed 2 MIDs (0.75 and 1.25).

1 **Table 258: Summary table of group guided self-help (ED) compared with other group in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BED Group Guided SH(ED) (95% CI)
BMI	234 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.16 standard deviations higher (0.11 lower to 0.44 higher)
Binge eating	183 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.35 standard deviations lower (0.66 to 0.04 lower)
Depression	44 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.53 standard deviations lower (1.15 lower to 0.09 higher)
EDE Q Global Score	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q global score in the intervention groups was 0.07 standard deviations higher (0.24 lower to 0.38 higher)
EDE Q Restraint	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q restraint in the intervention groups was 0.22 standard deviations lower (0.52 lower to 0.09 higher)
EDE Q Eating concern	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q eating concern in the intervention groups was 0.08 standard deviations lower (0.39 lower to 0.22 higher)
EDE Q Weight concern	190 (1 study)	⊕⊕⊖⊖ LOW1,4		Not calculable for SMD values	The mean ede q weight concern in the intervention groups was

		due to risk of bias, imprecision			0.26 standard deviations higher (0.05 lower to 0.57 higher)
EDE Q Shape concern	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q shape concern in the intervention groups was 0.09 standard deviations higher (0.21 lower to 0.4 higher)
Quality of life	176 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.01 standard deviations higher (0.31 lower to 0.32 higher)
Remission_ITT	51 (1 study)	⊕⊖⊖⊖ VERY LOW1,5 due to risk of bias, imprecision	RR 0.57 (0.21 to 1.52)	375 per 1000	161 fewer per 1000 (from 296 fewer to 195 more)
BMI FU	231 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.02 standard deviations lower (0.29 lower to 0.26 higher)
Binge eating FU	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.23 standard deviations higher (0.02 lower to 0.48 higher)
Depression FU	41 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.49 standard deviations lower (1.13 lower to 0.14 higher)
EDE Q Global Score FU	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q global score fu in the intervention groups was 0.40 standard deviations lower (0.71 to 0.09 lower)
EDE Q Restraint FU	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q restraint fu in the intervention groups was 0.21 standard deviations higher (0.1 lower to 0.52 higher)
EDE Q Eating concern FU	190 (1 study)	⊕⊕⊖⊖ LOW1,4		Not calculable for SMD values	The mean ede q eating concern fu in the intervention groups was

		due to risk of bias, imprecision			0.29 standard deviations higher (0.02 lower to 0.6 higher)
EDE Q Weight concern FU	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q weight concern fu in the intervention groups was 0.07 standard deviations higher (0.23 lower to 0.37 higher)
EDE Q Shape concern FU	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede q shape concern fu in the intervention groups was 0.42 standard deviations higher (0.11 to 0.73 higher)
Quality of life FU	167 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life fu in the intervention groups was 0.01 standard deviations higher (0.31 lower to 0.33 higher)
Remission_ITT FU	51 (1 study)	⊕⊕⊖⊖ LOW1,6 due to risk of bias, imprecision	RR 1.97 (0.78 to 4.99)	188 per 1000	182 more per 1000 (from 41 fewer to 748 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 Unclear how they generated random sequence for randomisation and if allocation concealment was performed. It is unclear if either the participants, investigators or assessors were blind.
- 2 For a continuous outcome, there were fewer than 400 participants.
- 3 95% CI crossed 1 MID (-0.5).
- 4 95% CI crossed 1 MID (0.5).
- 5 95% CI crossed 2 MIDs (0.75 and 1.25).
- 6 95% CI crossed 1 MID (1.25).

1 Table 259: Summary table of group self-help (ED) compared with wait list controls in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BED Group SH (ED) (95% CI)

BMI	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.09 standard deviations higher (0.25 lower to 0.42 higher)
Binge eating	136 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.41 standard deviations lower (0.75 lower to 0.07 higher)
EDE-Q Global Score	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global score in the intervention groups was 0.00 standard deviations higher (0.34 lower to 0.34 higher)
EDE-Q Restraint	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q restraint in the intervention groups was 0.08 standard deviations higher (0.26 lower to 0.42 higher)
EDE-Q Eating concern	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concern in the intervention groups was 0.09 standard deviations higher (0.25 lower to 0.42 higher)
EDE-Q Shape concern	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concern in the intervention groups was 0.00 standard deviations higher (0.34 lower to 0.34 higher)
EDE-Q Weight concern	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concern in the intervention groups was 0.00 standard deviations higher (0.34 lower to 0.34 higher)
Quality of life	136 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.08 standard deviations higher (0.27 lower to 0.45 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Unclear how they generated random sequence for randomisation and if allocation concealment was performed. It is unclear if either the participants, investigators or assessors were blind.
2 For a continuous outcome, there were fewer than 400 participants.
3 95% CI crossed 1 MID (-0.5).

1 **Table 260: Summary table of group guided self-help (ED) compared with wait list controls in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BED Group Guided SH (ED) (95% CI)
BMI	129 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.26 standard deviations higher (0.09 lower to 0.61 higher)
Binge eating	129 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.83 standard deviations lower (1.19 to 0.47 lower)
EDE-Q Global Score	129 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global score in the intervention groups was 0.22 standard deviations lower (0.57 lower to 0.13 higher)
EDE-Q Restraint	129 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q restraint in the intervention groups was 0.34 standard deviations lower (0.69 to 0.01 lower)
EDE-Q Eating concern	129 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concern in the intervention groups was 0.18 standard deviations lower (0.53 lower to 0.17 higher)
EDE-Q Shape concern	129 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concern in the intervention groups was 0.09 standard deviations lower (0.43 lower to 0.26 higher)
EDE-Q Weight concern	129 (1 study)	⊕⊕⊕⊖ LOW1,4		Not calculable	The mean ede-q weight concern in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.00 standard deviations higher (0.35 lower to 0.35 higher)
Quality of life	129 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.09 standard deviations higher (0.28 lower to 0.47 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Unclear how they generated random sequence for randomisation and if allocation concealment was performed. It is unclear if either the participants, investigators or assessors were blind.					
2 95% CI crossed 1 MID (0.5).					
3 95% CI crossed 1 MID (-0.5).					
4 For a continuous outcome, there were fewer than 400 participants.					

1 **Table 261: Summary table of group psychoeducation compared with another group in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other Group	Risk difference with BED Group Psychoeducation (95% CI)
BMI	234 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.02 standard deviations higher (0.25 lower to 0.29 higher)
Binge eating	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.05 standard deviations higher (0.25 lower to 0.35 higher)
Depression	44 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.48 standard deviations higher (0.17 lower to 1.13 higher)
EDE-Q Global Score	253 (1 study)	⊕⊕⊖⊖ LOW1,4		Not calculable for SMD values	The mean ede-q global score in the intervention groups was

		due to risk of bias, imprecision			0.45 standard deviations lower (0.7 to 0.2 lower)
EDE-Q Restraint	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q restraint in the intervention groups was 0.22 standard deviations lower (0.52 lower to 0.09 higher)
EDE-Q Eating Concern	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concern in the intervention groups was 0.22 standard deviations lower (0.52 lower to 0.09 higher)
EDE-Q Shape Concern	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concern in the intervention groups was 0.30 standard deviations lower (0.6 lower to 0.01 higher)
EDE-Q Weight Concern	190 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concern in the intervention groups was 0.55 standard deviations lower (0.86 to 0.24 lower)
Did not Achieve Remission_ITT	51 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision	RR 1.32 (0.94 to 1.85)	371 per 1000	119 more per 1000 (from 22 fewer to 316 more)
Quality of life	176 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.01 standard deviations lower (0.32 lower to 0.3 higher)
BMI FU	243 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.06 standard deviations higher (0.21 lower to 0.33 higher)
Binge eating FU	190 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.03 standard deviations higher (0.27 lower to 0.34 higher)
Depression FU	41 (1 study)	⊕⊕⊖⊖ LOW1,4		Not calculable for SMD values	The mean depression fu in the intervention groups was

		due to risk of bias, imprecision			1.01 standard deviations lower (1.83 to 0.18 lower)
EDE-Q Global Score FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global score fu in the intervention groups was 0.37 standard deviations lower (0.67 to 0.06 lower)
EDE-Q Restraint FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q restraint fu in the intervention groups was 0.29 standard deviations lower (0.59 lower to 0.02 higher)
EDE-Q Eating Concern FU	190 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concern fu in the intervention groups was 0.20 standard deviations lower (0.51 lower to 0.1 higher)
EDE-Q Shape Concern FU	190 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concern fu in the intervention groups was 0.37 standard deviations lower (0.68 to 0.07 lower)
EDE-Q Weight Concern FU	190 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concern fu in the intervention groups was 0.51 standard deviations lower (0.82 to 0.2 lower)
Quality of life FU	167 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life fu in the intervention groups was 0.03 standard deviations lower (0.35 lower to 0.3 higher)
Did not Achieve Remission_ITT FU	51 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision	RR 1.13 (0.83 to 1.55)	286 per 1000	37 more per 1000 (from 49 fewer to 157 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear how they generated random sequence for randomisation and if allocation concealment was performed. It is unclear if either the participants, investigators or assessors were blind.

2 For a continuous outcome, there were fewer than 400 participants.

3 95% CI crossed 1 MID (0.5).
4 95% CI crossed 1 MID (-0.5).
5 95% CI crossed 1 MID (1.25).

8.2.2.61 Self-help

2 **Table 262: Summary table of guided self-help (ED) (self-help with support) compared with any other intervention in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BED Guided SH (ED) (95% CI)
Binge eating	490 (7 studies)	⊕⊕⊕⊖ MODERATE ^{1,2} due to risk of bias			The mean binge eating in the intervention groups was 0.28 standard deviations lower (0.47 to 0.09 lower)
Vomiting	90 (1 study)	⊕⊖⊖⊖ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision			The mean vomiting in the intervention groups was 0.81 standard deviations lower (1.24 to 0.38 lower)
Use of laxatives	90 (1 study)	⊕⊖⊖⊖ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision			The mean use of laxatives in the intervention groups was 0.21 standard deviations higher (0.21 lower to 0.62 higher)
BMI	690 (7 studies)	⊕⊕⊕⊖ MODERATE ¹ due to risk of bias			The mean bmi in the intervention groups was 0.04 standard deviations higher (0.11 lower to 0.2 higher)
Depression	394 (5 studies)	⊕⊕⊖⊖ LOW ^{5,6} due to risk of bias, indirectness			The mean depression in the intervention groups was 0.29 standard deviations lower (0.5 to 0.08 lower)
Remission_ITT	661 (9 studies)	⊕⊖⊖⊖ VERY LOW ^{6,7,8,9} due to risk of bias, inconsistency, imprecision	RR 1.76 (1.42 to 2.19)	242 per 1000	184 more per 1000 (from 102 more to 288 more)

EDE-Global severity	389 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{2,7,10} due to risk of bias, indirectness, imprecision			The mean ede-global severity in the intervention groups was 0.14 standard deviations lower (0.35 lower to 0.07 higher)
EDE- Shape concern	740 (7 studies)	⊕⊕⊕⊕ VERY LOW ^{2,4,6,7,8} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- shape concern in the intervention groups was 0.27 standard deviations lower (0.53 to 0.02 lower)
EDE- Weight concern	740 (7 studies)	⊕⊕⊕⊕ VERY LOW ^{2,4,6,7,8} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- weight concern in the intervention groups was 0.22 standard deviations lower (0.52 lower to 0.08 higher)
EDE- Restraint	740 (7 studies)	⊕⊕⊕⊕ VERY LOW ^{2,4,6,7,8} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- restraint in the intervention groups was 0.37 standard deviations lower (0.6 to 0.13 lower)
EDE- Eating concern	650 (6 studies)	⊕⊕⊕⊕ VERY LOW ^{6,7,10,11} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- eating concern in the intervention groups was 0.27 standard deviations lower (0.43 to 0.11 lower)
Excessive exercise	90 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3,4} due to risk of bias, indirectness, imprecision			The mean excessive exercise in the intervention groups was 0.28 standard deviations lower (0.7 lower to 0.13 higher)
Satisfaction with life	284 (2 studies)	⊕⊕⊕⊕ MODERATE ¹² due to risk of bias			The mean satisfaction with life in the intervention groups was 0.12 standard deviations higher (0.13 lower to 0.36 higher)
Binge eating FU	300 (4 studies)	⊕⊕⊕⊕ LOW ^{10,13} due to risk of bias, imprecision			The mean binge eating fu in the intervention groups was 0.09 standard deviations higher (0.15 lower to 0.33 higher)
BMI FU	409 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{6,7,10} due to risk of bias, indirectness, imprecision			The mean bmi fu in the intervention groups was 0.02 standard deviations higher (0.18 lower to 0.22 higher)

EDE- Weight concern FU	368 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8,10,14} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- weight concern fu in the intervention groups was 0.12 standard deviations higher (0.31 lower to 0.56 higher)
EDE- Restraint FU	368 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8,10,14} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- restraint fu in the intervention groups was 0.12 standard deviations lower (0.52 lower to 0.27 higher)
EDE- Shape concern FU	368 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8,10,14} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- shape concern fu in the intervention groups was 0.00 standard deviations higher (0.42 lower to 0.42 higher)
EDE- Eating concern FU	368 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,8,10,14} due to risk of bias, inconsistency, indirectness, imprecision			The mean ede- eating concern fu in the intervention groups was 0.06 standard deviations lower (0.47 lower to 0.36 higher)
EDE-Q-Global score-FU	260 (2 studies)	⊕⊕⊕⊕ LOW ¹⁰ due to risk of bias, imprecision			The mean ede-q-global score-fu in the intervention groups was 0.32 standard deviations lower (0.58 to 0.06 lower)
Remission FU_ITT	229 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{6,7,15} due to risk of bias, indirectness, imprecision	RR 1.40 (1.06 to 1.85)	374 per 1000	150 more per 1000 (from 22 more to 318 more)
Quality of life FU	167 (1 study)	⊕⊕⊕⊕ LOW ^{10,16} due to risk of bias, imprecision			The mean quality of life fu in the intervention groups was 0.01 standard deviations higher (0.31 lower to 0.33 higher)
Depression FU	150 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{4,6,13} due to risk of bias, indirectness, imprecision			The mean depression fu in the intervention groups was 0.39 standard deviations lower (0.71 to 0.06 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

GRADE Working Group grades of evidence

High quality: Further research is very unlikely to change our confidence in the estimate of effect.

Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very low quality: We are very uncertain about the estimate.

1 Across studies it was unclear if allocation concealment was conducted (or adequately). In Peterson 2001 neither the investigator nor assessor were blind and in Dunn 2005 the participants were not blind. In Grilo 2013 the assessors were blind, but it was unclear if the others were blind. In Carter, randomisation and allocation concealment was adequate, however, participants, investigators and assessors were not blind. In other studies, it was unclear if either the participants, assessors or investigators were blind. High drop outs were reported >20%.

2 Dunn 2006 included a mixed population of BN and BED

3 in Dunn 2005, no details were provided on how the random sequence was generated and it was unclear if allocation concealment was performed. The participants were not blind and it was unclear if investigators or assessors were blind. High drop outs were reported >20%.

4 95% CI crossed 1 MID (-0.5).

5 In Carrard, allocation concealment was not conducted. It was unclear in all other studies. Across studies, it was unclear if all or either the participants, assessors or investigators were blind. In Carrard, assessors were not blind, whilst in Striegel-Moore assessors were blind. High drop outs were reported >20%.

6 Striegel-Moore 2010 included a mixed population of BED (53%) and BN (47%)

7 Across studies it was unclear if allocation concealment was conducted (or adequately). It was also unclear if either or all of the participants, assessors or investigators were blind. High drop outs were reported >20%.

8 Heterogeneity was detected, I² >50%

9 For a dichotomous outcome, there were fewer than 300 events.

10 For a continuous outcome, there are fewer than 400 participants.

11 Heterogeneity was detected, I² >80%,

12 No details were provided on how random sequence was generated and it was unclear if allocation concealment was conducted. In Cassin, only assessors were blind, and in Peterson neither the assessors nor investigators were blind. High drop outs were detected >20%.

13 It was unclear if allocation concealment was conducted. In Peterson 2009, neither the assessors or investigators were blind, Whilst in the other study, it was unclear if either the participants, investigators or assessors were blind. High dropout rates were detected >20%.

14 It was unclear how random sequence was generated and it was unclear if allocation concealment was conducted. In Peterson, neither the assessors nor investigators were blind. Whilst in Striegel-Moore 2001, assessors were blind but it was unclear if either investigators or participants were blind. In Carter, randomisation and allocation concealment was adequate, however, participants, investigators and assessors were not blind. High dropout rates were detected in Peterson 2009.

15 95% CI crossed 1 MID (1.25).

16 No details were provided on how random sequence was generated and it was unclear if allocation concealment was conducted. Neither the assessors nor investigators were blind. High drop outs were detected >20%.

1 Table 263: Summary table of guided self-help (ED) (self-help with support) compared with wait list controls in adults with BED.

Outcomes			Anticipated absolute effects
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	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Risk with WLC	Risk difference with BED Guided SH (ED) (95% CI)
Binge eating	218 (3 studies)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.85 standard deviations lower (1.14 to 0.56 lower)
BMI	188 (2 studies)	⊕⊕⊕⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi in the intervention groups was 0.17 standard deviations higher (0.12 lower to 0.46 higher)
EDE- Weight concern	248 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.48 standard deviations lower (1.04 lower to 0.08 higher)
EDE- Shape concern	248 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.58 standard deviations lower (1.16 lower to 0 higher)
EDE- Restraint	252 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.43 standard deviations lower (0.96 lower to 0.11 higher)
EDE- Eating concern	248 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.90 standard deviations lower (1.83 lower to 0.03 higher)
EDE-Global	248 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-global in the intervention groups was 0.71 standard deviations lower (1.34 to 0.08 lower)
Quality of life	109 (1 study)	⊕⊕⊖⊖ LOW7,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.09 standard deviations higher (0.28 lower to 0.47 higher)

Did not achieve Remission	59 (1 study)	⊕⊕⊕⊖ LOW9,10 due to risk of bias, imprecision	RR 0.54 (0.38 to 0.78)	80 per 1000	37 fewer per 1000 (from 18 fewer to 50 fewer)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio;					
GRADE Working Group grades of evidence High quality: Further research is very unlikely to change our confidence in the estimate of effect. Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate. Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate. Very low quality: We are very uncertain about the estimate.					
1 It was unclear how the random sequence was generated and if allocation concealment was conducted (except in Carter). In Masson, the assessors were blind but it was unclear if participants or investigators were blind. In Peterson 2009, neither the investigators or assessors were blind nor was it clear if participants were. In Carter, participants, assessors and investigators were not blind. High dropouts were reported >20%.					
2 95% CI crossed 1 MID (-0.5).					
3 It was unclear how the random sequence was generated and if allocation concealment was conducted (except in Carter 1988). Peterson 2009, neither the investigators nor assessors were blind and it was unclear if participants were. In Carter, participants, assessors and investigators were not blind. High dropouts were reported >20%.					
4 For a continuous outcome, there were fewer than 400 participants.					
5 Heterogeneity was detected, I2 >50%					
6 Heterogeneity was detected, I2 >80%					
7 It was unclear in either study if allocation concealment was conducted. Neither the assessors or investigators were blind nor was it unclear if participants were. High dropouts were detected >20%.					
8 95% CI crossed 1 MID (0.5).					
9 Allocation concealment was conducted but neither the participants, investigators or assessors were blind. It was unclear how many participants were randomised.					
10 For a dichotomous outcome, there were fewer than 300 participants.					

1 Table 264: Summary table of self-help (ED) (self-help without support) compared with another intervention in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BED Self-help (ED) (95% CI)
Binge eating	475 (6 studies)	⊕⊕⊕⊖ MODERATE1 due to risk of bias		Not calculable	The mean binge eating in the intervention groups was

				for SMD values	0.25 standard deviations higher (0.06 to 0.43 higher)
Vomiting	90 (1 study)	⊕⊕⊕⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.81 standard deviations higher (0.38 to 1.24 higher)
Use of laxatives	90 (1 study)	⊕⊕⊕⊖ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean use of laxatives in the intervention groups was 0.21 standard deviations lower (0.62 lower to 0.21 higher)
BMI	417 (4 studies)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.13 standard deviations lower (0.33 lower to 0.06 higher)
Depression	236 (4 studies)	⊕⊕⊕⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.07 standard deviations higher (0.19 lower to 0.33 higher)
Remission_ITT	345 (6 studies)	⊕⊕⊕⊖ LOW1,6 due to risk of bias, imprecision	RR 0.84 (0.68 to 1.04)	494 per 1000	79 fewer per 1000 (from 158 fewer to 20 more)
EDE- Restraint	389 (4 studies)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.39 standard deviations higher (0.19 to 60 higher)
EDE- Shape concern	389 (4 studies)	⊕⊕⊕⊖ LOW5,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.24 standard deviations higher (0.04 to 0.44 higher)
EDE- Weight concern	389 (4 studies)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.30 standard deviations higher (0.1 to 0.51 higher)
EDE- Eating concern	389 (3 studies)	⊕⊕⊕⊖ LOW3,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.34 standard deviations higher (0.14 to 0.55 higher)

EDE- Global severity	437 (5 studies)	⊕⊕⊕⊕ LOW3,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- global severity in the intervention groups was 0.30 standard deviations higher (0.11 to 0.5 higher)
Excessive exercise	90 (1 study)	⊕⊕⊕⊕ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean excessive exercise in the intervention groups was 0.28 standard deviations higher (0.13 lower to 0.7 higher)
Satisfaction with life	284 (2 studies)	⊕⊕⊕⊕ LOW5,9 due to risk of bias, imprecision		Not calculable for SMD values	The mean satisfaction with life in the intervention groups was 0.11 standard deviations higher (0.13 lower to 0.35 higher)
Bingeng FU	227 (3 studies)	⊕⊕⊕⊕ LOW5,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean binging fu in the intervention groups was 0.06 standard deviations lower (0.34 lower to 0.21 higher)
BMI FU	296 (3 studies)	⊕⊕⊕⊕ LOW5,10 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.10 standard deviations lower (0.34 lower to 0.14 higher)
Depression FU	37 (1 study)	⊕⊕⊕⊕ VERY LOW10,11 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.18 standard deviations higher (0.51 lower to 0.88 higher)
Remission FU_ITT	118 (2 studies)	⊕⊕⊕⊕ LOW6,12 due to risk of bias, imprecision	RR 0.78 (0.5 to 1.2)	458 per 1000	101 fewer per 1000 (from 229 fewer to 92 more)
EDE- Restraint FU	259 (2 studies)	⊕⊕⊕⊕ LOW13,14 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint fu in the intervention groups was 0.20 standard deviations higher (0.05 lower to 0.45 higher)
EDE- Shape concern FU	259 (2 studies)	⊕⊕⊕⊕ LOW5,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern fu in the intervention groups was 0.07 standard deviations higher (0.18 lower to 0.32 higher)
EDE- Weight concern FU	259 (2 studies)	⊕⊕⊕⊕ VERY LOW5,12,15		Not calculable	The mean ede- weight concern fu in the intervention groups was

		due to risk of bias, inconsistency, imprecision		for SMD values	0.04 standard deviations higher (0.22 lower to 0.29 higher)
EDE- Eating concern FU	259 (2 studies)	⊕⊕⊖⊖ LOW5,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern fu in the intervention groups was 0.01 standard deviations higher (0.24 lower to 0.27 higher)
EDE-Q Global Score FU	260 (2 studies)	⊕⊕⊖⊖ LOW5,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global score fu in the intervention groups was 0.08 standard deviations higher (0.17 lower to 0.33 higher)
Quality of life FU	167 (1 study)	⊕⊕⊖⊖ LOW5,12 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life fu in the intervention groups was 0.02 standard deviations higher (0.3 lower to 0.34 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 Across studies it was unclear if allocation concealment was conducted (except for Carter). In addition, it was unclear if all or either the participants, investigators or assessors were blind. In Dunn, the participants were not blind, in Peterson 2009 the investigators and assessors were not blind, whilst in Grilo assessors were blind. High dropouts were reported >20%.
- 2 It was unclear if allocation concealment was conducted. In addition, the participants were not blind but it was unclear if investigators and assessors were blind. High dropouts were reported >20%.
- 3 95% CI crossed 1 MID (0.5).
- 4 95% CI crossed 1 MID (-0.5).
- 5 For a continuous outcome, there were fewer than 400 participants.
- 6 95% CI crossed 1 MID (0.75).
- 7 Across studies it was unclear if allocation concealment was conducted (except in Carter). In Loeb 2000 it was unclear if all or either the participants, investigators or assessors were blind. In Dunn, the participants were not blind, in Peterson 2009 the investigators and assessors were not blind, In Carter, participants, investigators, assessors were not blind. High dropouts were reported >20%.
- 8 Across studies it was unclear if allocation concealment was conducted (except in Carter). In Loeb 2000 it was unclear if all or either the participants, investigators or assessors were blind. In Dunn, the participants were not blind, in Peterson 2009 the investigators and assessors were not blind. In Grilo the assessors were blind. In Carter, the investigators, participants, assessors were not blind. High dropouts were reported >20%.
- 9 It was unclear if allocation concealment was conducted. In Cassin 2008 the assessors were blind, but it was unclear if investigators and participants were blind. In Peterson, the investigators and assessors were not blind but it was unclear if participants were blind. High dropouts were reported >20%.
- 10 It was unclear if allocation concealment was conducted (except in Carter). In Peterson 2009, the investigators and assessors were not blind but it was unclear if participants were blind. In Peterson 2001, it was unclear if any were blind. It was unclear if investigators, assessors and participants were not blind. High dropouts were reported >20%.

11 95% CI crossed 2 MIDs (-0.5 and 0.5).
 12 It was unclear if allocation concealment was conducted (except in Carter). In Peterson 2009, the investigators and assessors were not blind but it was unclear if participants were blind. In Carter, participants, assessors and participants were not blind. High dropouts were reported >20%.
 13 It was unclear if allocation concealment was conducted (except in Carter). In Peterson 2001, it was unclear if either the participants, investigator or assessors were blind. In Carter, participants, assessors and investigators were not blind.
 14 For a dichotomous outcome, there were fewer than 300 events.
 15 Heterogeneity was detected I2 >50%.

1 Table 265: Summary table of self-help (ED) (self-help without support) compared with wait list controls in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BED Self-help (ED) (95% CI)
Binge eating	196 (2 studies)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.40 standard deviations lower (0.68 to 0.11 lower)
BMI	205 (2 studies)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.01 standard deviations higher (0.27 lower to 0.28 higher)
Remission_ITT	60 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision	RR 5.36 (1.34 to 21.36)	80 per 1000	349 more per 1000 (from 27 more to 1000 more)
EDE- Restraint	196 (2 studies)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.05 standard deviations lower (0.33 lower to 0.23 higher)
EDE- Shape concern	196 (2 studies)	⊕⊕⊕⊕ VERY LOW1,3,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.19 standard deviations lower (0.47 lower to 0.09 higher)
EDE- Weight concern	196 (2 studies)	⊕⊕⊕⊕ VERY LOW1,3,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0.14 standard deviations lower (0.42 lower to 0.15 higher)

EDE- Eating concern	196 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{1,3,6} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.25 standard deviations lower (0.54 lower to 0.04 higher)
EDE-Q- Global severity	196 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{1,3,5} due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-q- global severity in the intervention groups was 0.20 standard deviations lower (0.49 lower to 0.08 higher)
Quality of life	110 (1 study)	⊕⊕⊖⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.08 standard deviations higher (0.29 lower to 0.45 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 It was unclear if allocation concealment was conducted, except in Carter. In Peterson 2009, the investigators and assessors were not blind but it was unclear if participants were blind. In Carter, participants, assessors, investigators were not blind. High dropouts were reported >20%.
- 2 95% CI crossed 1 MID (-0.5).
- 3 For a continuous outcome, there were fewer than 400 participants.
- 4 For a dichotomous outcome, there were fewer than 300 events.
- 5 Heterogeneity detected I² >50%.
- 6 Heterogeneity detected, I² >80%.

1 Table 266: Summary table of internet self-help (ED) compared with wait list controls in young people and adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with BED Internet SH (ED) (95% CI)
Binge eating - Adults	118 (2 studies)	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating - adults in the intervention groups was 0.03 standard deviations lower (0.4 lower to 0.34 higher)
BMI - Young people	93 (1 study)	⊕⊕⊖⊖ LOW ^{3,4}		Not calculable	The mean BMI - young people in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.21 standard deviations lower (0.62 lower to 0.2 higher)
BMI - Adults	118 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI - adults in the intervention groups was 0.38 standard deviations higher (0.02 to 0.75 higher)
Depression - Young people	93 (1 study)	⊕⊕⊖⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - young people in the intervention groups was 0.32 standard deviations lower (0.72 lower to 0.09 higher)
Depression - Adults	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - adults in the intervention groups was 0.38 standard deviations lower (0.84 lower to 0.08 higher)
EDI Drive for thinness	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness in the intervention groups was 0.38 standard deviations lower (0.84 lower to 0.08 higher)
EDI Bulimia	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia in the intervention groups was 0.85 standard deviations lower (1.33 to 0.37 lower)
EDI Body dissatisfaction	74 (1 study)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction in the intervention groups was 0.01 standard deviations higher (0.44 lower to 0.47 higher)
Remission_ITT	74 (1 study)	⊕⊕⊖⊖ LOW6,7 due to risk of bias, imprecision	RR 4.33 (1.35 to 13.96)	81 per 1000	270 more per 1000 (from 28 more to 1000 more)
EDE-Total	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-total in the intervention groups was 0.38 standard deviations lower (0.84 lower to 0.08 higher)
EDE- Restraint	74 (1 study)	⊕⊕⊖⊖ LOW2,6		Not calculable	The mean ede- restraint in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.01 standard deviations lower (0.47 lower to 0.45 higher)
EDE- Shape concern	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.3 standard deviations lower (0.76 lower to 0.15 higher)
Global severity index	74 (1 study)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean global severity index in the intervention groups was 0.44 standard deviations lower (0.9 lower to 0.02 higher)
Quality of life	74 (1 study)	⊕⊕⊖⊖ LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.01 standard deviations lower (0.46 lower to 0.45 higher)
Binge eating FU - Adults	109 (2 studies)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu - adults in the intervention groups was 0.05 standard deviations higher (0.33 lower to 0.42 higher)
BMI FU - Young people	93 (1 study)	⊕⊕⊖⊖ LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu - young people in the intervention groups was 0.27 standard deviations lower (0.67 lower to 0.14 higher)
BMI FU - Adults	109 (2 studies)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu - adults in the intervention groups was 0.33 standard deviations higher (0.05 lower to 0.71 higher)
Depression FU - Young people	93 (1 study)	⊕⊕⊖⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu - young people in the intervention groups was 0.17 standard deviations higher (0.24 lower to 0.58 higher)
Depression FU - Adults	74 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu - adults in the intervention groups was 0.4 standard deviations lower (0.86 lower to 0.06 higher)
EDE- Restraint FU	74 (1 study)	⊕⊕⊖⊖ LOW4,6		Not calculable	The mean ede- restraint fu in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.08 standard deviations higher (0.37 lower to 0.54 higher)
EDE- Shape concern FU	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern fu in the intervention groups was 0.23 standard deviations lower (0.69 lower to 0.23 higher)
EDE-Total FU	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-total fu in the intervention groups was 0.3 standard deviations lower (0.76 lower to 0.16 higher)
EDI Drive for thinness FU	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu in the intervention groups was 0.44 standard deviations lower (0.9 lower to 0.02 higher)
EDI Bulimia FU	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia fu in the intervention groups was 0.32 standard deviations lower (0.78 lower to 0.14 higher)
EDI Body dissatisfaction FU	74 (1 study)	⊕⊕⊖⊖ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction fu in the intervention groups was 0.13 standard deviations higher (0.33 lower to 0.58 higher)
Global severity index- FU	74 (1 study)	⊕⊕⊖⊖ LOW4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean global severity index- fu in the intervention groups was 0.33 standard deviations lower (0.79 lower to 0.13 higher)
Quality of life-FU	74 (1 study)	⊕⊕⊖⊖ LOW5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life-fu in the intervention groups was 0.12 standard deviations higher (0.33 lower to 0.58 higher)
Remission FU_ITT	74 (1 study)	⊕⊕⊖⊖ LOW6,8 due to risk of bias, imprecision	RR 2 (0.98 to 4.09)	216 per 1000	216 more per 1000 (from 4 fewer to 668 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

- 1 In Carrard, allocation concealment was not conducted and it was unclear in Shapiro if it was performed. In Carrard assessors were not blind and it was unclear if either participants or investigators were blind. In Shapiro assessors were only blind at baseline measurement it was unclear if participants or investigators were blind. High dropouts were reported >20%.
- 2 For a continuous outcome, there were fewer than 400 participants.
- 3 In Jones 2008 it was unclear if allocation concealment was performed. Assessors were not blind and it was unclear if either participants or investigators were blind.
- 4 95% CI Crossed 1 MID (-0.5).
- 5 95% CI Crossed 1 MID (0.5).
- 6 In Carrard, allocation concealment was not conducted, Assessors were not blind and it was unclear if either participants or investigators were blind. High dropouts were reported >20%.
- 7 For a dichotomous outcome, there were fewer than 300 events.
- 8 95% CI crossed 1 MID (1.25).

1 **Table 267: Summary table of guided self-help (ED) (self-help with support) compared with another guided self-help (ED) in adults with**
 2 **BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with BED Guided SH (ED) vs. Guided SH (95% CI)
Binge eating	75 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.48 standard deviations lower (0.94 to 0.02 lower)
BMI	75 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.19 standard deviations lower (0.64 lower to 0.27 higher)
Depression	75 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.25 standard deviations lower (0.71 lower to 0.2 higher)
Remission_ITT	75 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	RR 2.51 (1.34 to 4.71)	237 per 1000	358 more per 1000 (from 81 more to 879 more)

EDE- Restraint	75 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- restraint in the intervention groups was 0.38 standard deviations lower (0.84 lower to 0.08 higher)
EDE- Shape concern	75 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- shape concern in the intervention groups was 0.12 standard deviations lower (0.57 lower to 0.33 higher)
EDE- Weight concern	75 (1 study)	⊕⊕⊕⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- weight concern in the intervention groups was 0 standard deviations higher (0.45 lower to 0.45 higher)
EDE- Eating concern	75 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede- eating concern in the intervention groups was 0.44 standard deviations lower (0.9 lower to 0.02 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 It was unclear if allocation concealment was performed. It was unclear if either the participants, assessors or investigators were blind. High dropouts were detected >20%.					
2 95% CI crossed 1 MID (-0.5).					
3 For a dichotomous outcome, there were fewer than 300 events.					
4 For a continuous outcome there were fewer than 400 participants.					

1 **Table 268: Internet self-help versus any other intervention in adults with binge eating disorder at the end of treatment and**
2 **followup.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Other	Risk difference with BED Internet (95% CI)
BMI	44 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi in the intervention groups was 0.22 standard deviations higher (0.38 lower to 0.81 higher)

Binge eating	44 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.45 standard deviations higher (0.15 lower to 1.05 higher)
BMI FU	28 (1 study)	⊕⊕⊕⊕ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi fu in the intervention groups was 0.16 standard deviations higher (0.58 lower to 0.9 higher)
Binge eating FU	28 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating fu in the intervention groups was 0.39 standard deviations higher (0.36 lower to 1.15 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; FU: follow up

1 It was unclear if allocation concealment was performed or how the random sequence was generated. It was unclear if either the participants, assessors or investigators were blind. High drop outs were detected >20%.
2 95% CI crossed 1 MID (0.5)
3 95% CI crossed 2 MIDs (-0.5 and 0.5)

1

8.2.2.72 Family therapy

3 **Table 269: Summary table of findings for family therapy versus wait list control in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Wait list control	Risk difference with Family Therapy-ED (95% CI)
Weight (kg)	62 (1 study) 6 months	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) in the intervention groups was 0.08 standard deviations higher (0.42 lower to 0.58 higher)
Binge Frequency EDE-Q-OBE	62 (1 study) 6 months	⊕⊕⊕⊕ LOW1,2		Not calculable for SMD values	The mean ede-q objective binge episode in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Wait list control	Risk difference with Family Therapy-ED (95% CI)
		due to risk of bias, imprecision			0.56 standard deviations lower (1.07 to 0.05 lower)
Depression Beck Depression Inventory (BDI)	62 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.52 standard deviations lower (1.02 to 0.01 lower)
Family Functioning Dyadic Adjustment Scale	62 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean family functioning in the intervention groups was 0.04 standard deviations lower (0.54 lower to 0.46 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Gorin 2003: Dropout rate>20% (34% for whole sample), inadequate randomization method (used blocks by binge eating frequency), unclear allocation concealment, participant and assessor blinding.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 Table 270: Summary table of findings for family therapy versus group CBT-ED in adults with BED at end of treatment.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT	Risk difference with Family Therapy-ED (95% CI)
Weight (kg)	63 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) in the intervention groups was 0.2 standard deviations higher (0.29 lower to 0.7 higher)
Binge Frequency EDE-Q-OBE	63 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.24 standard deviations higher (0.26 lower to 0.73 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT	Risk difference with Family Therapy-ED (95% CI)
Depression Beck Depression Inventory (BDI)	63 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.31 standard deviations lower (0.81 lower to 0.19 higher)
Family Functioning Level of Expressed Emotion (LEE)	63 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean family functioning in the intervention groups was 0.09 standard deviations lower (0.59 lower to 0.4 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Gorin 2003: Dropout rate>20% (34% for whole sample), inadequate randomization method (used blocks by binge eating frequency), unclear allocation concealment, participant and assessor blinding.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 Table 271: Summary table of findings for family therapy versus group CBT-ED in adults with BED at follow up.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT	Risk difference with Family Therapy-ED (95% CI)
Weight (kg) FU	63 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight (kg) fu in the intervention groups was 0.22 standard deviations higher (0.28 lower to 0.71 higher)
Binge Frequency FU EDE-Q-OBE	63 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0.52 standard deviations higher (0.01 to 1.02 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT	Risk difference with Family Therapy-ED (95% CI)
Depression FU Beck Depression Inventory (BDI)	63 (1 study) 6 months	⊕⊕⊖⊖ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.07 standard deviations lower (0.57 lower to 0.42 higher)
Family Functioning FU Level of Expressed Emotion (LEE)	63 (1 study) 6 months	⊕⊕⊖⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean family functioning fu in the intervention groups was 0.01 standard deviations lower (0.5 lower to 0.49 higher)
1 Gorin 2003: Dropout rate>20% (34% for whole sample), inadequate randomization method (used blocks by binge eating frequency), unclear allocation concealment, participant and assessor blinding. 2 CI crosses either 0.5 or -0.5 (SMD). 3 <400 participants.					

1

2

1 8.2.3 Economic evidence

2 8.2.3.1 Systematic literature review

3 The systematic search of the economic literature undertaken for the guideline identified one
4 study on the cost utility of CBT guided self-help in adults with recurrent binge eating disorder
5 (Lynch et al., 2010). The study was conducted in the US.

6 References to all included studies and evidence tables for all economic evaluations included
7 in the systematic literature review are provided in Appendix P. Completed methodology
8 checklists of the studies are provided in Appendix O. Economic evidence profiles of studies
9 considered during guideline development (that is, studies that fully or partly met the
10 applicability and quality criteria) are presented in Appendix Q.

11 Lynch and colleagues (2010) evaluated the cost effectiveness and cost-utility of CBT guided
12 self-help (CBT-GSH) when compared with treatment as usual (TAU) in adults with recurrent
13 binge eating disorder. The economic analysis was undertaken alongside an RCT (Striegel-
14 Moore 2010) (N=123) conducted in the US. The intervention involved 8 brief coaching
15 sessions provided by a master's-level therapist. The first session lasted 60 min and each
16 subsequent session lasted 20 to 25 min. TAU was defined as people seeking help from
17 primary care providers or nutrition care providers and self-referral to the mental health
18 department. The analysis was conducted from a health and social care perspective (plus out-
19 of-pocket expenses). The results could be calculated excluding out-of-pocket expenses. The
20 study considered a range of costs including weight and eating disorder services, other
21 medical services, psychiatric medications and peoples' expenses (time and expenditure for
22 health care services, non-health services, over the counter medications and other weight
23 loss products). The resource use estimates were based on the RCT (N=123). The unit costs
24 were obtained from published studies, local market unit costs and wages in order to value
25 participants' time spent receiving interventions. The measures of outcome for the economic
26 analysis included the number of binge free days and quality adjusted life years (QALYs).
27 However, the health related quality of life (HRQoL) weights used to estimate QALYs were
28 derived by three experts. The weights were based on 52 disease categories from the ICD-9
29 using the person trade-off method of valuation. The time horizon of the analysis was 12
30 months.

31 The intervention resulted in a greater number of mean binge-free days at 12 month follow up
32 compared with TAU (330.7 versus 305.5, respectively; a difference of 25.2, p-value = 0.002).
33 The intervention also resulted in a greater number of QALYs at 12 month follow up (0.932
34 versus 0.863, respectively; a difference of 0.069, p-value not reported).

35 From a health and social care sector perspective the mean total costs per participant over 12
36 months were \$3,527 for the intervention and \$3,806 for TAU, a difference of -\$279 (p-value
37 not reported) in 2006 US dollars. Similarly, when considering health and social care plus out-
38 of-pocket expenses the mean total costs per participant over 12 months were \$3,671 for the
39 intervention and \$4,098 for TAU, a difference of -\$427 (p = 0.3).

40 From both perspectives CBT-GSH was dominant (that is, it was less costly and more
41 effective). Bootstrapping indicated that CBT-GSH had better outcomes and lower costs
42 (health and social care plus out-of-pocket expenses) in 69% of replications when compared
43 with TAU.

44 From both perspectives, at a willingness-to-pay (WTP) of \$40 per additional binge free day,
45 the probability that the intervention was cost effective was 90% and at a WTP of \$100 per
46 additional binge free day the probability was 98%. Deterministic sensitivity analysis from a
47 health and social care perspective plus out-of-pocket expenses indicated that when removing
48 one high-cost outlier and when using only cases with complete data the results did not
49 change.

1 The analysis was judged by the committee to be partially applicable to the NICE decision-
2 making context, as it was conducted in the US. The authors estimated QALYs but the
3 weights were based on expert opinion. However, this was not a major limitation since the
4 intervention was found to be dominant when a natural outcome (i.e. the number of binge
5 eating days) was used, and therefore the interpretation of the results was straightforward and
6 did not require further judgments. Overall, this was a well conducted study and was judged
7 by the committee to have only minor methodological limitations.

8 **8.2.3.2 Economic modelling**

9 Two decision-analytical models were developed to assess the relative cost effectiveness of
10 interventions for adults with BED. The choice of treatments assessed in the economic
11 analyses was determined by the availability of respective clinical data (that is, full remission
12 at the end of treatment) included in the guideline systematic literature review. The economic
13 analyses considered effective treatments, as demonstrated by the systematic review of
14 clinical evidence, that were deemed appropriate by the committee as treatment options for
15 people with BED in the UK. The study population in both models comprised of adults with
16 BED.

17 Clinical data were derived from studies included in the guideline systematic review of clinical
18 evidence and other published literature. Clinical data (that is, full remission at the end of
19 treatment) were analysed using mixed treatment comparison technique. Full remission was
20 defined as cessation of BED-related symptoms over and above two weeks. The comparisons
21 between psychological interventions in the area of BED created two separate networks that
22 could not be linked. Consequently, two separate NMAs were undertaken, which informed two
23 different economic models. Interventions across the two economic models could not be
24 compared due to the lack of a common comparator between the interventions that would
25 allow the relative effects across interventions to be assessed. Details on the methods and
26 clinical data utilised in the NMAs that were undertaken to estimate full remission for each
27 treatment option considered in the economic analyses are presented in Appendix R.

28 The economic models assessed the following interventions:

- 29 • model one included individual therapies: Interpersonal Psychotherapy (IPT)-general (that
30 is, not specific to eating disorders), behavioural weight loss, self-help ED with support,
31 self-help ED no support, and no treatment (wait list);
- 32 • model two included group therapies: behavioural weight loss, CBT-ED, and IPT-ED.

33 Pharmacological interventions created a separate (3rd), limited network in the NMA, had
34 small numbers randomised and generally showed no effectiveness. As a result, these were
35 not considered in a separate NMA and economic analysis.

36 The rationale for economic modelling, the methodology adopted, the results and the
37 conclusions from economic analyses are described in detail in Appendix R. The section
38 7.2.3.2.2 provides a summary of the methods employed. This section provides only the
39 results of the 2 NMAs and associated economic analyses.

40 **8.2.3.2.1 NMA and economic modelling results - individual therapies**

41 The results of the NMA indicated that wait list had the lowest probability of full remission
42 (mean 0.20 over 16 weeks), followed by self-help ED with no support (0.56), behavioural
43 weight loss (0.72), self-help ED with support (0.73), and IPT-general (0.78). All treatments
44 showed a significant effect compared with wait list. Also, self-help ED with no support was
45 significantly worse than self-help ED with support with an OR of 0.46 (95% CrI: 0.25 to 0.76)

46 According to the deterministic analysis, wait list was dominated by self-help ED with no
47 support (that is, self-help ED with no support resulted in lower costs and also was more
48 effective). Similarly, behavioural weight loss was dominated by self-help ED with support

1 (that is, self-help ED with support resulted in lower costs and also was more effective). Both
2 wait list and behaviour weight loss options were thus excluded from further analysis. When
3 calculating incremental cost-effectiveness ratios (ICERs) for all consecutive pairs of options
4 self-help ED with support versus self-help ED with no support resulted in the ICER of £7,381
5 per QALY. IPT-general was not cost effective (that is, it resulted in a cost per QALY versus
6 self-help ED with support that was above upper NICE cost-effectiveness threshold of
7 £30,000 per QALY.

8 The ICER of self-help ED with support (vs. self-help ED with no support) was sensitive to the
9 utility value of remission and the cost of remission associated with self-help ED with support.
10 The ICER of IPT individual (vs. self-help ED with support) was above the upper NICE cost-
11 effectiveness threshold of £30,000 per QALY in all considered scenarios.

12 Conclusions of probabilistic analysis were the same as those of deterministic analysis. Self-
13 help ED with support had the highest probability of being the most cost-effective treatment
14 option, at any level of willingness-to-pay per additional QALY gained above £7,000 per
15 QALY. At the lower NICE cost-effectiveness threshold of £20,000 per QALY (NICE, 2008b)
16 the probability of self-help ED with support being cost effective was 0.83.

178.2.3.2.2 **NMA and economic modelling results - group therapies**

18 The results of the NMA indicated that group behavioural weight loss had the lowest
19 probability of full remission (mean 0.27 over 16 weeks), followed by IPT-ED group (0.37) and
20 CBT-ED group (0.45). Only CBT-ED group showed a significant effect compared with
21 behavioural weight loss OR 2.31 (95% CrI: 1.16 to 4.19).

22 According to the deterministic analysis, IPT-ED group was extendedly dominated by
23 behavioural weight loss group and CBT-ED group (that is, IPT-ED group was less effective
24 and more costly than a linear combination of group behavioural weight loss and CBT-ED
25 group). CBT-ED group (vs. behavioural weight loss group) resulted in an ICER of £3,834 per
26 QALY and was the preferred treatment option.

27 According the deterministic sensitivity analyses the ICER of CBT-ED group (vs. behavioural
28 weight loss group) was robust to changes in all model inputs. Under none of the scenarios
29 examined IPT-ED group or the behavioural weight loss were the preferred treatment options.

30 Conclusions of the probabilistic analysis were the same as those of deterministic analysis.
31 CBT-ED group had the highest probability of being the most cost-effective treatment option,
32 at any level of willingness-to-pay per additional QALY gained above £3,500 per QALY. At the
33 lower NICE cost-effectiveness threshold of £20,000 per QALY the probability of CBT-ED
34 group being cost effective was 0.74.

358.2.3.2.3 **Strengths and limitations**

36 Clinical data on remission were synthesised using network meta-analytic techniques. Such
37 methods enabled evidence synthesis from both direct and indirect comparisons between
38 treatments. The base-case economic analysis considered only data on remission at the end
39 of treatment. Due to the lack of suitable data the cost estimates during the follow up were
40 based on the committee expert opinion. Also, due to the lack of suitable data utility values for
41 BED were derived from people with an eating disorder not otherwise specified.

1 **8.2.4 Clinical evidence**

2 **8.2.4.1 Individual Therapy**

3 **38.2.4.1.1 Hybrid therapy versus any other hybrid therapy in adults with binge eating disorder at**
4 **end of treatment**

5 Low quality evidence from one RCT (n=60) showed hybrid therapy is more effective on EDE-
6 global compared with another hybrid therapy.

7 Low quality evidence from one RCT (n=60) showed no difference in the effect of hybrid
8 therapy on weight loss compared with another hybrid therapy.

9 **98.2.4.1.2 CBT-ED versus any other intervention in young people with binge eating disorder at**
10 **end of treatment**

11 Low to very low quality evidence from one RCT (n=26) showed no difference in the effect of
12 CBT-ED on BMI, EDE-dietary restraint, EDE-shape concern, social adjustment, remission
13 compared with any other intervention.

14 Low quality evidence from two RCTs (n=144) showed no difference in the effect of CBT-ED
15 on EDE-weight concern compared with any other intervention.

16 Low quality evidence from one RCT (n=26) showed CBT-ED is more effective on depression
17 and EDE-eating concern compared with any other intervention.

18 **188.2.4.1.3 CBT-ED versus any other intervention in adults with binge eating disorder at end of**
19 **treatment**

20 Low quality evidence from two RCTs (n=253 to 256) showed no difference in the effect of
21 CBT-ED on binge eating and EDE-weight concern compared with any other intervention.

22 Low quality evidence from one RCT (n=141) showed no difference in the effect of CBT-ED
23 on depression compared with any other intervention.

24 Low quality evidence from two RCTs (n=253 to 256) showed CBT-ED is more effective on
25 EDE-dietary concern, EDE-shape concern and EDE-eating concern compared with any other
26 intervention.

27 Low quality evidence from one RCT (n=26) showed CBT-ED is more effective EDE-global
28 score compared with any other intervention.

29 Low quality evidence from one RCT (n=26) showed CBT-ED is less effective on remission
30 compared with any other intervention but there was some uncertainty

31 **318.2.4.1.4 CBT-ED versus any other intervention in adults with binge eating disorder at follow up**

32 Low quality evidence from two RCTs (n=346) showed no difference in the effect of CBT-ED
33 on BMI compared with any other intervention.

34 Low quality evidence from one RCT (n=141) showed no difference in the effect of CBT-ED
35 on depression compared with any other intervention.

36 Low quality evidence from two RCTs (n=258) showed no difference in the effect of CBT-ED
37 on binge eating compared with any other intervention.

38 Low quality evidence from two RCTs (n=346) showed CBT-ED is more effective on EDE-
39 global score compared with any other intervention.

40

- 1 Low quality evidence from two RCTs (n=231) showed CBT-ED is more effective on EDE-
2 weight concern, EDE-dietary restraint, EDE-shape concern, EDE-eating concern compared
3 with any other intervention.
- 4 Low quality evidence from one RCT (n=87) showed no difference in the effect of CBT-ED on
5 remission compared with any other intervention.
- 68.2.4.1.5 *Interpersonal psychotherapy (IPT) versus any other intervention in adults with binge
7 eating disorder at end of treatment***
- 8 Low quality evidence from one RCT (n=205) showed no difference in the effect of IPT on
9 BMI, binge eating and remission compared with any other intervention.
- 108.2.4.1.6 *Interpersonal psychotherapy (IPT) versus any other intervention in adults with binge
11 eating disorder at follow up***
- 12 Low quality evidence from one RCT (n=205) showed no difference in the effect of IPT on BMI
13 and binge eating compared with any other intervention.
- 148.2.4.1.7 *Dialectical behaviour therapy (DBT) versus wait list control in adults with binge eating
15 disorder at end of treatment***
- 16 Low quality evidence from one RCT (n=32) showed no difference in the effect of DBT on
17 binge eating compared with wait list controls.
- 18 Low quality evidence from one RCT (n=32) showed DBT is more effective on vomiting, EDE-
19 global and depression compared with wait list controls.
- 20 8.2.4.2 *Behavioural therapy (BT) versus any other intervention in adults with binge eating
21 disorder at end of treatment.***
- 22 Low quality evidence from one RCT (n=112) showed no difference in the effect of
23 behavioural therapy on binge eating, purging, symptom checklist, EDE-dietary restraint,
24 EDE-weight concern, EDE-shape concern, EDE-eating concern, EDI-bulimia, EDI- body
25 dissatisfaction and EDI-drive for thinness compared with any other intervention.
- 26 Low quality evidence from one RCT (n=148) showed behavioural therapy may be less
27 effective on remission compared with any other intervention but there was some uncertainty.
- 28 8.2.4.3 *Behavioural therapy versus any other intervention in adults with binge eating disorder
29 at follow up***
- 30 Low quality evidence from one RCT (n=87) showed no difference in the effect of behavioural
31 therapy on purging, binge eating, symptom checklist, EDE-weight concern, EDE-shape
32 concern, EDE-eating concern, EDE-dietary restraint, EDI- body dissatisfaction, EDI-bulimia
33 and EDI-drive for thinness compared with any other intervention.
- 34 Low quality evidence from one RCT (n=112) showed no difference in the effect of
35 behavioural therapy on remission compared with any other intervention.
- 36 8.2.4.4 *CBT general therapy versus any other intervention in adults with binge eating disorder
37 at end of treatment.***
- 38 Low quality evidence from one RCT (n=112) showed no difference in the effect of general
39 CBT on purging, binge eating, EDE-weight concern, EDE-shape concern, EDE-eating
40 concern, EDE-dietary restraint, EDI-bulimia, EDI-drive for thinness, global severity index and
41 remission compared with any other intervention.

- 1 Low quality evidence from one RCT (n=112) showed general CBT is less effective on EDI-
2 body dissatisfaction compared with any other intervention, but there was some uncertainty.
- 3 **8.2.4.5 CBT general therapy versus any other intervention in adults with binge eating disorder**
4 **at follow up**
- 5 Low quality evidence from one RCT (n=87) showed no difference in the effect of general
6 CBT on purging, binge eating, EDE-weight concern, EDE-shape concern, EDE-eating
7 concern, EDE-dietary restraint, EDI- body dissatisfaction, EDI-bulimia, EDI-drive for thinness
8 and global severity index compared with any other intervention.
- 9 Low quality evidence from one RCT (n=112) showed general CBT is more effective on
10 remission compared with any other intervention.
- 11 **8.2.4.6 Group therapy**
- 12 **128.2.4.6.1 Group mindfulness versus any another group intervention in adults with binge eating**
13 **disorder at end of treatment**
- 14 Low quality evidence from one RCT (n=103) showed no difference in group mindfulness on
15 BMI, binge eating, depression compared with another group intervention.
- 16 **168.2.4.6.2 Group mindfulness versus any another group intervention in adults with binge eating**
17 **disorder at follow up**
- 18 Low quality evidence from one RCT (n=103) showed no difference in group mindfulness on
19 BMI, binge eating, depression compared with another group intervention.
- 20 **208.2.4.6.3 Group mindfulness versus wait list controls in adults with binge eating disorder at the**
21 **end of treatment**
- 22 Low quality evidence from one RCT (n=100) showed no difference in group mindfulness on
23 BMI compared with wait list controls.
- 24 Low quality evidence from one RCT (n=100) showed group mindfulness is more effective on
25 binge eating, depression and binge eating scale compared with wait list controls.
- 26 **268.2.4.6.4 Group mindfulness versus wait list controls in adults with binge eating disorder at**
27 **follow up**
- 28 Low quality evidence from one RCT (n=100) showed no difference in group mindfulness on
29 BMI compared with wait list controls.
- 30 Low quality evidence from one RCT (n=100) showed group mindfulness is more effective on
31 binge eating, depression and binge eating scale compared with wait list controls.
- 32 **328.2.4.6.5 Group CBT-ED versus any other intervention in adults with binge eating disorder at**
33 **end of treatment**
- 34 Moderate quality evidence from six RCTs (n=530) showed group CBT-ED may be less
35 effective on decreasing weight compared with any other intervention but there was some
36 uncertainty.
- 37 Moderate quality evidence from 9 RCTs (n=795) showed no difference in group CBT-ED on
38 binge eating compared with any other intervention.
- 39 Moderate quality evidence from seven RCTs (n=588) showed no difference in group CBT-ED
40 on depression compared with any other intervention.

- 1 Low quality evidence from one RCT (n=53) showed no difference in group CBT-ED on
2 anxiety compared with any other intervention.
- 3 Very low quality evidence from two RCTs (n=266) showed group CBT-ED may be less
4 effective on EDE-global clinical score compared with any other intervention
- 5 Very low quality evidence from three RCTs (n=241) showed no difference in group CBT-ED
6 on EDE-shape concerns compared with any other intervention.
- 7 Very low quality evidence from four RCTs (n=384) showed no difference in group CBT-ED on
8 EDE-dietary restraint compared with any other intervention.
- 9 Very low quality evidence from four RCTs (n=384) showed group CBT-ED may be more
10 effective on EDE-weight concern compared with any other intervention but there was some
11 uncertainty.
- 12 Very low quality evidence from four RCTs (n=384) showed group CBT-ED may be less
13 effective on EDE-eating concern compared with any other intervention but there was some
14 uncertainty.
- 15 Very low quality evidence from one RCT (n=158) showed no difference in group CBT-ED on
16 global symptom score compared with any other intervention.
- 17 Low quality evidence from four RCTs (n=404) showed group CBT-ED is more effective on
18 remission compared with any other intervention.
- 19 **198.2.4.6.6 Group CBT-ED versus any other intervention in adults with binge eating disorder at
20 follow up**
- 21 Moderate quality evidence from six RCTs (n=514) showed group CBT-ED may be less
22 effective on reducing weight compared with any other intervention but there was some
23 uncertainty.
- 24 Moderate quality evidence from seven RCTs (n=651) showed no difference in the effect of
25 group CBT-ED on binge eating compared with any other intervention.
- 26 Moderate quality evidence from six RCTs (n=587) showed no difference in the effect of group
27 CBT-ED on depression compared with any other intervention.
- 28 Very low quality evidence from two RCTs (n=185) showed group CBT-ED is less effective on
29 anxiety compared with any other intervention.
- 30 Very low quality evidence from three RCTs (n=266) showed group CBT-ED is less effective
31 on EDE-global clinical score compared with any other intervention.
- 32 Very low quality evidence from three RCTs (n=266) showed group CBT-ED is less effective
33 on EDE-dietary restraint compared with any other intervention but there was some
34 uncertainty.
- 35 Very low quality evidence from four RCTs (n=350) showed group CBT-ED is less effective on
36 EDE-shape concern compared with any other intervention.
- 37 Very low quality evidence from five RCTs (n=540) showed group CBT-ED is less effective on
38 EDE-weight concern and EDE-eating concern compared with any other intervention
- 39 Low quality evidence from one RCT (n=138) showed no difference in the effect of group
40 CBT-ED on global symptom index compared with any other intervention.
- 41 Low quality evidence from three RCTs (n=279) showed no difference in the effect of group
42 CBT-ED on remission compared with any other intervention.

- 18.2.4.6.7 **Group CBT-ED versus wait list controls in adults with binge eating disorder at end of treatment**
2
- 3 Low quality evidence from three RCTs (n=181) showed no difference in the effect of group
4 CBT-ED on weight compared with wait list controls.
- 5 Very low quality evidence from three RCTs (n=160) showed no difference in the effect of
6 group CBT-ED on depression compared with wait list controls.
- 7 Low quality evidence from two RCTs (n=141) showed no difference in the effect of group
8 CBT-ED on binge eating compared with wait list controls.
- 98.2.4.6.8 **Group CBT-ED versus wait list controls in adults with binge eating disorder at follow up**
10
- 11 Low quality evidence from two RCTs (n=130) showed no difference in the effect of group BT-
12 ED on BMI compared with wait list controls.
- 13 Low quality evidence from two RCTs (n=137) showed no difference in the effect of group BT-
14 ED on depression compared with wait list controls.
- 15 Low quality evidence from two RCTs (n=130) showed group BT-ED is more effective on
16 binge eating compared with wait list controls.
- 178.2.4.6.9 **Group BT-ED versus wait list controls in adults with binge eating disorder at end of treatment**
18
- 19 Low quality evidence from one RCT (n=72) showed no difference in the effect of group BT-
20 ED on binge eating, EDE-total and anxiety compared with wait list controls.
- 21 Low quality evidence from one RCT (n=72) showed group BT-ED is more effective on
22 depression compared with wait list controls.
- 23 Low quality evidence from one RCT (n=100) showed no difference in the effect of group BT-
24 ED on remission compared with wait list controls.
- 28.2.4.6.10 **Group BT-ED versus any other intervention in adults with binge eating disorder at end of treatment**
26
- 27 Low quality evidence from one RCT (n=98) showed no difference in the effect of group BT-
28 ED on depression, BMI and weight loss compared with any other intervention.
- 29 Low quality evidence from one RCT (n=98 to 101) showed group BT-ED is more effective on
30 remission, EDE- eating concern and EDE-dietary restraint compared with any other
31 intervention.
- 32 Low quality evidence from one RCT (n=98) showed group BT-ED is more effective on EDE-
33 shape concerns and EDE-weight concern compared with any other intervention but there
34 was some uncertainty.
- 38.2.4.6.11 **Group BT-ED versus any other intervention in adults with binge eating disorder at follow up**
36
- 37 Low quality evidence from one RCT (n=88) showed no difference in the effect of group BT-
38 ED on BMI, weight loss, depression, EDE-shape concern, EDE-eating concern compared
39 with any other intervention.
- 40 Low quality evidence from one RCT (n=88) showed group BT-ED is more effective on EDE-
41 dietary restraint compared with any other intervention.

- 1 Low quality evidence from one RCT (n=88 to 101) showed group BT-ED is more effective on
2 EDE-weight concern and remission compared with any other intervention but there was
3 some uncertainty.
- 8.2.4.6.12 Group CBT-ED (body exposure) versus CBT-ED (cognitive) in adults with binge eating
4 disorder at end of treatment**
- 5
6 Low quality evidence from one RCT (n=24 to 28) showed no difference in the effect of group
7 CBT-ED (body exposure) on EDE-restraint, EDE-eating concern, EDE-weight concern, EDE-
8 shape concern, BMI, depression, binge eating and remission compared with CBT-ED
9 (cognitive).
- 10.2.4.6.13 Group CBT-ED (body exposure) versus CBT-ED (cognitive) in adults with binge eating
11 disorder at follow up**
- 12
13 Low quality evidence from one RCT (n=24 to 28) showed no difference in the effect of group
14 CBT-ED (body exposure) on EDE-restraint, EDE-eating concern, EDE-weight concern, EDE-
15 shape concern, BMI, depression, binge eating and remission compared with CBT-ED
(cognitive).
- 16.2.4.6.14 Group interpersonal psychotherapy (IPT) versus any other intervention in adults with
17 binge eating disorder at end of treatment**
- 18
19 Low quality evidence from one RCT (n=158 to 162) showed no difference in the effect of
20 group IPT on binge eating, remission, EDE-shape concern, EDE-eating concern, EDE-weight
concern, global symptom index and BMI compared with any other intervention.
- 21
22 Low quality evidence from one RCT (n=158) showed group IPT is less effective on
depression compared with any other intervention but there was some uncertainty.
- 23
24 Low quality evidence from one RCT (n=158) showed group IPT is less effective on EDE-
restraint compared with any other intervention.
- 28.2.4.6.15 Group interpersonal psychotherapy (IPT) versus any other intervention in adults with
26 binge eating disorder at follow up**
- 27
28 Low quality evidence from one RCT (n=138) showed no difference in the effect of group IPT
29 on binge eating, EDE-shape concern, EDE-eating concern, EDE-weight concern, EDE-
restraint, global symptom index, depression and BMI compared with any other intervention.
- 30
31 Low quality evidence from one RCT (n=138) showed group IPT is less effective on EDE-
restraint compared with any other intervention but there was some uncertainty.
- 38.2.4.6.16 Group counselling versus any other intervention in adults with binge eating disorder
33 at end of treatment**
- 34
35 Low quality evidence from one RCT (n=88 to 98) showed no difference in the effect of group
counselling on BMI, depression and weight loss compared with any other intervention.
- 36
37 Low quality evidence from one RCT (n=98 to 101) showed group counselling is less effective
on EDE-dietary restraint and EDE-eating concern compared with any other intervention.
- 38
39 Low quality evidence from one RCT (n=98) showed group counselling is less effective on
40 EDE-shape concern and EDE-weight concern compared with any other intervention but there
was some uncertainty.
- 41
42 Low quality evidence from one RCT (n=98) showed group counselling is more effective on
remission compared with any other intervention.

- 1 Low quality evidence from one RCT (n=98) showed group counselling is less effective on
2 patient preference compared with any other intervention but there was some uncertainty.
- 8.2.4.6.17 Group counselling versus any other intervention in adults with binge eating disorder
at follow up**
- 4
- 5 Low quality evidence from one RCT (n=88) showed no difference in the effect of group
6 counselling on BMI, depression, EDE-shape concerns, EDE-eating concern and weight loss
7 compared with any other intervention.
- 8 Low quality evidence from one RCT (n=88 to 101) showed group counselling is less effective
9 on remission and EDE-weight concern compared with any other intervention but there was
10 some uncertainty.
- 11 Low quality evidence from one RCT (n=88) showed group counselling is less effective on
12 EDE-dietary restraint compared with any other intervention.
- 18.2.4.6.18 Group diet versus any other group intervention in adults with binge eating disorder at
end of treatment**
- 14
- 15 Low quality evidence from three RCTs (n=242) showed group diet is more effective on
16 weight compared with any other intervention.
- 17 Low quality evidence from three RCTs (n=241) showed group diet is less effective on binge
18 eating compared with any other intervention but there was some uncertainty.
- 19 Very low to low quality evidence from two RCTs (n=85) showed no difference in the effect of
20 group diet on EDE-shape concern, EDE-weight concern, EDE-eating concern and EDE-
21 restraint compared with any other intervention.
- 22 Low quality evidence from four RCTs (n=327) showed group diet is less effective on
23 depression compared with any other intervention but there was some uncertainty.
- 24 Low quality evidence from one RCT (n=125) showed no difference in the effect of group diet
25 on EDE-global compared with any other intervention.
- 26 Low quality evidence from three RCTs (n=242) showed group diet is less effective on
27 remission compared with any other intervention.
- 28 In a sub-group analysis, low quality evidence from one RCT (n=48) showed no difference in
29 the effect of group diet on EDE-shape concern and EDE-restraint compared with any other
30 intervention in people who binged less than 18 times per month.
- 31 In a sub-group analysis, low quality evidence from one RCT (n=37) showed group diet is less
32 effective on EDE-shape concern EDE-restraint compared with any other intervention in
33 people who binged more than 18 times per month.
- 38.2.4.6.19 Group diet versus any other group intervention in adults with binge eating disorder at
follow up**
- 35
- 36 Low quality evidence from three RCTs (n=229) showed no difference in the effect of group
37 diet on weight compared with any other intervention.
- 38 Low quality evidence from three RCTs (n=241) showed group diet is effective on binge
39 eating compared with any other intervention but there was some uncertainty.
- 40 Low quality evidence from two RCTs (n=71) showed no difference in the effect of group diet
41 on EDE-shape concern, EDE-weight concern, EDE-eating concern and EDE-restraint
42 compared with any other intervention.

- 1 Low quality evidence from one RCT (n=125) showed no difference in the effect of group diet
2 on EDE-global compared with any other intervention.
- 3 Low quality evidence from three RCTs (n=205) showed no difference in the effect of group
4 diet on depression compared with any other intervention.
- 5 Low quality evidence from two RCTs (n=117) showed group diet is less effective on
6 remission compared with any other intervention.
- 7.2.4.6.20 Group self-help (ED) versus any other group intervention in adults with binge eating
8 disorder at end of treatment**
- 9 Low quality evidence from two RCTs (n=234) showed group self-help is more effective on
10 BMI compared with another group intervention, but there was some uncertainty.
- 11 Low quality evidence from one RCT (n=190) showed group diet is less effective on binge
12 eating, EDE-global score, EDE-restraint and EDE-eating concern compared with any other
13 intervention.
- 14 Low quality evidence from one RCT (n=190) showed group diet is less effective on EDE-
15 shape concern and EDE-weight concern compared with any other intervention but there was
16 some uncertainty.
- 17 Low quality evidence from one RCT (n=167) showed no difference in the effect of group self-
18 help on depression and quality of life compared with another group intervention.
- 19 Low quality evidence from one RCT (n=51) showed group self-help is more effective on
20 remission compared with another group intervention.
- 28.2.4.6.21 Group self-help (ED) versus any other group intervention in adults with binge eating
22 disorder at follow up**
- 23 Low quality evidence from two RCTs (n=231) showed no difference in the effect of group
24 self-help on BMI compared with another group intervention.
- 25 Low quality evidence from one RCTs (n=167 to 190) showed no difference in the effect of
26 group self-help on binge eating, EDE-eating concern, EDE-shape concern, EDE-weight
27 concern, EDE-global score and quality of life compared with another group intervention.
- 28 Low quality evidence from one RCT (n=44 to 51) showed no difference in the effect of group
29 self-help on depression and remission compared with another group intervention.
- 30 Low quality evidence from one RCT (n=190) showed group self-help is less effective on
31 EDE-restraint compared with another group intervention.
- 38.2.4.6.22 Group guided self-help (ED) versus any other group intervention in adults with binge
33 eating disorder at end of treatment**
- 34 Low quality evidence from two RCTs (n=234) showed no difference in the effect of group
35 guided self-help (ED) on BMI compared with another group intervention.
- 36 Low quality evidence from one RCT (n=183) showed group guided self-help (ED) is more
37 effective on binge eating compared with another group intervention.
- 38 Low quality evidence from one RCT (n=44) showed group guided self-help (ED) is more
39 effective on depression compared with another group intervention but there was some
40 uncertainty.
- 41 Very low to low quality evidence from one RCT (n=176 to 190) showed no difference in the
42 effect of group guided self-help (ED) on EDE-global, EDE-eating concern, EDE-shape
43 concern and quality of life compared with another group intervention.

1 Low quality evidence from one RCT (n=190) showed group guided self-help (ED) is more
2 effective on EDE-restraint compared with another group intervention but there was some
3 uncertainty.

4 Low quality evidence from one RCT (n=190) showed group guided self-help (ED) is less
5 effective on EDE-weight concern compared with another group intervention but there was
6 some uncertainty.

7 Very low evidence from one RCT (n=51) showed no difference in the effect of group guided
8 self-help (ED) on remission compared with another group intervention.

9.2.4.6.23 Group guided self-help (ED) versus any other group intervention in adults with binge eating disorder at follow up

11 Low quality evidence from two RCTs (n=231) showed no difference in the effect of group
12 guided self-help (ED) on BMI compared with another group intervention.

13 Low quality evidence from one RCT (n=190) showed group guided self-help (ED) is less
14 effective on binge eating compared with another group intervention, but there was some
15 uncertainty.

16 Low quality evidence from one RCT (n=44) showed no difference in the effect of group
17 guided self-help (ED) on depression compared with another group intervention.

18 Low quality evidence from one RCT (n=190) showed group guided self-help (ED) is more
19 effective on EDE-global core compared with another group intervention.

20 Low quality evidence from one RCT (n=167 to 190) showed no difference in the effect of
21 group guided self-help (ED) on EDE-restraint, EDE-weight concern and quality of life
22 compared with another group intervention.

23 Low quality evidence from one RCT (n=44) showed group guided self-help (ED) is less
24 effective on EDE-eating concern compared with another group intervention but there was
25 some uncertainty.

26 Low quality evidence from one RCT (n=190) showed group guided self-help (ED) is less
27 effective on EDE-shape concern compared with another group intervention.

28 Low quality evidence from one RCT (n=51) showed no difference in the effect of group
29 guided self-help (ED) on remission compared with another group intervention.

30.2.4.6.24 Group self-help (ED) versus wait list controls in adults with binge eating disorder at end of treatment

32 Low quality evidence from one RCT (n=136) showed no difference in the effect of group
33 guided self-help (ED) on BMI, EDE-global, EDE-weight concern, EDE-eating concern, EDE-
34 shape concern, EDE-restraint and quality of life compared with wait list controls.

35 Low quality evidence from one RCT (n=136) showed group guided self-help (ED) is more
36 effective on binge eating compared with wait list controls, but there was some uncertainty.

38.2.4.6.25 Group guided self-help (ED) versus wait list controls in adults with binge eating disorder at end of treatment

39 Low quality evidence from one RCT (n=129) showed group guided self-help (ED) is less
40 effective on BMI compared with wait list controls but there was some uncertainty.

41 Low quality evidence from one RCT (n=129) showed group guided self-help (ED) is more
42 effective on binge eating and EDE-restraint compared with wait list controls.

1 Low quality evidence from one RCT (n=129) showed no difference in the effect of group
2 guided self-help (ED) on EDE-global, EDE-eating concern, EDE-shape concern, EDE-weight
3 concern and quality of life compared with wait list controls.

8.2.4.6.26 Group psychoeducation versus another group intervention in adults with binge eating disorder at end of treatment

6 Low quality evidence from two RCTs (n=234) showed no difference in group
7 psychoeducation on BMI compared with another group intervention.

8 Low quality evidence from one RCT (n=174 to 190) showed no difference in group
9 psychoeducation on binge eating and quality of life compared with another group
10 intervention.

11 Low quality evidence from one RCT (n=44) showed no difference in group psychoeducation
12 on depression compared with another group intervention.

13 Low quality evidence from one RCT (n=190 to 253) showed group psychoeducation is more
14 effective on EDE-global score and EDE-weight concern compared with another group
15 intervention.

16 Low quality evidence from one RCT (n=190) showed group psychoeducation is more
17 effective on EDE-restraint, EDE-eating concern and EDE-shape concern and compared with
18 another group intervention but there was some uncertainty.

19 Low quality evidence from one RCT (n=51) showed group psychoeducation is more effective
20 on remission compared with another group intervention, but there was some uncertainty.

8.2.4.6.27 Group psychoeducation versus another group intervention in adults with binge eating disorder at follow up

23 Low quality evidence from two RCTs (n=243) showed no difference in group
24 psychoeducation on BMI compared with another group intervention.

25 Low quality evidence from one RCT (n=167 to 190) showed no difference in group
26 psychoeducation on binge eating, EDE-eating concern and quality of life compared with
27 another group intervention.

28 Low quality evidence from one RCT (n=41) showed group psychoeducation is more effective
29 on depression compared with another group intervention.

30 Low quality evidence from one RCT (n=190) showed group psychoeducation is more
31 effective on EDE-global, EDE-shape concern and EDE-weight concern compared with
32 another group intervention.

33 Low quality evidence from one RCT (n=190) showed group psychoeducation is more
34 effective on EDE-restraint compared with another group intervention but there was some
35 uncertainty.

36 Low quality evidence from one RCT (n=51) showed no difference in group psychoeducation
37 on remission compared with another group intervention.

8.2.4.7 Self-help therapy

8.2.4.7.1 Guided self-help (ED) versus another other intervention in adults with binge eating disorder at end of treatment

41 Moderate quality evidence from seven RCTs (n=490) showed guided self-help (ED) is more
42 effective binge eating compared with any other intervention.

- 1 Very low quality evidence from one RCT (n=90) showed guided self-help (ED) is more
2 effective on vomiting compared with any other intervention.
- 3 Very low quality evidence from one RCT (n=90) showed no difference in the effect of guided
4 self-help (ED) on use of laxatives and excessive exercise compared with any other
5 intervention.
- 6 Moderate quality evidence from seven RCTs (n=690) showed no difference in the effect of
7 guided self-help (ED) on BMI compared with any other intervention.
- 8 Low quality evidence from five RCTs (n=394) showed guided self-help (ED) is more effective
9 depression compared with any other intervention.
- 10 Very low quality evidence from nine RCTs (n=661) showed guided self-help (ED) is more
11 effective remission compared with any other intervention.
- 12 Very low quality evidence from four RCTs (n=389) showed guided self-help (ED) is more
13 effective EDE-global severity compared with any other intervention, but there was some
14 uncertainty
- 15 Very low quality evidence from seven RCTs (n=740) showed guided self-help (ED) is more
16 effective on EDE-shape concern and EDE-restraint compared with any other intervention.
- 17 Very low quality evidence from seven RCTs (n=740) showed guided self-help (ED) is more
18 effective on EDE-weight concern compared with any other intervention but there was some
19 uncertainty
- 20 Very low quality evidence from six RCTs (n=650) showed guided self-help (ED) is more
21 effective on EDE-eating concern compared with any other intervention.
- 22 Moderate quality evidence from two RCTs (n=284) showed no difference in the effect of
23 guided self-help (ED) on satisfaction with life compared with any other intervention.
- 24 **248.2.4.7.2 Guided self-help (ED) versus another other intervention in adults with binge eating
25 disorder at follow up**
- 26 Low quality evidence from four RCTs (n=300) showed no difference in the effect of guided
27 self-help (ED) on binge eating compared with any other intervention.
- 28 Very low quality evidence from four RCTs (n=409) showed no difference in the effect of
29 guided self-help (ED) on BMI compared with any other intervention.
- 30 Very low quality evidence from three RCTs (n=368) showed no difference in the effect of
31 guided self-help (ED) on EDE-weight concern compared with any other intervention.
- 32 Very low quality evidence from three RCTs (n=368) showed no difference in the effect of
33 guided self-help (ED) on EDE-restraint compared with any other intervention.
- 34 Very low quality evidence from three RCTs (n=368) showed no difference in the effect of
35 guided self-help (ED) on EDE-shape concern or EDE-eating concern compared with any
36 other intervention.
- 37 Low quality evidence from two RCTs (n=260) showed guided self-help (ED) is more effective
38 on EDE-global score compared with any other intervention.
- 39 Very low quality evidence from three RCTs (n=229) showed guided self-help (ED) is more
40 effective on remission compared with any other intervention.
- 41 Low quality evidence from one RCT (n=167) showed no difference in the effect of guided
42 self-help (ED) on quality of life compared with any other intervention.

- 1 Very low quality evidence from two RCTs (n=150) showed guided self-help (ED) is more
2 effective on depression compared with any other intervention.
- 38.2.4.7.3 Guided self-help (ED) versus wait list controls in adults with binge eating disorder at
4 end of treatment**
- 5 Low quality evidence from three RCTs (n=218) showed guided self-help (ED) is more
6 effective on binge eating compared with wait list controls.
- 7 Low quality evidence from two RCTs (n=188) showed no difference in the effect of guided
8 self-help (ED) on BMI compared with wait list controls.
- 9 Very low quality evidence from two RCTs (n=248 to 252) showed guided self-help (ED) is
10 more effective on EDE-weight concern, EDE-eating concern and EDE-global compared with
11 wait list controls but there was some uncertainty.
- 12 Very low quality evidence from two RCTs (n=248) showed guided self-help (ED) is more
13 effective on EDE-shape concern compared with wait list controls.
- 14 Very low quality evidence from two RCTs (n= 252) showed no difference in guided self-help
15 (ED) EDE-restraint compared with wait list controls
- 16 Low quality evidence from one RCT (n=109) showed no difference in the effect of guided
17 self-help (ED) on quality of life compared with wait list controls.
- 18 Low quality evidence from one RCTs (n=59) showed guided self-help (ED) is more effective
19 on remission compared with wait list controls.
- 208.2.4.7.4 Self-help (ED) versus any other intervention in adults with binge eating disorder at end
21 of treatment**
- 22 Moderate quality evidence from six RCTs (n=475) showed self-help (ED) is less effective on
23 binge eating compared with any other intervention.
- 24 Low quality evidence from one RCT (n=90) showed self-help (ED) is less effective on
25 vomiting compared with any other intervention.
- 26 Low quality evidence from one RCT (n=90) showed no difference in the effect of self-help
27 (ED) on the use of laxatives and excessive exercise compared with any other intervention.
- 28 Low quality evidence from four RCTs (n=417) showed self-help (ED) is more effective on
29 BMI compared with any other intervention, but there was some uncertainty.
- 30 Low quality evidence from four RCTs (n=236) showed no difference in the effect of self-help
31 (ED) on depression compared with any other intervention.
- 32 Low quality evidence from six RCTs (n=345) showed self-help (ED) is less effective on
33 remission compared with any other intervention but there was some uncertainty.
- 34 Low quality evidence from four RCTs (n=389) showed self-help (ED) is less effective on
35 EDE-restraint, EDE-shape concern, EDE-weight concern and EDE-eating concern compared
36 with any other intervention.
- 37 Low quality evidence from five RCTs (n=437) showed self-help (ED) is less effective on EDE-
38 global compared with any other intervention.
- 39 Low quality evidence from two RCTs (n=284) showed no difference in the effect of self-help
40 (ED) on the satisfaction with life compared with any other intervention.

18.2.4.7.5 Self-help (ED) versus any other intervention in adults with binge eating disorder at follow up

2
3 Low quality evidence from three RCTs (n=227 to 296) showed no difference in the effect of
4 self-help (ED) on binge eating and BMI compared with any other intervention.

5 Low quality evidence from one RCT (n=37) showed no difference in the effect of self-help
6 (ED) on depression compared with any other intervention.

7 Low quality evidence from two RCTs (n=118) showed no difference in the effect of self-help
8 (ED) on remission compared with any other intervention.

9 Low quality evidence from two RCTs (n=259) showed self-help (ED) is less effective on EDE-
10 restraint compared with any other intervention but there was some uncertainty.

11 Very low to low quality evidence from two RCTs (n=259 to 260) showed no difference in the
12 effect of self-help (ED) on EDE-shape concern, EDE-weight concern, EDE-eating concern
13 and EDE-global compared with any other intervention.

14 Low quality evidence from one RCT (n=167) showed no difference in the effect of self-help
15 (ED) on the quality of life compared with any other intervention.

168.2.4.7.6 Self-help (ED) versus wait list controls in adults with binge eating disorder at end of treatment

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17
18 Low quality evidence from two RCTs (n=196) showed self-help (ED) is more effective on
19 binge eating compared with any other intervention but there was some uncertainty.

20 Low quality evidence from one RCT (n=60) showed self-help (ED) is more effective on
21 remission compared with any other intervention.

22 Very low to low quality evidence from two RCTs (n=196 to 205) showed no difference in the
23 effect of self-help (ED) on BMI, EDE-weight concern, EDE-restraint and EDE-shape concern
24 compared with wait list controls.

25 Very low quality evidence from two RCTs (n=196) showed self-help (ED) is more effective on
26 EDE-eating concern and EDE-global severity compared with any other intervention, but there
27 was some uncertainty.

28 Low quality evidence from one RCT (n=110) showed no difference in the effect of self-help
29 (ED) on quality of life compared with wait list controls.

308.2.4.7.7 Internet self-help (ED) versus wait list controls in adults with binge eating disorder at end of treatment

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31
32 Low quality evidence from two RCTs (n=118) showed no difference in the effect of internet
33 self-help (ED) on binge eating compared with wait list controls

34 Low quality evidence from two RCTs (n=118) showed internet self-help (ED) is less effective
35 on BMI compared with wait list controls, but there was some uncertainty.

36 Low quality evidence from one RCT (n=74) showed internet self-help (ED) is more effective
37 on depression, EDI-drive for thinness, EDE-total, global severity index compared with wait
38 list controls, but there was some uncertainty.

39 Low quality evidence from one RCT (n=74) showed internet self-help (ED) is more effective
40 on EDI-bulimia and remission compared with wait list controls.

41 Low quality evidence from one RCT (n=74) showed no difference in the effect of internet self-
42 help (ED) on EDI-body dissatisfaction, EDE-restraint, EDE-shape concern and quality of life
43 compared with wait list controls.

- 18.2.4.7.8 **Internet self-help (ED) versus wait list controls in young people with binge eating disorder at end of treatment**
2
3 Low quality evidence from one RCT (n=93) showed no difference in the effect of internet self-
4 help (ED) on binge eating compared with wait list controls.
5 Low quality evidence from one RCT (n=93) showed internet self-help (ED) is more effective
6 on depression compared with wait list controls, but there was some uncertainty
- 78.2.4.7.9 **Internet self-help (ED) versus wait list controls in adults with binge eating disorder at follow up**
8
9 Low quality evidence from two RCTs (n=118) showed internet self-help (ED) is less effective
10 on BMI compared with wait list controls, but there was some uncertainty.
11 Low quality evidence from one RCT (n=74) showed internet self-help (ED) is more effective
12 on depression, EDI-drive for thinness and remission compared with wait list controls but
13 there was some uncertainty.
14 Low quality evidence from one RCT (n=74) showed no difference in the effect of internet self-
15 help (ED) on EDE-restraint, EDE-shape concern, EDE-total, EDI-body dissatisfaction, EDI-
16 bulimia, global severity index and quality of life compared with wait list controls.
- 18.2.4.7.10 **Internet self-help (ED) versus wait list controls in young people with binge eating disorder at follow up**
18
19 Low quality evidence from one RCT (n=93) showed no difference in the effect of internet self-
20 help (ED) on BMI and depression compared with wait list controls.
- 28.2.4.7.11 **Guided self-help (ED) versus another guided self-help (ED) in adults with binge eating disorder at end of treatment**
22
23 Low quality evidence from one RCT (n=74) showed guided self-help (ED) is more effective
24 on binge eating and remission compared with another guided self-help.
25 Low quality evidence from one RCT (n=74) showed no difference in the effect of guided self-
26 help (ED) on BMI, depression, EDE-shape concern and EDE-weight concern compared with
27 another guided self-help.
28 Low quality evidence from one RCT (n=74) showed guided self-help (ED) is more effective
29 on EDE-restraint and EDE-eating concern compared with another guided self-help, but there
30 was some uncertainty.
- 38.2.4.7.12 **Internet self-help (ED) versus any other intervention in adults with binge eating disorder at end of treatment**
32
33 Low quality evidence from one RCT (n=44) showed no difference in the effect of internet self-
34 help (ED) on BMI and binge eating compared with any other intervention.
- 38.2.4.7.13 **Internet self-help (ED) versus any other intervention in adults with binge eating disorder at follow up**
36
37 Low quality evidence from one RCT (n=44) showed no difference in the effect of internet self-
38 help (ED) on BMI and binge eating compared with any other intervention.
- 39 **8.2.4.8 Family therapy**
- 408.2.4.8.1 **Family therapy versus wait list control in adults with binge eating disorder**
41 Low quality evidence from one RCT (n=62) showed no difference in the effect of family
42 therapy on weight and family functioning compared with wait list controls.

1 Low quality evidence from one RCT (n=63) showed family therapy is more effective on binge
2 frequency and depression compared with wait list controls.

38.2.4.8.2 **Family therapy versus any other intervention in adults with binge eating disorder at 4 end of treatment**

5 Low quality evidence from one RCT (n=63) showed no difference in the effect of family
6 therapy on weight, binge frequency, depression and family functioning compared with any
7 other intervention.

88.2.4.8.3 **Family therapy versus any other intervention in adults with binge eating disorder at 9 follow up**

10 Low quality evidence from one RCT (n=63) showed no difference in the effect of family
11 therapy on Weight, depression and family functioning compared with any other intervention.

12 Low quality evidence from one RCT (n=63) showed family therapy is less effective on binge
13 frequency compared with any other intervention.

14 **8.2.5 Economic evidence statements**

15 There was evidence from one US study (N=123) which found guided self-help to be
16 dominant when compared with treatment as usual. The reviewed study was only partially
17 applicable and was characterised by minor methodological limitations.

18 In the economic analysis conducted for this guideline, self-help ED with support appeared to
19 be more cost-effective option for adults with BED when compared with other individual
20 therapies. Self-help ED with support had the highest probability of being the most cost-
21 effective treatment option, at any level of willingness-to-pay per additional QALY gained
22 above £7,000 per QALY. At the lower NICE cost-effectiveness threshold of £20,000 per
23 QALY the probability of self-help ED with support being cost effective was 0.83. Similarly,
24 CBT-ED group when compared with other group therapies was the most cost-effective option
25 for adults with BED. CBT-ED group had the highest probability of being the most cost-
26 effective treatment option, at any level of willingness-to-pay per additional QALY gained
27 above £3,500 per QALY. At the lower NICE cost-effectiveness threshold of £20,000 per
28 QALY the probability of CBT-ED group being cost effective was 0.74. The evidence from the
29 guideline economic analysis was directly applicable to the UK context and it was
30 characterised by potentially serious methodological limitations.

31 No economic evidence on the cost effectiveness of interventions for children and young
32 people with BED was available.

33 **8.2.6 Recommendations and link to evidence**

34
35

Psychological treatment for adults with BED

130. Explain to people with binge eating disorder that psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is not a therapy target in itself. Refer to the NICE guideline on [obesity identification, assessment and management](#) for guidance on weight loss and bariatric surgery.

First-line psychological treatment for adults

131. Offer a binge-eating-disorder-focused guided self-help programme to adults with binge eating disorder.

132. Binge-eating-disorder-focused guided self-help programmes for adults should:

- use cognitive behavioural self-help materials
- focus on adherence to the self-help programme
- supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)
- focus exclusively on helping the person follow the programme.

133. If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED).

Second-line psychological treatment for adults

134. Group CBT-ED programmes for adults with binge eating disorder should:

- typically consist of 16 weekly 90-minute group sessions over 4 months
- focus on psychoeducation, self-monitoring of the eating behaviour and helping the person analyse their problems and goals
- include making a daily food intake plan and identifying binge eating cues
- include body exposure training and helping the person to identify and change negative beliefs about their body
- help with avoiding relapses and coping with current and future risks and triggers.

135. If an individual refuses group CBT-ED, or such treatment is not available, consider individual CBT-ED for BED.

136. Individual CBT-ED for adults with binge eating disorder should:

- typically consist of 16–20 sessions
- develop a formulation of the person's psychological issues, to determine how dietary and emotional factors contribute to their binge eating
- based on the formulation:
 - advise people to eat regular meals and snacks to avoid feeling hungry

	<ul style="list-style-type: none"> o address the emotional triggers for their binge eating, using cognitive restructuring, behavioural experiments and exposure • include weekly monitoring of binge eating behaviours, dietary intake and weight • share the weight record with the person • address body-image issues if present • explain to the person that although CBT-ED does not aim at weight loss, stopping binge eating can have this effect in the long term • advise the person not to try to lose weight (for example by dieting) during treatment, because this is likely to trigger binge eating.
<p>Relative value of different outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating binge eating disorder. For this population, it was agreed binge eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
<p>Trade-off between clinical benefits and harms</p>	<p>First-line psychological treatment for adults</p> <p>Guided self-help</p> <p>There were clear benefits of the guided self-help for binge eating disorder in adults on remission and binge eating compared with waitlist controls. Other outcomes that showed favourable results included scores on EDE-global and the majority of its subscales. No difference were found on BMI and quality of life. Long-term follow up data was not available. Data on all-cause mortality, adverse events, resource use, relapse, general psychopathology, body weight, general functioning, family functioning and service user experience was not reported.</p> <p>When compared with another intervention, the benefits in adults of guided self-help were still evident. Positive effects were found on remission, binge eating, vomiting, depression, and the subscales of the EDE. A trend for a benefit was found on EDE-global but there was no difference on BMI, reducing excessive exercise, satisfaction with life, and laxative use.</p> <p>Follow-up data at 6 and 12 months showed that guided self-help was still favoured on remission compared with any other intervention. Guided self-help also appeared to maintain improvements on scores on the EDE-dietary restraint subscale, although there was some uncertainty. However, there was no difference on binge frequency, BMI, the subscales of the EDE, quality of life and depression. No data at any time point was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.</p> <p>One study compared two different types of guided self-help, one based on the manual by Fairburn 1995 (which focuses on developing a regular pattern of</p>

moderate eating, self-control strategies and problem-solving) and one based on the LEARN behavioural weight loss manual (which focuses on making a gradual and moderate lifestyle change with goal of calorie restriction and increased physical activity). The former group showed favourable results on remission and binge eating.

When comparing self-help for BED to other interventions, the results were less positive. Both remission and binge eating favoured any other interventions but with considerable uncertainty. However, self-help was favoured any other intervention for vomiting, EDE-global and EDE-subscales. BMI showed a trend to be lower in the self-help group, but no difference was found on reducing excessive exercise, laxative use, depression scores, or improving satisfaction of life.

At 6 to 12 months follow up, no differences were found on remission, binge eating or any other outcome, with the exception of scores on EDE-restraint, which again favoured self-help group compared with any other intervention. No data was reported at any time point on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.

Self-help for BED compared with wait list controls showed favourable results in adults on remission and binge eating, in addition to showing a trend favouring scores on EDE-global and EDE-eating concern. No difference was found on the effect of self-help on BMI, EDE-restraint, EDE-shape concern, EDE-weight concern and quality of life. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning, general psychopathology and service user experience.

Other interventions investigated in adults included internet self-help. Compared with wait list controls, a benefit was found on remission but no difference was found on binge eating. Other favourable results included EDI-bulimia and a trend to favour EDI-drive for thinness, EDE-total, global severity index. No other differences were found between depression, EDI-body dissatisfaction, EDE-restraint, EDE-shape concern and quality of life. There appeared to be negative effect on BMI.

At 2 to 6 months follow up, there was a trend to still favour internet self-help over wait list controls for remission but no difference was found in binge eating, depression, EDE-restraint, EDE-shape concern, EDE-total, EDI-bulimia, EDI-body dissatisfaction, global severity index, quality of life. There was a trend to favour EDI-drive for thinness and depression. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.

Internet self-help was also compared with other interventions and showed no difference on BMI and binge eating between the two groups at the end of treatment and at follow up. No other outcomes were reported.

Group interventions

Compared with wait list controls, group CBT-ED reduced binge eating at the end of treatment, but had no effect on weight or depression. At follow up, there were still benefits on binge eating. No difference in weight or depression was found. Remission data was not available.

A group mindfulness intervention compared with waitlist controls showed favourable results on remission and binge eating, in addition to depression. However, there was no difference on BMI between the two arms. The same trends were found at long-term follow up. There was no difference between group mindfulness and any other intervention at the end of treatment and follow up on remission, binge eating and BMI.

CBT-ED compared with any other intervention at the end of treatment showed positive results on remission and a trend for improving binge eating. There were also favourable results on EDE-weight concern, though less favourable results on EDE-global, EDE-eating concern and weight. There were no differences between CBT-ED and any other intervention on depression, anxiety, EDE-dietary restraint, EDE-shape concern, and EDE-global score.

At follow up, the benefits on remission and binge eating were no longer evident. Weight, anxiety, EDE-global and the EDE-subcales all favoured the other interventions. No difference on depression or global symptom score was found.

Compared with another group treatment, group behavioural therapy for eating disorders was more effective on EDE-eating concern, EDE-dietary restraint and remission at the end of treatment. No difference between the two treatment arms was found on depression, BMI and weight loss and only a trend to favour EDE-shape concerns and EDE-weight concern.

At follow up, group behavioural therapy for eating disorders may be more effective on EDE-dietary restraint and remission (with some uncertainty) compared with another group therapy. Other outcomes showed no difference between the two treatment arms including depression, BMI, weight loss, EDE-shape concern and EDE-eating concern. EDE-dietary restraint favoured group behavioural therapy and there was a trend favouring group behavioural therapy on EDE-weight concern.

Group interpersonal psychotherapy (IPT) showed no additional benefit on remission or binge eating compared with any other intervention. Similarly, no difference was found on BMI, scores on the EDE-subcales and global symptom index but there was a trend to improve depression but not EDE-restraint. At follow up no differences were found (with the exception of a negative effect on EDE-restraint).

Group counselling compared with any other intervention showed favourable effects on remission at end of treatment but no other benefit. EDE-subcales all favoured any other intervention, as did the preference of the person receiving treatment. At long-term follow up, interestingly remission now favoured any other treatment (but there was some uncertainty) and no difference was found in BMI, weight loss or depression. Again, any other intervention was favoured on the EDE-subcales (with the exception of EDE-dietary restraint and EDE-weight concerns) and preference of the person receiving treatment.

Group diet compared with any other group intervention showed a positive result on body weight but negative results for most of the other outcomes. Remission rates and binge eating (with some uncertainty) and depression favoured any other intervention. There was no difference between group diet and any other intervention on any of the EDE-subcales. At follow up, remission still favoured the other group and binge eating also showed a trend to favour the other arm, but no differences were found in all other outcomes.

Group self-help for eating disorders compared with any other intervention showed a benefit on remission and a trend to reduce BMI. However, there was no benefit on binge eating and most of the other outcomes favoured the other arm. At follow up, there was no difference between group self-help and any other intervention on the majority of outcomes.

When compared with any other intervention, group guided self-help for eating disorders still showed a benefit on binge eating but no difference on remission was found. Depression and EDE-restraint also favoured group guided self-help. No difference in EDE-global, EDE-shape concern, EDE-eating concern or quality of life was found. EDE-weight concern favoured any other intervention. At follow-up

none of the benefits were still evident and the majority of outcomes were similar between the two treatment arms, with the exception of scores on the EDE-shape concern, EDE-eating concern and EDE-weight concern subscales where the other treatment arm was favoured.

Group self-help for eating disorders compared with wait list controls showed a trend for a reduction in binge eating but no difference in BMI, quality of life, EDE-global or EDE-subcales. When compared with any other intervention, there were mixed results. Remission was improved in group self-help but there was no difference between these arms on binge eating, BMI, depression, quality of life, EDE-shape concern and EDE-eating. EDE-global, EDE-restraint, EDE-weight concern were all favoured by any other intervention.

Group guided self-help for eating disorders compared with waitlist control showed a benefit on binge eating and EDE-restraint with no difference on any other outcome including BMI (where there was a trend to be higher), quality of life, EDE-global and the remaining EDE subscales.

Adverse events or all-cause mortality were not reported in any of the studies.

Individual therapy

Other interventions that were considered but for which there was no convincing evidence included CBT-ED, IPT and DBT. Comparing one type of combined therapy to another in adults showed it favoured one intervention (CBT-ED and a weight loss intervention [diet, exercise, counselling]) to another type of combined therapy (combined brief strategic thinking and weight loss group) for a global clinical score but no difference was found in weight loss. Remission data was not included because the duration over which the symptoms were measured was unclear. No data was reported on binge eating, all-cause mortality, adverse events, resource use, relapse, general functioning, body weight, family functioning and service user experience.

Individual CBT-ED compared with any other intervention in adults showed no difference in binge eating, depression and EDE-weight concern and less favourable effects on remission (with some uncertainty). Positive results were found on EDE-dietary restraint, EDE-shape concern, EDE-eating concern and EDE-global score.

At 12 months follow up, CBT-ED showed no difference on binge eating, BMI and remission compared with any other intervention. However, there were some benefits on EDE-global and the EDE-subcales. No difference on depression was found. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, body weight, family functioning and service user experience.

Interpersonal psychotherapy (IPT), which focuses on our relationship difficulties, had demonstrated no additional benefit both at end of treatment and follow up on remission, binge eating and BMI compared with any other intervention at the end of treatment and at follow up. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, eating disorder psychopathology, family functioning, general psychopathology and service user experience.

Dialectical behaviour therapy (DBT) showed no difference on binge eating compared with wait list controls. However, vomiting episodes, EDE-global and depression scores favoured DBT. No data was reported on remission, all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.

	<p>Behavioural therapy compared with any other treatment showed remission was improved at the end of treatment (with some uncertainty), but not at follow up. No other outcomes showed a difference including binge eating, purging, subscales of the EDE and EDI, and symptom checklist. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.</p> <p>Compared with any other treatment at end of treatment and follow up, I CBT demonstrated no significant effect on binge eating and most of the other outcomes (including on the subscales of the EDE and EDI). However, remission at follow up favoured general CBT compared with any other treatment. No data was reported on all-cause mortality, adverse events, resource use, relapse, general functioning, family functioning and service user experience.</p> <p>Family therapy</p> <p>One study on family therapy in adults with binge eating disorders was identified. Compared with wait list controls, benefits on binge frequency and depression were found at the end of treatment but not on weight or family functioning.</p> <p>Family therapy showed similar effects as another intervention on weight, binge eating, depression and family functioning at the end of treatment. At 6 months follow up, similar results were found except family functioning was less effective in binge eating compared with another intervention.</p> <p>No evidence was found on the critical outcome of remission, nor the important outcomes of general functioning, service user experience, resource use, adverse events, quality of life, all-cause mortality and relapse.</p> <p>Young people with binge eating disorder</p> <p>In young people, individual CBT-ED also failed to show much benefit compared with any other intervention. Both binge eating and remission were similar between the two arms (with a trend for remission to favour any other intervention), as was BMI, EDE-weight concern, EDE-dietary restraint, EDE-shape concern and social adjustment. Depression and EDE-eating concern favoured CBT-ED at the end of treatment.</p> <p>One study was identified on the effects of internet self-help compared with wait list controls on young people with binge eating disorder. It showed a benefit on depression compared with wait list control but there was some uncertainty. No other differences were detected at the end of treatment or at follow up. Adverse events or all-cause mortality were not reported in any of the RCTs on adults or young people.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>Existing economic evidence pertaining to the psychological therapies for adults with binge eating disorder was very limited and the committee could not draw any conclusions from it.</p> <p>The guideline economic analysis demonstrated that self-help for an eating disorder with support is the most cost-effective individual treatment option for people with binge eating disorder. At the lower NICE cost-effectiveness threshold of £20,000 per QALY (NICE, 2008b) the probability of self-help for an eating disorder with support being cost effective was 0.83. Results were robust under all other scenarios examined in one-way sensitivity analyses.</p> <p>The guideline economic analysis demonstrated that CBT-ED group is the most cost-effective group treatment option for people with binge eating disorder. Also, at the lower NICE cost-effectiveness threshold of £20,000 per QALY (NICE, 2008b) the probability of CBT-ED group being cost effective was 0.74.</p>

	<p>It was not possible to compare self-help for an eating disorder with support and CBT-ED group in 1 analysis (due to the lack of common comparator between the treatments). However, the intervention costs are £238 and £317 per participant, for self-help for an eating disorder with support and CBT-ED group, respectively (in 2014/15 prices). Consequently, the committee expressed the view that self-help for an eating disorder with support should be offered as a first line treatment and CBT-ED group only if self-help for an eating disorder with support is ineffective or is unacceptable.</p> <p>The committee expressed the concern that in some cases group therapy may not be available or an individual may refuse group treatment. Given the lack of effective individual interventions for adults with BED, the committee extrapolated the effectiveness and cost effectiveness of interventions from adults with other eating disorders including anorexia nervosa and bulimia nervosa.</p>
<p>Quality of evidence</p>	<p>The evidence for psychotherapies for binge eating disorder was mostly low quality. The evidence was downgraded for risk of bias for reasons including a lack of detail regarding randomisation method, allocation concealment, and whether the participants, investigators or assessors were blinded. Significant dropout rates were also detected, with more than 20% dropouts in several of the studies.</p> <p>Guided self-help Moderate quality evidence was available for guided self-help compared with any other intervention. This comparison had some of the highest number of studies and participants available for the meta-analysis. However, some outcomes were downgraded because of indirectness (depending on the % contribution the study made to the effect size) owing to the inclusion of a mixture of people with binge eating disorder and EDNOS. Despite this, the committee were most confident with the data on guided self-help, and hence recommended it as a first-line treatment for adults with binge eating disorder.</p> <p>Group therapy When comparing the different therapies for binge eating disorder, the results showed that group CBT-ED was the most effective after guided self-help. It was one of the few interventions, in addition to guided self-help, that showed convincing results on remission at the end of treatment (22% increase in remission rates) and a trend for benefits to be sustained at long-term follow up (14%).</p> <p>Individual therapy For the comparison of two forms of combined CBT-ED treatments, remission data was excluded because the patient's symptoms were measured over one week, rather than the minimum required by the committee. The study was described as 'combined' because it included inpatient and outpatient care, combined with a diet, exercise and psychotherapy. Thus, it was difficult to isolate what the mutative component of the programme was.</p> <p>The evidence for the other treatments was of low quality. With the exception of the study on IPT, the studies on these interventions also failed to report data on remission. The committee thus did not consider the evidence sufficient to merit a recommendation.</p>
<p>Other considerations</p>	<p>In most of the studies, weight or BMI did not differ at the end of treatment between two active treatment arms or even with waitlist controls, highlighting that psychotherapy is not particularly effective at promoting weight loss. This supports the view that only focusing on weight loss is not appropriate goal for obese people. For these reasons, the committee highlighted the importance of explaining to people with binge eating disorder that psychological treatment alone has a limited effect on weight and that weight loss is a post-therapy target.</p>

	<p>The committee used their knowledge and experience, based on the details of the guided self-help manuals used in the reviewed studies, to generate the recommendations on what the treatment should include.</p> <p>Consequently, the committee agreed to recommend that if an individual refuses group CBT-ED or such a treatment is not available, then individual CBT-ED should be considered. The committee noted the lack of evidence on individual CBT-ED in this population but noted that it was effective as part of a combined intervention and also that services offering interventions for people who refused group CBT-ED would have skilled staff able to provide CBT-ED and therefore for that reason decided to recommend CBT-ED as a third-line treatment option.</p> <p>Given the limited evidence for the treatment of BED, the committee generated a research recommendation to compare the clinical and cost effectiveness of individual eating-disorder focused cognitive behavioural therapy (CBT-ED) with guided self-help and group CBT-ED for adults with binge eating disorder in adults and (see next LETR) in children and young people.</p> <p>Assessment of progress at 4 weeks</p> <p>The committee were aware of evidence from RCTs that shows assessment review of progress during the early stages of a psychological treatment can predict the likelihood of a full-response at the end of treatment. For this reason they felt it was important to have an early assessment of progress at 4 weeks and if the person is not showing signs of responding to self-help then they should be offered group CBT-ED.</p>
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- 1 **18. Research recommendation: Compare the clinical and cost effectiveness of**
 2 **individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) with**
 3 **guided self-help and group CBT-ED for adults with binge eating disorder?**

4 **Psychological treatment for children and young people with BED**

	<p>137. For children and young people with binge eating disorder, offer the same treatments recommended for adults with binge eating disorder.</p>
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating binge eating disorder. For this population, it was agreed binge eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>In young people with binge eating disorder, individual CBT-ED showed no difference in its effectiveness compared with any other treatment (treatment as usual). Both binge eating and remission were similar between the two arms (with a trend for remission to favour any other treatment), as was BMI, EDE-weight concern, EDE-dietary restraint, EDE-shape concern and social adjustment. CBT-ED did show favourable results on depression and EDE-eating concern at the end of treatment. No data was available at follow up.</p>

	<p>One study was identified on the effects of internet self-help compared with wait list controls on young people with binge eating disorder. It showed no additional benefit on binge eating compared with wait list controls but a trend to improve depression. No difference was found at follow up. Remission was not reported.</p> <p>Adverse events or all-cause mortality were not reported in any of the studies.</p>
Trade-off between net health benefits and resource use	<p>The committee noted that there is a lack of evidence on the effectiveness and cost effectiveness of interventions for young people with BED. Consequently, the committee extrapolated the cost effectiveness of interventions from the economic analyses conducted for this guideline for adults with BED. According to the economic analyses, for adults with BED self-help with support was the most cost effective individual treatment and CBT-ED group was the most cost effective group treatment. It was impossible to compare self-help with support and CBT-ED group in one analysis (due to the lack of common comparator between the treatments). However, the intervention costs are £238 and £317 per participant, for self-help for an eating disorder with support and CBT-ED group, respectively (in 2014/15 prices). Consequently, the committee expressed the view that self-help for an eating disorder with support should be offered as a first line treatment and CBT-ED group in cases where self-help with support is ineffective or is unacceptable. In cases where group therapy is not available or an individual refuses group treatment, the committee recommended individual CBT. The effectiveness and cost effectiveness of individual CBT was extrapolated from adults with other eating disorders including anorexia nervosa and bulimia nervosa.</p>
Quality of evidence	<p>The evidence for psychotherapies for binge eating disorder in children and young people was mostly low quality. The evidence was downgraded for risk of bias for reasons including a lack of detail regarding randomisation method, allocation concealment, and whether the participants, investigators or assessors were blinded. High dropout rates were also detected, with more than 20% dropouts in several of the studies. In both comparisons, only one study was identified and a small number of participants were included (n=26 to 93). No data on remission was reported in the study that examined internet self-help compared with wait list controls.</p>
Other considerations	<p>Due to the fact that the evidence on young people was not strong enough to generate a recommendation, the committee agreed to extrapolate the evidence from adults with binge eating disorder to children and young people. They felt it was important to include a recommendation on how to treat this population, rather than a research recommendation alone, given the number of young people with this disorder.</p> <p>Due to the lack of evidence on children and young people with binge eating disorder the committee decided to generate a research recommendation to investigate the clinical and cost effectiveness of psychological treatments (such as individual or group CBT-ED) for children and young people with binge eating disorder..</p>

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- 19. Research recommendation: Compare the clinical and cost effectiveness of individual eating-disorder-focused CBT-ED with guided self-help and group CBT-ED for children and young people with binge eating disorder.**

1 8.3 Carer interventions

2 8.3.1 Review question: Does any psychological intervention produce benefits/harms 3 in the parents or carers of children or young people with an eating disorder 4 compared with any other intervention or controls?

5 The review protocol summary, including the review question and the eligibility criteria used
6 for this section of the guideline, can be found in Table 272. Further information about the
7 search strategy can be found in Appendix H; the full review protocols can be found in
8 Appendix F.

9 This review considers all psychological interventions for the parents or carers of children or
10 young people with an eating disorder. The interventions were categorised according to their
11 mode of delivery (e.g. group, self-help), the age of the people with the eating disorder, and
12 the type of eating disorder and were compared to wait list controls, treatment as usual or any
13 other intervention.

14 **Table 272: Clinical review protocol summary**

Component	Description
Review question(s)	Does any psychological intervention produce benefits/harms in the parents or carers of children or young people with an eating disorder compared with any other intervention or controls?
Population	<ul style="list-style-type: none"> Family or carers of people with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder)
Intervention(s)	Psychological interventions may include: <ul style="list-style-type: none"> Family-based Parent only (not necessarily focussed on eating disorder) Parent-focused therapy (PFT) Group Parent-Training (GPT) Separated family therapy Parents with person with ED (greater focus on eating disorder) Behavioural Family Therapy (BFT) Behavioural family systems therapy (BFST). Family-based Treatment (FBT) Family Day Workshops (FDW) Family Therapy (FT) Family therapy for anorexia nervosa (FT-AN) Multi-Family Group Day Treatment (MFGDT) Multi-Family Group Therapy (MFGT) Systemic Family Therapy (SFT) Systemic Family Therapy for AN (SFT-AN) Multifamily therapy (MFT) is synonymous with (MFGT; MFGDT). Uniting couples in the treatment of AN (UCAN) Conjoint family therapy
Comparison	<ul style="list-style-type: none"> Wait list control Treatment as usual Another intervention
Critical outcomes	<ul style="list-style-type: none"> Parent's or carer's general psychopathology (including mood/depression/anxiety) Family functioning Quality of life

Component	Description
	<ul style="list-style-type: none"> • Other primary outcomes commonly reported in studies that just target the family/carer <p>The following outcomes will be included if the family or carer intervention includes the child or person with an eating disorder:</p> <ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • General functioning • Resource use. • Service user experience • All-cause mortality. • Adverse events • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 8.3.2 Clinical evidence

2 No studies were found that met the eligibility criteria for this review.

3 8.3.3 Economic evidence

4 No economic evidence on the cost effectiveness of interventions for the parents or carers of
5 children or young people with binge eating disorder was identified by the systematic search
6 of the economic literature undertaken for this guideline. Details on the methods used for the
7 systematic search of the economic literature are described in Chapter 3.

8 8.3.4 Clinical evidence statements

9 No studies were found that met the eligibility criteria for this review.

10 8.3.5 Economic evidence statements

11 No economic evidence on the cost effectiveness of interventions for the parents or carers of
12 children or young people with binge eating disorder was available.

13 8.3.6 Recommendations and link to evidence

14 Working with family members and carers

See Section 6.3.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes, when assessing whether any interventions help the parents and carers of children and young people with an eating disorder. The critical outcomes for the parents and carers were: general psychopathology, family functioning, quality of life and other primary outcomes reported by the study.</p> <p>Other outcomes that are critical for the child or young person with the eating disorder include remission and binge eating or body weight, depending on the eating disorder.</p>

	Other outcomes that are of lesser importance but clearly important outcomes include, general functioning, service user experience, all-cause mortality, adverse events and eating disorder psychopathology.
Trade-off between clinical benefits and harms	Bulimia nervosa or binge eating disorder (this chapter and chapter 7) No relevant published evidence was found on parents or carers of children and young people with bulimia nervosa or binge eating disorder. For discussion of carer interventions for other eating disorders, see the LETRs in the relevant chapters.
Trade-off between net health benefits and resource use	The committee expressed the view that offering family members and carers an assessment of their own needs may incur additional healthcare resources (that is, time required to perform such assessment). However, the committee considered the cost of providing such assessment to be small, taking into account the potential reduction in family and carers' burden, potential depression and other health vulnerabilities which may be costly to other parts of the healthcare system, especially considering that the burden on family and carers can last for many years and increase their morbidity and stress. Consequently, the committee judged that assessment that aims to improve family and carers' experience are likely to represent good value for money.
Quality of evidence	The quality of the evidence was mostly very low. The outcomes were downgraded because it was unclear how they randomised, if allocation concealment was performed or if participants were blinded. In some, not all, assessors were blinded. High dropout rates were also detected in some groups >20%. Imprecision was detected in most outcomes due to the 95% confidence interval crossing one or two MID's or because it did not meet the optimal information size. Outcomes were not always measured at the end of treatment or at follow up. It is not known if any improvements in the carer's general psychopathology also translated to benefits in the children with the eating disorder.
Other considerations	Given the very low quality of the data with very few positive findings favouring one arm over the other, the committee came to the consensus that there was not enough evidence to support a recommendation on any specific treatment for parents or carers of people with an eating disorder. See the LETR in Section 6.3 for further discussion of carer interventions.

1 8.4 Pharmacological interventions

2 8.4.1 Review question: Does any pharmacological intervention produce 3 benefits/harms on specified outcomes in people with eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 273. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all pharmacological interventions that may be delivered to children,
9 young people and adults with an eating disorder with or without a psychological intervention.
10 The interventions were categorised according to the type of pharmacological intervention, the
11 age of the participants and the type of eating disorder. In addition, the interventions were
12 grouped according to their type of therapy and were compared to placebo, wait list controls
13 TAU or any other intervention.

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Table 273: Clinical review protocol summary

Component	Description
Review question(s)	Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	<ul style="list-style-type: none"> • Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). • Strata: <ul style="list-style-type: none"> ○ children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years ○ eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Pharmacological interventions may include:</p> <ul style="list-style-type: none"> • Antidepressants, e.g. SSRIs, fluoxetine (Prozac) • Anxiolytics (antianxiety) • Antipsychotics • Antiemetic medication, e.g. ondansetron • Antiepileptic/anticonvulsant, e.g. topiramate (Topomax) • Appetite suppressant, e.g. lisdexamfetamine dimesylate <p>Pharmacological in combination with any psychological intervention</p>
Comparison	<ul style="list-style-type: none"> • Placebo • Wait list control • Treatment as usual • Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN • Adverse events
Important outcomes	<ul style="list-style-type: none"> • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Relapse • Resource use • Quality of life • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

2 8.4.2 Clinical evidence

3 23 RCTs (n=2544) met the eligibility criteria for this review (Arnold et al., 2002; Grilo et al.,
4 2005b; Grilo et al., 2012; Guerdjikova et al., 2008; Guerdjikova et al., 2009; Guerdjikova et
5 al., 2012; Hudson et al., 1998; McElroy et al., 2000; McElroy et al., 2003a; McElroy et al.,
6 2007a; McElroy et al., 2013; McElroy et al., 2011; McElroy et al., 2015a; McElroy et al.,

1 2007b; McElroy et al., 2003b; McElroy et al., 2015b; McElroy et al., 2016; McElroy et al.,
2 2006; Molinari et al., 2005; Ricca et al., 2001a; White and Grilo, 2013). All of the studies
3 were in adults and the majority of participants were obese females. The majority of studies
4 examined the efficacy of antidepressants versus placebo in treating binge eating disorder
5 and used flexible rather than fixed doses.

6 Eight studies (n=470) compared an antidepressant with placebo (Arnold 2002, Grilo
7 2005/2012, Guerdjikova 2008, Guerdjikova 2012, Hudson 1998, McElroy, Hudson &
8 Malhotra 2003, McElroy 2000, White 2013). Two studies (n=150; Leombruni 2008, Ricca
9 2001) compared one antidepressant with another, fluoxetine with sertraline and fluvoxamine,
10 respectively.

11 Two studies (n=173) compared an antidepressant with individual therapy (Molinari 2005,
12 Ricca 2001). Four studies (n=579), all of which used obese participants, compared an
13 antiepileptic with placebo (Guerdjikova 2009, McElroy & Arnold 2003, McElroy 2006, McElroy
14 & Hudson 2007).

15 Three studies (n=1033) compared an appetite suppressant, lisdexamfetamine dimesylate, a
16 dextroamphetamine prodrug approved for the treatment of ADHD in children, with placebo
17 (McElroy et al., 2015b; McElroy et al., 2016). McElroy & Hudson 2016 examined the efficacy
18 of fixed doses of 30, 50 and 70 mg with placebo. The two studies reported in McElroy &
19 Hudson 2016 used flexible doses, starting from 30 mg/day and increasing up to 70 mg/day if
20 tolerated and clinically needed. Two studies (n=109) compared a substance abuse treatment
21 agent with placebo (McElroy et al., 2011; McElroy et al., 2013).

22 Two studies were found that did not fit the above categories (McElroy et al., 2007a; McElroy
23 et al., 2015a). McElroy & Guerdjikova 2007 (n=40) compared atomoxetine, a norepinephrine
24 reuptake inhibitor, with placebo. McElroy & Guerdjikova 2015 (n=60) compared armodafinil,
25 an active isomer of modafinil, with placebo.

26 **8.4.2.1 Combined pharmacological and psychological interventions**

27 Six studies (n=434) were identified that compared a combined pharmacological and
28 psychological intervention with any other intervention (Brambilla et al., 2009; Claudino et al.,
29 2007; Cristina et al., 2014; Grilo et al., 2005b; Grilo et al., 2012; Grilo et al., 2005a; Molinari
30 et al., 2005; Ricca et al., 2001b). The majority of the participants were adult females. Three
31 of the 6 studies (n=203) examined adjunctive antidepressant treatment to CBT with CBT
32 alone (Cristina 2014, Molinari 2005, Ricca 2001). One study (n=108) compared fluoxetine
33 and CBT-ED with placebo and CBT-ED (Grilo 2005; Grilo 2012). Two studies (n=138)
34 compared a combined antidepressant and CBT intervention with another combined
35 antidepressant and CBT intervention (Cristina 2014, Ricca 2001). One study (n=73)
36 compared an antiepileptic combined with group CBT-ED with placebo and group CBT-ED
37 (Claudino 2007). One study (n=30) compared adjunctive topiramate treatment to sertraline,
38 1700 kcal diet and Group CBT with sertraline, 1700 kcal diet and Group CBT only (Brambilla
39 2009). One study (n=50) compared a combined antiobesity agent orlistat and guided self-
40 help CBT-ED with placebo and guided self-help CBT-ED (Grilo & Masheb 2005).

41 An overview of the trials included in the meta-analysis can be found in Table 274. Summary
42 of findings tables can be found in Table 285, Table 286, Table 287, Table 288, Table 289,
43 Table 290, Table 291, Table 292, Table 293 and Table 294. See also the study selection flow
44 chart in Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and
45 exclusion list in Appendix J.

1 **Table 274: Study information for trials included in the meta-analysis of a pharmacological intervention versus placebo, wait list**
2 **control, or another intervention for adults with binge eating disorder.**

Study ID	N Randomized	Female (%)	Mean BMI (kg/m ²) or Weight (kg)	Sample	Type(s) of pharmacological intervention	Intervention Age at onset and/or duration of illness (years)	Max dose/day of intervention	Duration (weeks)	Comparison(s) Age at onset and/or duration of illness (years)	Duration or max dose/day of comparison(s)
Arnold 2002	60	93	BMI=38.1 (7.0)	DSM-IV	AD - SSRI	Fluoxetine Duration of illness: 19.9 (12.5)	80 mg	6	Placebo Duration of illness: 16.7 (9.5)	na
Brambilla 2009	30	100	BMI=35.7 (6.0)	DSM-IV and obesity	AD – SSRI, AE,	Sertraline + Topiramate + Group CBT-ED + 1700 kcal Diet Duration of illness: 15 (10)	150 mg for both	26	Sertraline + Group CBT-ED + 1700 kcal diet Duration of illness: 9 (5) Group CBT-ED Duration of illness: 13 (6)	150 mg
Claudino 2007	73	96	BMI=37.4 (4.2)	DSM-IV-TR with obesity	AE	Topiramate + Group CBT-ED	200 mg	21	Placebo + Group CBT-ED	na
Cristina 2014	30	Not reported	Not reported	Not reported	AD – SSRI, SNRI	Paroxetine + CBT-ED	Not reported	52	1. CBT-ED 2. Venlafaxine + CBT-ED	2. not reported
Grilo & Masheb 2005	50	88	Not reported	DSM-IV BED with obesity	AO	Orlistat + Guided Self-Help CBT-ED	360 mg	12	Placebo + Guided Self-Help CBT-ED	na
Grilo 2005/2012	108	78	BMI=36.3 (7.9)	DSM-IV	AD - SSRI	Fluoxetine Age at onset: 24.5 (11.9)	60 mg	16	Placebo Age at onset: 23.8 (19) Fluoxetine (SSRI) + CBT-ED Age at onset: 22.4 (13)	60 mg

Study ID	N Randomized	Female (%)	Mean BMI (kg/m ²) or Weight (kg)	Sample	Type(s) of pharmacological intervention	Intervention Age at onset and/or duration of illness (years)	Max dose/day of intervention	Duration (weeks)	Comparison(s) Age at onset and/or duration of illness (years)	Duration or max dose/day of comparison(s)
									Placebo + CBT-ED Age at onset: 25.9 (18.1)	
Guerdjikova 2008	44	98	BMI=40.20 (5.8)	DSM-IV with obesity	AD - SSRI	Escitalopram	30 mg	12	Placebo	na
Guerdjikova 2009	51	76	BMI=40.1 (6.5)	DSM-IV with obesity	AE	Lamotrigine Age at onset: 29.77 (16.06)	200 mg	16	Placebo Age at onset: 21.4 (15.3)	na
Guerdjikova 2012	40	88	BMI=40.6 (7.4)	DSM-IV with comorbid depressive disorder	AD - SNRI	Duloxetine	120 mg	12	Placebo	na
Hudson 1998	85	91	BMI=35. (7.3)	Draft criteria for DSM-IV BED	AD - SSRI	Fluvoxamine	300 mg	9	Placebo	na
Leombruni 2008	42	100	BMI=39.3 (3.5)	DSM-IV with obesity	AD - SSRI	Fluoxetine	80 mg	24	Sertraline	200 mg
McElroy 2000	34	94	BMI=36.1 (7.3)	DSM-IV	AD - SSRI	Sertraline	200 mg	6	Placebo	na
McElroy & Arnold 2003	61	87	BMI=43.1 (6.9)	DSM-IV-TR with obesity	AE	Topiramate	600 mg	14	Placebo	na
McElroy 2006	60	88	BMI=41.7 (8.6)	DSM-IV-TR with obesity	AE	Zonisamide Duration of illness: 19 (13.8)	600 mg	16	Placebo Duration of illness: 17.9 (12.9)	na
McElroy & Guerdjikova 2007	40	83	BMI=39.4 (7.8)	DSM-IV-TR	NRI	Atomoxetine	120 mg	10	Placebo	na

Study ID	N Randomized	Female (%)	Mean BMI (kg/m ²) or Weight (kg)	Sample	Type(s) of pharmacological intervention	Intervention Age at onset and/or duration of illness (years)	Max dose/day of intervention	Duration (weeks)	Comparison(s) Age at onset and/or duration of illness (years)	Duration or max dose/day of comparison(s)
McElroy & Hudson 2007	407	86	BMI=38.5 (5.3)	DSM-IV with obesity	AE	Topiramate Age at onset: 25.4 (13.5) Duration of illness: 18.6 (14.3)	400 mg	16	Placebo Age at onset: 23.9 (14.3) Duration of illness: 20.6 (14.5)	na
McElroy 2011	40	85	BMI=39.5 (0.3)	DSM-IV-TR	SATA	Acamprosate	2997 mg	10	Placebo	na
McElroy 2013	69	90	BMI=39.0 (5.8)	DSM-IV-TR with obesity	SATA	ALK-33 (Samidorphan)	10 mg	6	Placebo	na
McElroy & Guerdjikova 2015	60	85	BMI=40.1 (8.0)	DSM-IV TR + EDE-Q	WPA	Armodafinil	250 mg	10	Placebo	na
McElroy & Hudson 2015	260	82	BMI=34.9 (5.3)	DSM-IV-TR	AS	Lisdexamfetamine dimesylate	30, 50 or 70 mg	11	Placebo	na
McElroy 2016 Study 1	383	86	BMI=33.5 (6.3)	DSM-IV-TR + CGI-S≥4	AS	Lisdexamfetamine dimesylate	70 mg	12	Placebo	na
McElroy 2016 Study 2	390	80	BMI=33.5 (6.3)	DSM-IV-TR + CGI-S≥4	AS	Lisdexamfetamine dimesylate	70 mg	12	Placebo	na
Molinari 2005	65	Not reported	BMI=38.4 (3.8) (n=60)	DSM-IV	AD - SSRI	Fluoxetine	60 mg	54	CBT Fluoxetine + CBT	60 mg
Ricca 2001	108	59	BMI=32.3 (5.8)	DSM-IV	AD - SSRI	Fluoxetine Duration of illness: 5.1 (4.1)	60 mg	24	CBT-ED Duration of illness: 6.4 (6) Fluvoxamine Duration of illness: 5.3 (4.8)	300 mg 60 mg 300 mg

Study ID	N Randomized	Female (%)	Mean BMI (kg/m ²) or Weight (kg)	Sample	Type(s) of pharmacological intervention	Intervention Age at onset and/or duration of illness (years)	Max dose/day of intervention	Duration (weeks)	Comparison(s) Age at onset and/or duration of illness (years)	Duration or max dose/day of comparison(s)
									Fluoxetine (SSRI) + CBT-ED Duration of illness: 4.9 (5.1) Fluvoxamine + CBT-ED Duration of illness: 4.8 (4.4)	
White 2013	61	100	BMI=35.8 (6.8)	DSM-IV-TR, overweight and obese	AD - NDRI	Bupropion	300 mg	8	Placebo	na

- 1 Abbreviations: AD, antidepressant; AE, antiepileptic/anticonvulsant; AO, antiobesity; AS, appetite suppressant; BED, Binge Eating Disorder; BMI, Body Mass Index; CBT, Cognitive Behavioural Therapy; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revision; na, not available; NRI, Norepinephrine Reuptake Inhibitor; NDRI, Norepinephrine-Dopamine Reuptake Inhibitor; SATA, substance abuse treatment agent; SSRI, Selective Serotonin Reuptake Inhibitor; SNRI, Serotonin-Norepinephrine Reuptake Inhibitor.

5 Table 275: Summary of table for antidepressants compared to placebo at the end of treatment in adults with BED

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antidepressants (95% CI)
Remission ≥2 weeks assessment period (e.g. EDE OBE)	199 (4 studies) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4,5,6} due to risk of bias, indirectness, imprecision	RR 1.39 (0.92 to 2.09)	270 per 1000	105 more per 1000 (from 22 fewer to 294 more)
Binge Frequency binge episodes/week or month, binge days/week	196 (4 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4,5,7} due to risk of bias, indirectness, imprecision		Not calculable for	The mean binge frequency in the intervention groups was 0.18 standard deviations lower (0.42 lower to 0.06 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antidepressants (95% CI)
				SMD values	
BMI or Weight	379 (8 studies)	⊕⊕⊕⊕ VERY LOW1,2,3,4,5,7,8,9,10,11,12,13 due to risk of bias, inconsistency, indirectness, imprecision, publication bias		Not calculable for SMD values	The mean bmi or weight in the intervention groups was 0.06 standard deviations lower (0.33 lower to 0.21 higher)
Withdrawn due to Adverse Events	255 (5 studies)	⊕⊕⊕⊕ VERY LOW2,3,5,7,8,9,10,13 due to risk of bias, indirectness, imprecision, publication bias	RR 2.35 (0.91 to 6.08)	32 per 1000	43 more per 1000 (from 3 fewer to 161 more)
EDE-Q Global Scale from: 0 to 6.	115 (2 studies)	⊕⊕⊕⊕ LOW1,4,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global in the intervention groups was 0.03 standard deviations higher (0.34 lower to 0.39 higher)
EDE-Q Dietary Restraint Scale from: 0 to 6.	115 (2 studies)	⊕⊕⊕⊕ VERY LOW1,4,12,14 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-q dietary restraint in the intervention groups was 0.07 standard deviations higher (0.51 lower to 0.66 higher)
EDE-Q Eating Concerns Scale from: 0 to 6.	115 (2 studies)	⊕⊕⊕⊕ LOW1,4,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concerns in the intervention groups was 0.15 standard deviations higher (0.22 lower to 0.52 higher)
EDE-Q Weight Concerns Scale from: 0 to 6.	115 (2 studies)	⊕⊕⊕⊕ LOW1,4,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concerns in the intervention groups was 0.1 standard deviations higher (0.27 lower to 0.46 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antidepressants (95% CI)
EDE-Q Shape Concerns Scale from: 0 to 6.	115 (2 studies)	⊕⊕⊕⊖ LOW1,4,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concerns in the intervention groups was 0.11 standard deviations lower (0.47 lower to 0.26 higher)
Depression HRSD, BDI, IDS-C	382 (8 studies)	⊕⊕⊕⊖ VERY LOW1,2,3,4,5,7,8,9,10,11,13 due to risk of bias, indirectness, imprecision, publication bias		Not calculable for SMD values	The mean depression in the intervention groups was 0.2 standard deviations lower (0.4 lower to 0.01 higher)
Clinical Global Impressions - Severity of Illness Scale from: 1 to 7.	267 (6 studies)	⊕⊕⊕⊖ VERY LOW2,3,5,6,8,9,10,11,13 due to risk of bias, indirectness, imprecision, publication bias		Not calculable for SMD values	The mean clinical global impressions - severity of illness in the intervention groups was 0.71 standard deviations lower (0.96 to 0.46 lower)
Clinical Global Impressions - Severity of Illness for depressive disorders Scale from: 1 to 7.	38 (1 study)	⊕⊕⊕⊖ VERY LOW3,5,6 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean clinical global impressions - severity of illness for depressive disorders in the intervention groups was 0.51 standard deviations lower (1.16 lower to 0.14 higher)
Clinical Global Impressions - Improvement of Illness for depressive disorders Scale from: 1 to 7.	38 (1 study)	⊕⊕⊕⊖ VERY LOW3,5,6 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean clinical global impressions - improvement of illness for depressive disorders in the intervention groups was 0.54 standard deviations lower (1.19 lower to 0.11 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

1 Grilo 2005/2012: Randomization method and allocation concealment unclear. Assessor blinding unclear. Intervention group dropout rate>20%.

2 Guerdjikova 2008: Randomisation method unclear. Intervention group dropout rate>20%.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antidepressants (95% CI)
<p>3 Guerdjikova 2012: Duloxetine group significantly older than placebo group. Randomization method unclear. Dropout rate for both groups>20%. 4 White 2013: Randomization method and allocation concealment unclear. Assessor blinding unclear. 5 Population for Guerdjikova 2012 were BED patients with comorbid depressive disorder. 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD). 7 <300 events (dichotomous outcome) or <400 participants (continuous outcome). 8 Hudson 1998: fluvoxamine group had significantly higher number of patients with lifetime history of major depression. Randomization method and allocation concealment unclear. Intervention group dropout rate>20%. 9 McElroy and Hudson 2003: Randomisation method and allocation concealment unclear. Assessor blinding unclear. Dropout rate for both groups>20%. 10 Arnold 2002: Randomization method and allocation concealment unclear. Assessor blinding unclear. Dropout rate for both groups>20%. 11 McElroy 2000: Randomization method and allocation concealment unclear. Assessor blinding unclear. Intervention group dropout rate>20%. 12 I²>50%. 13 One study (Hudson 1998) published before 2000. 14 CI crosses both 0.5 and -0.5 (SMD).</p>					

1 Table 276: Summary of table for antidepressant-1 versus antidepressant-2 at end of treatment in adults with BED

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with	Risk difference with Antidepressant-1 v Antidepressant-2 (95% CI)
Binge Frequency Mean binge episodes/month	43 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.33 standard deviations higher (0.27 lower to 0.94 higher)
BMI	31 (1 study)	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.40 standard deviations lower (1.11 lower to 0.31 higher)
#>5% Weight Loss	37 (1 study)	⊕⊖⊖⊖ VERY LOW3,4 due to risk of bias, imprecision	RR 1.05 (0.52 to 2.1)	450 per 1000	22 more per 1000 (from 216 fewer to 495 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with	Risk difference with Antidepressant-1 v Antidepressant-2 (95% CI)
Withdrawn due to Adverse Events	43 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 0.52 (0.11 to 2.56)	182 per 1000	87 fewer per 1000 (from 162 fewer to 284 more)
# Binge Eating Scale score < 17	39 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4} due to risk of bias, imprecision	RR 0.91 (0.44 to 1.88)	455 per 1000	41 fewer per 1000 (from 255 fewer to 400 more)
Binge Eating Scale	31 (1 study)	⊕⊕⊕⊕ LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.32 standard deviations higher (0.39 lower to 1.03 higher)
EDI-2 Drive for Thinness	31 (1 study)	⊕⊕⊕⊕ LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 drive for thinness in the intervention groups was 0.26 standard deviations lower (0.97 lower to 0.45 higher)
EDI-2 Bulimia	31 (1 study)	⊕⊕⊕⊕ LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 bulimia in the intervention groups was 0.24 standard deviations higher (0.46 lower to 0.95 higher)
EDI-2 Body Dissatisfaction	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi-2 body dissatisfaction in the intervention groups was 0.1 standard deviations lower (0.81 lower to 0.6 higher)
Depression	31 (1 study)	⊕⊕⊕⊕ LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.24 standard deviations lower (0.95 lower to 0.47 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with	Risk difference with Antidepressant-1 v Antidepressant-2 (95% CI)
Clinical Global Impression - Severity of Illness	31 (1 study)	⊕⊕⊖⊖ LOW2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical global impression - severity of illness in the intervention groups was 0.32 standard deviations higher (0.39 lower to 1.03 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Ricca 2001: inadequate randomization method, treatment allocation unclear. No participant, investigator nor assessor blinding. Dropout rate of both treatment groups >20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 Leombruni 2008: Randomization method and allocation concealment unclear. Investigator and assessor blinding unclear. Dropout rate both groups >20%, reasons not stated.					
4 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).					

1 **Table 277: Summary of table for antidepressant-1 versus antidepressant-2 at follow up in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with	Risk difference with Antidepressant-1 v Antidepressant-2 (95% CI)
Binge Frequency 12-mo FU	32 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency 12-mo fu in the intervention groups was 1.17 standard deviations higher (0.41 to 1.93 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Ricca 2001: inadequate randomization method, treatment allocation unclear. No participant, investigator nor assessor blinding. Dropout rate of both treatment groups >20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 **Table 278: Summary of table for antidepressant versus another intervention at end of treatment in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any individual therapy	Risk difference with Antidepressants (95% CI)
Binge Frequency Mean binge episodes/month	103 (2 studies) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4,5} due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 2.57 standard deviations higher (2.02 to 3.13 higher)
% Weight Loss	40 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean % weight loss in the intervention groups was 2.26 standard deviations lower (3.07 to 1.45 lower)
EDI-2 Bulimia	40 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi-2 bulimia in the intervention groups was 2.52 standard deviations higher (1.67 to 3.38 higher)
Depression MMPI-2 Depression	40 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 1.17 standard deviations higher (0.5 to 1.85 higher)
Family Functioning MMPI-2 Family Problems	40 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,4,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean family functioning in the intervention groups was 0.14 standard deviations higher (0.48 lower to 0.76 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Ricca 2001: Randomization method inadequate (allocated to treatment groups enrolment day, allocation concealment unclear. No participant, investigator, assessor blinding. Dropout rate for both arms>20%.

2 Molinari 2005: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear.

3 I2>=50%.

4 Molinari 2005: both Fluoxetine+CBT and CBT only groups also had Group Nutritional Counselling + Diet.

5 <400 participants.

6 CI crosses either 0.5 or -0.5 (SMD).

1 **Table 279: Summary of table for antidepressant versus another intervention at follow up in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any CBT	Risk difference with Antidepressants (95% CI)
Binge Frequency FU Mean binge episodes/month	49 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 3.08 standard deviations higher (2.19 to 3.97 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; FU: Follow up					
1 Ricca 2001: Randomization method inadequate (allocated to treatment groups enrolment day, allocation concealment unclear. No participant, investigator, assessor blinding. Dropout rate for both arms >20%.					
2 <400 participants.					

2 **Table 280: Summary of table for antiepileptics/anticonvulsants versus placebo in adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antiepileptics (95% CI)
Remission	111 (2 studies)	⊕⊕⊕⊖ VERY LOW1,2,3,4 due to risk of bias, inconsistency, imprecision	RR 0.88 (0.62 to 1.25)	564 per 1000	68 fewer per 1000 (from 214 fewer to 141 more)
Binge Frequency binge episodes/week or binge days/week	111 (2 studies)	⊕⊕⊕⊖ LOW1,2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.23 standard deviations lower (0.49 lower to 0.03 higher)
Withdrawn due to Adverse Events	573 (4 studies)	⊕⊕⊕⊖ LOW1,2,4,5,6 due to risk of bias, imprecision	RR 1.94 (1.22 to 3.08)	83 per 1000	78 more per 1000 (from 18 more to 173 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antiepileptics (95% CI)
BMI	565 (4 studies)	⊕⊕⊕⊕ LOW1,2,4,5,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.45 standard deviations lower (0.62 to 0.29 lower)
EDE-Q Global	51 (1 study)	⊕⊕⊕⊕ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global in the intervention groups was 0.44 standard deviations lower (0.99 lower to 0.12 higher)
EDE-Q Restraint	51 (1 study)	⊕⊕⊕⊕ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q restraint in the intervention groups was 0.12 standard deviations lower (0.67 lower to 0.43 higher)
EDE-Q Weight Concerns	51 (1 study)	⊕⊕⊕⊕ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concerns in the intervention groups was 0.48 standard deviations lower (1.04 lower to 0.08 higher)
EDE-Q Eating Concerns	51 (1 study)	⊕⊕⊕⊕ VERY LOW2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concerns in the intervention groups was 0.03 standard deviations lower (0.58 lower to 0.51 higher)
EDE-Q Shape Concerns	51 (1 study)	⊕⊕⊕⊕ LOW2,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concerns in the intervention groups was 0.48 standard deviations lower (1.04 lower to 0.08 higher)
Depression	565 (4 studies)	⊕⊕⊕⊕ LOW1,2,3,5,6 due to risk of bias, inconsistency		Not calculable for SMD values	The mean depression in the intervention groups was 0.07 standard deviations higher (0.1 lower to 0.23 higher)
Clinical Global Impressions - Severity of Illness	172 (3 studies)	⊕⊕⊕⊕ VERY LOW1,2,3,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean clinical global impressions - severity of illness in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Antiepileptics (95% CI)
					0.65 standard deviations lower (0.83 to 0.47 lower)
General functioning Sheehan Disability Scale Total	445 (2 studies)	⊕⊕⊕⊖ MODERATE ^{2,6} due to risk of bias		Not calculable for SMD values	The mean general functioning in the intervention groups was 0.24 standard deviations lower (0.43 to 0.05 lower)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 McElroy 2006: Randomization method and allocation concealment unclear. Dropout rate for both groups >20%. 2 Guerdjikova 2009: Randomization method unclear. Dropout rate for both groups >20%. 3 I ² >50%. 4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD). 5 McElroy and Arnold 2003: Randomization method and allocation concealment unclear. Dropout rate for both groups >20%. 6 McElroy and Hudson 2007: Randomization method and allocation concealment unclear. Dropout rate for both groups >20%. 7 CI crosses both 0.5 and -0.5 (SMD).					

1 **Table 281: Summary of table for appetite suppressants (lisdexamfetamine dimesylate) versus placebo in adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Appetite Suppressants (95% CI)
Remission (ITT) 100% reduction binge episodes in past 4 weeks	1032 (3 studies)	⊕⊕⊕⊖ MODERATE ^{1,2} due to risk of bias	RR 2.6 (2.02 to 3.36)	138 per 1000	220 more per 1000 (from 141 more to 325 more)
BMI (change scores)	983 (3 studies)	⊕⊕⊖⊖ LOW ^{1,2,3} due to risk of bias, inconsistency		Not calculable for SMD values	The mean bmi (change scores) in the intervention groups was 1.24 standard deviations lower (1.51 to 0.98 lower)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Appetite Suppressants (95% CI)
Withdrawn due to Adverse Events	1004 (3 studies)	⊕⊕⊖⊖ LOW1,2,4 due to risk of bias, imprecision	RR 2.05 (1.01 to 4.18)	21 per 1000	22 more per 1000 (from 0 more to 66 more)
Binge Eating Scale from: 0 to 46.	255 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 4.11 standard deviations lower (4.59 to 3.63 lower)
Depression MADRS. Scale from: 0 to 60.	255 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.28 standard deviations higher (0.01 lower to 0.57 higher)
General Physical Functioning SF-12 Physical. Scale from: 0 to 100.	255 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean general physical functioning in the intervention groups was 0.27 standard deviations higher (0.01 lower to 0.56 higher)
General Mental Functioning SF-12 Mental. Scale from: 0 to 100.	255 (1 study)	⊕⊕⊖⊖ LOW1,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean general mental functioning in the intervention groups was 0.03 standard deviations higher (0.26 lower to 0.32 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

1 McElroy 2015: Dropout rate for all arms $\geq 20\%$.

2 McElroy and Hudson 2016 Study 1 and 2: unclear whether assessor blinded. McElroy and Hudson 2016 Study 2: dropout rate for both groups $\geq 20\%$.

3 I² $> 50\%$.

4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

5 < 300 events (dichotomous outcome) or < 400 participants (continuous outcome).

1 **Table 282: Summary of table for substance abuse treatment agents versus placebo in adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Substance Abuse Treatment Agents (95% CI)
Remission	109 (2 studies)	⊕⊕⊕⊖ LOW1,2,3 due to risk of bias, imprecision	RR 0.72 (0.42 to 1.24)	404 per 1000	113 fewer per 1000 (from 234 fewer to 97 more)
BMI (raw and change scores)	86 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,3,4 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.22 standard deviations lower (0.66 lower to 0.22 higher)
Weight (raw and change scores)	86 (2 studies)	⊕⊕⊕⊖ LOW1,2,5 due to risk of bias, imprecision		Not calculable for SMD values	The weight in the intervention groups was 0.05 standard deviations lower (0.48 lower to 0.38 higher)
Binge episode Frequency Mean binge episodes/week (raw and change scores)	86 (2 studies)	⊕⊕⊕⊖ LOW1,2,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge episode frequency in the intervention groups was 0.15 standard deviations lower (0.58 lower to 0.28 higher)
Binge Day Frequency binge days/week (raw and change scores)	86 (2 studies)	⊕⊕⊕⊖ LOW1,2,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge day frequency in the intervention groups was 0.07 standard deviations higher (0.36 lower to 0.5 higher)
Withdrawn due to Adverse Event	108 (2 studies)	⊕⊖⊖⊖ VERY LOW1,2,4,5 due to risk of bias, inconsistency, imprecision	RR 10.69 (2.13 to 53.57)	18 per 1000	170 more per 1000 (from 20 more to 922 more)
Depression MADRS	24 (1 study)	⊕⊕⊕⊖ VERY LOW2,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.08 standard deviations lower (0.9 lower to 0.75 higher)
Depression – change scores BDI	62 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression – change scores in the intervention groups was 0.43 standard deviations higher (0.08 lower to 0.95 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Substance Abuse Treatment Agents (95% CI)
General physical functioning SF-12 Physical	24 (1 study)	⊕⊕⊕⊖ VERY LOW ^{2,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean general physical functioning in the intervention groups was 0.25 standard deviations higher (0.58 lower to 1.08 higher)
General mental functioning SF-12 Mental	24 (1 study)	⊕⊕⊕⊖ LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean general mental functioning in the intervention groups was 0.39 standard deviations higher (0.45 lower to 1.22 higher)
Clinical Global Impressions - Severity of Illness	86 (2 studies)	⊕⊕⊕⊖ LOW ^{1,2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical global impressions - severity of illness in the intervention groups was 0.17 standard deviations higher (0.26 lower to 0.61 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 McElroy 2013: Unclear randomization method and treatment allocation. Intervention group dropout rate ≥ 50%.

2 McElroy 2011: Unclear randomization method. Dropout rate for both groups > 20%.

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4 I² > 80%.

5 < 300 events (dichotomous outcome) or < 400 participants (continuous outcome).

1 Table 283: Summary of table for atomoxetine versus placebo in adults with BED

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Atomoxetine (95% CI)
Remission 100% decrease frequency binge episodes from baseline	40 (1 study)	⊕⊕⊕⊖ LOW ^{1,2} due to risk of bias, imprecision	RR 2.33 (1.13 to 4.83)	316 per 1000	420 more per 1000 (from 41 more to 1000 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo	Risk difference with Atomoxetine (95% CI)
BMI	40 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI or weight in the intervention groups was 0.74 standard deviations lower (1.38 to 0.1 lower)
Weight loss (kg)	40 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (kg) in the intervention groups was 0.77 standard deviations higher (0.12 to 1.41 higher)
Binge Frequency Binge episodes/week or binge days/week	40 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.72 standard deviations lower (1.17 to 0.27 lower)
Withdrawn due to Adverse Events	40 (1 study)	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision	RR 3 (0.34 to 26.45)	50 per 1000	100 more per 1000 (from 33 fewer to 1000 more)
Depression HDRS	40 (1 study)	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.05 standard deviations higher (0.57 lower to 0.67 higher)
Clinical Global Impressions - Severity of Illness	40 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical global impressions - severity of illness in the intervention groups was 1.1 standard deviations lower (1.77 to 0.44 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 McElroy 2007: Randomization method and allocation concealment unclear. Dropout rate for both arms >20%.

2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

3 CI crosses both 0.5 and -0.5.

1 **Table 284: Summary of table for armodafinil versus placebo in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Armodafinil v Placebo (95% CI)
Remission	55 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.21 (0.47 to 3.14)	214 per 1000	45 more per 1000 (from 114 fewer to 459 more)
BMI - Change scores	55 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI - change scores in the intervention groups was 0.67 standard deviations lower (1.22 to 0.13 lower)
Withdrawn due to adverse events	60 (1 study)	⊕⊕⊕⊕ LOW ^{1,4} due to risk of bias, imprecision	RR 1 (0.15 to 6.64)	67 per 1000	0 fewer per 1000 (from 57 fewer to 376 more)
Binge Frequency - Change scores	55 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency - change scores in the intervention groups was 0.46 standard deviations lower (0.84 to 0.09 lower)
Clinical Global Impressions Severity - Change scores	55 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean clinical global impressions severity - change scores in the intervention groups was 0.49 standard deviations lower (1.03 lower to 0.04 higher)
Depression - Change scores	55 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - change scores in the intervention groups was 0.01 standard deviations higher (0.52 lower to 0.54 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 McElroy & Guerdjikova 2015: Dropout rate of both groups >=47%.

2 CI crosses both 0.75 and 1.25 (Risk Ratio), or 0.5 and -0.5 (SMD).

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or 0.5 or -0.5 (SMD).

4 <300 events.

1 **Table 285: Summary table of findings for antidepressant and CBT-ED versus CBT-ED at end of treatment in adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT	Risk difference with Antidepressant+CBT (95% CI)
Binge Frequency	105 (2 studies) 12 months	⊕⊕⊕⊕ VERY LOW1,2,3,4,5 due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.14 standard deviations higher (0.6 lower to 0.89 higher)
% Weight Loss	40 (1 study)	⊕⊕⊕⊕ VERY LOW2,4,6 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean % weight loss in the intervention groups was 0.2 standard deviations lower (0.82 lower to 0.43 higher)
EDI-2 Bulimia	40 (1 study)	⊕⊕⊕⊕ VERY LOW2,4,7 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi-2 bulimia in the intervention groups was 1.25 standard deviations higher (0.57 to 1.94 higher)
Not withdrawn due to Adverse Events	105 (2 studies) 12 months	⊕⊕⊕⊕ VERY LOW1,2,4,7 due to risk of bias, indirectness, imprecision	RR 0.92 (0.84 to 1.02)	1000 per 1000	80 fewer per 1000 (from 160 fewer to 20 more)
Binge Eating Scale Scale from: 0 to 46.	30 (1 study) 12 months	⊕⊕⊕⊕ LOW6,8 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.42 standard deviations lower (1.19 lower to 0.35 higher)
Depression MMPI-2 Depression	70 (2 studies) 12 months	⊕⊕⊕⊕ VERY LOW2,3,4,6,8 due to risk of bias, inconsistency, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.18 standard deviations higher (0.31 lower to 0.68 higher)
Family Functioning MMPI-2 family problems	40 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW2,4,6		Not calculable for	The mean family functioning in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT	Risk difference with Antidepressant+CBT (95% CI)
		due to risk of bias, indirectness, imprecision		SMD values	0.28 standard deviations higher (0.34 lower to 0.91 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio;</p> <p>1 Ricca 2001: Inadequate randomization method. Allocation concealment unclear. No participant, investigator and assessor blinding. Dropout rate of four of five groups >20%.</p> <p>2 Molinari 2005: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear.</p> <p>3 I2 >50%.</p> <p>4 Molinari 2005: Treatment was carried out in both in-patient (4 weeks) and out-patient setting (50 weeks); both Fluoxetine+CBT and CBT only groups also had Group Nutritional Counselling + Diet.</p> <p>5 CI crosses both 0.5 and -0.5 (SMD).</p> <p>6 CI crosses either 0.5 or -0.5 (SMD).</p> <p>7 <300 events (dichotomous outcome) or <400 participants (continuous outcome).</p> <p>8 Cristina 2014: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear. No details provided regarding dropouts.</p>					

1 **Table 286: Summary table of findings for antidepressant and CBT-ED versus CBT-ED at follow up in adults with BED**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT	Risk difference with Antidepressant+CBT (95% CI)
Binge Frequency FU	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 4.42 standard deviations lower (5.53 to 3.3 lower)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval;</p>					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT	Risk difference with Antidepressant+CBT (95% CI)
1 Ricca 2001: Inadequate randomization method. Allocation concealment unclear. No participant, investigator and assessor blinding. Dropout rate of four of five groups >20%.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 287: Summary table of findings for antidepressant and CBT-ED versus placebo and CBT-ED at end of treatment in adults with**
2 **BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+CBT	Risk difference with Antidepressant+CBT (95% CI)
Remission EDE-Q No OBE/28 days	54 (1 study) 12 months	⊕⊕⊕⊖ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.08 (0.67 to 1.73)	536 per 1000	43 more per 1000 (from 177 fewer to 391 more)
BMI	54 (1 study) 12 months	⊕⊕⊕⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.1 standard deviations higher (0.43 lower to 0.63 higher)
Binge Frequency Mean binge episodes/month	54 (1 study) 12 months	⊕⊕⊕⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.33 standard deviations higher (0.21 lower to 0.87 higher)
EDE-Q Global	54 (1 study) 12 months	⊕⊕⊕⊖ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global in the intervention groups was 0.08 standard deviations higher (0.46 lower to 0.61 higher)
EDE-Q Dietary Restraint	54 (1 study) 12 months	⊕⊕⊕⊖ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q dietary restraint in the intervention groups was 0 standard deviations higher (0.53 lower to 0.53 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+CBT	Risk difference with Antidepressant+CBT (95% CI)
EDE-Q Eating Concerns	54 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concerns in the intervention groups was 0.19 standard deviations lower (0.73 lower to 0.34 higher)
EDE-Q Weight Concerns	54 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concerns in the intervention groups was 0.16 standard deviations lower (0.69 lower to 0.38 higher)
EDE-Q Shape Concerns	54 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concerns in the intervention groups was 0.06 standard deviations lower (0.6 lower to 0.47 higher)
Depression BDI	54 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.38 standard deviations higher (0.16 lower to 0.92 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Grilo 2005/2012: randomization method and allocation concealment unclear. Assessor blinding unclear. Dropout rate of three of four groups >20%.					
2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).					
3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 Table 288: Summary table of findings for antidepressant and CBT-ED versus placebo and CBT-ED at follow up in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+CBT	Risk difference with Antidepressant+CBT (95% CI)
Remission FU EDE-Q No OBE/28 days	54 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 0.75 (0.34 to 1.69)	357 per 1000	89 fewer per 1000 (from 236 fewer to 246 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+CBT	Risk difference with Antidepressant+CBT (95% CI)
BMI FU	41 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.43 standard deviations higher (0.19 lower to 1.05 higher)
Binge Frequency FU Mean binge episodes/month	41 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0 standard deviations higher (0.61 lower to 0.62 higher)
EDE-Q Global FU	41 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q global fu in the intervention groups was 0.29 standard deviations lower (0.91 lower to 0.33 higher)
EDE-Q Dietary Restraint FU	41 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q dietary restraint fu in the intervention groups was 0.36 standard deviations lower (0.98 lower to 0.26 higher)
EDE-Q Eating Concerns FU	41 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concerns fu in the intervention groups was 0.04 standard deviations lower (0.65 lower to 0.58 higher)
EDE-Q Weight Concerns FU	41 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concerns fu in the intervention groups was 0.32 standard deviations lower (0.94 lower to 0.3 higher)
EDE-Q Shape Concerns FU	41 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concerns fu in the intervention groups was 0.45 standard deviations lower (1.07 lower to 0.17 higher)
Depression FU BDI	41 (1 study)	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.04 standard deviations lower (0.65 lower to 0.58 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+CBT	Risk difference with Antidepressant+CBT (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Grilo 2005/2012: randomization method and allocation concealment unclear. Assessor blinding unclear. Dropout rate of three of four groups >20%.					
2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).					
3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 **Table 289: Summary table of findings for antidepressant-1 and CBT-ED versus antidepressant-2 and CBT-ED at end of treatment in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant-2+CBT	Risk difference with Antidepressant-1+CBT (95% CI)
Binge Frequency Binge episodes/month	45 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.5 standard deviations lower (1.09 lower to 0.1 higher)
Withdrawn due to Adverse Events	45 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision	RR 1.05 (0.24 to 4.64)	130 per 1000	7 more per 1000 (from 99 fewer to 475 more)
Binge Eating Scale	20 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW3,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.25 standard deviations higher (0.63 lower to 1.13 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Ricca 2001: Randomization method inadequate. Allocation concealment unclear. No participant, investigator and assessor blinding. Dropout rate for groups all >20%.					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant-2+CBT	Risk difference with Antidepressant-1+CBT (95% CI)
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).					
4 Cristina 2014: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear. No details provided regarding dropouts.					

1 **Table 290: Summary table of findings for antidepressant-1 and CBT-ED versus antidepressant-2 and CBT-ED at follow up in adults with BED.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant-2+any CBT	Risk difference with Antidepressant-1+any CBT (95% CI)
Binge Frequency FU Binge episodes/month	34 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0.34 standard deviations lower (1.01 lower to 0.34 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Ricca 2001: Randomization method inadequate. Allocation concealment unclear. No participant, investigator and assessor blinding. Dropout rate for groups all >20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

3 **Table 291: Summary table of findings for antiepileptic and group CBT-ED versus placebo and group CBT-ED in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+gCBT-ED	Risk difference with Antiepileptic+gCBT-ED (95% CI)
BMI	56 (1 study)	⊕⊕⊖⊖ LOW1,2		Not calculable for SMD values	The mean BMI in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+gCBT-ED	Risk difference with Antiepileptic+gCBT-ED (95% CI)
		due to risk of bias, imprecision			0.41 standard deviations lower (0.94 lower to 0.12 higher)
# patients achieving Weight Loss>10%	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 3.18 (0.99 to 10.17)	115 per 1000	252 more per 1000 (from 1 fewer to 1000 more)
Not withdrawn due to Adverse Events	73 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	RR 0.97 (0.9 to 1.05)	1000 per 1000	30 fewer per 1000 (from 100 fewer to 50 more)
Binge Eating Scale	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.17 standard deviations lower (0.69 lower to 0.36 higher)
Depression BDI	56 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.24 standard deviations higher (0.29 lower to 0.77 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Claudino 2007: topiramate group significantly older and report more depression than placebo group. Dropout rate for placebo group>20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 <300 events (dichotomous outcome).					

1 **Table 292: Summary table of findings for antidepressant, antiepileptic, group behavioural weight loss therapy and group CBT versus**
2 **antidepressant, group behavioural weight loss therapy and group CBT in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Antidepressant+gBWLT+gCBT	Risk difference with Antidepressant+Antiepileptic+gBWLT+gCBT+ (95% CI)
BMI	20 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi in the intervention groups was 0.41 standard deviations higher (0.48 lower to 1.29 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Brambilla 2009: Randomization method and allocation concealment unclear. Weight and BMI significantly higher at baseline in 1700kcal Group BWLT+Topiramate+Sertraline+CBT group compared to 1700kcal Group BWLT+Sertraline+CBT group.					
2 CI crosses either 0.5 or -0.5.					

3 **Table 293: Summary table of findings for antiobesity agent and guided self-help CBT-ED versus placebo and guided self-help CBT-ED**
4 **in adults with binge eating disorder at end of treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED (95% CI)
Remission (ITT)	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.78 (0.98 to 3.24)	360 per 1000	281 more per 1000 (from 7 fewer to 806 more)
Binge frequency EDE OBE in past 28 days	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.07 standard deviations lower (0.63 lower to 0.48 higher)
Weight loss>=5% (ITT)	50 (1 study)	⊕⊕⊖⊖ LOW1,2	RR 4.5 (1.08 to 18.77)	80 per 1000	280 more per 1000 (from 6 more to 1000 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED (95% CI)
		due to risk of bias, imprecision			
Weight loss (kg)	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (kg) in the intervention groups was 0.62 standard deviations higher (0.05 to 1.19 higher)
Mean percentage weight loss	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean percentage weight loss in the intervention groups was 0.58 standard deviations higher (0.01 to 1.15 higher)
EDE Global	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.34 standard deviations lower (0.9 lower to 0.22 higher)
EDE Dietary restraint	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede dietary restraint in the intervention groups was 0.05 standard deviations higher (0.5 lower to 0.61 higher)
EDE Eating concern	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.1 standard deviations lower (0.65 lower to 0.46 higher)
EDE Weight concern	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.21 standard deviations lower (0.77 lower to 0.34 higher)
EDE Shape concern	50 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.39 standard deviations lower (0.95 lower to 0.17 higher)
Depression BDI	50 (1 study)	⊕⊕⊕⊕ LOW1,2		Not calculable	The mean depression in the intervention groups was 0.54 standard deviations lower (1.11 lower to 0.02 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED (95% CI)
		due to risk of bias, imprecision		for SMD values	
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Grilo, Masheb & Salent 2005: high risk of bias (unclear allocation concealment, dropout rate of both groups >=20%).					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 **Table 294: Summary table of findings for antiobesity agent and guided self-help CBT-ED versus placebo and guided self-help CBT-ED**
2 **in adults with binge eating disorder at follow up**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Antiobesity+gSH CBT v Placebo+gSH CBT at 3-mo FU (95% CI)
Remission (ITT)	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1 (0.59 to 1.7)	520 per 1000	0 fewer per 1000 (from 213 fewer to 364 more)
Binge frequency EDE OBE in past 28 days	50 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.1 standard deviations higher (0.46 lower to 0.65 higher)
Weight loss >=5% (ITT)	50 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision	RR 4 (0.94 to 17)	80 per 1000	240 more per 1000 (from 5 fewer to 1000 more)
Weight loss (kg)	50 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (kg) in the intervention groups was 0.5 standard deviations higher (0.07 lower to 1.06 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Antiobesity+gSH CBT v Placebo+gSH CBT at 3-mo FU (95% CI)
Mean percentage weight loss	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean percentage weight loss in the intervention groups was 0.48 standard deviations higher (0.09 lower to 1.04 higher)
EDE Global	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.09 standard deviations lower (0.65 lower to 0.46 higher)
EDE Dietary restraint	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede dietary restraint in the intervention groups was 0.15 standard deviations lower (0.71 lower to 0.4 higher)
EDE Eating concern	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.07 standard deviations lower (0.63 lower to 0.48 higher)
EDE Weight concern	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.08 standard deviations higher (0.47 lower to 0.64 higher)
EDE Shape concern	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.07 standard deviations lower (0.62 lower to 0.49 higher)
Depression BDI	50 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.47 standard deviations lower (1.03 lower to 0.09 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with Antiobesity+gSH CBT v Placebo+gSH CBT at 3-mo FU (95% CI)
1 Grilo, Masheb & Salent 2005: high risk of bias (unclear allocation concealment, dropout rate of both groups $\geq 20\%$). 2 CI crosses both 0.75 and 1.25 (Risk Ratio). 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

- 1
- 2
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1 **8.4.3 Economic evidence**

2 The systematic search of the economic literature undertaken for the guideline identified:

- 3 • One US study on the cost utility of lisdexamfetamine dimesylate (LDX) in adults with binge
4 eating disorder in the US (Agh et al., 2016).

5 References to included studies and evidence tables for all economic evaluations included in
6 the systematic literature review are provided in Appendix P. Completed methodology
7 checklists of the studies are provided in Appendix O. Economic evidence profiles of studies
8 considered during guideline development (that is, studies that fully or partly met the
9 applicability and quality criteria) are presented in Appendix Q.

10 Agh and colleagues (2016) evaluated the cost utility of LDX compared with no drug treatment
11 in adults with BED in the US. BED population comprised women with mild, moderate and
12 severe and extreme binge eating behaviour. This was a modelling study (a decision
13 analytical Markov cohort model). Treatment with LDX (50 or 70 mg/day) was for 12 weeks.
14 The analysis was conducted from a health care perspective and considered a range of costs
15 including drug treatment, general internist, family doctor, psychiatrist, psychologist,
16 psychotherapist, nurse practitioner, gynaecologist, emergency room and hospital
17 admissions. The effectiveness data was from 2 RCTs (RCT 1, N=383; RCT 2, N=390;
18 McElroy 2015) and the resource use was obtained from a national survey (N=22,397). The
19 unit costs were obtained from a national source (Medical Expenditure Panel Survey). The
20 measure of outcome for the economic analysis was QALYs. Utility values were based on the
21 EQ-5D-5L individual patient level data of the clinical trials (McElroy 2015) and were valued
22 using US population norms. The time horizon of the analysis was 52 weeks.

23 Treatment with LDX resulted in a greater number of QALYs at 52 weeks compared with no
24 drug treatment (0.917 versus 0.911, respectively; a difference of 0.006). The mean total
25 costs per participant over 52 weeks were \$7,042 for the LDX and \$6,867 for no drug
26 treatment, a difference of \$175 (in favour of no drug treatment group) in 2013 US dollars.
27 The ICER of LDX when compared with no treatment was \$27,618 per QALY gained.
28 Bootstrapping indicated that at willingness-to-pay of \$50,000 per QALY LDX had an 82%
29 chance of being cost-effective.

30 Deterministic sensitivity analyses indicated that the model was most sensitive to the utility of
31 remission (that is, non-symptomatic BED). The results were robust to changes in other model
32 inputs.

33 The analysis was judged by the committee to be partially applicable to the NICE decision-
34 making context, as it has been conducted in the US. This was a well conducted study and
35 was judged by the committee to have only minor methodological limitations.

36 **8.4.4 Clinical evidence statements**

37 **8.4.4.1 Antidepressants versus placebo in adults with BED**

38 Very low quality evidence from four RCTs (n=199) showed antidepressants are more
39 effective on increasing remission compared with placebo but there was some uncertainty.

40 Very low quality from four RCTs (n=196) showed antidepressants are more effective on
41 binge frequency compared with placebo but there was some uncertainty.

42 Very low quality evidence from eight RCTs (n=379) showed no difference in the effect of
43 antidepressants on BMI/weight compared with placebo.

- 1 Very low quality evidence from five RCTs (n=255) showed antidepressants increase the
2 number of number who withdrew due to adverse effects compared with placebo but there
3 was some uncertainty.
- 4 Very low to low quality evidence from two RCTs (n=115) showed no difference in the effect of
5 antidepressants on EDE-global, EDE-dietary restraint, EDE-eating concerns, EDE-weight
6 concerns and EDE-shape concerns compared with placebo.
- 7 Very low quality evidence from eight RCTs (n=382) showed antidepressants are more
8 effective on depression compared with placebo, but there was some uncertainty.
- 9 Very low quality evidence from six RCTs (n=267) showed antidepressants are more effective
10 on reducing the severity of BED compared with placebo.
- 11 Very low quality evidence from one RCT (n=38) showed no difference in the effect of
12 antidepressants on reducing the severity of, and ameliorating, comorbid depressive disorders
13 compared with placebo.
- 14 **8.4.4.2 Antidepressant-1 versus antidepressant-2 at end of treatment in adults with BED**
- 15 Low quality evidence from one RCT (n=43) showed no difference in the effect of one
16 antidepressant (fluoxetine) on binge frequency and the number of people who withdrew from
17 the RCTs due to adverse events compared with another antidepressant (fluvoxamine).
- 18 Low quality evidence from one RCT (n=31) showed no difference in the effect of one
19 antidepressant (fluoxetine) on BMI, binge eating scale, EDI-2-drive for thinness, EDI-2-
20 bulimia, EDI-2-body dissatisfaction, depression and severity of illness compared with another
21 antidepressant (sertraline).
- 22 Very low quality evidence from one RCT (n=37) showed no difference in the effect of one
23 antidepressant (fluoxetine) on the number of people who achieved $\geq 5\%$ weight loss
24 compared with another antidepressant (sertraline).
- 25 Very low quality evidence from one RCT (n=39) showed no difference in the effect of one
26 antidepressant (fluoxetine) on the number of people who achieved a binge eating scale score
27 < 17 compared with another antidepressant (sertraline).
- 28 **8.4.4.3 Antidepressant-1 versus antidepressant-2 at follow up in adults with BED**
- 29 Low quality evidence from one RCT (n=32) showed one antidepressant (fluoxetine) is less
30 effective on binge frequency compared with another antidepressant (fluvoxamine).
- 31 **8.4.4.4 Antidepressant versus any other intervention at end of treatment in adults with BED**
- 32 Very low quality evidence from two RCTs (n=103) showed antidepressants are less effective
33 at reducing binge frequency compared with any other intervention.
- 34 Very low quality evidence from one RCT (n=40) showed antidepressants are less effective
35 on weight loss, improving scores on EDI-2-bulimia and reducing depression compared with
36 any other intervention.
- 37 Very low quality evidence from one RCT (n=40) showed no difference in the effect of
38 antidepressants on family functioning compared with any other intervention.
- 39 **8.4.4.5 Antidepressant versus any other intervention at follow up in adults with BED**
- 40 Low quality evidence from one RCT (n=49) showed antidepressants are less effective in
41 reducing binge frequency compared with any other intervention.

1 **8.4.4.6 Antiepileptics (anticonvulsants) versus placebo in adults with binge eating disorder**

2 Very low quality evidence from two RCTs (n=111) showed no difference in the effect of
3 antiepileptics/anticonvulsants on remission compared with placebo.

4 Low quality evidence from two RCTs (n=111) showed antiepileptics/anticonvulsants are more
5 effective in reducing binge frequency compared with placebo but there was some
6 uncertainty.

7 Low quality evidence from four RCTs (n=573) showed that antiepileptics/anticonvulsants
8 increased the number who withdrew due to adverse effects compared with those who took
9 placebo.

10 Low quality evidence from four RCTs (n=565) showed antiepileptics/anticonvulsants are
11 more effective on BMI compared with placebo.

12 Low quality evidence from four RCTs (n=565) showed no difference in the effect of
13 antiepileptics/anticonvulsants on depression compared with placebo.

14 Very low to low quality evidence from one RCT (n=51) showed no difference in the effect of
15 antiepileptics/anticonvulsants on EDE-Q-global, EDE-Q-dietary restraint and EDE-Q-eating
16 concerns compared with placebo.

17 Low quality evidence form one RCT (n=51) showed antiepileptics/anticonvulsants are more
18 effective in reducing scores on EDE-Q-weight concerns and EDE-Q-shape concerns
19 compared with placebo but there was some uncertainty.

20 Very low quality evidence from three RCTs (n=172) showed antiepileptics/anticonvulsants
21 are more effective on reducing the severity of BED compared with placebo.

22 Moderate quality evidence from two RCTs (n=445) showed antiepileptics/anticonvulsants are
23 more effective in improving general functioning compared with placebo.

24 **8.4.4.7 Appetite suppressants (lisdexamfetamine dimesylate) versus placebo in adults with**
25 **binge eating disorder**

26 Moderate quality of evidence from three RCTs (n=1032) showed appetite suppressants are
27 more effective in increasing remission compared with placebo.

28 Low quality evidence from three RCTs (n=983) showed appetite suppressants are more
29 effective in increasing change in BMI compared with placebo.

30 Low quality evidence from three RCTs (n=1004) showed that more people who took appetite
31 suppressants withdrew from the studies due to adverse effects compared to those taking
32 placebo.

33 Low quality evidence from one RCT (n=255) showed appetite suppressants are more
34 effective in reducing binge eating scores compared with placebo.

35 Low quality evidence from one RCT (n=255) showed appetite suppressants are less effective
36 on depression compared with placebo, although there was some uncertainty.

37 Low quality evidence from one RCT (n=255) showed appetite suppressants are more
38 effective in improving general physical functioning compared with placebo, although there
39 was some uncertainty.

40 Low quality evidence from one RCT (n=255) showed no difference in the effect of appetite
41 suppressants in improving general mental functioning compared with placebo.

1 **8.4.4.8 Substance abuse treatment agents versus placebo in adults with binge eating**
2 **disorder**

3 Very low quality evidence from two RCTs (n=109) showed no difference in the effect of
4 substance abuse treatment agents on remission compared with placebo.

5 Very low quality evidence from two RCTs (n=86) showed no difference in the effect of
6 substance abuse treatment agents in reducing BMI and Weight compared with placebo.

7 Low quality evidence from two RCTs (n=86) showed no difference in the effect of substance
8 abuse treatment agents in reducing binge episode, binge day frequency and the severity of
9 BED compared to placebo.

10 Very low quality evidence from one RCT (n=62) showed substance abuse treatment agents
11 are less effective on depression compared to placebo but there was some uncertainty.

12 Very low quality evidence from two RCTs (n=108) showed that more people who took
13 substance abuse treatment agents withdrew due to adverse effects compared with those
14 who took placebo.

15 Very low to low quality evidence from one RCT (n=24) showed no difference in the effect of
16 substance abuse treatment agents on general mental health or physical functioning
17 compared to placebo.

18 **8.4.4.9 Other pharmacological interventions**

19 **Atomoxetine (norepinephrine reuptake inhibitor) versus placebo in adults with BED**

20 Low quality evidence from one RCT (n=40) showed that atomoxetine is more effective on
21 remission, BMI, weight loss, and binge frequency and severity of binge eating disorder
22 compared with placebo.

23 Very low quality evidence from one RCT (n=40) showed no difference in the number of
24 people who withdrew due to adverse effects compared with those who took placebo.

25 Very low quality evidence from one RCT (n=40) showed no difference in the effect of
26 atomoxetine on depression compared with placebo.

27 **Armodafinil versus placebo in adults with BED**

28 Very low quality evidence from one RCT (n=55 to 60) showed no difference in the effect of
29 armodafinil on remission, depression and the number who withdrew due to adverse effects
30 compared with placebo.

31 Low quality evidence from one RCT (n=55) showed armodafinil is more effective in reducing
32 BMI and binge frequency compared with placebo.

33 Low quality of evidence from one RCT (n=55) showed armodafinil is more effective on
34 severity of binge eating disorder compared with placebo, although there was some
35 uncertainty.

36 **8.4.4.10 Combined pharmacological and psychological interventions**

37 **Antidepressants and CBT-ED versus CBT-ED in adults with BED at end of treatment**

38 Very low quality evidence from two RCTs (n=105) showed no difference in the effect of
39 antidepressant and CBT-ED on binge frequency compared with CBT-ED alone.

40 Very low quality evidence from one RCT (n=40) showed no difference in the effect of
41 antidepressant and CBT-ED on weight loss and family functioning compared with CBT-ED
42 alone.

1 Very low quality evidence from one RCT (n=40) showed antidepressant and CBT-ED is less
2 effective on EDI-2-bulimia compared with CBT-ED alone.

3 Very low quality evidence from two RCTs (n=105) showed antidepressant and CBT-ED
4 increase the number who withdraw due to adverse events compared with CBT-ED alone, but
5 there was some uncertainty.

6 Very low quality evidence from two RCTs (n=70) showed no difference in the effect of
7 antidepressant and CBT-ED on depression compared with CBT-ED alone.

8 **Antidepressants and CBT-ED versus CBT-ED in adults with BED at follow up**

9 Low quality evidence from one RCT (n=50) showed antidepressant and CBT is more
10 effective on binge frequency compared with CBT-ED alone.

11 **Antidepressant and CBT-ED versus placebo and CBT-ED in adults with BED at end of 12 treatment**

13 Very low to low quality evidence from one RCT (n=54) showed no difference in the effect of
14 antidepressants and CBT-ED on remission, BMI, binge frequency, EDE-Q-global, EDE-Q-
15 dietary restraint, EDE-Q-eating concerns, EDE-Q-weight concerns, EDE-Q-shape concerns
16 and depression compared with placebo and CBT-ED.

17 **Antidepressant and CBT-ED versus placebo and CBT-ED in adults with BED at follow 18 up**

19 Very low quality evidence from one RCT (n=54) showed no difference in the effect of
20 Antidepressants and CBT-ED on remission compared with placebo and CBT-ED.

21 Very low to low quality evidence from one RCT (n=41) showed no difference in the effect of
22 antidepressants and CBT-ED, BMI, binge frequency, EDE-Q-global, EDE-Q-dietary restraint,
23 EDE-Q-eating concerns, EDE-Q-weight concerns, EDE-Q-shape concerns and depression
24 compared with placebo and CBT-ED.

25 **Antidepressant-1 and CBT-ED versus antidepressant-2 and CBT-ED in adults with 26 BED at end of treatment**

27 Low quality evidence from one RCT (n=45) showed no difference in the effect of one
28 antidepressant and CBT-ED on binge frequency compared with another antidepressant and
29 CBT-ED.

30 Very low quality evidence from one RCT (n=45) showed one antidepressant and CBT-ED
31 may be less effective on the number of people who withdrew from the RCT due to adverse
32 events score compared with another antidepressant and CBT-ED, although there was some
33 uncertainty.

34 Very low quality evidence from one RCT (n=20) showed no difference in the effect of one
35 antidepressant and CBT-ED on binge eating scale score compared with another
36 antidepressant and CBT-ED.

37 **Antidepressant-1 and CBT-ED versus antidepressant-2 and CBT-ED in adults with 38 BED at follow up**

39 Low quality evidence from one RCT (n=34) showed no difference in the effect of one
40 antidepressant and CBT-ED on binge frequency compared with another antidepressant and
41 CBT-ED.

42 **Antiepileptics and group CBT-ED versus placebo and group CBT-ED in adults with 43 BED**

1 Low quality evidence from one RCT (n=56) showed no difference in the effect of
2 antiepileptics and group CBT-ED on BMI, binge eating score and depression compared with
3 placebo and group CBT-ED.

4 Low quality evidence from one RCT (n=56) showed antiepileptics and group CBT-ED
5 increase the number who achieve more than 10% weight loss compared with placebo and
6 group CBT-ED, although there was some uncertainty.

7 Very low quality from one RCT (n=73) showed antiepileptics and group CBT-ED increase the
8 number who withdraw due to adverse effects compared with placebo and group CBT-ED, but
9 there was some uncertainty.

10 **Antidepressant, antiepileptic, group behavioural weight loss therapy and group CBT** 11 **versus antidepressant, group behavioural weight loss therapy and group CBT**

12 Low quality evidence from one RCT (n=20) showed no difference in the effect of
13 antidepressant, antiepileptic, group behavioural weight loss therapy and group CBT on BMI
14 compared with a combined antidepressant, group behavioural weight loss therapy and group
15 CBT.

16 **Antiobesity agent and guided self-help CBT-ED versus placebo and guided self-help** 17 **(CBT-ED) in adults with binge eating disorder at end of treatment**

18 Low quality evidence from one RCT (n=50) showed an antiobesity agent and guided self-
19 help CBT-ED is more effective on remission and depression compared with placebo and
20 guided self-help CBT-ED but there was some uncertainty.

21 Low quality evidence from one RCT (n=50) showed antiobesity agent and guided self-help
22 CBT-ED is more effective on number of people losing 5% or more weight, weight loss and
23 mean percentage weight loss compared with placebo and guided self-help CBT-ED.

24 Low quality evidence from one RCT (n=50) showed no difference in the effect of antiobesity
25 agent and guided self-help CBT-ED on binge frequency, EDE-global, EDE-dietary restraint,
26 EDE-eating concern, EDE-weight concern and EDE-shape concern compared with placebo
27 and guided self-help CBT-ED.

28 **Antiobesity agent and guided self-help CBT-ED versus placebo and guided self-help** 29 **(CBT-ED) in adults with binge eating disorder at follow up**

30 Low quality evidence from one RCT (n=50) showed no difference in the effect of antiobesity
31 agent and guided self-help CBT-ED on remission, binge frequency, EDE-global, EDE-dietary
32 restraint, EDE-eating concern, EDE-weight concern and EDE-shape concern compared with
33 placebo and guided self-help CBT-ED.

34 Low quality evidence from one RCT (n=50) showed an antiobesity agent and guided self-
35 help CBT-ED is more effective on the number of people who lost 5% or more weight, weight
36 loss, mean percentage weight loss and depression compared with placebo and guided self-
37 help CBT-ED but there was some uncertainty.

38 **8.4.5 Economic evidence statements**

39 The existing economic evidence on pharmacological interventions for people with binge
40 eating disorder was very limited and not directly applicable to the NICE decision-making
41 context. The reviewed modelling study found that lisdexamfetamine dimesylate was
42 potentially cost effective when compared with no drug treatment in the US. However, this
43 drug is not licensed for the use in the UK. The reviewed study was characterised by minor
44 methodological limitations.

1 Generally, the data on pharmacological interventions for people with BED was very scarce
2 with very small numbers randomised. Pharmacological interventions showed no benefit in
3 the NMA conducted for this guideline and they were not considered in the economic model.
4 Details on the methods used for the systematic search of the economic literature are
5 described in Chapter 3. Details and findings of the NMA are provided in the Appendix R.

6 8.4.6 Recommendations and link to evidence

7 Medication for binge eating disorder

138. Do not offer medication as the sole treatment for binge eating disorder.	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of pharmacotherapies for treating binge eating disorder. For this population, it was agreed binge eating frequency and remission were of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>In adults with binge eating disorder, antidepressants versus placebo showed little effect on the critical outcomes remission or binge eating frequency. There was also no difference EDE-global, EDE-subcales and a trend to reduce depression but there was some uncertainty. Global severity of illness favoured antidepressant, but more people withdrew due to adverse events. There was also no difference in the severity of comorbid depressive disorders. No evidence was found on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>A head-to-head of two different antidepressants showed no difference in binge frequency at the end of treatment. All other outcomes also showed no difference between the two arms including: body weight or BMI, binge frequency, binge eating scale, EDE-subcales, depression or global severity of illness. At 12 months' follow up binge frequency favoured fluvoxamine over fluoxetine. No other outcomes were reported. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>When antidepressants are compared with another intervention (CBT-ED), the results mostly favoured CBT-ED for binge frequency, weight loss, depression and EDI-2 Bulimia. Family functioning showed no difference. At 12 months' follow up, binge frequency favoured CBT-ED over antidepressants. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, cost effectiveness, resource use, and service user experience.</p> <p>When an antiepileptic was compared with placebo no difference was found in remission rates and only a trend to reduce binge frequency (there was some uncertainty No difference was found in EDE-total, EDE-restraint, EDE-eating</p>

concern and depression and a trend to improve EDE-weight concern and EDE-shape concern (but there was some uncertainty). No evidence was found on the important outcomes of quality of life, all-cause mortality, relapse, family functioning, cost effectiveness, resource use, and service user experience.

Appetite suppressants (lisdexamphetamine) showed favourable results compared with placebo on remission, change in BMI and binge eating. There was also a trend of improvement in general physical functioning (though there was some uncertainty) in the appetite suppressant group, but no difference on general mental functioning. However, more people withdrew due to adverse events, and there was a trend towards higher depression scores in the appetite suppression arm compared with placebo. No evidence was found on the important outcomes of quality of life, all-cause mortality, relapse, cost effectiveness, resource use, and service user experience.

Substance abuse treatment agents appeared to be less effective on remission (though there was some uncertainty) but have no effect on binge eating, BMI, weight, depression, global severity of illness and general function compared with placebo. More participants withdrew due to adverse events in the active treatment arm. No evidence was found on the important outcomes of quality of life, all-cause mortality, relapse, family functioning, cost effectiveness, resource use, and service user experience.

Comparing a norepinephrine reuptake inhibitor (atomoxetine) with placebo in adults with binge eating disorder showed it may benefit remission, binge eating, loss in body weight and global severity of illness. No difference in depression or the number who withdrew due to adverse events. No evidence was found on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.

Armodafinil showed some benefit on reducing BMI, but had no effect on remission compared with placebo. There was a trend for it to improve binge frequency and global impressions severity, but it had no effect on depression nor withdrawals due to adverse events. No evidence was found on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.

Combining antidepressants with CBT-ED and comparing it with CBT-ED alone showed very little difference in any of the outcomes at the end of treatment. Binge frequency and binge eating scale were similar, as was depression, weight loss and adverse events. EDI-2 bulimia favoured CBT-ED alone. At 12 months' follow up, binge frequency was reduced in the combined treatment arm compared with CBT-ED alone. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, cost effectiveness, resource use, and service user experience.

When antidepressants are combined with CBT-ED and compared with CBT-ED but this time with a placebo, the results again showed very little difference between the two groups at the end of treatment. The outcomes included remission, binge frequency, BMI, EDE-global, EDE-subscales, general psychopathology and depression. The same results were found at 12 months' follow up. No evidence was found on the critical outcome of adverse events, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.

Comparing two different antidepressants combined with CBT-ED showed no difference in any of the outcomes between the two treatment groups at the end of

	<p>treatment or at follow up. The antidepressants compared included: fluoxetine versus fluvoxamine and paroxetine and venlafaxine. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>No differences were found between antiepileptics and group CBT-ED compared with placebo and group CBT-ED on binge eating, weight and depression. There was a trend to favour the number of people who achieved weight loss exceeding 10%. More people also withdrew due to adverse events although there was some uncertainty. No evidence was found on the critical outcome of remission, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>No difference was found on weight between antidepressants combined with an antiepileptic, CBT-ED and diet compared with an antidepressant, CBT and diet. The only difference between the two arms was the antiepileptic treatment and thus it appears to have no effect. No evidence was found on the critical outcomes of remission and adverse events, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, general psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>An anti-obesity agent (orlistat, a lipase inhibitor) combined with guided self-help CBT-ED compared with placebo and guided self-help CBT-ED showed no difference in remission rates and depression at the end of treatment but there was some uncertainty. However, more people lost weight if they were taking the antiobesity agent. No difference was found on EDE-subcales or binge frequency.</p> <p>At follow up, no difference between the groups was found in any of the outcomes. There was a trend for greater weight loss in those who were also taking the antiobesity agent but there was some uncertainty. No evidence was found on the critical outcome of adverse events, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p>
Trade-off between net health benefits and resource use	<p>There was little evidence for the effectiveness of pharmacological treatments for people with BED. As a result, the committee expressed the view that such treatments are also likely to be not cost-effective. There was some positive economic evidence on lisdexamphetamine. However, this drug is not licenced for the use in the UK. Also, there is a lack of data suggesting that the drug effect is enduring and as such it was not recommended for people with BED.</p>
Quality of evidence	<p>The evidence for pharmacological interventions for binge eating disorder was mostly of very low quality. The evidence was downgraded for risk of bias for reasons including a lack of detail regarding randomisation method, allocation concealment, and whether the participants, investigators or assessors were blinded.</p> <p>For many comparisons only one or two studies were available with few participants. Imprecision was often detected because the 95% confidence interval crossed one or two MIDs or the outcome did not meet the optimal information size.</p>
Other considerations	<p>There were few treatments that showed positive results on both remission and binge eating at the end of treatment and follow up. And follow up data was not</p>

<p>always reported thus making it difficult for the committee to ascertain the long-term effects.</p> <p>Appetite suppressants appeared to show positive results on remission and weight loss at the end of treatment, however depression and general functioning appeared to favour the placebo arm at the end of treatment. No data was available at follow up.</p> <p>No evidence of drug treatment for children and young people with binge eating disorder was identified.</p> <p>In conclusion, due to the few studies identified for each comparison and the generally small sample sizes, the committee agreed that the evidence was not strong enough to recommend any of the drug treatments as the sole treatment for binge eating disorder.</p>

1 8.5 Nutritional interventions

2 8.5.1 Review question: Does any nutritional intervention produce benefits/harms on 3 specified outcomes in people with eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 295. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all nutritional interventions that may be delivered to children, young
9 people and adults with an eating disorder with or without a pharmacological intervention. The
10 interventions were categorised according to type of nutritional intervention, the age of the
11 participants and the type of eating disorder. In addition, the interventions were grouped
12 according to their type of therapy and were compared to wait list controls, placebo, TAU or
13 any other intervention.

14 **Table 295: Clinical review protocol summary**

Component	Description
Review question(s)	Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	<ul style="list-style-type: none"> • Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> • children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years • eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<ul style="list-style-type: none"> • Nutritional intervention • Method of feeding • Nutritional in combination with any pharmacological intervention • Examples of nutritional interventions are nutritional counselling (with or without educational and supportive groups) and supplements (e.g. zinc)
Comparison	<ul style="list-style-type: none"> • Placebo • Wait list control • Treatment as usual

Component	Description
	<ul style="list-style-type: none"> • Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 8.5.2 Clinical evidence

2 13 studies (n=1217) met the eligibility criteria for this review, all of which were in adults
3 (Agras et al., 1994b; Barnes et al., 2014; Devlin et al., 2005; Golay et al., 2005; Goodrick et
4 al., 1998; Grilo and Masheb, 2005; Masheb and Grilo, 2007; Grilo et al., 2011; Grilo and
5 White, 2013; Hilbert et al., 2015; Masheb et al., 2011; Munsch et al., 2007; Nauta et al.,
6 2000; Nauta et al., 2001; Reeves et al., 2001; Wilson et al., 2010). The majority of studies
7 were in females and used individual or group behavioural weight loss therapy, which involves
8 a substantial exercise component. In this sense, these studies can be considered combined
9 interventions as they are not restricted to purely nutritional components. An overview of the
10 trials included in the meta-analysis can be found in Table 296. Further information about both
11 included and excluded studies can be found in Appendix J.

12 Eight studies (n=943) met the eligibility criteria for nutritional interventions compared with any
13 other intervention, all of which were in adults (Barnes 2014; Goodrick 1998, Grilo
14 2005/Masheb 2007, Grilo 2011, Munsch 2007, Nauta 2000/2001, Reeves 2001, Wilson
15 2010/Hilbert 2015).

16 Six of the 13 studies (n=531) investigated the effectiveness of a nutritional treatment with
17 another treatment compared with another intervention or wait list controls, some of which
18 provided a number of different pairwise comparisons. Combined nutritional interventions
19 included behavioural weight loss therapy and online motivational interviewing (Barnes 2014),
20 CBT-ED with either general nutritional counselling or low energy density diet (Masheb 2011),
21 an antidepressant fluoxetine with group behavioural weight control therapy (Devlin 2005), an
22 antidepressant fluoxetine with CBT-ED and group behavioural weight control therapy (Agras
23 1994) and an antiobesity agent orlistat with either behavioural weight loss therapy (Grilo
24 2013) or a mild hypocaloric diet (Golay 2005).

1 Summary of findings for those on binge eating disorder can be found in Table 297, Table
2 298, Table 299, Table 300, Table 301, Table 302, Table 303, Table 304, Table 305, Table
3 306, Table 307, Table 308, Table 309, Table 310, Table 311, Table 312, Table 313, Table
4 314, Table 315, Table 316, Table 317, Table 318 and Table 319, Table 321 and Table 322.
5 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
6 evidence tables in Appendix L and exclusion list in Appendix J.

1 **Table 296: Study information for trials included in the meta-analysis of nutritional interventions versus any other intervention, wait list control or TAU for adults with binge eating disorder.**
2

Study ID	N randomised	Female (%)	Mean BMI (SD), kg/m ²	Sample	Type of nutritional intervention	Intervention	Comparison	Duration
Agras 1994	108	100	38.6 (6.6)	Adult BED	Diet	CBT then Weight Loss Therapy + Desipramine	CBT then Weight Loss Therapy Weight Loss Therapy	9 months + 3-mo FU
Barnes 2014	89	76	35.3 (7.0)	Overweight and obese adults (BMI 25-55 kg/m ²) with and without BED	Diet/Nutritional Counselling	Behavioural Weight Loss Therapy + Online Motivational Interviewing	Online Nutritional Counselling TAU	12 weeks + 3-mo FU
Devlin 2005	116	78	40.9 (6.9)	Adult BED ≥6 months	Group Diet	Group Behavioural Weight Control Therapy + Fluoxetine + CBT-ED	Group Behavioural Weight Control Therapy + Fluoxetine Group Behavioural Weight Control Therapy + Placebo Group Behavioural Weight Control Therapy + Placebo + CBT-ED	20 weeks
Golay 2005	89	91	36.5 (4.5)	Adult BED with obesity	Diet	Individualized hypocaloric diet + Orlistat (360 mg/day)	Individualized hypocaloric diet + placebo	24 weeks
Goodrick 1998	219	100	33.0 (3.3)	Adult 14-41 kgs overweight based on 1983 MLIC Height/Weight tables; BES score>21	Diet/Nutritional Counselling	Group Dieting Treatment	Group Nutritional Counselling WLC	6 months + 12-mo FU

Study ID	N randomised	Female (%)	Mean BMI (SD), kg/m ²	Sample	Type of nutritional intervention	Intervention	Comparison	Duration
Grilo 2005/ Masheb 2007	90	79	35.5 (6.7)	Adult BED, BMI>27 kg/m ²	Diet	Guided Self-Help Behavioural Weight Loss Therapy	Guided Self-Help CBT-ED Guided Self-Help	12 weeks
Grilo 2011	125	67	38.8 (5.8)	Adult BED with obesity	Group Diet	Group Behavioural Weight Loss Therapy Age at onset: 44.6 (10.5)	Group CBT-ED Group CBT-ED then Group Behavioural Weight Loss Therapy	6 months
Grilo 2013	79	78	38.1 (6.2)	Adult BED with obesity	Diet	Behavioural Weight Loss treatment (adapted Diabetes Prevention Program) + Orlistat (320mg/day)	Behavioural Weight Loss treatment (adapted Diabetes Prevention Program) + Placebo	4 months + 6 months FU
Masheb 2011	50	76	39.1 (6.6)	Adult BED	Diet	Low-Energy Density Diet + CBT-ED Age at onset: 25.4 (12.2)	General Nutritional Counselling + CBT-ED Age at onset 23.1 (11.6)	6 months + 6 months FU
Munsch 2007	80	89	34.0 (4.0)*	Adult BED	Group Diet	Group Behavioural Weight Loss Therapy	Group CBT-ED	16 weeks + 6 assessm ent a month for 12 months
Nauta 2000/2001	37	100	33.1 (4.3)**	Obese adults with and without BED	Group Diet	Group Healthy Eating Program	Group Cognitive Therapy	15 weeks + 12 months FU
Reeves 2001	98	100	194.4 (22) lbs	Obese adults + BES score>20	Diet	Behavioural Self- Management	WLC	6 months

Study ID	N randomised	Female (%)	Mean BMI (SD), kg/m ²	Sample	Type of nutritional intervention	Intervention	Comparison	Duration
Wilson 2010/Hilbert 2015	205	85	36.4 (5.0)	Adult BED, BMI 27-45 kg/m ²	Diet	Behavioural Weight Loss Therapy	Guided Self-Help CBT-ED Interpersonal Psychotherapy	6 months + 12 months and 24-months FU

- 1 Notes: *n=75; **, figure is for whole sample including obese adults without BED. Abbreviations: BES, Binge Eating Scale; FU, follow up; MLIC, Metropolitan Life Insurance Company; TAU, treatment as usual; WLC, wait list controls.

3 Table 297: Summary table of findings for online nutritional counselling versus TAU in adult with BED at end of treatment.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Online Nutritional Counselling (95% CI)
Weight Change	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight change in the intervention groups was 0.72 standard deviations lower (1.25 to 0.19 lower)
EDE Global	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.4 standard deviations lower (0.92 lower to 0.11 higher)
Depression BDI	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.34 standard deviations lower (0.86 lower to 0.17 higher)
General functioning Treatment Self-Regulation Questionnaire - Autonomous Motivation	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable for	The mean general functioning in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Online Nutritional Counselling (95% CI)
		due to risk of bias, indirectness, imprecision		SMD values	0.23 standard deviations higher (0.28 lower to 0.74 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE Global scores significantly different at baseline.					
2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).					
3 CI crosses either 0.5 or -0.5 (SMD).					

1 Table 298: Summary table of findings for online nutritional counselling versus TAU in adult with BED at follow up.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Online Nutritional Counselling (95% CI)
Weight Change FU	59 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight change fu in the intervention groups was 0.74 standard deviations lower (1.27 to 0.21 lower)
EDE Global FU	59 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.24 standard deviations lower (0.76 lower to 0.27 higher)
Depression FU BDI	59 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to indirectness, imprecision		Not calculable for	The mean depression fu in the intervention groups was 0.35 standard deviations lower (0.86 lower to 0.17 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with Online Nutritional Counselling (95% CI)
				SMD values	
General functioning Treatment Self-Regulation Questionnaire - Autonomous Motivation FU	59 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general functioning in the intervention groups was 0.11 standard deviations lower (0.62 lower to 0.4 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE Global scores significantly different at baseline.					
2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).					
3 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 299: Summary table of findings for group nutritional counselling versus wait list control in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Group Nutritional Counselling (95% CI)
BMI	120 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.22 standard deviations higher (0.14 lower to 0.57 higher)
Binge Eating Scale	120 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.83 standard deviations lower (1.2 to 0.46 lower)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Group Nutritional Counselling (95% CI)
CI: Confidence interval;					
1 Goodrick 1998: randomization method and allocation concealment unclear. No participant nor assessor blinding. Investigator blinding unclear. Reasons for dropout not clear. Participants paid fee to participate in study to be returned only if they attended >19 first 26 meetings and completion of 6- and 12-mo FU assessments.					
2 Goodrick 1998: Women only. Participants were selected on basis of 14-41 kg overweight based on 1983 Metropolitan Life Insurance Company Height/Weight tables and having Binge Eating Scale score >21.					
3 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 300: Summary table of findings for group behavioural weight loss therapy versus wait list control in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with GBWLT (95% CI)
BMI/Weight	205 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI/weight in the intervention groups was 0.20 standard deviations higher (0.07 lower to 0.48 higher)
Binge Eating Scale	123 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 1.07 standard deviations lower (1.45 to 0.69 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Goodrick 1998: randomization method and allocation concealment unclear. No participant nor assessor blinding. Investigator blinding unclear. Reasons for dropout not clear. Participants paid fee to participate in study to be returned only if they attended >19 first 26 meetings and completion of 6- and 12-mo FU assessments.

2 Reeves 2001: randomization method and allocation concealment unclear. No participant blinding. Assessor and investigator blinding unclear. Dropout rate of intervention group >20%.

3 Goodrick 1998: Women only. Participants were selected on basis of 14-41 kg overweight based on 1983 Metropolitan Life Insurance Company Height/Weight tables and having Binge Eating Scale score >21.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with GBWLT (95% CI)
4 Reeves 2001: Women only. Participants were selected on basis of weight \geq 31 lbs or $<$ 90 lbs overweight based on 1983 Metropolitan Height/Weight tables, and Binge Eating Scale score $>$ 20.					
5 $<$ 400 participants.					

1 **Table 301: Summary table of findings for behavioural weight loss therapy versus any other intervention in adults with BED at end of**
2 **treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with BWLT (95% CI)
Remission	205 (1 study) 2 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.96 (0.84 to 1.11)	844 per 1000	34 fewer per 1000 (from 135 fewer to 93 more)
Rapid Response \geq 70% reduction binge eating by 4th week treatment	205 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision	RR 1.05 (0.88 to 1.27)	695 per 1000	35 more per 1000 (from 83 fewer to 188 more)
Binge Frequency EDE, past 28 days	205 (1 study) 2 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.07 standard deviations higher (0.22 lower to 0.37 higher)
BMI	205 (1 study) 2 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.12 standard deviations lower (0.41 lower to 0.18 higher)
EDE Global	205 (1 study) 2 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.36 standard deviations higher (0.06 to 0.66 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with BWLT (95% CI)
# 5% Reduction in Weight	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 3 (2.08 to 4.33)	213 per 1000	426 more per 1000 (from 230 more to 709 more)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p> <p>1 Wilson 2010/Hilbert 2015: adequate randomisation, unclear allocation concealment. No participant blinding, unclear investigator and assessor blinding. Dropout rates of Diet and CBT group >20%.</p> <p>2 <300 events (dichotomous outcome) or <400 participants (continuous outcome).</p> <p>3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).</p>					

1 **Table 302: Summary table of findings for behavioural weight loss therapy versus any other intervention in adults with BED at 1 year follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with BWLT (95% CI)
Binge Frequency 12-mo FU EDE Binges/past 28 days	205 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency 12-mo fu in the intervention groups was 0.24 standard deviations higher (0.06 lower to 0.54 higher)
BMI 12-mo FU	205 (1 study) 1 years	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI 12-mo fu in the intervention groups was 0.04 standard deviations higher (0.26 lower to 0.33 higher)
EDE Global 12-mo FU	205 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global 12-mo fu in the intervention groups was 0.41 standard deviations higher (0.11 to 0.71 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with BWLT (95% CI)
# 5% Reduction in Weight 12-mo FU	205 (1 study) 1 years	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.26 (0.87 to 1.82)	333 per 1000	87 more per 1000 (from 43 fewer to 273 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Wilson 2010/Hilbert 2015: adequate randomisation, unclear allocation concealment. No participant blinding, unclear investigator and assessor blinding. Dropout rates of Diet and CBT group >20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).					

1 **Table 303: Summary table of findings for behavioural weight loss therapy versus any other intervention in adults with BED at 2 year follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with BWLT (95% CI)
Binge Frequency 24-mo FU EDE Binges/past 28 days	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency 24-mo fu in the intervention groups was 0.23 standard deviations higher (0.07 lower to 0.52 higher)
BMI 24-mo FU	205 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI 24-mo fu in the intervention groups was 0.07 standard deviations higher (0.22 lower to 0.37 higher)
EDE Global 24-mo FU	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global 24-mo fu in the intervention groups was 0.27 standard deviations higher (0.03 lower to 0.57 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with BWLT (95% CI)
# 5% Reduction in Weight 24-mo FU	205 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.35 (0.92 to 1.96)	312 per 1000	109 more per 1000 (from 25 fewer to 300 more)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Wilson 2010/Hilbert 2015: adequate randomisation, unclear allocation concealment. No participant blinding, unclear investigator and assessor blinding. Dropout rates of Diet and CBT group >20%.					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					
3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).					

1 Table 304: Summary table of findings for guided self-help behavioural weight loss versus any other intervention in adults with BED.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with GSH BWL (95% CI)
Remission	90 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.52 (0.27 to 1.01)	500 per 1000	240 fewer per 1000 (from 365 fewer to 5 more)
Rapid Response >=65% reduction in binge eating by week 4 of treatment	75 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 0.76 (0.5 to 1.16)	622 per 1000	149 fewer per 1000 (from 311 fewer to 99 more)
BMI	90 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.06 standard deviations higher (0.37 lower to 0.49 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with GSH BWL (95% CI)
Binge Frequency	90 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.29 standard deviations higher (0.14 lower to 0.72 higher)
EDE-Q Dietary Restraint	90 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q dietary restraint in the intervention groups was 0.28 standard deviations higher (0.15 lower to 0.71 higher)
EDE-Q Eating Concerns	90 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q eating concerns in the intervention groups was 0.26 standard deviations higher (0.17 lower to 0.69 higher)
EDE-Q Weight Concerns	90 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q weight concerns in the intervention groups was 0.03 standard deviations higher (0.4 lower to 0.46 higher)
EDE-Q Shape Concerns	90 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q shape concerns in the intervention groups was 0.05 standard deviations higher (0.38 lower to 0.48 higher)
Depression BDI	90 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.18 standard deviations higher (0.25 lower to 0.61 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Grilo 2005/Masheb 2007: No participant nor investigator blinding. Dropout rate for Guided Self-Help Behavioural Weight Loss Therapy >40%. Difference between other groups >20%.

2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

3 <400 participants.

1 **Table 305: Summary table of findings for group behavioural weight loss therapy versus any other intervention in adults with BED at**
2 **end of treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with Group BWLT (95% CI)
Remission No OBEs/28 days (EDE)	207 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW ^{1,2,3,4,5} due to risk of bias, inconsistency, indirectness, imprecision	RR 0.99 (0.74 to 1.33)	429 per 1000	4 fewer per 1000 (from 111 fewer to 141 more)
Remission - subgroup analysis of severity of illness <18 binges/month No OBEs/28 days (EDE)	170 (2 studies) 1 years	⊕⊕⊕⊕ VERY LOW ^{1,2,4,6} due to risk of bias, inconsistency, imprecision	RR 1.11 (0.79 to 1.54)	427 per 1000	47 more per 1000 (from 90 fewer to 231 more)
Remission - subgroup analysis of severity of illness >18 binges/month No OBEs/28 days (EDE)	37 (1 study) 1 years	⊕⊕⊕⊕ LOW ^{3,6} due to risk of bias, imprecision	RR 0.66 (0.35 to 1.24)	667 per 1000	227 fewer per 1000 (from 433 fewer to 160 more)
No longer meets all DSM-IV BED criteria	37 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{3,6} due to risk of bias, indirectness, imprecision	RR 1.21 (0.88 to 1.65)	750 per 1000	158 more per 1000 (from 90 fewer to 487 more)
Binge Frequency Binge days or binge episodes in past 28 days	175 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW ^{1,2,3,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.42 standard deviations higher (0.12 to 0.72 higher)
BMI or Weight	207 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW ^{1,2,3,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean bmi or weight in the intervention groups was 0.54 standard deviations lower (0.82 to 0.26 lower)
Weight Loss (lbs)	90 (1 study) 1 years	⊕⊕⊕⊕ LOW ^{1,6} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (lbs) in the intervention groups was 0.53 standard deviations higher (0.11 to 0.96 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with Group BWLT (95% CI)
EDE Global Scale from: 0 to 6.	90 (1 study) 1 years	⊕⊕⊕⊕ LOW1,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.12 standard deviations higher (0.3 lower to 0.53 higher)
EDE Restraint Scale from: 0 to 6.	175 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW1,2,3,7 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede restraint in the intervention groups was 0.17 standard deviations higher (0.12 lower to 0.47 higher)
EDE Shape Concern Scale from: 0 to 6.	175 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW1,2,3,4,6 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.22 standard deviations higher (0.27 lower to 0.71 higher)
EDE Shape Concern - subgroup analysis of severity of illness <18 binges/month Scale from: 0 to 6.	138 (2 studies) 1 years	⊕⊕⊕⊕ LOW1,2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern - subgroup analysis of severity of illness <18 binges/month in the intervention groups was 0.01 standard deviations higher (0.33 lower to 0.34 higher)
EDE Shape Concern - subgroup analysis of severity of illness >18 binges/month Scale from: 0 to 6.	37 (1 study) 1 years	⊕⊕⊕⊕ LOW3,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern - subgroup analysis of severity of illness >18 binges/month in the intervention groups was 0.83 standard deviations higher (0.15 to 1.51 higher)
EDE Weight Concern Scale from: 0 to 6.	175 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW1,2,3,4,6 due to risk of bias, inconsistency, indirectness, imprecision	175	Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.16 standard deviations higher (0.44 lower to 0.77 higher)
EDE Weight Concern - subgroup analysis of severity of illness <18 binges/month Scale from: 0 to 6.	138 (2 studies) 1 years	⊕⊕⊕⊕ LOW1,2,7 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern - subgroup analysis of severity of illness <18 binges/month in the intervention groups was 0.1 standard deviations lower (0.43 lower to 0.23 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with Group BWLT (95% CI)
EDE Weight Concern - subgroup analysis of severity of illness >18 binges/month Scale from: 0 to 6.	37 (1 study) 1 years	⊕⊕⊕⊕ LOW3,6 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern - subgroup analysis of severity of illness >18 binges/month in the intervention groups was 0.9 standard deviations higher (0.21 to 1.58 higher)
EDE Eating Concern Scale from: 0 to 6.	175 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW1,2,3,6 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.22 standard deviations higher (0.07 lower to 0.52 higher)
Depression BDI. Scale from: 0 to 63.	184 (3 studies) 1 years	⊕⊕⊕⊕ VERY LOW1,2,3,7 due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.12 standard deviations higher (0.17 lower to 0.41 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio;

- 1 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Group BWLT and Group CBT dropout rates both >20%. Dropout reasons not stated.
- 2 Munsch 2007: randomization method used permuted block design. Allocation concealment unclear. No participant, investigator nor assessor blinding. Dropout rates of both Group BWLT and Group CBT groups >20%. Dropout reasons not stated.
- 3 Nauta 2000/2001: randomization method and allocation concealment unclear. No investigator blinding, assessor blinding unclear.
- 4 I2>50%.
- 5 CI crosses both 0.75 and 1.25 (Risk Ratio).
- 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
- 7 <400 participants.

1 **Table 306: Summary table of findings for group behavioural weight loss therapy versus any other intervention in adults with BED at**
2 **follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with GBWLT (95% CI)
Remission FU	108 (2 studies) 1 years	⊕⊕⊕⊖ VERY LOW ^{1,2,3,4} due to risk of bias, indirectness, imprecision	RR 0.92 (0.66 to 1.27)	613 per 1000	49 fewer per 1000 (from 208 fewer to 165 more)
Binge Frequency FU Binge days or episodes in past 28 days	197 (3 studies) 1 years	⊕⊕⊕⊖ VERY LOW ^{1,2,3,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0.21 standard deviations higher (0.07 lower to 0.49 higher)
BMI or Weight FU	198 (3 studies) 1 years	⊕⊕⊕⊖ VERY LOW ^{1,2,3,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI or weight fu in the intervention groups was 0.1 standard deviations lower (0.38 lower to 0.19 higher)
Weight Loss (lbs) FU	90 (1 study) 1 years	⊕⊕⊕⊖ LOW ^{5,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss (lbs) fu in the intervention groups was 0.11 standard deviations higher (0.3 lower to 0.53 higher)
EDE Global FU	90 (1 study) 1 years	⊕⊕⊕⊖ LOW ^{5,7} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.12 standard deviations higher (0.29 lower to 0.54 higher)
EDE Restraint FU	152 (3 studies)	⊕⊕⊕⊖ VERY LOW ^{1,2,3,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede restraint fu in the intervention groups was 0.09 standard deviations higher (0.23 lower to 0.41 higher)
EDE Shape Concern FU	152 (3 studies)	⊕⊕⊕⊖ VERY LOW ^{1,2,3,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concern fu in the intervention groups was 0.03 standard deviations lower (0.35 lower to 0.3 higher)
EDE Weight Concern FU	152 (3 studies)	⊕⊕⊕⊖ VERY LOW ^{1,2,3,5,6}		Not calculable for SMD values	The mean ede weight concern fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any other intervention	Risk difference with GBWLT (95% CI)
		due to risk of bias, indirectness, imprecision			0.1 standard deviations higher (0.23 lower to 0.42 higher)
EDE Eating Concern FU	152 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede eating concern fu in the intervention groups was 0.08 standard deviations lower (0.4 lower to 0.24 higher)
Depression FU BDI	161 (3 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3,5,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.1 standard deviations higher (0.21 lower to 0.42 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Munsch 2007: randomization method used permuted block design. Allocation concealment unclear. No participant, investigator nor assessor blinding. Dropout rates of both Diet and Group CBT groups >20%. Dropout reasons not stated.

2 Nauta 2000/2001: randomization method and allocation concealment unclear. No investigator blinding, assessor blinding unclear.

3 Nauta 2000: Women only.

4 CI crosses both 0.75 and 1.25 (Risk Ratio).

5 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Diet and Group CBT dropout rates both >20%. Dropout reasons not stated.

6 <400 participants.

7 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1 **Table 307: Summary table of findings for group behavioural weight loss therapy versus group nutritional counselling in adults with**
2 **BED at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group Nutritional Counselling	Risk difference with GBWLT (95% CI)
BMI	127 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable for SMD values	The mean BMI in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group Nutritional Counselling	Risk difference with GBWLT (95% CI)
		due to risk of bias, indirectness, imprecision			0.1 standard deviations lower (0.45 lower to 0.25 higher)
Binge Eating Scale	127 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.24 standard deviations lower (0.59 lower to 0.11 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Goodrick 1998: randomization method and allocation concealment unclear. No participant nor assessor blinding. Investigator blinding unclear. Reasons for dropout not clear. Participants paid fee to participate in study to be returned only if they attended >19 first 26 meetings and completion of 6- and 12-mo FU assessments.

2 Goodrick 1998: Women only. Participants were selected on basis of 14-41 kg overweight based on 1983 Metropolitan Life Insurance Company Height/Weight tables and having Binge Eating Scale score >21.

3 <400 participants.

4 CI crosses 0.5 or -0.5 (SMD).

1 **Table 308: Summary table of findings for group behavioural weight loss therapy versus group nutritional counselling in adults with**
2 **BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group Nutritional Counselling	Risk difference with GBWLT (95% CI)
BMI FU	127 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.1 standard deviations higher (0.25 lower to 0.44 higher)
Binge Eating Scale FU	127 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge eating scale fu in the intervention groups was 0.07 standard deviations lower (0.41 lower to 0.28 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group Nutritional Counselling	Risk difference with GBWLT (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; FU: Follow up					
1 Goodrick 1998: randomization method and allocation concealment unclear. No participant nor assessor blinding. Investigator blinding unclear. Reasons for dropout not clear. Participants paid fee to participate in study to be returned only if they attended >19 first 26 meetings and completion of 6- and 12-mo FU assessments.					
2 Goodrick 1998: Women only. Participants were selected on basis of 14-41 kg overweight based on 1983 Metropolitan Life Insurance Company Height/Weight tables and having Binge Eating Scale score >21.					
3 <400 participants.					

1 **Table 309: Summary table of findings for behavioural weight loss therapy and online motivational interviewing versus TAU in adult**
2 **with BED at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with BWLT + Motivational Interviewing (95% CI)
Weight Change	60 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight change in the intervention groups was 0.45 standard deviations lower (0.96 lower to 0.06 higher)
EDE Global	60 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.23 standard deviations higher (0.28 lower to 0.74 higher)
Depression BDI	60 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for	The mean depression in the intervention groups was 0.1 standard deviations lower (0.61 lower to 0.41 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with BWLT + Motivational Interviewing (95% CI)
				SMD values	
General functioning Treatment Self-Regulation Questionnaire - Autonomous Motivation	60 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general functioning in the intervention groups was 0.34 standard deviations higher (0.17 lower to 0.85 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE Global scores significantly different at baseline.					
2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).					
3 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 310: Summary table of findings for behavioural weight loss therapy and online motivational interviewing versus TAU in adult**
2 **with BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with BWLT + Online Motivational interviewing (95% CI)
Weight Change FU	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight change fu in the intervention groups was 0.37 standard deviations lower (0.88 lower to 0.14 higher)
EDE Global FU	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable for	The mean ede global fu in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with TAU	Risk difference with BWLT + Online Motivational interviewing (95% CI)
		due to risk of bias, indirectness, imprecision		SMD values	0.21 standard deviations higher (0.3 lower to 0.72 higher)
Depression FU BDI	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.06 standard deviations lower (0.57 lower to 0.44 higher)
General functioning Treatment Self-Regulation Questionnaire - Autonomous Motivation FU	60 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general functioning in the intervention groups was 0.1 standard deviations lower (0.61 lower to 0.4 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE Global scores significantly different at baseline.					
2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).					
3 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 311: Summary table of findings for behavioural weight loss therapy and online motivational interviewing versus online**
2 **nutritional counselling in adults with BED at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Online Nutritional Counselling	Risk difference with BWLT + Online Motivational Interviewing (95% CI)
Weight Change	59 (1 study) 3 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2,3}		Not calculable for SMD values	The mean weight change in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Online Nutritional Counselling	Risk difference with BWLT + Online Motivational Interviewing (95% CI)
		due to risk of bias, indirectness, imprecision			0.25 standard deviations higher (0.26 lower to 0.76 higher)
EDE Global	59 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.74 standard deviations higher (0.21 lower to 1.27 higher)
Depression BDI	59 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.24 standard deviations higher (0.27 lower to 0.75 higher)
General functioning Treatment Self-Regulation Questionnaire - Autonomous Motivation	59 (1 study) 3 months	⊕⊖⊖⊖ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general functioning in the intervention groups was 0.14 standard deviations higher (0.37 lower to 0.65 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE Global scores significantly different at baseline.					
2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).					
3 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 312: Summary table of findings for behavioural weight loss therapy and online motivational interviewing versus online**
2 **nutritional counselling in adults with BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Online Nutritional Counselling	Risk difference with BWLT + Online Motivational Interviewing (95% CI)
Weight Change FU	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean weight change fu in the intervention groups was 0.35 standard deviations higher (0.17 lower to 0.86 higher)
EDE Global FU	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.46 standard deviations higher (0.06 lower to 0.97 higher)
Depression FU BDI	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.31 standard deviations higher (0.2 lower to 0.82 higher)
General functioning Treatment Self-Regulation Questionnaire - Autonomous Motivation FU	59 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean general functioning in the intervention groups was 0 standard deviations higher (0.51 lower to 0.51 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE Global scores significantly different at baseline.					
2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).					
3 CI crosses either 0.5 or -0.5 (SMD).					
4 CI crosses both 0.5 and -0.5 (SMD).					

1 **Table 313: Summary table of findings for low-energy density diet and CBT-ED versus general nutritional counselling and CBT-ED in**
2 **adults with BED at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Nutritional Counselling + CBT-ED	Risk difference with LE Density Diet+CBT-ED (95% CI)
Remission	50 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.18 (0.66 to 2.11)	440 per 1000	79 more per 1000 (from 150 fewer to 488 more)
BMI (Change scores)	50 (1 study) 6 months	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (change scores) in the intervention groups was 0.36 standard deviations higher (0.19 lower to 0.92 higher)
# >=5% weight loss	50 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.6 (0.61 to 4.22)	200 per 1000	120 more per 1000 (from 78 fewer to 644 more)
Mean % Weight Loss	50 (1 study) 6 months	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean % weight loss in the intervention groups was 0.3 standard deviations higher (0.26 lower to 0.86 higher)
EDE Global	50 (1 study) 6 months	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.2 standard deviations lower (0.75 lower to 0.36 higher)
EDE Weight Concern	50 (1 study) 6 months	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.39 standard deviations lower (0.95 lower to 0.17 higher)
EDE Shape Concern	50 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0 standard deviations higher (0.55 lower to 0.55 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Nutritional Counselling + CBT-ED	Risk difference with LE Density Diet+CBT-ED (95% CI)
EDE Eating Concern	50 (1 study) 6 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.2 standard deviations higher (0.36 lower to 0.75 higher)
Depression	50 (1 study) 6 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.1 standard deviations higher (0.46 lower to 0.65 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Masheb 2011: Allocation concealment unclear. No participant blinding, investigator blinding unclear. Intervention group dropout rate=20%. No details of dropouts provided.
2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1 **Table 314: Summary table of findings for low-energy density diet and CBT-ED versus general nutritional counselling and CBT-ED in adults with BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Nutritional Counselling + CBT-ED	Risk difference with LE Density diet + CBT-ED (95% CI)
BMI (change scores) FU	50 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (change scores) fu in the intervention groups was 0.26 standard deviations higher (0.3 lower to 0.81 higher)
Mean % Weight Loss FU	50 (1 study) 6 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean % weight loss fu in the intervention groups was 0.2 standard deviations higher (0.36 lower to 0.76 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with General Nutritional Counselling + CBT-ED	Risk difference with LE Density diet + CBT-ED (95% CI)
Binge Frequency FU EDE	50 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0.54 standard deviations higher (0.02 lower to 1.11 higher)
# patients achieving >=5% weight loss FU	50 (1 study) 6 months	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision	RR 1.17 (0.46 to 2.98)	240 per 1000	41 more per 1000 (from 130 fewer to 475 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Masheb 2011: Allocation concealment unclear. No participant blinding, investigator blinding unclear. Intervention group dropout rate=20%. No details of dropouts provided.

2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

1 **Table 315: Summary table of findings for group CBT-ED followed by group behavioural weight loss therapy versus group CBT-ED in adults with BED at end of treatment.**

2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT-ED	Risk difference with Group Diet + Group CBT-ED (95% CI)
Remission	80 (1 study) 12 months	⊕⊖⊖⊖ VERY LOW1,2 due to risk of bias, imprecision	RR 1.09 (0.68 to 1.75)	444 per 1000	40 more per 1000 (from 142 fewer to 333 more)
Binge Frequency binge episodes/month	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.18 standard deviations higher (0.26 lower to 0.62 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT-ED	Risk difference with Group Diet + Group CBT-ED (95% CI)
BMI	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.07 standard deviations higher (0.37 lower to 0.51 higher)
Weight Loss	80 (1 study) 12 weeks	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss in the intervention groups was 0.44 standard deviations higher (0.01 lower to 0.88 higher)
EDE Global	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.11 standard deviations lower (0.55 lower to 0.33 higher)
EDE Restraint	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint in the intervention groups was 0.11 standard deviations higher (0.34 lower to 0.55 higher)
EDE Eating Concern	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.32 standard deviations lower (0.77 lower to 0.12 higher)
EDE Shape Concern	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.15 standard deviations lower (0.59 lower to 0.3 higher)
EDE Weight Concern	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.17 standard deviations lower (0.61 lower to 0.27 higher)
Depression	80 (1 study) 12 months	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.04 standard deviations lower (0.49 lower to 0.4 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT-ED	Risk difference with Group Diet + Group CBT-ED (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Diet+Group CBT and Group CBT groups dropout rates both >20%. Dropout reasons not stated.					
2 CI crosses both 0.75 and 1.25 (Risk Ratio).					
3 CI crosses either 0.5 or -0.5 (SMD).					
4 <400 participants.					

1 **Table 316: Summary table of findings for group CBT-ED followed by group behavioural weight loss therapy versus group CBT-ED in adults with BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT-ED	Risk difference with Group CBT-ED then Group BWLT (95% CI)
Binge Frequency FU binge episodes/month	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency fu in the intervention groups was 0.19 standard deviations higher (0.25 lower to 0.64 higher)
BMI FU	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.07 standard deviations higher (0.37 lower to 0.51 higher)
Weight Loss FU	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss fu in the intervention groups was 0.14 standard deviations higher (0.3 lower to 0.59 higher)
EDE Global FU	80 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.12 standard deviations lower (0.56 lower to 0.32 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT-ED	Risk difference with Group CBT-ED then Group BWLT (95% CI)
EDE Restraint FU	80 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint fu in the intervention groups was 0.09 standard deviations lower (0.53 lower to 0.36 higher)
EDE Eating Concern FU	80 (1 study)	⊕⊕⊖⊖ LOW _{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern fu in the intervention groups was 0 standard deviations higher (0.44 lower to 0.44 higher)
EDE Shape Concern FU	80 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern fu in the intervention groups was 0.23 standard deviations lower (0.67 lower to 0.22 higher)
EDE Weight Concern FU	80 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern fu in the intervention groups was 0.09 standard deviations lower (0.54 lower to 0.35 higher)
Depression FU	80 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.07 standard deviations higher (0.37 lower to 0.51 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval;</p> <p>1 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Diet+Group CBT and Group CBT groups dropout rates both >20%. Dropout reasons not stated. 2 CI crosses either 0.5 or -0.5 (SMD). 3 <400 participants.</p>					

1 **Table 317: Summary table of findings for antidepressant and group behavioural weight loss therapy versus placebo and group**
2 **behavioural weight loss therapy in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo + GBWLT	Risk difference with Antidepressant + GBWLT (95% CI)
Weight	63 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight in the intervention groups was 0.03 standard deviations higher (0.46 lower to 0.53 higher)
Binge Frequency EDE OBE	63 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.16 standard deviations lower (0.66 lower to 0.33 higher)
Binge Eating Scale	63 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.13 standard deviations lower (0.62 lower to 0.37 higher)
General Psychopathology Brief symptom inventory	63 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.07 standard deviations lower (0.56 lower to 0.43 higher)
Depression	63 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.38 standard deviations lower (0.88 lower to 0.12 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Devlin 2005: Randomization method and allocation concealment unclear. Dropout rates of all groups >20%. Dropout by groups not provided. Not clear if baseline measures for groups are similar.

2 CI crosses either 0.5 or -0.5 (SMD).

1 **Table 318: Summary table of findings for antidepressant, CBT-ED and group behavioural control therapy versus placebo, CBT-ED and**
2 **group behavioural weight control therapy in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+CBT-ED+GBWCT	Risk difference with Antidepressant+CBT-ED+GWBCT (95% CI)
Weight	53 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean weight in the intervention groups was 0.08 standard deviations lower (0.62 lower to 0.46 higher)
Binge Frequency EDE OBE	53 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge frequency in the intervention groups was 0.24 standard deviations lower (0.78 lower to 0.3 higher)
Binge Eating Scale	53 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 0.06 standard deviations lower (0.6 lower to 0.48 higher)
General Psychopathology	53 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.19 standard deviations lower (0.73 lower to 0.35 higher)
Depression	53 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - fluoxetine+group behavioural weight control+cbt in the intervention groups was 0.24 standard deviations lower (0.78 lower to 0.3 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Devlin 2005: Randomization method and allocation concealment unclear. Dropout rates of all groups>20%. Dropout by groups not provided. Not clear if baseline measures for groups are similar.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 319: Summary table of findings for CBT-ED then antidepressant and group behavioural weight loss therapy versus CBT-ED**
2 **then group behavioural weight loss therapy in adults with BED.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with CBT-ED then GBWLT	Risk difference with CBT-ED then Antidepressant + GBWLT (95% CI)
Weight	72 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean weight in the intervention groups was 0.28 standard deviations higher (0.18 lower to 0.74 higher)
Depression BDI	72 (1 study) 3 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision, publication bias		Not calculable for SMD values	The mean depression in the intervention groups was 0.14 standard deviations lower (0.6 lower to 0.32 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Agras 1994: Randomization method and allocation concealment unclear. No participant blinding, investigator and assessor blinding unclear. Dropout rate of CBT+Weight Loss+Desipramine and Weight Loss groups both >20%. Reasons for dropout not provided.

2 CI crosses either 0.5 or -0.5 (SMD).

3 Published before 2000.

3 **Table 320: Antiobesity agent and diet versus placebo and diet in adults with binge eating disorder at end of treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+Diet	Risk difference with Antiobesity+Diet (95% CI)
Weight loss	73 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight loss in the intervention groups was 0.9 standard deviations higher (0.47 to 1.33 higher)
No longer meets BED DSM-IV criteria	73 (1 study)	⊕⊕⊕⊕ LOW ^{1,2} due to risk of bias, imprecision	RR 1.09 (0.83 to 1.44)	706 per 1000	64 more per 1000 (from 120 fewer to 311 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+Diet	Risk difference with Antiobesity+Diet (95% CI)
EDI Total	89 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total in the intervention groups was 0.3 standard deviations lower (0.72 lower to 0.12 higher)
General psychopathology HADS	89 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.42 standard deviations lower (0.84 lower to 0 higher)
Depression BDI	89 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.40 standard deviations lower (0.82 lower to 0.02 higher)
No longer meets Generalized Anxiety disorder DSM-IV criteria	73 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.2 (0.87 to 1.66)	618 per 1000	124 more per 1000 (from 80 fewer to 408 more)
No longer meets Major depressive disorder DSM-IV criteria	73 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision	RR 1.1 (0.97 to 1.26)	882 per 1000	88 more per 1000 (from 26 fewer to 229 more)
Quality of Life Nottingham Health Profile	89 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean quality of life in the intervention groups was 0.2 standard deviations lower (0.62 lower to 0.21 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio;					
1 Golay 2005: high risk of bias (unclear whether baseline similar, unclear randomisation method and allocation concealment; placebo+diet arm dropout rate>20%).					
2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 **Table 321: Antiobesity agent and behavioural weight loss therapy versus placebo and behavioural weight loss therapy in adults with**
2 **binge eating disorder at end of treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+BWLT	Risk difference with Antiobesity+BWLT (95% CI)
Remission (ITT) No OBEs in past 28 days	40 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision	RR 0.86 (0.54 to 1.36)	700 per 1000	98 fewer per 1000 (from 322 fewer to 252 more)
BMI	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean bmi in the intervention groups was 0.31 standard deviations higher (0.33 lower to 0.95 higher)
EDE Global Scale from: 0 to 6.	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.49 standard deviations lower (1.13 lower to 0.16 higher)
EDE Dietary restraint Scale from: 0 to 6.	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede dietary restraint in the intervention groups was 0.28 standard deviations lower (0.92 lower to 0.36 higher)
EDE Eating concern Scale from: 0 to 6.	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0 standard deviations higher (0.64 lower to 0.64 higher)
EDE Shape concern Scale from: 0 to 6.	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.27 standard deviations lower (0.91 lower to 0.37 higher)
EDE Weight concern Scale from: 0 to 6.	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.51 standard deviations lower (1.15 lower to 0.14 higher)
Depression BDI	38 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3}		Not calculable for SMD values	The mean depression in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+BWLT	Risk difference with Antiobesity+BWLT (95% CI)
		due to risk of bias, indirectness, imprecision			0.51 standard deviations lower (1.16 lower to 0.13 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio;					
1 Grilo 2013: high risk of bias (unclear randomisation method and allocation concealment, dropout rate of both groups >=20%). Participants limited to Latino/Latina patients. 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD). 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).					

1 **Table 322: Antiobesity agent and behavioural weight loss therapy versus placebo and behavioural weight loss therapy in adults with**
2 **binge eating disorder at follow up**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+Diet	Risk difference with Antiobesity+Diet at 6-mo FU (95% CI)
Remission (ITT)	40 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision	RR 1 (0.54 to 1.86)	500 per 1000	0 fewer per 1000 (from 230 fewer to 430 more)
BMI	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean bmi in the intervention groups was 0.16 standard deviations higher (0.49 lower to 0.81 higher)
EDE Global	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.43 standard deviations lower (1.08 lower to 0.22 higher)
EDE Dietary restraint	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2}		Not calculable	The mean ede dietary restraint in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Placebo+Diet	Risk difference with Antiobesity+Diet at 6-mo FU (95% CI)
		due to risk of bias, indirectness, imprecision		for SMD values	0.08 standard deviations lower (0.73 lower to 0.56 higher)
EDE Eating concern	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.54 standard deviations lower (1.2 lower to 0.12 higher)
EDE Shape concern	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.32 standard deviations lower (0.97 lower to 0.32 higher)
EDE Weight concern	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.29 standard deviations lower (0.94 lower to 0.36 higher)
Depression	37 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.94 standard deviations lower (1.62 to 0.25 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Grilo 2013: high risk of bias (unclear randomisation method and allocation concealment, dropout rate of both groups >=20%). Participants limited to Latino/Latina patients.

2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1
2
3

1 **8.5.3 Economic evidence**

2 No economic evidence on the cost effectiveness of nutritional interventions for people with
3 binge eating disorder was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **8.5.4 Clinical evidence statements**

7 **8.5.4.1 Online nutritional counselling versus treatment as usual in adults with binge eating** 8 **disorder at end of treatment**

9 Very low quality evidence from one RCT (n=59) showed online nutritional counselling is less
10 effective on weight change compared with treatment as usual.

11 Very low quality evidence from one RCT (n=59) showed no difference in the effect of online
12 nutritional counselling on EDE-global, depression and general functioning compared with
13 treatment as usual.

14 **8.5.4.2 Online nutritional counselling versus treatment as usual in adults with binge eating** 15 **disorder at follow up**

16 Very low quality evidence from one RCT (n=59) showed online nutritional counselling is less
17 effective on weight change compared with treatment as usual.

18 Very low quality evidence from one RCT (n=59) showed no difference in the effect of online
19 nutritional counselling on EDE-global, depression and general functioning compared with
20 treatment as usual.

21 **8.5.4.3 Group nutritional counselling versus wait list controls in adults with BED**

22 Very low quality evidence from one RCT (n=120) showed no difference in the effect of group
23 nutritional counselling on BMI and binge eating scale compared with wait list controls.

24 Very low quality evidence from one RCT (n=120) showed group nutritional counselling is
25 more effective on BMI and binge eating scale compared with wait list controls.

26 **8.5.4.4 Group behavioural weight loss therapy versus wait list controls in adults with BED**

27 Very low quality evidence from two RCTs (n=205) showed group behavioural weight loss
28 therapy is more effective on BMI/weight compared with wait list controls, although there was
29 some uncertainty.

30 Very low quality evidence from one RCT (n=123) showed group behavioural weight loss
31 therapy is more effective on binge eating scale score compared with wait list controls.

32 **8.5.4.5 Behavioural weight loss therapy versus any other intervention in adults with binge** 33 **eating disorder at end of treatment**

34 Low quality evidence from one RCT (n=205) showed no difference in the effect of
35 behavioural weight loss therapy on remission, rapid response, binge frequency and BMI
36 compared with any other intervention.

37 Low quality evidence from one RCT (n=205) showed behavioural weight loss therapy is more
38 effective on the number who achieve a 5% or more reduction in weight compared with any
39 other intervention.

1 Low quality evidence from one RCT (n=205) showed behavioural weight loss therapy is less
2 effective on EDE-global compared with any other intervention.

3 **8.5.4.6 Behavioural weight loss therapy versus any other intervention in adults with binge**
4 **eating disorder at 1 year follow up**

5 Low quality evidence from one RCT (n=205) showed behavioural weight loss therapy is less
6 effective on reducing binge frequency compared with any other intervention, although there
7 was some uncertainty.

8 Low quality evidence from one RCT (n=205) showed no difference in the effect of
9 behavioural weight loss therapy on BMI or the number who achieve a 5% or more reduction
10 in weight compared with any other intervention.

11 Low quality evidence from one RCT (n=205) showed behavioural weight loss therapy is less
12 effective on EDE-global compared with any other intervention.

13 **8.5.4.7 Behavioural weight loss therapy versus any other intervention in adults with binge**
14 **eating disorder at 2 year follow up**

15 Low quality evidence from one RCT (n=205) showed behavioural weight loss therapy is less
16 effective on binge frequency and EDE-global compared with any other intervention, although
17 there was some uncertainty.

18 Low quality evidence from one RCT (n=205) showed behavioural weight loss therapy is more
19 effective on the number who achieve a 5% or more reduction in weight compared with any
20 other intervention, although there was some uncertainty.

21 Low quality evidence from 1 one RCT (n=205) showed no difference in the effect of
22 behavioural weight loss therapy on BMI compared with any other intervention.

23 **8.5.4.8 Guided self-help behavioural weight loss versus any other intervention in adults with**
24 **binge eating disorder**

25 Low quality evidence from one RCT (n=90) showed guided self-help behavioural weight loss
26 is less effective on remission compared with any other intervention, although there was some
27 uncertainty.

28 Low quality evidence from one RCT (n=75 to 90) showed no difference in the effect of guided
29 self-help behavioural weight loss on rapid response, BMI, binge frequency, EDE-Q-dietary
30 restraint, EDE-Q-eating concern, EDE-Q-weight concern, EDE-Q-shape concern and
31 depression compared with any other intervention.

32 **8.5.4.9 Group behavioural weight loss therapy versus any other intervention in adults with**
33 **binge eating disorder at end of treatment**

34 Very low quality evidence from three RCTs (n=207) showed no difference in the effect of
35 group behavioural weight loss therapy on remission compared with any other intervention.

36 Very low quality evidence from two RCTs (n=170) showed no difference in the effect of group
37 behavioural weight loss therapy on remission for people who binged less than 18 times per
38 month compared with any other intervention.

39 Low quality evidence from one RCT (n=37) showed no difference in the effect of group
40 behavioural weight loss therapy on remission for people who binged more than 18 times per
41 month compared with any other intervention.

42 Very low quality evidence from three RCTs (n=207) showed that group behavioural weight
43 loss therapy is more effective on BMI/weight compared with any other intervention.

- 1 Very low quality evidence from one RCT (n=37) showed group behavioural weight loss
2 therapy no difference on the number of people who met the DSM-IV BED criteria compared
3 with any other intervention.
- 4 Very low quality evidence from three RCTs (n=175) showed that group behavioural weight
5 loss therapy is less effective on binge frequency compared with any other intervention.
- 6 Very low quality evidence from one RCT (n=90) showed that group behavioural weight loss
7 therapy is more effective on weight loss compared with any other intervention.
- 8 Very low quality evidence from one RCT (n=90) showed no difference in the effect of group
9 behavioural weight loss therapy on EDE-global compared with any other intervention.
- 10 Very low quality evidence from three RCTs (n=175) showed no difference in the effect of
11 group behavioural weight loss therapy on EDE-dietary restraint, EDE-shape concern, EDE-
12 weight concern and depression compared with any other intervention.
- 13 Low quality evidence from two RCTs (n=170) showed no difference in the effect of group
14 behavioural weight loss therapy on EDE-shape concern for people who binge less than 18
15 times per month compared with any other intervention.
- 16 Low quality evidence from one RCT (n=37) showed group behavioural weight loss therapy is
17 less effective on EDE-shape concern for people who binge more than 18 times per month
18 compared with any other intervention.
- 19 Low quality evidence from two RCTs (n=170) showed no difference in the effect of group
20 behavioural weight loss therapy on EDE-weight concern for people who binge less than 18
21 times per month compared with any other intervention.
- 22 Low quality evidence from one RCT (n=37) showed group behavioural weight loss therapy is
23 less effective on EDE-weight concern for people who binge more than 18 times per month
24 compared with any other intervention.
- 25 Very low quality evidence from three RCTs (n=175) showed group behavioural weight loss
26 therapy is less effective on reducing EDE-eating concern compared with any other
27 intervention, although there was some uncertainty.
- 28 Very low quality evidence from three RCTs (n=184) showed no difference in the effect of
29 group behavioural weight loss therapy on depression compared with any other intervention.
- 30 **8.5.4.10 Group behavioural weight loss therapy versus any other intervention in adults with**
31 **binge eating disorder at follow up**
- 32 Very low quality evidence from two RCTs (n=108) showed no difference in the effect of group
33 behavioural weight loss therapy on remission compared with any other intervention.
- 34 Very low quality evidence from three RCTs (n=166) showed group behavioural weight loss
35 therapy is less effective on binge frequency compared with any other intervention but there
36 was some uncertainty.
- 37 Very low quality evidence from three RCTs (n=198) showed no difference in the effect of
38 group behavioural weight loss therapy on BMI/weight compared with any other intervention.
- 39 Low quality evidence from one RCT (n=90) showed no difference in the effect of group
40 behavioural weight loss therapy on weight loss and EDE-global compared with any other
41 intervention.
- 42 Very low quality evidence from three RCTs (n=152) showed no difference in the effect of
43 group behavioural weight loss therapy on EDE-dietary restraint, EDE-shape concern, EDE-
44 weight concern and EDE-eating concern compared with any other intervention.

- 1 Very low quality evidence from three RCTs (n=161) showed no difference in the effect of
2 group behavioural weight loss therapy on depression compared with any other intervention.
- 3 **8.5.4.11 Group behavioural weight loss therapy versus group nutritional counselling in adults
4 with BED at end of treatment**
- 5 Very low quality evidence from one RCT (n=127) showed no difference in the effect of group
6 behavioural weight loss therapy on BMI and binge eating scale score compared with group
7 nutritional counselling.
- 8 **8.5.4.12 Group behavioural weight loss therapy versus group nutritional counselling in adults
9 with BED at follow up**
- 10 Very low quality evidence from one RCT (n=127) showed no difference in the effect of group
11 behavioural weight loss therapy on BMI and binge eating scale score compared with group
12 nutritional counselling.
- 13 **8.5.4.13 Behavioural weight loss therapy and online motivational interviewing versus
14 treatment as usual in adults with binge eating disorder at end of treatment**
- 15 Very low quality evidence from one RCT (n=60) showed behavioural weight loss therapy and
16 online motivational interviewing is less effective on weight change compared with any
17 treatment as usual, although there was some uncertainty.
- 18 Very low quality evidence from one RCT (n=60) showed no difference in the effect of
19 behavioural weight loss therapy and online motivational interviewing on EDE-global,
20 depression and general functioning compared with treatment as usual.
- 21 **8.5.4.14 Behavioural weight loss therapy and online motivational interviewing versus
22 treatment as usual in adults with binge eating disorder at follow up**
- 23 Very low quality evidence from one RCT (n=60) showed no difference in the effect of
24 behavioural weight loss therapy and online motivational interviewing on weight change, EDE-
25 global, depression and general functioning compared with treatment as usual.
- 26 **8.5.4.15 Behavioural weight loss therapy and online motivational interviewing versus online
27 nutritional counselling at end of treatment**
- 28 Very low quality evidence from one RCT (n=59) showed no difference in the effect of
29 behavioural weight loss therapy and online motivational interviewing on weight change, EDE-
30 global, depression and general functioning compared with online nutritional counselling.
- 31 **8.5.4.16 Behavioural weight loss therapy and online motivational interviewing versus online
32 nutritional counselling at follow up**
- 33 Very low quality evidence from one RCT (n=59) showed no difference in the effect of
34 behavioural weight loss therapy and online motivational interviewing on weight change,
35 depression and general functioning compared with online nutritional counselling.
- 36 Very low quality evidence from one RCT (n=59) showed behavioural weight loss therapy and
37 online motivational interviewing is less effective on EDE-global compared with online
38 nutritional counselling, although there was some uncertainty.

1 **8.5.4.17 Low-energy density diet and CBT-ED versus general nutritional counselling and CBT-ED in adults with BED at end of treatment**

2
3 Very low to low quality evidence from one RCT (n=50) showed no difference in the effect of
4 low-energy density diet and CBT-ED on remission, change in BMI, the number who lost more
5 than 5 percent, mean percent weight loss, EDE-global, EDE-weight concern, EDE-shape
6 concern, EDE-eating concern and depression compared with general nutritional counselling
7 and CBT-ED.

8 **8.5.4.18 Low-energy density diet and CBT-ED versus general nutritional counselling and CBT-ED in adults with BED at follow up**

9
10 Very low to low quality evidence from one RCT (n=50) showed no difference in the effect of
11 low-energy density diet and CBT-ED on change in BMI, mean % weight loss and the number
12 of people losing greater than 5% of their weight compared with general nutritional counselling
13 and CBT-ED.

14 Low quality evidence from one RCT (n=50) showed low-energy density diet and CBT-ED is
15 less effective on binge frequency compared with general nutritional counselling and CBT-ED,
16 although there was some uncertainty.

17 **8.5.4.19 Group CBT-ED then group behavioural weight loss therapy versus group CBT-ED in adults with BED at end of treatment**

18
19 Very low quality to low quality evidence from one RCT (n=80) showed no difference in the
20 effect of group CBT-ED followed by group behavioural weight loss therapy on remission,
21 binge frequency, BMI, EDE-global, EDE-dietary restraint, EDE-eating concern, EDE-shape
22 concern, EDE-weight concern and depression compared with group CBT-ED only.

23 Low quality evidence from one RCT (n=80) showed group CBT-ED followed by group
24 behavioural weight loss therapy is more effective on weight loss compared with group CBT-
25 ED only, although there was some uncertainty.

26 **8.5.4.20 Group CBT-ED then group behavioural weight loss therapy versus group CBT-ED in adults with BED at follow up**

27
28 Low quality evidence from one RCT (n=80) showed no difference in the effect of group CBT-
29 ED followed by group behavioural weight loss therapy on binge frequency, BMI, weight loss,
30 EDE-global, EDE-dietary restraint, EDE-eating concern, EDE-shape concern, EDE-weight
31 concern and depression compared with group CBT-ED only.

32 **8.5.4.21 Antidepressant and group behavioural weight control therapy versus placebo and group behavioural weight control therapy in adults with BED**

33
34 Low quality evidence from one RCT (n=63) showed no difference in the effect of
35 antidepressant and group behavioural weight control therapy on weight, binge frequency,
36 Binge Eating Scale score, general psychopathology and depression compared with placebo
37 and group behavioural weight control therapy.

38 **8.5.4.22 Antidepressant, CBT-ED and group behavioural weight control therapy versus placebo, CBT-ED and group behavioural weight control therapy in adults with BED**

39
40 Low quality evidence from one RCT (n=53) showed no difference in the effect of
41 antidepressant, CBT-ED and group behavioural weight control therapy on weight, binge
42 frequency, Binge Eating Scale score, general psychopathology and depression compared
43 with placebo, CBT-ED and group behavioural weight control therapy.

1 **8.5.4.23 CBT-ED then antidepressant and group behavioural weight loss therapy versus CBT-**
2 **ED then group behavioural weight loss therapy in adults with BED**

3 Very low quality evidence from one RCT (n=72) showed no difference in the effect of CBT-
4 ED followed by antidepressant and group behavioural weight loss therapy on weight and
5 depression compared with CBT-ED followed by group behavioural weight loss therapy.

6 **8.5.4.24 Antiobesity agent and diet versus placebo and diet in adults with binge eating**
7 **disorder at end of treatment**

8 Low quality evidence from one RCT (n=73) showed antiobesity agent and diet is more
9 effective on weight loss compared with placebo and diet.

10 Low quality evidence from one RCT (n=73) showed no difference in the effect of antiobesity
11 agent and diet on the number of people meeting DSM-IV criteria for BED or anxiety, EDI-total
12 and quality of life compared with placebo and diet.

13 Low quality evidence from one RCT (n=89) showed antiobesity agent and diet was more
14 effective on general psychopathology compared with placebo and diet.

15 Very low quality evidence from one RCT (n=89) showed antiobesity agent and diet is more
16 effective on depression compared with placebo and diet, although there was some
17 uncertainty.

18 Low quality evidence from one RCT (n=73) showed an antiobesity agent and diet is more
19 effective on reducing the number of people still meeting DSM-IV criteria for major depressive
20 disorder compared with placebo and diet, although there was uncertainty.

21 **8.5.4.25 Antiobesity agent and behavioural weight loss therapy versus placebo and**
22 **behavioural weight loss therapy in adults with binge eating disorder at end of**
23 **treatment**

24 Very low quality evidence from one RCT (n=40) showed no difference in the effect of
25 antiobesity agent and behavioural weight loss therapy on remission compared with placebo
26 and behavioural weight loss therapy.

27 Very low quality evidence from one RCT (n=38) showed no difference in the effect of
28 antiobesity agent and behavioural weight loss therapy on BMI, EDE-global, EDE-dietary
29 restraint, EDE-eating concern, EDE-shape concern, EDE-weight concern and depression on
30 depression compared with placebo and behavioural weight loss therapy.

31 **8.5.4.26 Antiobesity agent and behavioural weight loss therapy versus placebo and**
32 **behavioural weight loss therapy in adults with binge eating disorder at follow up**

33 Very low quality evidence from one RCT (n=40) showed no difference in the effect of
34 antiobesity agent and behavioural weight loss therapy on remission (ITT) compared with
35 placebo and behavioural weight loss therapy.

36 Very low quality evidence from one RCT (n=37) showed no difference in the effect of
37 antiobesity agent and behavioural weight loss therapy on BMI, EDE-global, EDE-dietary
38 restraint, EDE-eating concern, EDE-shape concern, and EDE-weight concern compared with
39 placebo and behavioural weight loss therapy.

40 Very low quality evidence from one RCT (n=37) showed antiobesity agent and behavioural
41 weight loss therapy is more effective on depression compared with placebo and behavioural
42 weight loss therapy.

1 **8.5.5 Economic evidence statements**

2 No economic evidence on the cost effectiveness of nutritional interventions for people with
3 binge eating disorder was available.

4 **8.5.6 Recommendations and link to evidence**

5 **Nutritional counselling**

	<p>The committee expressed the view that nutritional counselling is an integral part of most eating disorder specific psychological interventions so they did not make a recommendation about this for people with binge eating disorder.</p>
<p>Critical and important outcomes</p>	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of nutritional interventions for treating binge eating disorder in children, young people and adults. For this population, binge eating and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, family functioning and service user experience.</p>
<p>Trade off benefits and harms</p>	<p>Adults with binge eating disorder</p> <p>Online nutritional counselling was less effective on change in weight compared with treatment as usual showed, but was equally effective on depression, EDE global and general functioning in people with binge eating disorder. No critical outcomes were measured. Similar results were found at follow up. No evidence was found on the critical outcomes of remission and binge eating, nor on the important outcomes of adverse events, quality of life, all-cause mortality, relapse, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>Group nutritional counselling showed a benefit on weight and binge eating compared with wait list controls. No evidence was found on the critical outcome of remission, nor on the important outcomes of adverse events, quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>Group behavioural weight loss therapy appeared to reduce body weight (with some uncertainty) and had a positive effect on binge eating compared with wait list controls. No evidence was found on the critical outcome of remission, nor on the important outcomes of adverse events, quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>No difference was found between behavioural weight loss therapy and any intervention on remission, binge frequency, rapid response and weight at the end of treatment. EDE-global appeared to favour any other treatment but there was some uncertainty. There was some inconsistency in the results since one outcome showed the number of people who achieved a 5% reduction in body weight favoured the behavioural weight loss therapy.</p> <p>At one year follow up, no difference was found in weight or the number who achieved a 5% reduction in body weight. The results for EDE-global favoured any other treatment and binge frequency but there was some uncertainty. No</p>

	<p>evidence was found on the important outcomes of adverse events, quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>Guided self-help behavioural weight loss showed less favourable results on remission compared with any other intervention but there was some uncertainty. Other outcomes showed no difference, including binge eating, weight loss, depression and EDE-subscale results. No evidence was found on the important outcomes of adverse events, quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>Group behavioural weight loss therapy had a similar effect the number meeting the DSM criteria for BED, any of the EDE-subscales or depression compared with any other intervention. It appeared to increase weight loss but was less effective on binge frequency. The benefit on weight was not maintained at follow up. With regards to remission, EDE-shape concern and EDE-weight concern, although there was no difference between group behavioural weight loss therapy and any other intervention, there was high heterogeneity.</p> <p>There was no obvious difference in risk of bias in the studies where heterogeneity was found but a subgroup analysis according to severity of illness indicated that it favoured group behavioural weight loss therapy on remission for people who engaged in less than 18 binge episodes per month, although there was some uncertainty. However, there was no difference between group behavioural weight loss therapy and any other intervention for people who engaged in over 18 binge episodes per month. By contrast, the subgroup analysis indicated that whilst there was no difference on EDE-shape concern and EDE-weight concern for people who engaged in less than 18 binge episodes per month, group behavioural weight loss therapy was more effective for those who engaged in over 18 binge episodes per month. No evidence was found on the important outcomes of adverse events, quality of life, all-cause mortality, relapse, general functioning, family functioning, cost effectiveness, resource use, and service user experience.</p> <p>Other comparisons that showed no important differences (that is no critical outcomes or outcomes that would influence decision making) in their effect included behavioural weight loss versus nutritional counselling, behavioural weight loss combined with online motivational interviewing compared with treatment as usual, behavioural weight loss combined with online motivational interviewing compared with online nutritional counselling, low energy diet and CBT-ED versus nutritional counselling and CBT-ED, group CBT-ED stepped care versus group CBT-ED, or adding an antidepressant to group behavioural weight loss with or without CBT-ED compared with placebo and therapy.</p> <p>Adverse events and all-cause mortality were not reported in any of the studies.</p>
<p>Trade-off between net health benefits and resource use</p>	<p>The committee expressed the view that dietary advice is an integral part of most eating disorder specific psychological interventions and providing such supplementary advice would not incur significant extra resource implications to the healthcare system.</p>
<p>Quality of the evidence</p>	<p>The quality of the evidence was generally of very low quality. The evidence was downgraded due to risk of bias for reasons including a lack of detail regarding randomisation method, allocation concealment, and whether the participants, investigators or assessors were blinded. High dropout rates were also detected, with more than 20% dropouts in several of the studies. Most of the comparisons had only 1 study and a small number of participants in each arm and very few of the studies measured remission.</p>

	No relevant studies in children or young people were identified. Heterogeneity was not detected.
Other considerations	The committee agreed that the evidence reviewed was not strong enough to recommend nutritional counselling or a healthy weight programme as the sole treatment for adults with binge eating disorder. Only one study was available for most comparisons and very few participants were included in the studies. Readmission was rarely reported making it difficult for them to see the clinical and cost-effectiveness of the treatments in addressing the eating disorder <i>per se</i> . Moreover, many of the interventions included in the review, e.g. behavioural weight loss therapy, appeared to target weight loss and not the eating disorder itself. The committee highlighted that nutritional advice and counselling are an integral part of psychological treatments so it is not generally needed if the person is receiving psychological treatment.. For this reason they did not feel the need to make a research recommendation.

1 8.6 Physical interventions

2 8.6.1 Review question: Do physical interventions, such as transcranial magnetic 3 stimulation or physiotherapy, produce benefits/harms in people with eating 4 disorders?

5 The review protocol summary, including the review question and the eligibility criteria used
6 for this section of the guideline, can be found in Table 349. Further information about the
7 search strategy can be found in Appendix H; the full review protocols can be found in
8 Appendix J.

9 This review considers all physical interventions that may be delivered to children, young
10 people and adults with an eating disorder. The interventions were categorised according to
11 type of physical intervention, the age of the participants and the type of eating disorder and
12 were compared to wait list controls, placebo, TAU or any other intervention.

13 **Table 323: Clinical review protocol summary**

Component	Description
Review question(s)	Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	Physical interventions may include: <ul style="list-style-type: none"> transcranial magnetic stimulation deep brain stimulation physiotherapy yoga physical exercise acupuncture mandometer massage

Component	Description
Comparison	<ul style="list-style-type: none"> • Placebo • Wait list control • Treatment as usual • Another intervention
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (include if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 8.6.2 Clinical evidence

2 Two RCTs (n=248) met the eligibility criteria for this review, all of which were for adults
 3 (McIver et al., 2009; Pendleton et al., 2002). The majority of participants in these studies
 4 were female. One study (Pendleton 2002) examined a combined physical and psychological
 5 intervention. An overview of the trials included in the analysis can be found in Table 324.
 6 Further information about both included and excluded studies can be found in Appendix J.

7

8

1 **Table 324: Study information for trials included in the analysis of physical interventions versus any other intervention or wait list control for people with binge eating disorder.**
2

Study ID	N Randomized	Female (%)	Mean BMI, kg/m2 (SD)	Sample	Intervention	Comparison(s)	Duration
					Age at onset and/or duration of illness (years)	Age at onset and/or duration of illness (years)	
Mclver 2009	90	100	34.1 (6.5)	Adult BMI>25, BES score>20.	Yoga	WLC	12 weeks
Pendleton 2002	114	100	36.2 (6.5)	Adult BED with obesity	Physical Exercise + gCBT-BED + Maintenance	1. Exercise + gCBT-BED 2. Exercise + Maintenance 3. CBT-BED	Non-maintenance groups: 4 months; 6-mo + 12-mo FU Maintenance groups: 10 months; 6-mo FU

3 Abbreviations: BED, binge eating disorder; BES, Binge Eating Scale; BMI, Body Mass Index; gCBT-BED, Group Cognitive Behavioural Therapy for binge eating disorder; FU,
4 follow up; WLC, wait list control.

5 **Table 325: Summary of findings table for yoga versus wait list control at the end of treatment in adults with binge eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Yoga (95% CI)
BMI	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups is 0.3 standard deviations higher (0.26 lower to 0.86 higher)
Binge Eating Scale	50 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge eating scale in the intervention groups was 1.77 standard deviations lower (2.43 to 1.11 lower)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Yoga (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Mclver 2009: Allocation concealment unclear. No participant, investigator nor assessor blinding. Dropout rate for both groups>20%.					
2 Sample was participants with BMI>25 and Binge Eating Scale score >20.					
3 CI crosses either 0.5 or -0.5 (SMD).					
4 <400 participants.					

1 **Table 326: Summary table of findings for aerobic exercise and group CBT-ED versus group CBT-ED in adults with BED at end of treatment.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT	Risk difference with Exercise+Group CBT (95% CI)
BMI (changes scores)	37 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (changes scores) in the intervention groups was 0.93 standard deviations lower (1.61 to 0.24 lower)
Depression BDI	37 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.51 standard deviations lower (1.17 lower to 0.15 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Droprate of Exercise+CBT group and CBT only group both >20%.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 327: Summary table of findings for aerobic exercise and group CBT-ED versus group CBT-ED in adults with BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT	Risk difference with Exercise+Group CBT (95% CI)
BMI (changes scores) FU	37 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (changes scores) fu in the intervention groups was 0.91 standard deviations lower (1.6 to 0.23 lower)
Depression FU BDI	37 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.26 standard deviations lower (0.91 lower to 0.39 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Droprate of Exercise+CBT group and CBT only group both >20%.
2 CI crosses either 0.5 or -0.5 (SMD).

2 **Table 328: Summary table of findings for aerobic exercise and group-CBT-ED versus group CBT-ED and maintenance in adults with BED at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT+Maintenance	Risk difference with Exercise+Group CBT (95% CI)
BMI (Change scores)	43 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (change scores) in the intervention groups was 0.28 standard deviations lower (0.88 lower to 0.33 higher)
Depression BDI	43 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.34 standard deviations lower (0.94 lower to 0.27 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT+Maintenance	Risk difference with Exercise+Group CBT (95% CI)
CI: Confidence interval;					
1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Droprate of Exercise+CBT group >20%.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 329: Summary table of findings for aerobic exercise and group-CBT-ED versus group CBT-ED and maintenance in adults with**
2 **BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT+Maintenance	Risk difference with Exercise+Group CBT (95% CI)
BMI (Change scores) FU	43 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (change scores) fu in the intervention groups was 0.18 standard deviations lower (0.78 lower to 0.42 higher)
Depression FU BDI	37 (1 study)	⊕⊖⊖⊖ VERY LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.02 standard deviations lower (0.58 lower to 0.62 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; FU: Follow up					
1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Droprate of Exercise+CBT group >20%.					
2 CI crosses either 0.5 or -0.5 (SMD).					
3 CI crosses both 0.5 and -0.5 (SMD).					

1 **Table 330: Summary table of findings for aerobic exercise, group CBT-ED and maintenance versus group CBT-ED and maintenance in**
2 **adults with BED at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT+Maintenance	Risk difference with Exercise+Group CBT+Maintenance (95% CI)
BMI (change scores)	47 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (change scores) in the intervention groups was 0.53 standard deviations lower (1.11 lower to 0.05 higher)
Depression BDI	47 (1 study) 12 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.55 standard deviations lower (1.14 lower to 0.03 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding.					
2 CI crosses either 0.5 or -0.5 (SMD).					

3 **Table 331: Summary table of findings for aerobic exercise, group CBT-ED and maintenance versus group CBT-ED and maintenance in**
4 **adults with BED at follow up.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT+Maintenance	Risk difference with Exercise+Group CBT+Maintenance (95% CI)
BMI (change scores) FU	47 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI (change scores) fu in the intervention groups was 0.57 standard deviations lower (1.15 lower to 0.02 higher)
Depression FU BDI	47 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.42 standard deviations lower (1 lower to 0.16 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group CBT+Maintenance	Risk difference with Exercise+Group CBT+Maintenance (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; FU: follow up					
1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. 2 CI crosses either 0.5 or -0.5 (SMD).					

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1 **8.6.3 Economic evidence**

2 No economic evidence on the cost effectiveness of physical interventions for people with
3 binge eating disorder was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **8.6.4 Clinical evidence statements**

7 **8.6.4.1 Yoga versus wait list control in adults with binge eating disorder at end of treatment**

8 Very low quality evidence from one RCT (n=50) showed no difference in the effect of yoga on
9 BMI compared with wait list controls.

10 Very low quality evidence from one RCT (n=50) showed yoga is more effective in reducing
11 scores on the binge eating scale compared with wait list controls.

12 **8.6.4.2 Aerobic exercise and group CBT-ED versus group CBT-ED at end of treatment**

13 Very low quality evidence from one RCT (n=37) showed exercise and group CBT-ED is more
14 effective on change in BMI compared with group CBT-ED.

15 Very low quality evidence from one RCT (n=37) showed no difference in the effect of
16 exercise and group CBT-ED on depression compared with group CBT-ED.

17 **8.6.4.3 Aerobic exercise and group CBT-ED versus group CBT-ED at follow up**

18 Very low quality evidence from one RCT (n=37) showed exercise and group CBT-ED is more
19 effective on change in BMI compared with group CBT-ED.

20 Very low quality evidence from one RCT (n=37) showed no difference in the effect of
21 exercise and group CBT-ED on depression compared with group CBT-ED.

22 **8.6.4.4 Aerobic exercise and group CBT-ED versus group CBT-ED and maintenance at end of treatment**

24 Very low quality evidence from one RCT (n=43) showed no difference in the effect of
25 exercise, group CBT-ED on change in BMI and depression compared with group CBT-ED
26 and maintenance.

27 **8.6.4.5 Aerobic exercise and group CBT-ED versus group CBT-ED and maintenance at follow up**

29 Very low quality evidence from one RCT (n=43) showed no difference in the effect of
30 exercise, group CBT-ED and maintenance on change in BMI and depression compared with
31 group CBT-ED and maintenance.

32 **8.6.4.6 Aerobic exercise, group CBT-ED and maintenance versus group CBT-ED and maintenance at end of treatment**

34 Very low quality evidence from one RCT (n=47) showed exercise, group CBT-ED and
35 maintenance is more effective on change in BMI and depression compared with group CBT-
36 ED and maintenance, but there was some uncertainty.

1 **8.6.4.7 Aerobic exercise, group CBT-ED and maintenance versus group CBT-ED and**
2 **maintenance at follow up**

3 Very low quality evidence from one RCT (n=47) showed exercise, group CBT-ED and
4 maintenance is more effective on change in BMI compared with group CBT-ED and
5 maintenance but there was some uncertainty.

6 Very low quality evidence from one RCT (n=47) showed no difference in the effect of
7 exercise, group CBT-ED and maintenance on depression compared with group CBT-ED and
8 maintenance.

9 **8.6.5 Economic evidence statements**

10 No economic evidence on the cost effectiveness of physical interventions for people with
11 binge eating disorder was available.

12 **8.6.6 Recommendations and link to evidence**

13 **Physical therapy for any eating disorder**

See Section 6.6.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes for the review on the effectiveness of physical interventions, such as transcranial magnetic stimulation or physiotherapy in people with eating disorders and it was agreed that for any eating disorder remission is of greatest concern. The other critical outcomes for anorexia nervosa are body weight and BMI and for binge eating disorder and bulimia nervosa it is binge eating.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in randomised controlled trials for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse, thus they were extracted where possible, but did not factor strongly in the decision making.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>Yoga appears to be effective at reducing scores on the binge eating scale compared with wait list controls for adults with binge eating disorder. However, this did not translate to a benefit in BMI. No evidence was found on the critical outcomes of remission and binge eating, nor on the important outcomes of quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p> <p>Aerobic exercise and group CBT-ED appeared to be more effective at reducing BMI compared with group CBT-ED alone in adults with binge eating disorder. No difference was found in depression scores. Similar results were found at follow up. When a maintenance component (12 biweekly meetings over 6 months) was added to both arms to make this part of the intervention more comparable with the aerobic exercise group (because they continued to meet up), there was a trend for a reduced BMI and depression in the aerobic exercise, group CBT-ED and maintenance group compared with the group CBT-ED and maintenance group at the end of treatment and for the trend in the benefit on BMI to be maintained at follow up but not depression. No evidence was found on the critical outcomes of remission and binge eating, nor on the important outcomes of quality of life, all-cause mortality, eating disorders psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p>

	For discussion of physical interventions for other eating disorders, see the LETRs in the relevant chapters.
Trade-off between net health benefits and resource use	There was no evidence for the effectiveness of physical interventions in people with eating disorders. As a result, such interventions are likely to be not cost effective.
Quality of evidence	<p>The evidence for physical interventions was mostly very low quality. The evidence was downgraded due to risk of bias for reasons including a lack of detail regarding randomisation method, allocation concealment, and whether the participants, investigators or assessors were blinded. High dropout rates were also detected, with more than 20% dropouts in several of the studies.</p> <p>Most of the outcomes were the result of a single study with a very low number of participants; only binge eating disorder had more than 100 participants in total. Imprecision was detected in most outcomes because the 95% confidence interval crossed one or two MIDs or it did not meet the optimal information size.</p> <p>Also, few of the studies measured remission and compensatory behaviours relevant to BED. Some outcomes were excluded from the review because it was either unclear regarding the duration over which these outcomes were measured or it did not satisfy the requirement that they were measured over a two week or more period as required by the committee.</p>
Other considerations	<p>The committee agreed that the evidence presented was not strong enough nor of sufficient quality to offer a physical intervention to people with BED.</p> <p>See LETR in Section 6.8.6 for further discussion of physical interventions.</p>

1 8.7 Management of long- and short-term complications

2 8.7.1 Review question: What interventions are effective at managing or reducing 3 short and long-term physical complications of eating disorders?

4 Further information about the search strategy can be found in Appendix H; the full review
5 protocols can be found in Appendix F.

6 This review considers all interventions that may be delivered to manage or reduce the short-
7 or long-term physical complications of eating disorders in children, young people and adults
8 and includes recovered as well as current service users. The interventions were categorised
9 according to type of physical complication and intervention, the age of the participants and
10 the type of eating disorder and were compared to the control arm as reported in the relevant
11 studies.

12 **Table 332: Clinical review protocol summary**

Component	Description
Review question(s)	What interventions are effective at managing or reducing short and long-term physical complications of eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Recovered or current service users <p>Strata:</p> <ul style="list-style-type: none"> children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years

Component	Description
	<ul style="list-style-type: none"> eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Interventions to address the following:</p> <ul style="list-style-type: none"> Low bone mineral density (risk of fracture) Growth (physical development) Pubertal development Tooth wear Low body weight <p>Interventions to address the long-term physical complications may include:</p> <ul style="list-style-type: none"> GH/IGF-I Calcium with and without Vitamin D Bisphosphonates (age dependent and exclude pregnancy) Exercise (low impact)/Physiotherapy Oestrogen (patches/exogenous/pills other) Testosterone (males/females) Weight gain vs. Weight restoration (brain size) <p>Interventions to address the short-term physical complications may include</p> <ul style="list-style-type: none"> Phosphates supplementation (refeeding) Potassium Thiamine (refeeding) Laxatives (for when underweight patients are constipated) Salbutamol (reduce food intake)
Comparison	<ul style="list-style-type: none"> Control arm as defined by study
Critical outcomes	<ul style="list-style-type: none"> Primary outcome as reported by study
Important outcomes	<ul style="list-style-type: none"> Secondary outcome as reported by study
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs Observational studies: including prospective or retrospective cohort studies, (if no RCTs) (if no RCTs)

1 8.7.2 Clinical evidence

2 No studies were found that met the eligibility criteria for this review.

3 8.7.3 Economic evidence

4 No economic evidence on the cost effectiveness of interventions for the management of
5 short and long-term physical complications of binge eating disorder was identified by the
6 systematic search of the economic literature undertaken for this guideline. Details on the
7 methods used for the systematic search of the economic literature are described in Chapter
8 3.

9 8.7.4 Clinical evidence statements

10 No studies were found that met the eligibility criteria for this review.

1 8.7.5 Economic evidence statements

2 No economic evidence on the cost effectiveness of interventions for the management of
3 short and long-term physical complications of binge eating disorder was available.

4 8.7.6 Recommendations and link to evidence

The committee agreed no recommendation was needed for this review question on those with binge eating disorder.	
Relative value of different outcomes	The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of nutritional interventions for treating binge eating disorder in children, young people and adults. For this population, binge eating and remission are of greatest concern. Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making. Other outcomes of concern for people with anorexia nervosa that are of lesser importance but clearly important outcomes include, general psychopathology, general functioning, family functioning and service user experience.
Trade-off between clinical benefits and harms	No relevant, published, RCT or observational evidence was identified.
Trade-off between net health benefits and resource use	No relevant existing economic evidence was identified.
Quality of evidence	No relevant, published, RCT or observational evidence was identified.
Other considerations	The committee agreed that no recommendation was needed on how to treat or manage people with binge eating disorders who have short or long-term complications.

5 8.8 Management of comorbidities

6 8.8.1 Review question: Does any intervention for an eating disorder need to be 7 modified in the presence of common long-term health conditions?

8 The review protocol summary, including the review question and the eligibility criteria used in
9 this section of the guideline, can be found in Table 358. Further information about the search
10 strategy can be found in Appendix H; the full review protocols can be found in Appendix F.

11 This review considers whether any intervention used to treat eating disorders in children,
12 young people and adults needs to be modified in the presence of a common long-term health
13 condition (i.e. comorbidity). The interventions were categorised according to their type, the
14 type of eating disorder and comorbidity examined and the age of the participants. The
15 comparison arm was the same intervention delivered to participants with the relevant eating
16 disorder but without the relevant comorbidity.

1

Table 333: Clinical review protocol summary

Component	Description
Review question(s)	Does any intervention for an eating disorder need to be modified in the presence of common long-term health conditions?
Population	<ul style="list-style-type: none"> • Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) and a common comorbidity (e.g. diabetes, hypothyroidism). • Mental comorbidities may include: <ul style="list-style-type: none"> ○ Depression ○ Anxiety ○ Social anxiety ○ Autism ○ Obsessive Compulsive Disorder ○ Personality Disorder ○ Learning disability ○ ADHD (Bulimia) ○ Self-harm ○ Substance misuse ○ Physical comorbidities may include: <ul style="list-style-type: none"> ○ Coeliac disease ○ Diabetes (type II – relevant to obesity) ○ Bowel disease ○ Cystic Fibrosis <p>Strata:</p> <ul style="list-style-type: none"> • children (≤ 12), young people (13–≤ 17 years), adults ≥ 18 years • eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Trials will be included that address the ED as primary or secondary aim to treating the comorbidity. Interventions may include:</p> <ul style="list-style-type: none"> • Psychotherapy (including psychoeducation) • Pharmacological • Nutritional • Physical • Combination of any listed above
Comparison	<ul style="list-style-type: none"> • The same intervention but delivered to people with an eating disorder without a comorbidity.
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF)

Component	Description
	<ul style="list-style-type: none"> • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs • Observational studies: including prospective or retrospective cohort studies, (if no RCTs) (if no RCTs)

1 **8.8.2 Clinical evidence**

2 **8.8.2.1 Major depressive disorder and a diabetes prevention programme**

3 One observational study was identified (n=131) that compared the effectiveness of a
4 diabetes prevention programme in a population who had a binge eating disorder and a major
5 depressive disorder (Pagoto et al., 2007). An overview of this trial can be found in Table 334.

6 **8.8.2.2 Diabetes**

7 One RCT (n=34) was found that fulfilled the criteria for this review (Kenardy et al., 2002).
8 This study compared group CBT-ED with a control, non-prescriptive group therapy in adults
9 with type II diabetes and binge eating disorder. This comparison provided insight into
10 whether CBT-ED is effective at achieving remission in this population.

11 Summary of findings for how to treat a binge eating disorder in the presence of a comorbidity
12 can be found in Table 336 and Table 337. See also the study selection flow chart in
13 Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and exclusion
14 list in Appendix J.

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1 **Table 334: Study information for observational study included in the review of interventions for people with binge eating disorder and**
2 **a major depressive disorder.**

Study ID	N	Mean age	BMI	Female	Group 1	Group 2	Intervention	Duration
Pagoto 2007	131	not reported	not reported	not reported	BED with comorbid major depressive disorder.	BED	Diabetes Prevention Program lifestyle intervention	16 sessions

3 **Table 335: Study information for the RCT included in the review of interventions for people with binge eating disorder and type II**
4 **diabetes.**

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
Kenardy 2002 Australia	Diabetes type II diabetes + binge eating disorder	51.8 (9.6) years	not reported	34	Time since diagnosis of diabetes (months)=39.1 (48.5)	Group CBT-ED	Control group Non-Prescriptive Therapy	10 weeks, 12 week FU

5 **Table 336: Summary of findings table for healthy weight program for people with binge eating disorder and major depressive disorder**
6 **versus those with binge eating disorder alone.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with BED alone group	Risk difference with BED and depression (95% CI)
Achieved Weight Loss Goal >=7%	39 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.03 (0.27 to 4)	176 per 1000	5 more per 1000 (from 129 fewer to 529 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with BED alone group	Risk difference with BED and depression (95% CI)
1 Pagoto 2007: retrospective chart review, no control intervention and unclear length of treatment, high selection bias. 2 CI crosses both 0.75 and 1.25.					

1 **Table 337: Summary of findings table for group CBT-ED versus non-prescriptive control group therapy for people with binge eating disorder and type II diabetes.**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with control	Risk difference with Group CBT-ED (95% CI)
Remission - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision	RR 1.6 (0.66 to 3.91)	294 per 1000	176 more per 1000 (from 100 fewer to 856 more)
BMI - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI - group cbt-ed v group not in the intervention groups was 0.63 standard deviations higher (0.06 lower to 1.32 higher)
Binge Frequency - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency - group cbt-ed v group not in the intervention groups was 0.32 standard deviations lower (1 lower to 0.36 higher)
EDI Bulimia - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi bulimia - group cbt-ed v group not in the intervention groups was 0.03 standard deviations lower (0.71 lower to 0.64 higher)
EDI Drive for Thinness - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6}		Not calculable for SMD values	The mean edi drive for thinness - group cbt-ed v group not in the intervention

		due to risk of bias, indirectness, imprecision			groups was 0.17 standard deviations lower (0.84 lower to 0.5 higher)
EDI Body Dissatisfaction - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction - group cbt-ed v group not in the intervention groups was 0.06 standard deviations higher (0.61 lower to 0.73 higher)
Quality of Life - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean quality of life - group cbt-ed v group not in the intervention groups was 0 standard deviations higher (0.67 lower to 0.67 higher)
Remission FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,7} due to risk of bias, indirectness, imprecision	RR 3.33 (1.11 to 10.03)	176 per 1000	411 more per 1000 (from 19 more to 1000 more)
BMI FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean BMI fu - group cbt-ed v group not in the intervention groups was 0.64 standard deviations higher (0.06 lower to 1.33 higher)
Binge Frequency FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean binge frequency fu - group cbt-ed v group not in the intervention groups was 0.52 standard deviations lower (1.2 lower to 0.17 higher)
EDI Bulimia FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi bulimia fu - group cbt-ed v group not in the intervention groups was 0.03 standard deviations lower (0.7 lower to 0.65 higher)
EDI Drive for Thinness FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu - group cbt-ed v group not in the intervention groups was 0.16 standard deviations higher (0.52 lower to 0.83 higher)

EDI Body Dissatisfaction FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction fu - group cbt-ed v group not in the intervention groups was 0.04 standard deviations higher (0.63 lower to 0.71 higher)
Quality of Life FU - Group CBT-ED v Group NPT	34 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2,6} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean quality of life fu - group cbt-ed v group not in the intervention groups was 0.17 standard deviations lower (0.84 lower to 0.51 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; NPT: Non-Prescriptive Therapy

1 Inadequate randomisation was performed and it was unclear if allocation concealment was carried out. Neither the participant or investigator was blind, nor was it clear if the assessor was blind. It was unclear how many participants completed the intervention.

2 Population included disturbed eating attitudes and behaviour based on EDI scale results.

3 95% CI crossed 2 MIDs (0.75 and 1.25)

4 95% CI crossed 1 MID (0.5)

5 95% CI crossed 1 MID (-0.5)

6 95% CI crossed 2 MIDs (-0.5 and 0.5)

7 95% CI crossed 1 MID (0.75)

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1 **8.8.3 Economic evidence**

2 No economic evidence on the cost effectiveness of interventions for binge eating disorder in
3 the presence of common long-term conditions was identified by the systematic search of the
4 economic literature undertaken for this guideline. Details on the methods used for the
5 systematic search of the economic literature are described in Chapter 3.

6 **8.8.4 Clinical evidence statements**

7 **8.8.4.1 Major depressive disorder**

8 **8.8.4.1.1 *Diabetes prevention programme in people with a BED and major depressive disorder*** 9 ***versus people with BED alone at the end of treatment.***

10 Very low quality evidence from one RCT (n=39) showed no difference in the effect of a
11 diabetes prevention program in people with binge eating disorder and comorbid major
12 depressive disorder on the number of people achieving 7% or greater weight loss compared
13 with people with binge eating disorder alone.

14 **8.8.4.2 Diabetes**

15 **8.8.4.2.1 *Group CBT-ED versus non-prescriptive control group therapy in people with type II*** 16 ***diabetes and BED at the end of treatment***

17 Very low quality evidence from one RCT (n=34) showed no difference in the effect of group
18 CBT-ED on binge frequency, EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction,
19 quality of life and remission compared with a control group therapy.

20 Very low quality evidence from one RCT (n=34) showed group CBT-ED is less effective on
21 decreasing BMI compared with compared with a control group therapy but there was some
22 uncertainty.

23 **8.8.4.2.2 *Group CBT-ED versus non-prescriptive control group therapy in people with type II*** 24 ***diabetes and BED at the end of treatment***

25 Very low quality evidence from one RCT (n=34) showed no difference in the effect of group
26 CBT-ED on binge frequency, EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction
27 and quality of life compared with a control group therapy.

28 Very low quality evidence from one RCT (n=34) showed group CBT-ED is less effective on
29 decreasing BMI compared with compared with a control group therapy but there was some
30 uncertainty.

31 Very low quality evidence from one RCT (n=34) showed group CBT-ED is more effective on
32 remission compared with compared with a control group therapy.

33 **8.8.4.2.3 *Group CBT-ED versus non-prescriptive control group therapy in people with type II*** 34 ***diabetes and BED at follow up***

35 Very low quality evidence from one RCT (n=34) showed group CBT-ED is less effective on
36 decreasing BMI compared with compared with a control group therapy but there was some
37 uncertainty

38 Very low quality evidence from one RCT (n=34) showed no difference in the effect of group
39 CBT-ED on binge frequency, EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction
40 and quality of life compared with a control group therapy.

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1 Very low quality evidence from one RCT (n=34) showed group CBT-ED is more effective on
2 remission compared with compared with a control group therapy.

3 **8.8.5 Economic evidence statements**

4 No economic evidence on the cost effectiveness of interventions for binge eating disorder in
5 the presence of common long-term conditions was available.

6 **8.8.6 Recommendations and link to evidence**

7 **Physical and mental health comorbidities**

	See Section 6.8.6 for relevant recommendations
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for OSFED, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>One observational study showed adults with binge eating disorder and major depression are equally responsive to a weight loss program (based on diabetes prevention) as those with just binge eating disorder. The only relevant outcome reported was the number who achieved weight loss greater than or equal to 7%. No other outcomes were reported.</p>
Trade-off between net health benefits and resource use	<p>The committee considered that providing care for people with eating disorders who have comorbid physical or mental health problems may have resource implications in terms of the extra time required to provide such care. However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate treatment and management of underlying health problems at an earlier stage (including eating disorder and comorbid mental health problem), before individuals require more resource intensive management, then the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>The evidence reported only one relevant outcome that is, those who achieved weight loss greater than or equal to 7%. Remission was not reported, nor was data available at the end of treatment only at 3.5 years post treatment. The recommended therapy was a behavioural weight loss programme and it was not found to be the most effective in achieving remission in our reviews. Nevertheless, the findings suggest that people with binge eating disorder and severe depression are equally able to respond to a behavioural weight loss programme as those with just binge eating disorder.</p>

Other considerations	The committee generated recommendations based on the limited data found and from their own knowledge and experience using informal consensus methods which had application all eating disorders. (See the LETR in section 6.8.6 for further discussion on the treatment of an eating disorders with a physical or mental health comorbidity).
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Diabetes

	See Section 7.8.6 for relevant recommendations
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem. In the case of diabetes, HbA1c levels and insulin omission days were considered critical outcomes. The other critical outcomes depended on the eating disorder included in the study. The committee noted for Type 1 diabetes, severity should be measured, or at least heavily informed, by HbA1c since HbA1c/ DKA frequency is the immediate risk factor; furthermore, BMI is less of a risk factor for death in those with Type 1 diabetes than HbA1c.</p> <p>Remission is of greatest concern for any eating disorder. In addition, for those with anorexia nervosa body weight or BMI are of greatest concern. For bulimia nervosa and binge eating disorder, binge eating is a critical outcome.</p> <p>For any eating disorder, other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but are clearly still important outcomes include general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>The ideal study design to answer the question of whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem would be to randomise people with an eating disorder and diabetes to two different treatment groups: One modified to address both the eating disorder and diabetes and one non-modified eating disorder treatment.</p> <p>One study randomised adults with type II diabetes and binge eating to either group CBT-ED or a non-prescriptive control therapy (NPT). The results showed no difference in remission or binge frequency at the end of treatment. BMI showed a trend to be higher in the group CBT-ED arm, however EDI-bulimia, EDI-drive for thinness, EDI-body dissatisfaction and quality of life were no different. At follow up, remission rates were higher in the CBT-ED arm, but again no difference in any of the other outcomes and BMI showed a trend to be higher in the group CBT-ED arm compared with controls. No data was available on HbA1c scores, all-cause mortality, resource use, relapse, general functioning, family functioning, general psychopathology or service user experience.</p> <p>An observational study compared the same diabetes prevention programme but in two populations, one with bulimia nervosa and a major depressive disorder and one with just any eating disorder. The results showed no difference in the degree of weight loss between the two populations. No data was available on HbA1c scores, remission, binge eating, all-cause mortality, resource use, relapse, general functioning, family functioning, or service user experience.</p>

Trade-off between net health benefits and resource use	<p>The committee considered that providing care for eating disorders in the presence of a long-term health problems, such as diabetes, may have resource implications in terms of extra time required to provide collaborative and comprehensive care. However, the committee expressed the view that if such care arrangements (that is, multidisciplinary approach, involvement of family members and carers, and the use of treatment plans) lead to better and appropriate treatment and management of health problems (including other long-term health problems such as diabetes) at an earlier stage, before individuals require more resource intensive management, then the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>The evidence was mostly low quality from the RCT studies and very low quality from all of the observational studies. In both types of study designs the sample size was generally small and only one study was available for most outcomes, thus imprecision was often detected due to the 95% confidence interval crossing a minimal important difference or the outcome did not meet the optimal information size.</p> <p>In the RCT where they compared group CBT-ED with a control therapy in the same population (people with type I diabetes and binge eating disorder) inadequate randomisation was performed and it was unclear if allocation concealment was carried out. Neither the participant or investigator was blind, nor was it clear if the assessor was blind. It was unclear how many participants completed the intervention.</p> <p>The observational study identified was considered indirect evidence since it was a diabetes prevention programme and the participants had major depressive disorder in addition to binge eating disorder or binge eating disorder alone. The only outcome reported was weight loss. The committee did not consider this study helpful</p> <p>Overall discussion</p> <p>No RCT or observational study met the criteria of what would have been the ideal study design for this review (as described above). One RCT compared the effectiveness of an intervention that addressed both the eating disorder and diabetes, but the other arm addressed just the diabetes. In another RCT, one intervention was modified but it was compared with a control therapy.</p> <p>In the observational studies, one study compared the same intervention but in those with either an eating disorder and diabetes or just the eating disorder alone. So it only provided insight into whether one group was more responsive to treatment than the other. In the other observational study, inpatient integrated care was compared with treatment as usual, but the treatment as usual only addressed the diabetes not the eating disorder. Thus, it did not provide insight into whether a modified eating disorder treatment was needed for those with a comorbidity.</p>
Other considerations	<p>See the LETR in Section 7.8.6 for further discussion of the treatment of eating disorders with comorbid diabetes.</p>

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Substance and medication misuse for any eating disorder

	<p>See Section 7.8.6 for relevant recommendations</p>
Relative value of	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge</p>

different outcomes	<p>eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for EDNOS, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>No evidence was identified that examined how an intervention for binge eating disorder might need to be modified in the presence of substance or medication misuse.</p>
Trade-off between net health benefits and resource use	<p>For discussion of interventions for treatment of other eating disorders with comorbid substance misuse, see the LETRs in Section 7.8.6.</p>
Quality of evidence	<p>No relevant published evidence was identified in people with BED.</p> <p>For discussion of interventions for treatment of other eating disorders with comorbid substance misuse, see the LETRs in Section 7.8.6.</p>
Other considerations	<p>See LETR in Section 7.8.6 for further details.</p>

9 Treatment and management of atypical eating disorders (eating disorders not otherwise specified)

9.1 Introduction

Many people with an eating disorder do not meet the diagnostic criteria for anorexia nervosa, bulimia nervosa or binge eating disorder. There is no consensus over how to refer to these states, so they are often described as 'atypical' eating disorders – even though in some settings they are more common than the 'typical' ones. Confusing matters further, the terminology used by the DSM to refer to these conditions has changed from eating disorder not otherwise specified (EDNOS) to other specified feeding or eating disorder (OSFED). The new DSM-5 diagnosis 'avoidant/restrictive food intake disorder' (ARFID) is not classed as an OSFED (atypical eating disorder).

In practice, these atypical states fall into two groups (Fairburn et al., 2007). There are eating disorders that closely resemble anorexia nervosa, bulimia nervosa or binge eating disorder, but do not quite meet their diagnostic criteria. There are also 'mixed states', in which the features of anorexia nervosa, bulimia nervosa or binge eating disorder are combined in an idiosyncratic way. In addition to these, purging disorder and night eating syndrome are also currently classified in DSM-5 as atypical eating disorders.

A common misconception is that the atypical eating disorders are milder or less severe than the typical eating disorders. This is not the case. They are associated with the same level of distress and impairment and they are just as self-perpetuating (Fairburn and Bohn, 2005). Almost all share the same over-concern about eating, shape and weight as seen in the typical eating disorders and the same tendency to engage in persistent and extreme dieting or other forms of disordered eating (such as binge eating and purging). Body weight also tends to be low if the dietary restriction is marked.

Most people with an atypical eating disorder are female and in their 20s. Many of them have a history of anorexia nervosa, bulimia nervosa or both, or will go onto develop a typical eating disorder, reflecting the diagnostic migration that is common among the eating disorders (Milos et al., 2005). Their prevalence and incidence in the general population is uncertain, because of the difficulty in defining them and because they are ignored by some assessment instruments (Smink et al., 2012). It seems that they are more common than the typical eating disorders.

9.2 Psychological interventions

Many people with an eating disorder do not meet the diagnostic criteria for anorexia nervosa, bulimia nervosa or binge eating disorder. There is no consensus over how to refer to these states, so they are often described as 'atypical' eating disorders – even though in some settings they are more common than the 'typical' ones. Confusing matters further, the terminology used by the DSM to refer to these conditions has changed from eating disorder not otherwise specified (EDNOS) to other specified feeding or eating disorder (OSFED). The new DSM-5 diagnosis 'avoidant/restrictive food intake disorder' (ARFID) is not classed as an OSFED (atypical eating disorder).

In practice, these atypical states fall into two groups (Fairburn et al., 2007). There are eating disorders that closely resemble anorexia nervosa, bulimia nervosa or binge eating disorder, but do not quite meet their diagnostic criteria. There are also 'mixed states', in which the features of anorexia nervosa, bulimia nervosa or binge eating disorder are combined in an

1 idiosyncratic way. In addition to these, purging disorder and night eating syndrome are also
2 currently classified in DSM-5 as atypical eating disorders.

3 A common misconception is that the atypical eating disorders are milder or less severe than
4 the typical eating disorders. This is not the case. They are associated with the same level of
5 distress and impairment and they are just as self-perpetuating (Fairburn and Bohn, 2005).
6 Almost all share the same over-concern about eating, shape and weight as seen in the
7 typical eating disorders and the same tendency to engage in persistent and extreme dieting
8 or other forms of disordered eating (such as binge eating and purging). Body weight also
9 tends to be low if the dietary restriction is marked.

10 Most people with an atypical eating disorder are female and in their 20s. Many of them have
11 a history of anorexia nervosa, bulimia nervosa or both, or will go onto develop a typical
12 eating disorder, reflecting the diagnostic migration that is common among the eating
13 disorders (Milos et al., 2005). Their prevalence and incidence in the general population is
14 uncertain, because of the difficulty in defining them and because they are ignored by some
15 assessment instruments (Smink et al., 2012). It seems that they are more common than the
16 typical eating disorders.

17 **9.2.1 Review question: Does any group or individual psychological intervention with 18 or without a pharmacological intervention produce benefits/harms in people 19 with eating disorders compared with any other intervention or controls?**

20 The review protocol summary, including the review question and the eligibility criteria used
21 for this section of the guideline, can be found in Table 338. Further information about the
22 search strategy can be found in Appendix H; the full review protocols can be found in
23 Appendix J.

24 This review considers all psychological interventions that may be delivered to children, young
25 people and adults with an eating disorder with or without a pharmacological intervention.
26 The interventions were categorised according to their mode of delivery, i.e. individual, group
27 or self-help, the age of the participants and the type of eating disorder. In addition, the
28 interventions were grouped according to their type of therapy and were compared to any
29 other intervention or to wait list controls.

30 **Table 338: Clinical review protocol summary**

Component	Description
Review question(s)	Does any group or individual psychological intervention with or without a pharmacological intervention produce benefits/harms in people with eating disorders compared with any other intervention or controls?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> children (<12), young people (13-17 years), adults ≥18 years eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical eating disorder) mode of delivery (i. individual ii. family iii. group iv. self-help)
Intervention(s)	Psychological intervention including: <ul style="list-style-type: none"> Dialectical behaviour therapy (DBT) Counselling (Nutritional/Other) Integrative Cognitive-Affective Therapy for Binge Eating (ICAT) Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) Cognitive remediation therapy (CRT)

Component	Description
	<ul style="list-style-type: none"> • Specialist supportive clinical management for anorexia nervosa (SSCM) • Behavioural therapy (BT) • CBT (General or ED specific) • Dynamic (IPT, Psychodynamic General or ED specific) • Guided Self Help w therapist guidance • Pure self help • E-therapies Psychological intervention in combination with any pharmacological intervention.
Comparison	<ul style="list-style-type: none"> • Wait list controls • Treatment as usual • Another other intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Frequency of binge eating for bulimia nervosa and binge eating disorder; and weight/body mass index (appropriate adjustment for age) for anorexia nervosa
Important outcomes	<ul style="list-style-type: none"> • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF). • Family functioning. • Service user experience • Quality of life. • All-cause mortality. • Relapse. • Adverse events • Resource use.
Study design	<ul style="list-style-type: none"> • Systematic reviews • RCTs

1 9.2.2 Clinical evidence

2 One RCT (n=35) on individual therapy versus group therapy was identified in people with
 3 EDNOS (Nevonen and Broberg, 2005). Three RCTs (n=396) were found that investigated
 4 the effects of self-help (guided and internet) compared with wait list controls in people with
 5 any eating disorder (Gulec et al., 2014; Hotzel et al., 2014; Traviss et al., 2011). Although the
 6 latter were on people with any eating disorder it was agreed they are best presented in the
 7 EDNOS chapter.

8 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
 9 evidence tables in Appendix L and exclusion list in Appendix J.

Study ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration	N initially randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU
Eating Disorder Not Otherwise Specified EDNOS: Individual therapy										
Nevonen 2005	20.5 (18-24)	21.4	100%	4.5 years after onset of illness	35	Individual hybrid (CBT-ED-IPT)	Group hybrid (CBT-ED-IPT)	23	23 weeks	1 year and 2.5 years
Any eating disorder: Self-help										
Gulec 2014	28.2 (7.8)	21.3 (5.5)	100%	Around half of the participants (n = 46) reported a duration of illness longer than 5 years BED or EDNOS. Unclear what ratio was. The majority of the participants (n = 85) had completed outpatient treatment.	105	Guided self-help (ED) internet based	Wait list controls	16	4 months	None reported
Hötzel 2014	27.6 (8.3)	20.4 (3.6)	100%	NR AN or BN	212	Guided self-help (ED) internet based	Wait list controls	6	6 weeks	None reported
Traviss 2011	37.1 (12.8)	28.0 (7.5)	98%	NR BN (27%), BED (24%) EDNOS (24%), no diagnosis	81	Guided self-help (ED)	Wait list controls	7	12 weeks	None reported

Study ID	Mean Age (SD)	Mean BMI (SD)	Females (%)	Stage of illness: duration (disordered eating) (24%)	N initially randomised	Intervention Category	Comparison Arm Category	Sessions N	Treatment Length	Long-term FU

1

2

3 Table 339: Summary table of findings for individual hybrid therapy versus group hybrid for adults with EDNOS.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Group hybrid	Risk difference with EDNOS Individual hybrid (95% CI)
Depression	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.11 standard deviations lower (0.77 lower to 0.56 higher)
General psychopathology	35 (1 study)	⊕⊕⊕⊕ VERY LOW ¹ due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology in the intervention groups was 0.13 standard deviations lower (0.79 lower to 0.54 higher)
Dietary restraint	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean dietary restraint in the intervention groups was 0.08 standard deviations higher (0.58 lower to 0.74 higher)
EDI Total	35 (1 study)	⊕⊕⊕⊕ LOW ^{1,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total in the intervention groups was 0.29 standard deviations higher (0.38 lower to 0.96 higher)
Remission ITT	35 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4,5} due to risk of bias, indirectness, imprecision	RR 0.79 (0.35 to 1.81)	444 per 1000	93 fewer per 1000 (from 289 fewer to 360 more)

Depression FU	35 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.55 standard deviations higher (0.12 lower to 1.23 higher)
General psychopathology FU	35 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean general psychopathology fu in the intervention groups was 0.33 standard deviations higher (0.33 lower to 1 higher)
Dietary restraint FU	35 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean dietary restraint fu in the intervention groups was 0.14 standard deviations higher (0.52 lower to 0.81 higher)
EDI Total FU	35 (1 study)	⊕⊕⊕⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi total fu in the intervention groups was 0.57 standard deviations higher (0.11 lower to 1.23 higher)
Remission ITT FU	35 (1 study)	⊕⊖⊖⊖ VERY LOW1,4,6 due to risk of bias, indirectness, imprecision	RR 0.81 (0.61 to 1.08)	944 per 1000	179 fewer per 1000 (from 368 fewer to 76 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Unclear methods of randomisation or if allocation concealment was performed. Participants were not blinded, unclear if investigators and assessors were blind. Considerable difference in dropout rates between individual 23% vs. group 5%,

2 95% CI crossed 2 MIDs (-0.5 and 0.5)

3 95% CI crossed 1 MID (0.5)

4 Remission was not a valid measure. It was defined as the percentage of participants who score one or more scale steps lower than their pre-treatment values for binge eating and/or purging at the RAB-R interview. However, you could move from several times each day to 5-7 days a week. Not necessarily zero times a week. Duration may be okay since it is based on DSM-IV.

5 95% CI crossed 2 MIDs (0.75 and 1.25)

6 95% CI crossed 1 MID (0.75)

1 **Table 340: Summary table of findings for internet self-help versus wait list controls for adults with any eating disorder.**

Outcomes	No of Participants	Quality of the evidence (GRADE)		Anticipated absolute effects
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	(studies) Follow up		Relative effect (95% CI)	Risk with WLC	Risk difference with Any ED Internet SH (95% CI)
EDE-Q Total score	78 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q total score in the intervention groups was 0.34 standard deviations lower (0.79 lower to 0.11 higher)
EDE-Restraint	290 (2 studies)	⊕⊕⊕⊖ VERY LOW3,4,5 due to risk of bias, inconsistency, imprecision		Not calculable for SMD values	The mean ede-restraint in the intervention groups was 0.09 standard deviations lower (0.32 lower to 0.14 higher)
EDE-Eating concern	290 (2 studies)	⊕⊕⊕⊖ VERY LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.01 standard deviations lower (0.24 lower to 0.22 higher)
EDE-Weight concern	290 (2 studies)	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.13 standard deviations higher (0.1 lower to 0.37 higher)
EDE-Shape concern	290 (2 studies)	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-shape concern in the intervention groups was 0.09 standard deviations higher (0.14 lower to 0.32 higher)
BMI	212 (1 study)	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.10 standard deviations higher (0.17 lower to 0.37 higher)
Depression	78 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression in the intervention groups was 0.31 standard deviations lower (0.76 lower to 0.14 higher)
Vomiting	212 (1 study)	⊕⊕⊕⊖ LOW3,5 due to risk of bias, imprecision		Not calculable	The mean vomiting in the intervention groups was

				for SMD values	0.21 standard deviations lower (0.48 lower to 0.06 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 No details were provided on how random sequence was generated and it was unclear if allocation concealment was performed. It was unclear if either the participants, investigators or assessors were blind.					
2 95% CI crossed 1 MID (-0.5).					
3 It was unclear if allocation concealment was performed. It was unclear if either the participants, investigators or assessors were blind. High dropouts were reported >20%.					
4 Heterogeneity was detected I ² >50%.					
5 For a continuous variable, there were fewer than 400 participants.					

1 **Table 341: Summary table of findings for guided self-help versus wait list controls for adults with any eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Any ED Guided SH (ED) (95% CI)
EDE-Q Total score	81 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-q total score in the intervention groups was 0.68 standard deviations lower (1.13 to 0.23 lower)
EDE-Restraint	81 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-restraint in the intervention groups was 0.49 standard deviations lower (0.93 to 0.05 lower)
EDE-Eating concern	81 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-eating concern in the intervention groups was 0.6 standard deviations lower (1.05 to 0.15 lower)
EDE-Shape concern	81 (1 study)	⊕⊕⊕⊖ LOW1,2		Not calculable	The mean ede-shape concern in the intervention groups was

		due to risk of bias, imprecision		for SMD values	0.59 standard deviations lower (1.03 to 0.14 lower)
EDE-Weight concern	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede-weight concern in the intervention groups was 0.6 standard deviations lower (1.05 to 0.15 lower)
BMI	81 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.18 standard deviations higher (0.26 lower to 0.61 higher)
Binge eating	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean binge eating in the intervention groups was 0.07 standard deviations lower (0.5 lower to 0.37 higher)
Vomiting	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean vomiting in the intervention groups was 0.12 standard deviations lower (0.55 lower to 0.32 higher)
Laxative use	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean laxative use in the intervention groups was 0.15 standard deviations lower (0.59 lower to 0.29 higher)
Exercise frequency	81 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean exercise frequency in the intervention groups was 0.02 standard deviations higher (0.42 lower to 0.45 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 It was unclear if allocation concealment was performed. It was unclear if either the participants, investigators or assessors were blind. High dropouts were reported >20%.

2 95% CI crossed 1 MID (-0.5).

3 For a continuous outcome, there were fewer than 400 participants.

- 1
- 2
- 3

1 **9.2.3 Economic evidence**

2 No economic evidence on the cost effectiveness of interventions for people with EDNOS was
3 identified by the systematic search of the economic literature undertaken for this guideline.
4 Details on the methods used for the systematic search of the economic literature are
5 described in Chapter 3.

6 **9.2.4 Clinical evidence statements**

7 **9.2.4.1 Individual therapy versus group therapy**

8 **89.2.4.1.1 Individual hybrid compared with group hybrid for people with EDNOS at the end of 9 treatment**

10 Very low quality evidence from one RCT (n=35) showed no difference in the effect of
11 individual hybrid therapy on depression, general psychopathology, EDE-restraint, EDI-total
12 and remission compared with group hybrid.

13 **139.2.4.1.2 Individual hybrid compared with group hybrid for people with EDNOS at follow up**

14 Very low quality evidence from one RCT (n=35) showed no difference in the effect of
15 individual hybrid therapy on depression, general psychopathology, EDE-restraint, EDI-total
16 and remission compared with group hybrid.

17 **179.2.4.1.3 Internet self-help compared with wait list control for people with any eating disorder at 18 the end of treatment**

19 Low quality evidence from one RCT (n=78) showed no difference in the effect of internet self-
20 help on EDE-total and depression compared with wait list controls.

21 Low quality evidence from one RCT (n=212) showed no difference in the effect of internet
22 self-help on BMI compared with wait list controls.

23 Low quality evidence from two RCTs (n=290) showed no difference in the effect of internet
24 EDE-restraint, EDE-eating concern, EDE-shape concern and EDE-weight concern compared
25 with wait list controls.

26 Low quality evidence from one RCT (n=212) showed internet self-help is more effective on
27 vomiting compared with wait list controls but there was some uncertainty.

28 **289.2.4.1.4 Guided self-help compared with wait list control for people with any eating disorder at 29 the end of treatment**

30 Low quality evidence from one RCT (n=81) showed guided self-help is more effective on
31 EDE-total, EDE-restraint, EDE-eating concern, EDE-shape concern and EDE-weight concern
32 compared with wait list controls.

33 Low quality evidence from one RCT (n=81) showed no difference in the effect of guided self-
34 help on BMI, binge eating, vomiting, laxative use and exercise frequency compared with wait
35 list controls.

36 **9.2.5 Economic evidence statements**

37 No economic evidence on the cost effectiveness of interventions for people with EDNOS was
38 available.

1 **9.2.6 Recommendations and link to evidence**2 **Psychological treatment for OSFED (EDNOS)**

139. For people with OSFED, consider using the treatments for the eating disorder it most closely resembles.	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating EDNOS (note: the recommendation replaces the term EDNOS with OSFED). For this population it was agreed that binge-eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with EDNOS that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>Only one RCT was found on the EDNOS population, which compared an individual combined treatment programme with a group combined treatment programme in adult females with EDNOS. At the end of the treatment there was no difference on remission, general psychopathology, EDE-dietary restraint, depression and EDI-total. Similar results were found at follow up. No data was available on binge frequency, adverse events, all-cause mortality, quality of life, resource use, relapse, body weight, general functioning, family functioning, or service user experience. The treatments in the combined study comprised CBT-ED followed by interpersonal psychotherapy in either an individual or group format. The results showed either format was equally effective for this population.</p> <p>Any eating disorder</p> <p>Three studies were found on those with any eating disorder. Two studies compared internet self-help with wait list controls at the end of treatment in adults with a range of eating disorders and showed no difference on EDE-subcales, BMI and depression. However, there was a trend for a reduction in vomiting in the internet self-help group, although there was some uncertainty. No data was available on remission, adverse events, all-cause mortality, quality of life, resource use, relapse, general functioning, family functioning, or service user experience.</p> <p>Another study compared guided self-help with wait list controls in adults with a range of eating disorders and showed no difference in BMI, binge eating, vomiting, laxative use and exercise frequency at the end of the treatment. However, there was a reduction on scores on the EDE-subcales in the guided self-help group. No data was available on remission, adverse events, all-cause mortality, quality of life, resource use, relapse, general psychopathology, general functioning, family functioning, or service user experience. Guided self-help appeared to show some benefit on the EDE-subcales compared with wait list controls but not when specific compensatory behaviours were measured.</p>
Trade-off between net health benefits and resource use	<p>The committee expressed the view that if something is cost effective for people with a particular eating disorder it was reasonable to assume that it would be for a person with EDNOS in-line with the clinical presentation of an eating disorder they most closely resemble.</p>

139. For people with OSFED, consider using the treatments for the eating disorder it most closely resembles.	
Quality of evidence	<p>The evidence was mostly low to very low quality. Outcomes were often downgraded for impression because the 95% confidence interval crossed one or two MIDs or it didn't meet the optimal information size.</p> <p>In the study on combined treatments, the definition of remission used was problematic - the percentage of participants who score one or more scale steps lower than their pre-treatment values for binge eating and/or purging using a revised version of the Rating of Anorexia/Bulimia interview - and could have been excluded for this reason. However, this definition of remission would include people who move from the 'binge or purge several times each day' category to 'binge or purge from five to seven days a week', rather than those who have stopped bingeing over a two week period.</p> <p>No data was available comparing the individual or group interventions with wait list controls, so it is difficult to know if they are better than no treatment alone. No data was available on children or young people with EDNOS.</p>
Other considerations	Given the scarcity of data on this population, the committee drew on their knowledge and experience and by informal consensus agreed that it was preferable to recommend psychological treatments for a person with EDNOS (OSFED) in line with the clinical presentation of the eating disorder that their signs and symptoms most closely resemble.

1 9.3 Carer interventions

2 9.3.1 Review question: Does any psychological intervention produce benefits/harms 3 in the parents or carers of children or young people with an eating disorder 4 compared with any other intervention or controls?

5 The review protocol summary, including the review question and the eligibility criteria used
6 for this section of the guideline, can be found in Table 342. Further information about the
7 search strategy can be found in Appendix H; the full review protocols can be found in
8 Appendix F.

9 This review considers all psychological interventions for the parents or carers of children or
10 young people with an eating disorder. The interventions were categorised according to their
11 mode of delivery (e.g. group, individual or self-help), the age of the people with the eating
12 disorder and the type of eating disorder. The control arm could include wait list controls,
13 treatment as usual or any other intervention, however results comparing an intervention with
14 wait list controls were always presented separately.

15 **Table 342: Clinical review protocol summary**

Component	Description
Review question(s)	Does any psychological intervention produce benefits/harms in the parents or carers of children or young people with an eating disorder compared with any other intervention or controls?
Population	<ul style="list-style-type: none"> Family or carers of people with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder)
Intervention(s)	Psychological interventions may include:

Component	Description
	<ul style="list-style-type: none"> • Family-based • Parent only (not necessarily focussed on eating disorder) • Parent-focused therapy (PFT) • Group Parent-Training (GPT) • Separated family therapy • Parents with person with ED (greater focus on eating disorder) • Behavioural Family Therapy (BFT) • Behavioural family systems therapy (BFST). • Family-based Treatment (FBT) • Family Day Workshops (FDW) • Family Therapy (FT) • Family therapy for anorexia nervosa (FT-AN) • Multi-Family Group Day Treatment (MFGDT) • Multi-Family Group Therapy (MFGT) • Systemic Family Therapy (SFT) • Systemic Family Therapy for AN (SFT-AN) • Multifamily therapy (MFT) is synonymous with (MFGT; MFGDT). • Uniting couples in the treatment of AN (UCAN) • Conjoint family therapy
Comparison	<ul style="list-style-type: none"> • Wait list controls • Treatment as usual • Another intervention
Critical outcomes	<ul style="list-style-type: none"> • Parent's or carer's general psychopathology (including mood/depression/anxiety) • Family functioning • Quality of life • Other primary outcomes commonly reported in studies that just target the family/carer <p>The following outcomes will be included if the family or carer intervention includes the child or person with an eating disorder:</p> <ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • General functioning • Resource use. • Service user experience • All-cause mortality. • Adverse events • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 9.3.2 Clinical evidence

2 Two RCTs (n=204) met the eligibility criteria for this review, one of which was in young
3 people (Spettigue et al., 2015), the other which was in adults (Goddard, 2011). An overview
4 of all the trials included in the review can be found in Table 343. Further information about
5 both included and excluded studies can be found in Appendix J.

6 One study (n=51) examined the efficacy of psychoeducation that included a 2-hour session
7 and bi-weekly telephone support calls in the time before formal assessment calls compared
8 with wait list controls (Spettigue 2015). Another study (n=153) examined the efficacy of the
9 Expert Carers Helping Others (ECHO) self-help intervention with and without guidance
10 (Goddard 2011).

11 Summary of findings for interventions for carers of people with any eating disorder can be
12 found in Table 344, Table 345 and Table 346. See also the study selection flow chart in
13 Appendix K, forest plots in Appendix M, study evidence tables in Appendix L and exclusion
14 list in Appendix J.

1 **Table 343: Study information for trials included in the review of interventions for carers of people with any eating disorder**

Study ID	Mean Age of Carer (SD)	Female carers (%)	Mean Age of patient (SD)	Female patients (%)	Sample	N Randomised	Intervention	Comparison	Number of sessions	Length of interventions	Follow up
Goddard 2011	49.6 (8.1)	89	20.9 (6.8)	95	Carers of people with an eating disorder	153 carers	Guided Self-Help (ECHO)	Self-Help Only (ECHO)	3 x 40m telephone guidance sessions	6 weeks	3 months
Spettigue 2015	Not reported	92	15.7 (1.5)	97	Carers of medically stable young people awaiting treatment from specialist ED programs	51 carers	Psychoeducation session + telephone support	Wait list control	2 hour psychoeducation session and 2 x weekly phone calls until assessment	Mean of 94 days (range 27-287) to assessment	-

2 Abbreviations: ECHO, Expert Carers Helping Others

3 **Table 344: Summary table of findings for psychoeducation versus wait list control in carers of young people with any eating disorder at end of treatment.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Psychoeducation (95% CI)
Carer Self-Efficacy Parents Versus Anorexia (PVA)	31 (1 study) 260 days	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for	The mean carer self-efficacy in the intervention groups was 1.74 standard deviations higher (0.89 to 2.59 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Psychoeducation (95% CI)
				SMD values	
Carer Knowledge of ED Knowledge of Eating Disorders Scale (KEDS)	28 (1 study) 260 days	⊕⊖⊖⊖ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean carer knowledge of ed in the intervention groups was 0.75 standard deviations higher (0.04 lower to 1.54 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval;</p> <p>1 Spettigue 2015: Randomization method unclear, allocation concealment unclear, participant and assessor not blinded, investigator blinding unclear, dropout rate for both arms >20%, available case analysis.</p> <p>2 Study targeted carers of medically stable young people awaiting assessment by specialized eating disorder program. End of treatment data for wait list control was after 1 month. At time of assessment, 4 of 36 young people were not diagnosed with an eating disorder. Mean time to assessment: 94 days, range 27-287 days</p> <p>3 Fewer than 400 participants.</p> <p>4 CI crosses either 0.5 or -0.5 (SMD).</p>					

1 **Table 345: Summary table of findings for psychoeducation versus wait list control in carers of young people with any eating disorder**
 2 **at formal assessment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with WLC	Risk difference with Psychoeducation (95% CI)
Carer Self-Efficacy FU Parents Versus Anorexia (PVA)	31 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean carer self-efficacy fu in the intervention groups was 0.89 standard deviations higher (0.14 to 1.64 higher)
Carer Knowledge of ED FU Knowledge of Eating Disorders Scale (KEDS)	28 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean carer knowledge of ed fu in the intervention groups was 0.99 standard deviations higher (0.18 to 1.8 higher)
Carer Burden FU Eating Disorder Symptom Impact Scale (EDSIS)	36 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean carer burden fu in the intervention groups was 0.57 standard deviations higher (0.11 lower to 1.25 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; FU: Follow up

1 Spettigue 2015: Randomization method unclear, allocation concealment unclear, participant and assessor not blinded, investigator blinding unclear, dropout rate for both arms >20%, available case analysis.

2 Study targeted carers of medically stable young people awaiting assessment by specialized eating disorder program. End of treatment data for wait list control was after 1 month. At time of assessment, 4 of 36 young people were not diagnosed with an eating disorder. Mean time to assessment: 94 days, range 27-287 days

3 CI crosses either 0.5 or -0.5 (SMD).

1 **Table 346: Summary table of findings for guided self-help versus self-help in carers of adults with any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Self-Help	Risk difference with Guided Self-Help (95% CI)
Carer Burden ECI Negative; EDSIS	120 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer burden in the intervention groups was 0.02 standard deviations higher (0.24 lower to 0.27 higher)
Carer Quality of Life General Health Questionnaire-12 (GHQ-12)	120 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer quality of life in the intervention groups was 0.07 standard deviations lower (0.43 lower to 0.28 higher)
Carer Self-Efficacy Revised Scale for Caregiving Self-Efficacy (CSE)	120 (1 study) 3 months	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer self-efficacy in the intervention groups was 0.15 standard deviations higher (0.21 lower to 0.51 higher)
Experience of Caregiving Inventory (ECI) Positive Experience of Caregiving Inventory (ECI)	120 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean experience of caregiving inventory (eci) positive in the intervention groups was 0.05 standard deviations higher (0.3 lower to 0.41 higher)
Carer Accommodation & Enabling AESED	120 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer accommodation & enabling in the intervention groups was 0.01 standard deviations lower (0.37 lower to 0.35 higher)
Carer General Psychopathology (Distress) Hospital & Anxiety Depression Scale (HADS)	120 (1 study) 3 months	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean carer general psychopathology (distress) in the intervention groups was 0.06 standard deviations lower (0.42 lower to 0.3 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; FU: Follow up					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Self-Help	Risk difference with Guided Self-Help (95% CI)
1 Goddard 2011: Unclear whether baseline characteristics of carers were similar. Also, dropout rate <20% and reasons not stated. 2 Fewer than 400 participants. 3 CI crosses either 0.5 or -0.5 (SMD).					

1

2

1 9.3.3 Economic evidence

2 No economic evidence on the cost effectiveness of interventions for the parents or carers of
3 children or young people with EDNOS was identified by the systematic search of the
4 economic literature undertaken for this guideline. Details on the methods used for the
5 systematic search of the economic literature are described in Chapter 3.

6 9.3.4 Clinical evidence statements

7 9.3.4.1 Psychoeducation versus wait list control in carers of young people with any eating 8 disorder at end of treatment

9 Very low quality evidence from one RCT (n=31) showed psychoeducation is more effective
10 on carer self-efficacy compared with wait list control.

11 Very low quality evidence from one RCT (n=28) showed psychoeducation may be more
12 effective on the carer's knowledge of eating disorders compared with wait list control,
13 although there was some uncertainty.

14 9.3.4.2 Psychoeducation versus wait list control in carers of young people with any eating 15 disorder at formal assessment

16 Very low quality evidence from one RCT (n=31) showed psychoeducation is more effective
17 on carer self-efficacy compared with wait list control.

18 Very low quality evidence from one RCT (n=28) showed psychoeducation is more effective
19 on the carer's knowledge of eating disorders compared with wait list control.

20 Very low quality evidence from one RCT (n=36) showed no difference in the effect of
21 psychoeducation on the burden of the eating disorder on the carer compared with wait list
22 control.

23 9.3.4.3 Guided self-help versus self-help in carers of adults with any eating disorder

24 Low quality evidence from one RCT (n=120) showed no difference in the effect of guided
25 self-help on the burden of the eating disorder on the carer, carer quality of life, carer self-
26 efficacy, carer positive experience of caregiving, carer accommodation and enabling and
27 carer general psychopathology compared with self-help only.

28 9.3.5 Economic evidence statements

29 No economic evidence on the cost effectiveness of interventions for the parents or carers of
30 children or young people with EDNOS was available.

31 9.3.6 Recommendations and link to evidence

32 Working with family members and carers

	See Section 6.3.6 for relevant recommendations
Relative value of different outcomes	The committee discussed the importance and relevance of various outcomes, when assessing whether any interventions help the parents and carers of children and young people with an eating disorder. The critical outcomes for the parents and carers were: general psychopathology, family functioning, quality of life, and other primary outcomes reported by the study.

	<p>Other outcomes that are critical for the child or young person with the eating disorder include remission and binge eating or body weight, depending on the eating disorder.</p> <p>Other outcomes that are of lesser importance but clearly important outcomes include, general functioning, service user experience, all-cause mortality, adverse events and eating disorder psychopathology.</p>
Trade-off between clinical benefits and harms	<p>Randomised control trials investigating interventions for the carers of young people with any eating disorder did not show many favourable outcomes.</p> <p>Psychoeducation compared with waitlist control showed a positive effect on carer self-efficacy and a trend to improve carer knowledge of eating disorders at the end of treatment. Long-term follow up showed favourable results in both but carer burden (only measured at follow up) was not different compared with wait list controls. No evidence was found on the critical outcomes of carer general psychopathology, family functioning, and quality of life, nor on the other important outcomes.</p> <p>Comparing guided self-help with self-help showed no difference in any of the carer-related outcomes at the end of treatment. No evidence was found on the other important outcomes.</p> <p>For discussion of carer interventions for other eating disorders, see the LETRs in 6.3.6</p>
Trade-off between net health benefits and resource use	<p>The committee expressed the view that offering family members and carers an assessment of their own needs may incur additional healthcare resources (that is, time required to perform such assessment). However, the committee considered the cost of providing such assessment to be small, taking into account the potential reduction in family and carers' burden, potential depression and other health vulnerabilities which may be costly to other parts of the healthcare system, especially considering that the burden on family and carers can last for many years and increase their morbidity and stress. Consequently, the committee judged that assessment that aims to improve family and carers' experience are likely to represent good value for money.</p>
Quality of evidence	<p>The quality of the evidence was mostly very low. High dropout rates >20% were also detected in some groups.</p> <p>Imprecision was detected in most outcomes due to the 95% confidence interval crossing one or two MIDs or because it did not meet the optimal information size.</p> <p>Outcomes were not always measured at the end of treatment or at follow up. It is not known if any improvements in the carer's general psychopathology also translated to benefits in the children with the eating disorder.</p>
Other considerations	<p>Given the very low quality of the data with lack of strong positive findings, the committee decided that there was not enough evidence to support a recommendation on any specific intervention for parents or carers of people with an eating disorder.</p> <p>See the LETR in Section 6.3.6 for further discussion of carer interventions.</p>

1 9.4 Pharmacological interventions

2 9.4.1 Review question: Does any pharmacological intervention produce 3 benefits/harms on specified outcomes in people with eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 347. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all pharmacological interventions that may be delivered to children,
9 young people and adults with an eating disorder with or without a psychological intervention.
10 The interventions were categorised according to the type of pharmacological intervention, the
11 age of the participants and the type of eating disorder. In addition, the interventions were
12 grouped according to their type of therapy and were compared to placebo, wait list controls
13 or any other intervention

14 **Table 347: Clinical review protocol summary**

Component	Description
Review question(s)	Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	<ul style="list-style-type: none"> • Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). • Strata: <ul style="list-style-type: none"> ○ children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years ○ eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	Pharmacological interventions may include: <ul style="list-style-type: none"> • Antidepressants, e.g. SSRIs, fluoxetine (Prozac) • Anxiolytics (antianxiety) • Antipsychotics • Antiemetic medication, e.g. ondansetron • Antiepileptic/anticonvulsant, e.g. topiramate (Topomax) • Appetite suppressant, e.g. lisdexamfetamine dimesylate • Pharmacological in combination with any psychological intervention
Comparison	<ul style="list-style-type: none"> • Placebo • Wait list control • Treatment as usual • Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN • Adverse events
Important outcomes	<ul style="list-style-type: none"> • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety)

Component	Description
	<ul style="list-style-type: none"> • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Relapse • Resource use • Quality of life • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 9.4.2 Clinical evidence

2 No studies were identified that met the eligibility criteria for this review. Further information
3 about excluded studies can be found in Appendix J. See also the study selection flow chart in
4 Appendix K.

5 9.4.3 Economic evidence

6 No economic evidence on the cost effectiveness of pharmacological interventions for the
7 treatment of EDNOS was identified by the systematic search of the economic literature
8 undertaken for this guideline. Details on the methods used for the systematic search of the
9 economic literature are described in Chapter 3.

10 9.4.4 Clinical evidence statements

11 No studies were identified that met the eligibility criteria for this review.

12 9.4.5 Economic evidence statements

13 No economic evidence on the cost effectiveness of pharmacological interventions for people
14 with EDNOS was available.

15 9.4.6 Recommendations and link to evidence

Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating OSFEDs. For this population it was agreed that binge-eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p>
Trade-off between clinical benefits and harms	<p>No RCT evidence was identified on pharmacological interventions for people with EDNOS.</p> <p>The committee expressed the view that if something is cost effective for people with a particular eating disorder it will be for a person with EDNOS in-line with the clinical presentation of an eating disorder they most closely resemble.</p>
Trade-off between net health benefits and resource use	<p>The network meta-analysis found no evidence for the effectiveness of pharmacological interventions for the management of people with bulimia nervosa and BED. As a result the committee expressed the view that such treatments are unlikely to be effective nor cost effective in people with EDNOS.</p>

Quality of evidence	No RCT evidence was identified on pharmacological interventions for people with EDNOS.
Other considerations	Given the absence of evidence for pharmacological interventions for EDNOs the committee decided not to recommend pharmacological interventions.

1 9.5 Nutritional interventions

2 9.5.1 Review question: Does any nutritional intervention produce benefits/harms on 3 specified outcomes in people with eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 348. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all nutritional interventions that may be delivered to children, young
9 people and adults with an eating disorder with or without a pharmacological intervention.
10 The interventions were categorised according to type of nutritional intervention, the age of
11 the participants and the type of eating disorder. In addition, the interventions were grouped
12 according to their type of therapy and were compared to wait list controls, placebo, or any
13 other intervention.

14 **Table 348: Clinical review protocol summary**

Component	Description
Review question(s)	Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<ul style="list-style-type: none"> Nutritional intervention Method of feeding Nutritional in combination with any pharmacological intervention Examples of nutritional interventions are nutritional counselling (with or without educational and supportive groups) and supplements (e.g. zinc)
Comparison	<ul style="list-style-type: none"> Placebo Wait list control Treatment as usual Another intervention (psychological, pharmacological, nutritional, physical)
Critical outcomes	<ul style="list-style-type: none"> Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) Binge eating for BN and BED Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> Adverse events All-cause mortality Cost effectiveness

Component	Description
	<ul style="list-style-type: none"> Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) Family functioning General psychopathology (including mood/depression/anxiety) General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) Quality of life Relapse Resource use Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs

1 9.5.2 Clinical evidence

2 No studies were identified that met the eligibility criteria for this review. Further information
3 about excluded studies can be found in Appendix J. See also the study selection flow chart in
4 Appendix K.

5 9.5.3 Economic evidence

6 No economic evidence on the cost effectiveness of nutritional interventions for people with
7 EDNOS was identified by the systematic search of the economic literature undertaken for
8 this guideline. Details on the methods used for the systematic search of the economic
9 literature are described in Chapter 3.

10 9.5.4 Clinical evidence statements

11 No studies were identified that met the eligibility criteria for this review

12 9.5.5 Economic evidence statements

13 No economic evidence on the cost effectiveness of nutritional interventions for people with
14 EDNOS was available.

15 9.5.6 Recommendations and link to evidence

The committee agreed that people with OFSED should be treated in-line with the eating disorder their symptoms most closely resemble	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of psychotherapies for treating OSFEDs. For this population it was agreed that binge-eating frequency and remission are of greatest concern.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p>
Trade-off between clinical benefits and harms	No relevant published evidence was identified.

Trade-off between net health benefits and resource use	No relevant published economic evidence was identified.
Quality of evidence	Not applicable
Other considerations	The committee agreed that people with EDNOS should be treated in-line with the eating disorder their symptoms most closely resemble.

1 9.6 Physical interventions

2 9.6.1 Review question: Do physical interventions, such as transcranial magnetic 3 stimulation or physiotherapy, produce benefits/harms in people with eating 4 disorders?

5 The review protocol summary, including the review question and the eligibility criteria used
6 for this section of the guideline, can be found in Table 349. Further information about the
7 search strategy can be found in Appendix H; the full review protocols can be found in
8 Appendix F.

9 This review considers all physical interventions that may be delivered to children, young
10 people and adults with an eating disorder. The interventions were categorised according to
11 type of physical intervention, the age of the participants and the type of eating disorder and
12 were compared to wait list controls, placebo, treatment as usual or any other intervention.

13 **Table 349: Clinical review protocol summary**

Component	Description
Review question(s)	Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, produce benefits/harms in people with eating disorders?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder). Strata: <ul style="list-style-type: none"> children (≤ 12), young people (13–≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	Physical interventions may include: <ul style="list-style-type: none"> transcranial magnetic stimulation deep brain stimulation physiotherapy yoga physical exercise acupuncture mandometer massage
Comparison	<ul style="list-style-type: none"> Placebo Wait list control Treatment as usual Another intervention

Component	Description
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs

1 9.6.2 Clinical evidence

2 Four RCTs (n=171) met the eligibility criteria for this review (Boerhout et al., 2016; Carei et
3 al., 2010; Hildebrandt et al., 2012; Trottier et al., 2015). The majority of studies were in an
4 outpatient setting and the majority of participants were adult females (no young people). One
5 study was conducted after participants had received treatment in an intensive day hospital
6 setting (Trottier 2015). Further information about both included and excluded studies can be
7 found in Appendix J.

8 Summary of findings for those on any eating disorder can be found in **Error! Reference s**
9 **ource not found.** Table 351, Table 352, Table 353, Table 354, Table 355 and Table 356.
10 See also the study selection flow chart in Appendix K, forest plots in Appendix M, study
11 evidence tables in Appendix L and exclusion list in Appendix J.

1 **Table 350: Study information for trials included in the analysis of physical interventions versus any other intervention or wait list**
 2 **control for people with any eating disorder.**

Study ID	N Randomized	Female (%)	Mean BMI (SD) (kg/m ²) or other	Sample	Intervention Age at onset and/or duration of illness (years)	Comparison(s) Age at onset and/or duration of illness (years)	Duration
Boerhout 2016	40	100	Not reported	Adult AN=9 BN=16 BED=4	Psychomotor therapy + supportive contact	Supportive contact	Not reported, Six 1 hour sessions of psychomotor therapy
Carei 2010	53	92	19.2 (2.7)	Young people & Adult outpatients AN=29; BN=9; EDNOS=15	Yoga + treatment as usual Length of illness for whole sample: 1.2 (1.4)	Treatment as usual Length of illness for whole sample: 1.2 (1.4)	9 weeks; 3 weeks FU
Hildebrandt 2012	33	88	21.9 (2.3)	Adult AN in partial remission=3 BN=2 EDNOS=26 BED=2	Acceptance-based mirror exposure therapy + treatment as usual	Non-Directive Body Image Therapy + treatment as usual	5 x 50 min sessions; 1-mo FU
Trottier 2015	45	100	22.6 (3.1)	Adults in partial remission AN=1; BN=29; EDNOS=4	Graded body image exposure + maintenance treatment as usual	Maintenance treatment as usual	4 weeks + 4-16 weeks of maintenance treatment as usual

3 Notes: *, participants randomised to interventions after intensive day hospital treatment. Abbreviations: FU: follow up

1 **Table 351: Summary table of findings for yoga and treatment as usual versus treatment as usual in young people with any eating disorder at end of treatment**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with treatment as usual	Risk difference with Yoga+ treatment as usual (95% CI)
BMI	53 (1 study) 3 weeks	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI in the intervention groups was 0.22 standard deviations higher (0.32 lower to 0.76 higher)
EDE Global	53 (1 study) 3 weeks	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global in the intervention groups was 0.05 standard deviations higher (0.49 lower to 0.59 higher)
EDE Restraint	53 (1 study) 3 weeks	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint in the intervention groups was 0.22 standard deviations lower (0.76 lower to 0.32 higher)
EDE Weight Concern	53 (1 study) 3 weeks	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern in the intervention groups was 0.14 standard deviations higher (0.4 lower to 0.68 higher)
EDE Shape Concern	53 (1 study) 3 days	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern in the intervention groups was 0.14 standard deviations higher (0.4 lower to 0.68 higher)
EDE Eating Concern	53 (1 study) 3 weeks	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern in the intervention groups was 0.09 standard deviations higher (0.45 lower to 0.62 higher)
Depression BDI-2	53 (1 study) 3 weeks	⊕⊖⊖⊖ VERY LOW1,3		Not calculable	The mean depression in the intervention groups was

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with treatment as usual	Risk difference with Yoga+ treatment as usual (95% CI)
		due to risk of bias, imprecision		for SMD values	0 standard deviations higher (0.54 lower to 0.54 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Carei 2010: Unclear randomization method (stratified, permuted block scheme after baseline measures. No participant blinding; unclear investigator and assessor blinding. Sample consisted of 29 AN, 9 BN, and 15 EDNOS).					
2 CI crosses either 0.5 or -0.5 (SMD).					
3 CI crosses both 0.5 and 0.5 (SMD).					

1 **Table 352: Summary table of findings for yoga and treatment as usual versus treatment as usual in young people with any eating disorder at follow up**

2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with treatment as usual	Risk difference with Yoga + treatment as usual (95% CI)
BMI FU	53 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI fu in the intervention groups was 0.21 standard deviations higher (0.33 lower to 0.75 higher)
EDE Global FU	53 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede global fu in the intervention groups was 0.38 standard deviations lower (0.92 lower to 0.17 higher)
EDE Restraint FU	53 (1 study)	⊕⊕⊖⊖ LOW _{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint fu in the intervention groups was 0.65 standard deviations lower (1.2 to 0.09 lower)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with treatment as usual	Risk difference with Yoga + treatment as usual (95% CI)
EDE Weight Concern FU	53 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concern fu in the intervention groups was 0.09 standard deviations lower (0.63 lower to 0.45 higher)
EDE Shape Concern FU	53 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concern fu in the intervention groups was 0.36 standard deviations lower (0.9 lower to 0.19 higher)
EDE Eating Concern FU	53 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concern fu in the intervention groups was 0.28 standard deviations lower (0.82 lower to 0.27 higher)
Depression FU BDI-2	53 (1 study)	⊕⊕⊕⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean depression fu in the intervention groups was 0.09 standard deviations lower (0.63 lower to 0.45 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; FU: Follow up					
1 Carei 2010: Unclear randomization method (stratified, permuted block scheme after baseline measures. No participant blinding; unclear investigator and assessor blinding. Sample consisted of 29 AN, 9 BN, and 15 EDNOS.					
2 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 353: Summary table of findings for body image therapy and maintenance treatment as usual versus maintenance treatment as usual in adults with any eating disorder at end of treatment**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with MTAU for adult ED	Risk difference with Body image therapy+MTAU (95% CI)

EDE weight concerns	45 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede weight concerns in the intervention groups was 0.11 standard deviations lower (0.7 lower to 0.47 higher)
EDE shape concerns	45 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concerns in the intervention groups was 0.24 standard deviations higher (0.35 lower to 0.82 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; FU: Follow up

1 Trotter 2015: Randomization method not specified, unclear allocation concealment; no participant nor investigator blinding, unclear assessor blinding. Dropout both groups >20%.

2 Participants received interventions after intensive day hospital treatment involving group cognitive behavioural program.

3 CI crosses either 0.5 or -0.5 (SMD).

1 **Table 354: Summary table of findings for body image therapy and maintenance treatment as usual versus maintenance treatment as usual in adults with any eating disorder at follow up**

2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with MTAU for adult ED 6-mo FU	Risk difference with Body image therapy+MTAU (95% CI)
EDE weight concerns	45 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede weight concerns in the intervention groups was 0.2 standard deviations higher (0.39 lower to 0.79 higher)
EDE shape concerns	45 (1 study) 6 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede shape concerns in the intervention groups was 0.03 standard deviations lower (0.61 lower to 0.56 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Trotter 2015: Randomization method not specified, unclear allocation concealment; no participant nor investigator blinding, unclear assessor blinding. Dropout both groups >20%.

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with MTAU for adult ED 6-mo FU	Risk difference with Body image therapy+MTAU (95% CI)
2 Participants received interventions after intensive day hospital treatment involving group cognitive behavioural program.					
3 CI crosses either 0.5 or -0.5 (SMD).					
4 CI crosses both 0.5 and -0.5 (SMD).					

1 **Table 355: Summary table of outcomes for body image therapy 1 (acceptance-based mirror exposure therapy and treatment as usual)**
 2 **versus body image therapy 2 (non-directive body image therapy and TAU) in adults with any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Body Image Therapy-2	Risk difference with Body Image Therapy-1 (95% CI)
EDE-Q Restraint	33 (1 study) 1 months	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede-q restraint in the intervention groups was 0.11 standard deviations lower (0.35 lower to 0.13 higher)
EDE-Q Eating Concern	33 (1 study) 1 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede-q eating concern in the intervention groups was 0.33 standard deviations lower (0.57 to 0.09 lower)
EDE-Q Shape Concern	33 (1 study) 1 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede-q shape concern in the intervention groups was 0.68 standard deviations lower (0.94 to 0.43 lower)
EDE-Q Weight Concern	33 (1 study) 1 months	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede-q weight concern in the intervention groups was 0.73 standard deviations lower (0.99 to 0.48 lower)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Hildebrandt 2012: Unclear randomization and allocation concealment. No assessor blinding. Control group dropout rate>20%.					
2 Inclusion criteria included participation in concurrent psychotherapy. 18 of the 31 participants were receiving either CBT or Family Therapy.					

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Body Image Therapy-2	Risk difference with Body Image Therapy-1 (95% CI)
3 <400 participants.					
4 CI crosses either 0.5 or -0.5 (SMD).					

1 **Table 356: Summary table of findings for psychomotor therapy and support versus support in adult females with any eating disorder**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Support	Risk difference with Psychomotor Therapy + Support (95% CI)
Self-Expression & Control Scale - Anger In	29 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean self-expression & control scale - anger in in the intervention groups was 0.49 standard deviations lower (1.24 lower to 0.26 higher)
Self-Expression & Control Scale - Anger Out	29 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean self-expression & control scale - anger out in the intervention groups was 0.28 standard deviations lower (1.02 lower to 0.47 higher)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval;					
1 Boerhout 2016: unclear randomisation method; no participant nor investigator blinding. Dropout rate of both groups >20%. Supportive contact included consultation with hospital staff once every one or two weeks, prescription of medication, psychoeducation, and diet management. Sample consisted of 9 AN, 16 BN and 4 BED participants.					
2 CI crosses either 0.5 or -0.5.					

2

3

4

1 **9.6.3 Economic evidence**

2 No economic evidence on the cost effectiveness of physical interventions for people with
3 EDNOS was identified by the systematic search of the economic literature undertaken for
4 this guideline. Details on the methods used for the systematic search of the economic
5 literature are described in Chapter 3.

6 **9.6.4 Clinical evidence statements**

7 **9.6.4.1 Yoga and treatment as usual versus treatment as usual in adults with any eating 8 disorder at end of treatment**

9 Low quality evidence from one RCT (n=53) showed no difference in the effect of yoga and
10 treatment as usual on BMI, EDE-global, EDE-dietary restraint, EDE-weight concern, EDE-
11 shape concern, EDE-eating concern and depression compared with treatment as usual.

12 **9.6.4.2 Yoga and treatment as usual versus treatment as usual in adults with eating disorder 13 at follow up**

14 Low quality evidence from one RCT (n=53) showed no difference in the effect of yoga and
15 treatment as usual on BMI, EDE-global, EDE-weight concern, EDE-shape concern, EDE-
16 eating concern and depression compared with treatment as usual.

17 Low quality evidence from one RCT (n=53) showed yoga and treatment as usual is more
18 effective on EDE-dietary restraint compared with treatment as usual.

19 **9.6.4.3 Graded body image therapy and maintenance treatment as usual versus maintenance 20 treatment as usual in adults with any eating disorder at end of treatment**

21 Very low quality evidence from one RCT (n=45) showed no difference in the effect of graded
22 body image exposure therapy and maintenance treatment as usual on EDE-weight concern
23 and EDE-shape concern compared with maintenance treatment as usual.

24 **9.6.4.4 Graded body image therapy and maintenance treatment as usual versus maintenance 25 treatment as usual in adults with any eating disorder at follow up**

26 Very low quality evidence from one RCT (n=45) showed no difference in the effect of graded
27 body image exposure therapy and maintenance treatment as usual on EDE-weight concern
28 and EDE-shape concerns compared with maintenance treatment as usual.

29 **9.6.4.5 Acceptance-based mirror exposure therapy and treatment as usual versus non- 30 directive body image therapy and treatment as usual in adults with any eating disorder 31 at end of treatment**

32 Very low quality evidence from one RCT (n=33) showed acceptance-based mirror exposure
33 therapy is more effective on EDE-Q-eating concern, EDE-Q-shape concern and EDE-Q-
34 weight concern compared with non-directive body image therapy.

35 Very low quality evidence from one RCT (n=33) showed no difference in the effect of
36 acceptance-based mirror exposure therapy on EDE-Q-dietary restraint compared with non-
37 directive body image therapy.

1 **9.6.4.6 Psychomotor therapy and supportive contact versus supportive contact in adults with**
2 **any eating disorder**

3 Very low quality evidence from one RCT (n=29) showed no difference in the effect of
4 psychomotor therapy and support on Self-Expression and Control Scale-anger in and Self-
5 Expression and Control Scale-anger out compared with support only.

6 **9.6.5 Economic evidence statements**

7 No economic evidence on the cost effectiveness of physical interventions for people with
8 EDNOS was available.

9 **9.6.6 Recommendations and link to evidence**

10 **Physical therapy for any eating disorder**

See Section 6.6.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes for the review on the effectiveness of physical interventions, such as transcranial magnetic stimulation or physiotherapy in people with eating disorders and it was agreed that for any eating disorder remission is of greatest concern. The other critical outcomes for anorexia nervosa are body weight and BMI and for binge eating disorder and bulimia nervosa it is binge eating.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in randomised controlled trials for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse, thus they were extracted where possible, but did not factor strongly in the decision making.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>An RCT was identified that compared yoga and treatment as usual with treatment as usual in adults with any eating disorder. At the end the treatment, no difference was found in any of the outcomes including BMI, EDE-total or any of the EDE- sub-scales. Similar findings were found at follow up (three weeks), however there was some improvement in EDE-restraint in the yoga and treatment as usual group compared with treatment as usual. No evidence was found on the critical outcomes of remission and binge eating, nor on the important outcomes of quality of life, all-cause mortality, relapse, general functioning, family functioning, resource use, and service user experience.</p> <p>A graded body image therapy (and maintenance treatment as usual) was compared with a maintenance treatment as usual in adults with any eating disorder. No difference was found in EDE-weight concerns or EDE-shape concerns at the end of treatment or at follow up. No evidence was found on the critical outcomes of remission, weight and binge eating, nor on the important outcomes of quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p> <p>An acceptance-based body image mirror exposure therapy was compared with a control therapy and showed an improvement in EDE-eating concerns, EDE-weight concerns, EDE-shape concerns, but not in EDE-restraint. No evidence was found on the critical outcomes of remission, weight and binge eating, nor on the important outcomes of quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p>

	<p>A psychomotor therapy and support was compared with support in females with any eating disorder and showed no difference at the end of treatment on self-expression and control anger scales. No evidence was found on the critical outcomes of remission, weight and binge eating, nor on the important outcomes of quality of life, all-cause mortality, eating disorder psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p> <p>For discussion of physical interventions for other eating disorders, see the LETRs in the relevant chapters.</p>
Trade-off between net health benefits and resource use	There was no evidence for the effectiveness of physical interventions in people with EDNOS. As a result, such interventions are likely to be not cost effective.
Quality of evidence	<p>The evidence for physical interventions was mostly very low quality.. High dropout rates were also detected, with more than 20% dropping out in each arm.</p> <p>Most of the outcomes were the result of a single study with a very low number of participants, only binge eating disorder had more than 100 participants in total. Imprecision was detected in most outcomes because the 95% confidence interval crossed one or two MIDs or it did not meet the optimal information size.</p> <p>Also, few studies measured remission and/or compensatory behaviours relevant to that eating disorder. Some outcomes were excluded from the study because it was either unclear over what duration they measured the symptoms or it was less than the two week minimum required by the committee.</p>
Other considerations	<p>The committee agreed that the evidence presented was not strong enough nor of sufficient quality to offer a physical intervention to people with EDNOS</p> <p>See LETR in Section 6.6.6 for further discussion of physical interventions.</p>

1 9.7 Management of long- and short-term complications

2 9.7.1 Review question: What interventions are effective at managing or reducing 3 short and long-term physical complications of eating disorders?

4 The review protocol summary, including the review question and the eligibility criteria used
5 for this section of the guideline, can be found in Table 357. Further information about the
6 search strategy can be found in Appendix H; the full review protocols can be found in
7 Appendix F.

8 This review considers all interventions that may be delivered to manage or reduce the short-
9 or long-term physical complications of eating disorders in children, young people and adults
10 and includes recovered as well as current service users. The interventions were categorised
11 according to type of physical complication and intervention, the age of the participants and
12 the type of eating disorder. The control arm varied depending on the study.

13 **Table 357: Clinical review protocol summary**

Component	Description
Review question(s)	What interventions are effective at managing or reducing short and long-term physical complications of eating disorders?

Component	Description
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) Recovered or current service users <p>Strata:</p> <ul style="list-style-type: none"> children (≤ 12), young people (13-≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Interventions to address the following:</p> <ul style="list-style-type: none"> Low bone mineral density (risk of fracture) Growth (physical development) Pubertal development Tooth wear Low body weight <p>Interventions to address the long-term physical complications may include:</p> <ul style="list-style-type: none"> GH/IGF-I Calcium with and without Vitamin D Bisphosphonates (age dependent and exclude pregnancy) Exercise (low impact)/Physiotherapy Oestrogen (patches/exogenous/pills other) Testosterone (males/females) Weight gain vs. Weight restoration (brain size) <p>Interventions to address the short-term physical complications may include</p> <ul style="list-style-type: none"> Phosphates supplementation (refeeding) Potassium Thiamine (refeeding) Laxatives (for when underweight patients are constipated) Salbutamol (reduce food intake)
Comparison	<ul style="list-style-type: none"> Control arm as defined by study
Critical outcomes	<ul style="list-style-type: none"> Primary outcome as reported by study
Important outcomes	<ul style="list-style-type: none"> Secondary outcome as reported by study
Study design	<ul style="list-style-type: none"> Systematic Reviews RCTs Observational studies: including prospective or retrospective cohort studies (if no RCTs)

1 9.7.2 Clinical evidence

2 No studies were identified that met the eligibility criteria for this review.

3 9.7.3 Economic evidence

4 No economic evidence on the cost effectiveness of interventions for managing short and
 5 long-term physical complications for people with EDNOS was identified by the systematic
 6 search of the economic literature undertaken for this guideline. Details on the methods used
 7 for the systematic search of the economic literature are described in Chapter 3.

8 9.7.4 Clinical evidence statements

9 No studies were identified that met the eligibility criteria for this review.

1 9.7.5 Economic evidence statements

2 No economic evidence on the cost effectiveness of interventions for managing short and
3 long-term physical complications for people with EDNOS was available.

4 9.7.6 Recommendations and link to evidence

See recommendation 139	
Relative value of different outcomes	The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of interventions for treating OSFEDs. For this population it was agreed that binge-eating frequency and remission are of greatest concern. Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.
Trade-off between clinical benefits and harms	No relevant clinical evidence was identified.
Trade-off between net health benefits and resource use	No relevant existing economic evidence was identified. The committee expressed the view that if something is potentially cost effective and represents value for money for people with anorexia nervosa, bulimia nervosa, and binge eating disorder, it will also do so for people with OSFED.
Quality of evidence	No relevant clinical evidence was identified.
Other considerations	The committee agreed that people with OSFED who have short or long-term physical complications associated with the eating disorder, should be treated in-line with the eating disorder their symptoms most closely resemble.

5 9.8 Management of comorbidities

6 9.8.1 Review question: Does any intervention for an eating disorder need to be 7 modified in the presence of common long-term health conditions?

8 The review protocol summary, including the review question and the eligibility criteria used in
9 this section of the guideline, can be found in. Further information about the search strategy
10 can be found in Appendix H; the full review protocols can be found in Appendix F.

11 This review considers whether any intervention used to treat eating disorders in children,
12 young people and adults needs to be modified in the presence of a common long-term health
13 condition (i.e. comorbidity). The interventions were categorised according to their type, the
14 type of eating disorder and comorbidity examined and the age of the participants. The
15 comparison arm was the same intervention delivered to participants with the relevant eating
16 disorder but without the relevant comorbidity.

17 Table 358: Clinical review protocol summary

Component	Description
Review question(s)	Does any intervention for an eating disorder need to be modified in the presence of common long-term health conditions?

Component	Description
Population	<ul style="list-style-type: none"> • Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) and a common comorbidity (e.g. diabetes, hypothyroidism). <p>Mental comorbidities may include:</p> <ul style="list-style-type: none"> ○ Depression ○ Anxiety ○ Social anxiety ○ Autism ○ Obsessive Compulsive Disorder ○ Personality Disorder ○ Learning disability ○ ADHD (Bulimia) ○ Self-harm ○ Substance misuse <p>Physical comorbidities may include:</p> <ul style="list-style-type: none"> ○ Coeliac disease ○ Diabetes (type II – relevant to obesity) ○ Bowel disease ○ Cystic Fibrosis <p>Strata:</p> <ul style="list-style-type: none"> • children (≤ 12), young people (13–≤ 17 years), adults ≥ 18 years • eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Intervention(s)	<p>Trials will be included that address the ED as primary or secondary aim to treating the comorbidity. Interventions may include:</p> <ul style="list-style-type: none"> • Psychotherapy (including psychoeducation) • Pharmacological • Nutritional • Physical • Combination of any listed above
Comparison	<ul style="list-style-type: none"> • The same intervention but delivered to people with an eating disorder without a comorbidity.
Critical outcomes	<ul style="list-style-type: none"> • Remission and long-term recovery (if symptoms were measured over a minimum 2 week period) • Binge eating for BN and BED • Body weight / BMI for AN
Important outcomes	<ul style="list-style-type: none"> • Adverse events • All-cause mortality • Cost effectiveness • Eating disorders psychopathology (cognitive distortion/eating behaviours/body image distortion) • Family functioning • General psychopathology (including mood/depression/anxiety) • General functioning, measured by return to normal activities, or by general mental health functioning measures such as Global Assessment of Functioning (GAF) • Quality of life • Relapse • Resource use

Component	Description
	<ul style="list-style-type: none"> • Service user experience (in patient vs. community)
Study design	<ul style="list-style-type: none"> • Systematic Reviews • RCTs • Observational studies: including prospective or retrospective cohort studies, (if no RCTs) (if no RCTs)

1 9.8.2 Clinical evidence

2 9.8.2.1 Diabetes

3 One RCT (n=85) was identified that compared the effectiveness of a parental and patient
4 group psychoeducation programme with treatment as usual for reducing symptoms in young
5 people with type 1 diabetes and disturbed eating attitudes (Olmsted et al., 2002).

6 Two observational studies (n=878) were found that met the inclusion criteria (Colton et al.,
7 2015; Custal et al., 2014). Both studies used two different populations, one with any eating
8 disorder and type I diabetes and compared them with one that just had any eating disorder.
9 The two groups were compared after either receiving the same treatment (CBT-ED) or
10 different treatments (group CBT-ED with additional care by a multidisciplinary team for those
11 with type I diabetes or just group CBT-ED alone). These comparisons allowed us to see if
12 those with diabetes can respond equally well to treatment as those with just an eating
13 disorder.

14 9.8.2.2 High alcohol misuse

15 One observational study (n=149) was found that addressed the comorbidity of alcohol
16 misuse in people with an eating disorder (Karacic et al., 2011). The study examined the
17 effect of transdiagnostic CBT-enhanced for eating disorders in adults with bulimia nervosa
18 and other eating disorders not otherwise specified (EDNOS).

19 Although this review question includes people with any eating disorder (anorexia nervosa,
20 bulimia nervosa, binge eating disorder, EDNOS), the committee wanted to firstly consider the
21 evidence for individual eating disorders to see if specific recommendations could be made. If
22 none was available, or it was deemed insufficient, then they agreed to make a general
23 recommendation for treating people with any eating disorder and a common long-term health
24 condition.

1 **Table 359: Study information of the RCTs included in the review of interventions for young people with disturbed eating and type I**
 2 **diabetes.**

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
Olmsted 2002	Diabetes Type 1 + Disturbed eating attitudes	16 (2)	23.4 (3.5)	85	Age of diabetes onset=9.1 (3.6) years Duration of DM=7 (3.4) years	Group Psychoeducation + treatment as usual Carers and patients	Treatment as usual. Quarterly visits and diabetes management conducted in multidisciplinary treatment setting	6 weeks, assessment at 10 weeks and 6-mo FU

3 Abbreviations: FU, follow up; DM, diabetes mellitus

4 **Table 360: Study information of the observational studies included in the review that compared outcomes in those with any eating**
 5 **disorder and type I diabetes versus eating disorder alone.**

Study	Eating Disorder	Age mean (SD)	BMI	N	Stage of illness	Intervention	Comparison	Duration
Colton 2015 Canada	AN/BN/EDNOS with or without type I diabetes (T1DM)	25.6 (6.4)	21.8 (4.5)	838	Age at diabetes diagnosis: 14.3 (8.2) years	Group CBT-ED + care by multidisciplinary team ED + T1DM	Group CBT-ED only	BN/EDNOS 6-8 weeks; AN 10-14 weeks Mean: 6.6 weeks (2.8)
Custal 2014 Spain	AN/BN/EDNOS with or without type I diabetes (T1DM)	25.3 (8)	23.34 (6.35)	40	Age of ED onset=19.5 (7.4) Duration of T1DM=10.3 (8.2) years	CBT-ED ED + T1DM	CBT-ED ED only	3-4 months

6 Abbreviations: AN, anorexia nervosa; BN, bulimia nervosa; EDNOS eating disorder not otherwise stated; ED, eating disorder; T1DM, type I diabetes mellitus;

1 **Table 361: Study information of the trials included in the review of interventions with people with an eating disorder and a**
 2 **comorbidity of alcohol misuse.**

Study ID	N	Mean age	BMI (kg/m ²) or Weight (kg)	Female %	Sample characteristics	Group 1	Group 2	Duration
Karacic 2011	149	26.2 (7.1)	23.0 (4.2)	95	DSM-IV BN, or other EDNOS	Eating disorder and high-alcohol use	Eating disorder and low alcohol use	20 weeks + 20/40/60 week FU

3 Note: *, High-alcohol use was defined as consuming ≥ 14 units/week in women and ≥ 21 units/week in men. Abbreviations: DSM-IV, Diagnostic and Statistical Manual of Mental
 4 Disorders, 4th Edition; EDNOS eating disorder not otherwise stated; FU, follow up

5 **Table 362: Summary table of findings for group psychoeducation versus treatment as usual for young people with disturbed eating**
 6 **and type I diabetes.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with treatment as usual for Disturbed eating + Diabetes TI - Young people	Risk difference with RCT: Psychoeducation (95% CI)
EDE Objective Binge Episodes - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede objective binge episodes - group psychoeducation-ed in the intervention groups was 0.13 standard deviations lower (0.56 lower to 0.31 higher)
EDE Restraint - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint - group psychoeducation-ed in the intervention groups was 0.33 standard deviations lower (0.77 lower to 0.1 higher)
EDE Eating Concerns - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concerns - group psychoeducation-ed in the intervention groups was 0.32 standard deviations lower (0.75 lower to 0.12 higher)

Eating disorders (update)

Treatment and management of atypical eating disorders (eating disorders not otherwise specified)

EDE Shape Concerns - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concerns - group psychoeducation-ed in the intervention groups was 0.07 standard deviations lower (0.5 lower to 0.36 higher)
EDE Weight Concerns - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concerns - group psychoeducation-ed in the intervention groups was 0.15 standard deviations lower (0.58 lower to 0.28 higher)
EDI Drive for Thinness - Group Psychoeducation-ED	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness - group psychoeducation-ed in the intervention groups was 0.28 standard deviations lower (0.73 lower to 0.17 higher)
EDI Bulimia - Group Psychoeducation-ED	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi bulimia - group psychoeducation-ed in the intervention groups was 0.35 standard deviations lower (0.8 lower to 0.1 higher)
EDI Body Dissatisfaction - Group Psychoeducation-ED	81 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction - group psychoeducation-ed in the intervention groups was 0.38 standard deviations lower (0.83 lower to 0.07 higher)
Insulin Omission Days - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,3 due to risk of bias, imprecision		Not calculable for SMD values	The mean insulin omission days - group psychoeducation-ed in the intervention groups was 0.17 standard deviations higher (0.26 lower to 0.6 higher)
HbA1c Level (%) - Group Psychoeducation-ED	82 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean hba1c level (%) - group psychoeducation-ed in the intervention groups was 0 standard deviations higher (0.44 lower to 0.44 higher)

Eating disorders (update)

Treatment and management of atypical eating disorders (eating disorders not otherwise specified)

EDE Objective Binge Episodes FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede objective binge episodes fu - group psychoeducation-ed in the intervention groups was 0.34 standard deviations lower (0.78 lower to 0.09 higher)
EDE Restraint FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede restraint fu - group psychoeducation-ed in the intervention groups was 0 standard deviations higher (0.43 lower to 0.43 higher)
EDE Overeating FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede overeating fu - group psychoeducation-ed in the intervention groups was 0.22 standard deviations lower (0.66 lower to 0.21 higher)
EDE Eating Concerns FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede eating concerns fu - group psychoeducation-ed in the intervention groups was 0.25 standard deviations lower (0.69 lower to 0.18 higher)
EDE Shape Concerns FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede shape concerns fu - group psychoeducation-ed in the intervention groups was 0.07 standard deviations lower (0.5 lower to 0.36 higher)
EDE Weight Concerns FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊖⊖ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean ede weight concerns fu - group psychoeducation-ed in the intervention groups was 0.08 standard deviations lower (0.51 lower to 0.36 higher)
EDI Drive for Thinness FU - Group Psychoeducation-ED	81 (1 study)	⊕⊕⊖⊖ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi drive for thinness fu - group psychoeducation-ed in the intervention groups was 0.03 standard deviations lower (0.48 lower to 0.41 higher)
EDI Bulimia FU - Group Psychoeducation-ED	81 (1 study)	⊕⊕⊖⊖ LOW1,2		Not calculable for SMD values	The mean edi bulimia fu - group psychoeducation-ed in the intervention

		due to risk of bias, imprecision			groups was 0.34 standard deviations lower (0.79 lower to 0.11 higher)
EDI Body Dissatisfaction FU - Group Psychoeducation-ED	81 (1 study)	⊕⊕⊕⊕ LOW1,2 due to risk of bias, imprecision		Not calculable for SMD values	The mean edi body dissatisfaction fu - group psychoeducation-ed in the intervention groups was 0.13 standard deviations lower (0.58 lower to 0.31 higher)
Insulin Omission Days FU - Group Psychoeducation-ED	85 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean insulin omission days fu - group psychoeducation-ed in the intervention groups was 0.04 standard deviations higher (0.4 lower to 0.47 higher)
HbA1c Level (%) FU - Group Psychoeducation-ED	82 (1 study)	⊕⊕⊕⊕ LOW1,4 due to risk of bias, imprecision		Not calculable for SMD values	The mean hba1c level (%) fu - group psychoeducation-ed in the intervention groups was 0 standard deviations higher (0.44 lower to 0.44 higher)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval;

1 Unclear if allocation concealment was performed. Neither the participant, investigator nor assessor were blind. Unclear how many completed the intervention.

2 95% CI crossed 1 MID (-0.5)

3 95% CI crossed 1 MID (0.5)

4 For a continuous outcome, there were fewer than 400 participants.

1 **Table 363: Summary table of findings for outcomes from observational studies in people with any eating disorder and type 1 diabetes**
 2 **versus any eating disorder.**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Any ED only	Risk difference with Any ED+Diabetes TI (95% CI)
Dropouts	40 (1 study)	⊕⊕⊕⊕ VERY LOW1,2,3	RR 1.45 (0.9 to 2.34)	500 per 1000	225 more per 1000 (from 50 fewer to 670 more)

Eating disorders (update)

Treatment and management of atypical eating disorders (eating disorders not otherwise specified)

		due to risk of bias, indirectness, imprecision			
Dropouts - Anorexia Nervosa	4 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,8} due to risk of bias, indirectness, imprecision	RR 1.00 (0.49 to 2.05)	See comment**	-
Dropouts - Bulimia Nervosa	10 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,4} due to risk of bias, indirectness, imprecision	RR 1.57 (0.77 to 3.22)	400 per 1000	228 more per 1000 (from 92 fewer to 888 more)
Dropouts - EDNOS	22 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision	RR 1.75 (0.71 to 4.31)	636 per 1000	477 more per 1000 (from 185 fewer to 1000 more)
Dropouts - Binge Eating Disorder	4 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2,5} due to risk of bias, indirectness, imprecision	RR 1 (0.14 to 7.1)	500 per 1000	0 fewer per 1000 (from 430 fewer to 1000 more)
Full or Partial Remission	873 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,6,7} due to risk of bias, indirectness, imprecision	RR 0.52 (0.33 to 0.81)	469 per 1000	225 fewer per 1000 (from 89 fewer to 314 fewer)
Full or Partial Remission - Anorexia Nervosa	276 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,5,6} due to risk of bias, indirectness, imprecision	RR 0.44 (0.13 to 1.48)	465 per 1000	260 fewer per 1000 (from 404 fewer to 223 more)
Full or Partial Remission - Bulimia Nervosa	293 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,6,7} due to risk of bias, indirectness, imprecision	RR 0.47 (0.23 to 0.97)	730 per 1000	387 fewer per 1000 (from 22 fewer to 562 fewer)
Full or Partial Remission - EDNOS	300 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{2,6,7} due to risk of bias, indirectness, imprecision	RR 0.58 (0.29 to 1.15)	471 per 1000	198 fewer per 1000 (from 335 fewer to 71 more)
Full or Partial Remission - Binge Eating Disorder	4 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,5,6}	RR 1 (0.14 to 7.1)	500 per 1000	0 fewer per 1000 (from 430 fewer to 1000 more)

		due to risk of bias, indirectness, imprecision			
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
** Absolute effects could not be calculated because zero events were included in the outcome.					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 The authors attempted to match the groups based on age, marital status, education, catchment area, onset of diagnosis. It was unclear whether the two groups were followed up for the same duration. The sample size was very small.					
2 They compared two different therapies for two different populations. The patients with an ED and T1DM were treated for both conditions, whilst the comparison group was an ED only group and were treated for just their ED.					
3 95% CI crossed 1 MID (1.25).					
4 95% CI crossed 1 MID (1.25).					
5 95% CI crossed 2 MIDs (0.75 and 1.25).					
6 In Custal 2014 the authors attempted to match the groups based on age, marital status, education, catchment area, onset of diagnosis. It was unclear whether the two groups were followed up for the same duration. The sample size was very small. In Cotton 2015, the authors did not attempt to match the groups, nor adjust for potential confounders. The control group data was selected from a different study/data base. It was unclear what the duration of follow up was for both groups. The investigators were not blind to participant's exposure to treatment.					
7 95% CI crossed 1 MID (0.75).					
8. Fewer than 300 events.					

1 Alcohol misuse

2 Table 364: Summary table of findings for CBT-Enhanced for eating disorders in people with an eating disorder and high-alcohol use versus people with an eating disorder and low-alcohol use

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with CBT-E for ED (95% CI)
EDE >1 SD above community norm	119 (1 study) 60 weeks	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, indirectness, imprecision	RR 1.16 (0.68 to 1.97)	321 per 1000	51 more per 1000 (from 103 fewer to 312 more)
Excessive Drinking	119 (1 study) 60 weeks	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, indirectness, imprecision	RR 4.08 (2.08 to 8.01)	119 per 1000	367 more per 1000 (from 129 more to 835 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Control	Risk difference with CBT-E for ED (95% CI)
EDE Global 60 week FU	104 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, indirectness, imprecision		Not calculable for SMD values	The mean ede global 60 week fu in the intervention groups was 0.23 standard deviations lower (0.66 lower to 0.2 higher)
<p>*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).</p> <p>CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up</p> <p>1 Karacic 2011: attrition bias (dropout for low alcohol group >20 %); sample did not have current alcohol use disorder comorbidity; group allocated on basis of self-reported alcohol use. Sample consisted of 67 BN, 10 BED and 72 EDNOS. Participants with anorexia nervosa were excluded.</p> <p>2 CI crosses both 0.75 and 1.25 (Risk Ratio) or 0.5 and -0.5 (SMD).</p> <p>3 <300 events.</p> <p>4 CI crosses 0.5 or -0.5 (SMD).</p>					

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1 **9.8.3 Economic evidence**

2 No economic evidence on the cost effectiveness of interventions for the management of
3 comorbidities of EDNOS was identified by the systematic search of the economic literature
4 undertaken for this guideline. Details on the methods used for the systematic search of the
5 economic literature are described in Chapter 3.

6 **9.8.4 Clinical evidence statements**

7 **Diabetes**

8 **9.8.4.1 Group psychoeducation versus treatment as usual in people with type I diabetes and 9 disturbed eating disorders at end of treatment**

10 Low quality evidence from one RCT (n=85) showed no difference in the effect of group
11 psychoeducation on binges, EDE-restraint, EDE-shape concern, EDE-eating concern, EDE-
12 weight concern, EDI-drive for thinness, EDI-bulimia, insulin omission days and HbA1c (%)
13 compared with treatment as usual.

14 Low quality evidence from one RCT (n=85) showed group psychoeducation is more effective
15 on EDI-body dissatisfaction compared with treatment as usual but there was some
16 uncertainty.

17 **9.8.4.2 Group psychoeducation versus treatment as in people with type I diabetes and usual 18 disturbed eating disorders at follow up**

19 Low quality evidence from one RCT (n=85) showed no difference in the effect of group
20 psychoeducation on EDE-restraint, EDE-shape concern, EDE-eating concern, EDE-weight
21 concern, EDI-drive for thinness, EDI-bulimia, EDI-body dissatisfaction, insulin omission days
22 and HbA1c (%) compared with treatment as usual.

23 Low quality evidence from one RCT (n=85) showed group psychoeducation is more
24 beneficial on frequency of binges compared with treatment as usual but there was some
25 uncertainty.

26 **9.8.4.3 Any eating disorder and type I diabetes versus any eating disorder at end of 27 treatment. Observational study.**

28 Very low quality evidence from one observational study (n=40) showed no difference in the
29 number of dropouts in those with any eating disorder and type I diabetes compared with an
30 eating disorder alone. This trend was apparent in all types of eating disorders: anorexia
31 nervosa, bulimia nervosa, binge eating disorder and EDNOS.

32 Very low quality evidence from two observational studies (n=873) showed lower rates of
33 remission in those with any eating disorder and type I diabetes compared with an eating
34 disorder alone. This trend was apparent in those with bulimia nervosa, but no difference was
35 found in those with anorexia nervosa, binge eating disorder and EDNOS

36 **Alcohol misuse**

37 **9.8.4.4 CBT-ED for people with an eating disorder and high or low alcohol misuse at end of 38 treatment**

39 Very low quality evidence from one observational study (n=119) showed no difference in the
40 effect of CBT-ED on the number of people who were more than 1 standard deviation above

1 EDE community norms in people with an eating disorder whose alcohol use was high
2 compared with those whose alcohol use was low.

3 Very low quality evidence from one observational study (n=119) showed that CBT-ED is less
4 effective on the number of people who were engaging in excessive drinking in people with an
5 eating disorder whose alcohol use was high compared with people with those whose alcohol
6 use was low.

7 **9.8.4.5 CBT-ED for people with an eating disorder and high or low alcohol misuse at follow up**

8 Very low quality evidence from one observational study (n=104) showed no difference in the
9 effect of CBT-ED for eating disorders on EDE-global in people with an eating disorder whose
10 alcohol use was high compared with people with an eating disorder whose alcohol use was
11 low.

12 **9.8.5 Economic evidence statements**

13 No economic evidence on the cost effectiveness of interventions for the management of
14 comorbidities of EDNOS was available.

15 **Recommendations and link to evidence**

See Section 6.8.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder including OFSED and a comorbidity. For disorders like binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for OSFED, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. The other outcomes that are critical are the primary outcomes that are relevant to the physical or mental health comorbidity being treated.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>For discussion of interventions for treatment of other eating disorders in addition to OFSED with a comorbidity, see the LETRs in the relevant chapters.</p>
Trade-off between net health benefits and resource use	<p>The committee considered that providing care for people with eating disorders who have comorbid physical or mental health problems may have resource implications in terms of the extra time required to provide such care. However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate treatment and management of underlying health problems at an earlier stage (including eating disorder and comorbid mental health problem), before individuals require more resource intensive management, then</p>

	the additional costs associated with facilitating such care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.
Quality of evidence	No evidence was identified for the treatment of OFSED and a physical or mental health comorbidity.
Other considerations	<p>The committee generated recommendations based on the limited data found and from their own knowledge and experience using informal consensus methods.</p> <p>See the LETR in section 6.8.6 for further discussion on the treatment of an eating disorders with a physical or mental health comorbidity. See the LETR in Section 7.8.6 for further discussion of the treatment of eating disorders with comorbid diabetes.</p>

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Diabetes

	See Section 7.8.6 for relevant recommendations
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem. In the case of diabetes, HbA1c levels and insulin omission days were considered critical outcomes. The other critical outcomes depended on the eating disorder included in the study. The committee noted for Type 1 diabetes, severity should be measured, or at least heavily informed, by HbA1c since HbA1c/ DKA frequency is the immediate risk factor; furthermore, BMI is less of a risk factor for death in those with Type 1 diabetes than HbA1c.</p> <p>Remission is of greatest concern for any eating disorder. In addition, for those with anorexia nervosa body weight or BMI are of greatest concern. For bulimia nervosa and binge eating disorder, binge eating is a critical outcome.</p> <p>For any eating disorder, other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with an eating disorder that are of lesser importance but are clearly still important outcomes include general psychopathology, general functioning, eating disorder psychopathology, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>The ideal study design to answer the question of whether a treatment for eating disorders needs to be modified in the presence of a long-term health problem would be to randomise people with an eating disorder and diabetes to two different treatment groups: One modified to address both the eating disorder and diabetes and one non-modified eating disorder treatment.</p> <p>No studies were found examining whether eating disorder treatments for OSFED need to be modified in presence of diabetes.</p>
Trade-off between net health benefits and resource use	See the LETR in Section 7.8.6 for further discussion of the treatment of eating disorders with comorbid diabetes.

Quality of evidence	See the LETR in Section 7.8.6 for further discussion of the treatment of eating disorders with comorbid diabetes.
Other considerations	See the LETR in Section 7.8.6 for further discussion of the treatment of eating disorders with comorbid diabetes.

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Substance and medication misuse

See Section 7.8.6 for relevant recommendations	
Relative value of different outcomes	<p>The committee discussed the importance and relevance of various outcomes when assessing the effectiveness of treating people with an eating disorder and a comorbidity. For binge eating disorder and bulimia nervosa, it was agreed binge eating frequency and remission are of greatest concern. For anorexia nervosa, body weight/BMI and remission are critical and for ofsed, remission and either binge eating or body weight/BMI depending on the eating disorder they most closely resemble. Other critical outcomes will include the primary outcomes relevant to the physical or mental health comorbidity being treated.</p> <p>Other outcomes that are important but are considered rare events or rarely measured in RCTs for eating disorders include all-cause mortality, adverse events, quality of life, resource use and relapse. They were therefore extracted where possible, but did not factor strongly in the decision-making.</p> <p>Other outcomes of concern for people with binge eating disorder that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, family functioning and service user experience.</p>
Trade-off between clinical benefits and harms	<p>Bulimia nervosa and EDNOS</p> <p>An observational study was identified where they extracted data from a randomised control trial and compared the outcomes in those with bulimia nervosa and EDNOS who had a low or high alcohol intake. The participants were treated with either broad or focused CBT-ED. At the end of 20 weeks treatment, there was no difference in the number who had EDE scores one standard deviation above community norms (i.e., relatively abnormal eating psychopathology) in those with a low or high alcohol intake. However, the number who continued to have excessive alcohol intake (defined as >21 units or >14 units/week for males and females respectively) was higher in those whose alcohol intake was high compared with those whose intake was low.</p> <p>At 60 weeks follow up, there continued to be no difference in EDE scores between those who had low versus high alcohol intake. No evidence was found on the critical outcomes of remission and binge eating, nor on the important outcomes of quality of life, all-cause mortality, general psychopathology, relapse, general functioning, family functioning, resource use, and service user experience.</p>
Trade-off between net health benefits and resource use	<p>The committee considered that providing care for people with an eating disorder who are misusing substances or medication may have resource implications in terms of the extra time required to facilitate care for such people (in particular the use of a multi-disciplinary approach). However, the committee expressed the view that if such care leads to better identification of health needs and this results in appropriate treatment and management of health problems (including eating disorder and substance and medication misuse) at an earlier stage, before individuals require more resource intensive management, then the additional costs</p>

	<p>associated with facilitating a multi-disciplinary care is expected to result in improved health outcomes in the longer term and potential future cost savings to the healthcare system.</p>
Quality of evidence	<p>The evidence used to generate these recommendations was very low quality.</p> <p>In the absence of RCT evidence the committee considered a single study with 119 participants who received a CBT-ED programme. However, there were few outcomes reported and no remission data. In the other study, again there were 81 participants but there was no data at the end of treatment (only at follow up) and again few outcomes were reported. They did however measure remission.</p>
Other considerations	<p>Limited published evidence was found on individual eating disorders, so the committee generated a recommendation incorporating the evidence from people with bulimia nervosa and EDNOS and made it relevant for treating people with any eating disorder and a substance misuse problem.</p> <p>The observational evidence suggested that people with bulimia nervosa or those with EDNOS, with a low or high alcohol intake, may be equally responsive to an eating disorder treatment. And for people with bulimia nervosa only, a positive long-term response to treatment may be equally found in those with a history of substance misuse as those with no history. Thus, the committee recommended that for people with an eating disorder who are misusing substances, offer treatment for the eating disorder unless the substance misuse is demonstrably interfering with this treatment.</p> <p>The observational evidence also suggested that treatment for an eating disorder may also reduce alcohol intake. In the study by Karacic 2011 over half the high alcohol intake group were no longer drinking excessively (52.8%, n=19) at the end of treatment, however, 12.5% (n=10) of the low alcohol intake group were now drinking above the safe limit (this data was not extracted because change scores were not presented).</p> <p>For these reasons, the committee decided using informal consensus that the person should be offered treatment for the eating disorder unless the substance misuse is interfering with the treatment.</p> <p>Although the evidence for this recommendation was based on a study that used a mixed sample of people with bulimia nervosa and EDNOS, the committee were confident that the findings would translate to those with any eating disorder. For this reason, they did not specify the type of eating disorder in their recommendation. For further details see the LETR in Section 7.8.6.</p>

10 Coordinating care and compulsory treatment

10.1 Introduction

Anorexia nervosa is a mental disorder and therefore the question of whether the Mental Health Acts (1983, substantially amended 2007) (Mental Health Act, 1983; Mental Health Act, 2007) can be used has been answered in the affirmative. The provision of nutrition, including by artificial means, is considered to be treatment for the mental disorder, along with other components. The Care Quality Commission (CQC, 2008) has issued guidance, which says, “some patients with anorexia nervosa – who might have the intellectual capacity to understand the nature, purpose and likely effect of treatment – may be unable to give valid consent, perhaps because their capacity to consent is compromised by fears of obesity or by denial of the consequences of their actions”. They also say, “Consideration of whether the treatment environment constitutes a deprivation of liberty might be an additional reason for considering compulsory treatment under the MHA may be required” (CQC 2008).

Compulsory treatment in adults

CQC (2008) clarifies that:

- the Mental Health Act (1983) can be used for patients with anorexia nervosa, because it is a mental disorder
- ‘there are likely to be particularly strong reasons for any application ... to be made by the Approved Mental Health Professional (AMHP) rather than by the Nearest Relative’
- medical treatment may include feeding by ‘nasogastric tube or other means’
- some patients may have the intellectual capacity to understand the treatment, but be unable to give valid consent to it because their capacity to consent is compromised by fears of obesity
- diagnostic and monitoring procedures, including blood tests, may be necessary as part of the medical treatment for the eating disorder
- ‘consideration of whether the treatment environment constitutes a deprivation of liberty might be an additional reason for considering compulsory treatment’ under the Mental Health Act (1983).

There appears to be an anomaly in that feeding by nasogastric tube or other ‘artificial means’ is considered to be ‘medical treatment’, but not a medical treatment for which consent or a second opinion is required after the first 3 months of compulsory treatment.

The Mental Capacity Act 2005 Code of Practice (Department for Constitutional Affairs, 2007) also specifically mentions that people with anorexia nervosa may have impaired decisional capacity despite having a good understanding of risk. It is possible to treat people under the Mental Capacity Act but, due to the complexities of assessing capacity and the extent of any deprivation of liberty, the Mental Health Act is the preferred instrument. The CQC guidance has not been updated since the introduction of the Deprivation of Liberty Safeguards in 2009. However, the Court of Protection recognised and upheld what it called the ‘primacy’ of the Mental Health Act (1983) in situations where patients met the criteria for detention under its powers and were objecting to treatment or admission. The Deprivation of Liberty Safeguards was intended to fill a gap left between the Mental Health Act (1983) and common law, not to provide an alternative to detention under that Act.

Compulsory treatment for atypical presentations of anorexia nervosa would be approached in the same way. Consideration of the use of the Mental Health Act (1983) for treatment of

1 bulimia nervosa is rare, reserved for cases where risks to health or life are severe or there is
2 significant psychiatric comorbidity that may constitute the grounds for detention.

3 Compulsory treatment will only be considered when less restrictive options, including
4 informal inpatient treatment, have been unsuccessful or are not appropriate. It is therefore
5 not surprising to find that detained patients have higher rates of comorbidity, take longer to
6 gain weight and have a subsequent higher mortality rate compared with non-detained
7 patients (Ramsay et al., 1999).

8 Studies have compared the outcomes for patients treated with and without their consent, but
9 the salient issues for patients, professionals and families relate to when compulsory powers
10 can be used, what can be done under them and how to decide whether the patient has
11 capacity to make particular treatment decisions.

12 **Children and Young People**

13 CQC (2008) also applies to children and young people but issues of capacity and consent
14 are potentially more complex in that, below the age of 16, there is no assumption of capacity,
15 and even for those over 16 up to age 18, there are caveats to the assumption of capacity.
16 For example, advance directives about care cannot be given by those aged between 16 and
17 18 years, and the safeguards provided by the Protection of Children Act 1999 (Protection of
18 Children Act, 1999) apply up to the age of 18.

19 For young people under the age of 16, the onus is on demonstrating competence to make
20 decisions, known as “Gillick competence”. Typically these would be decisions involving
21 assent (i.e. agreement) rather than refusal. If a young person refuses a recommended
22 treatment, the concept of the ‘zone of parental control’ is invoked. Sometimes criticised as a
23 vague concept, the ‘zone of parental control’ describes the changing level of parental
24 authority appropriate to a child’s development stage. For example, it would be normal for the
25 parents of a child or younger young people to decide what he or she ate, or whether they
26 needed to see a doctor, but decisions such as the need for restraint or feeding against their
27 own will lie outside the normal range of parental decisions.

28 The Department of Health (Department of Health, 2009) provides the following guidance on
29 consent in minors:

30 “Where a child under the age of 16 lacks capacity to consent (i.e. is not Gillick competent),
31 consent can be given on their behalf by any one person with parental responsibility (if the
32 matter is within the ‘zone of parental control’) or by the court. As is the case where patients
33 are giving consent for themselves, those giving consent on behalf of child patients must have
34 the capacity to consent to the intervention in question, be acting voluntarily and be
35 appropriately informed. The power to consent must be exercised according to the ‘welfare
36 principle’: that the child’s ‘welfare’ or ‘best interests’ must be paramount. Even where a child
37 lacks capacity to consent on their own behalf, it is good practice to involve the child as much
38 as possible in the decision-making process”.

39 In recent years there has been a preference in young people for use of the Mental Health Act
40 1983/2007 over parental consent or the Protection of Children Act 1999, although all three
41 are potentially applicable in young people who do not consent to treatment.

42 Although a young person may not have given consent, the term ‘compulsory treatment’ is
43 only utilised when treatment is given under the legal framework of the Mental Health Act
44 1983/2007 or Protection of Children Act 1999. The limited evidence base indicates that the
45 outcome of compulsory treatment may be different in young people compared to adult
46 patients. Ayton et al (2009) found that detained patients had more severe comorbidity and
47 greater risk on admission but did no worse than informal patients on follow up.

1 10.2 Compulsory treatment

2 10.2.1 Review question: What factors/indicators should be considered when 3 assessing whether a person with an eating disorder should be admitted for 4 compulsory treatment (including any form of restrictive interventions usually 5 implemented in refeeding)?

6 The review protocol summary, including the review question and the eligibility criteria used
7 for this section of the guideline, can be found in Table 365. Further information about the
8 search strategy can be found in Appendix H; the full review protocols can be found in
9 Appendix F.

10 This review considers what factor or indicators should be considered when assessing
11 whether children, young people or adults with an eating disorder should be admitted for
12 compulsory treatment. The studies were categorised according to the age of the participants
13 and whether they compared compulsory treatment under the legal auspices of the relevant
14 country with voluntary treatment or whether they conducted a regression analysis

15 **Table 365: Clinical review protocol summary**

Component	Description
Review question(s)	What factors/indicators should be considered when assessing whether a person with an eating disorder should be admitted for compulsory treatment (including any form of restrictive interventions usually implemented in refeeding)?
Population	<ul style="list-style-type: none"> Children, young people and adults with eating disorders (anorexia nervosa, bulimia nervosa, binge eating, atypical eating disorder) who need to be admitted for compulsory treatment Strata: <ul style="list-style-type: none"> children (≤ 12), young people (13–≤ 17 years), adults ≥ 18 years eating disorder (i. anorexia nervosa, ii. bulimia nervosa, iii. binge eating, iv. atypical eating disorder)
Factors/indicators	The following factors may be considered when admitting for compulsory treatment: <ul style="list-style-type: none"> body weight consent family functioning general functioning or general mental health functioning measures such as Global Assessment of Functioning (GAF). other medical indicators (i.e. low potassium) MARSIPAN check list
Comparison	<ul style="list-style-type: none"> Relevant comparison as reported by the papers
Critical outcomes	<ul style="list-style-type: none"> Primary outcomes as reported by the authors (may include ANOVA, or multiple regression analysis showing what factors are associated with a higher likelihood of compulsory treatment)
Important outcomes	<ul style="list-style-type: none"> Secondary outcomes as reported by the papers
Study design	<ul style="list-style-type: none"> Individual patient data meta-analysis Systematic reviews Observational non-RCT studies (prospective, retrospective or cross-sectional studies) RCTs will be included if they provided a multiple regression analysis looking at predictors of any relevant outcomes

Component	Description
	<ul style="list-style-type: none">• In the absence of any direct evidence, observational or RCTs studies will be included if they provide insight into the relative success of compulsory versus voluntary inpatient care or which factors are associated with a higher likelihood of being admitted.

1 10.2.2 Clinical evidence

2 Overall 6 observational studies (N = 1144) provided indirect evidence for this review
3 question, all of which were on young people (Ayton et al., 2009; Carney et al., 2004; Carney
4 et al., 2006; Carney et al., 2008; Griffiths et al., 1997; Ramsay et al., 1999; Ward et al., 2015;
5 Watson et al., 2000). Two studies (n=441) were relevant to those with any eating disorder
6 (Ayton 2009, Watson 2000).

7 Three studies (n=325) compared compulsory treatment with voluntary treatment in adults
8 with anorexia nervosa (Carney 2004/2006/2008, Griffiths 1997, Ramsay 1999/Ward 2015),
9 whilst two were conducted in people with any eating disorder, one of which was in young
10 people (Ayton 2009) and one in adults (Watson 2000). The results from these studies
11 showed the relative success of inpatient treatment if the person was admitted under
12 compulsory conditions versus voluntarily. Although the results from these studies did not
13 provide indicators or what factors should be considered when assessing whether a person
14 with an eating disorder should be admitted for compulsory treatment, the results were
15 extracted and presented to the committee in case they helped them decide whether
16 compulsory treatment is a viable treatment option compared with patients who are treated
17 voluntarily.

18 Two studies (n=279) conducted a regression analysis of the predictors or factors associated
19 with compulsory treatment in people with anorexia nervosa, both of which were on adults
20 (Carney et al., 2008; Schreyer et al., 2015). Another study (Vandereycken and
21 Vansteenkiste, 2009) (n=174) conducted a regression analysis to assess the impact of
22 compulsory treatment on the likelihood of patients dropping out of treatment.

23 None of the 3 studies that conducted a regression analysis directly answered the review
24 question. They investigated whether: a patient was more likely to drop out from inpatient
25 care; the factors associated with patients who undergo compulsory treatment (not
26 necessarily what factors they should be admitted for); and the impact of compulsory
27 treatment on outcomes from hospital. Nevertheless, they were presented in the hope they
28 may provide some insight or context for developing a recommendation.

29 An overview of the trials included in the narrative synthesis can be found in Table 366, Table
30 367 and Table 368. Further information about both included and excluded studies can be
31 found in Appendix J.

32 Summary of findings for those on anorexia nervosa can be found in Table 369, Table 370,
33 Table 371 and Table 372. See also the study selection flow chart in Appendix K, forest plots
34 in Appendix M, study evidence tables in Appendix L and exclusion list in Appendix J.

1 **Table 366: Study information for studies included in the analysis of compulsory treatment versus voluntary treatment in people with**
2 **any eating disorder**

Study ID	Number	Mean Age (SD)	Female (%)	Mean BMI (SD), kg/m ²	Compulsory treatment Country, legal statute	Mean length of hospitalisation (days)	Comparison	Mean length of hospitalisation (days)
Ayton 2009	50	16.2 (1.3)	94	15.0 (2.4)	UK, Section 3, MHA 1983/2007 Age at ED onset: 12.5 (1.9) years Duration of ED: 3.8 (2.1) years	243	Parental consent Age at ED onset: 14.3 (1.8) years Duration of ED: 1.9 (1.5) years	423
Watson 2000	391	24.8 (8.6)	88	17.4 (4.7)	USA, legally committed for involuntary treatment, Iowa Duration of ED: 1.6 (1.6) years	41 (36)	Voluntary treatment Duration of ED: 1.9 (1.5)	58 (47)

3 Abbreviations: ED, eating disorder; MHA, Mental Health Act.

4 **Table 367: Study information for studies included in analysis of compulsory treatment versus voluntary treatment in adults with**
5 **anorexia nervosa**

Study ID	Number	Female (%)	Mean BMI (SD), kg/m ²	Compulsory Treatment Country, legal statute	Mean length of hospitalisation (days)	Comparison	Mean length of hospitalisation (days)	Follow up
Carney 2004/2006/2008	75*	96	13.2 (1.7)	Australia, Guardianship Order, Guardianship Act 1987 Duration of AN: 8.1 (7.6) years	52 (47)	Informal admission Duration of AN: 6.3 (6.5) years	47 (53)	na
Griffiths 1997	88	Not reported	14.1 (2.2)	Australia, Guardianship Order, Guardianship Act 1987	105 (76)	Voluntary treatment	62 (42)	1 year
Ramsay 1999/Ward 2015	162	96	14.3 (2.5)	UK, Sections 2, 3, 4 or 5, MHA 1983/2007 Duration of AN: 8.2 (6.1)	113 (90)	Voluntary admission Duration of AN: 7.6 (6.4)	88 (53)	~5 and ~20 years

6 Notes: *, data is for 96 admissions. Abbreviations: AN, anorexia nervosa; MHA, Mental Health Act; na, not applicable.

1 **Table 368: Study information for studies that explore factors associated with compulsory treatment**

Study ID	Number of participants	Female (%)	Mean BMI (SD), kg/m ²	Groups	Type of regression: outcome investigated	Predictors of outcomes
Carney 2008	75*	96	13.8 (1.8)	Compulsory treatment Duration of AN: 8.1 (7.6) years vs. Voluntary treatment Duration of AN: 6.3 (6.5)	Multiple logistic regression: • likelihood of compulsory treatment	<ul style="list-style-type: none"> • age • aged 20-29 years • previous admissions • type of ED • psychiatric comorbidity • admission BMI • refeeding syndrome • length of treatment • tube feeding • locked ward
Schreyer 2015	204	95	16.3 (2.1)	Inpatients in specialty ED program completed questionnaire about perceived coercion	<ul style="list-style-type: none"> • Linear multiple regressions: • inpatient length of stay • discharge BMI • Binary logistic regression: • transition to partial hospital vs. early drop out • achieved target weight 	<ul style="list-style-type: none"> • perceived coercion • extraversion • admission BMI • binary logistic regression: • perceived coercion • EDI-2 Drive for Thinness • admission BMI
Vandereycken 2009	174	100	Not reported	Treatment in ED unit within psychiatric hospital.	<ul style="list-style-type: none"> • Logistic regression • dropout from treatment 	<ul style="list-style-type: none"> • compulsory treatment • voluntary treatment • duration of illness • inpatient treatment • outpatient treatment

1 **Table 369: Summary table of findings for compulsory treatment versus voluntary treatment in young people or adults with any eating**
2 **disorder at discharge from hospital**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Any ED: Compulsory Treatment (95% CI)
BMI at discharge - young people	47 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI at discharge - young people in the intervention groups was 0.69 standard deviations higher (0.06 to 1.32 higher)
BMI at discharge - adults	397 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean bmi at discharge - adults in the intervention groups was 0.05 standard deviations lower (0.32 lower to 0.21 higher)
Weight Gain (lbs) - adults	397 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain (lbs) - adults in the intervention groups was 0.33 standard deviations higher (0.07 to 0.6 higher)
Rate of Weight Gain (lbs/week) - adults	397 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean rate of weight gain (lbs/week) - adults in the intervention groups was 0.18 standard deviations higher (0.09 lower to 0.44 higher)
# achieving >85% ABW or BMI>18 - adults	397 (1 study)	⊕⊕⊕⊕ VERY LOW ^{3,4} due to risk of bias, imprecision	RR 0.98 (0.85 to 1.12)	807 per 1000	16 fewer per 1000 (from 121 fewer to 97 more)
# AN patients achieving >85% ABW - adults	178 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3} due to risk of bias, imprecision	RR 1.03 (0.82 to 1.31)	727 per 1000	22 more per 1000 (from 131 fewer to 225 more)
Morgan-Russell Outcome (change scores) - young people	47 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean morgan-russell outcome (change scores) - young people in the intervention groups was 0.53 standard deviations higher (0.09 lower to 1.16 higher)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Any ED: Compulsory Treatment (95% CI)
Length of Hospital Stay (days) - adults	397 (1 study)	⊕⊕⊕⊕ VERY LOW ^{2,3} due to risk of bias, imprecision		Not calculable for SMD values	The mean length of hospital stay (days) - adults in the intervention groups was 0.45 standard deviations higher (0.19 to 0.72 higher)
Regular Menstruation - young people	47 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 4.27 (1.77 to 10.3)	156 per 1000	511 more per 1000 (from 120 more to 1000 more)
Disengaged from Family Therapy - young people	50 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,5} due to risk of bias, imprecision	RR 0.57 (0.22 to 1.44)	441 per 1000	190 fewer per 1000 (from 344 fewer to 194 more)
Required Nasogastric Feeding - young people	50 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 5.84 (2.2 to 15.54)	118 per 1000	569 more per 1000 (from 141 more to 1000 more)
Prematurely Discharged - young people	50 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,5} due to risk of bias, imprecision	RR 0.35 (0.09 to 1.4)	353 per 1000	229 fewer per 1000 (from 321 fewer to 141 more)
General Functioning - young people	47 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean general functioning - young people in the intervention groups was 0.91 standard deviations lower (1.36 to 0.45 lower)
Depression - young people	47 (1 study) 12 months	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision		Not calculable for SMD values	The mean depression - young people in the intervention groups was 0.77 standard deviations lower (1.41 to 0.14 lower)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Any ED: Compulsory Treatment (95% CI)
1 Ayton 2009: high selection bias (group allocation likely to affect outcome, no attempt to balance design, baseline not comparable); high performance bias (compulsory group treated significantly longer than voluntary group, sig more in compulsory group required nasogastric feeding). 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD). 3 Watson 2000: low selection bias (group allocation likely to affect outcome); high performance bias (no participant nor investigator blinding). 4 <300 events (dichotomous outcome) or <400 participants (continuous outcome). 5 CI crosses both 0.75 and 1.25 (Risk Ratio).					

1 **Table 370: Summary table of findings for compulsory treatment versus voluntary treatment in young people with any eating disorder**
2 **at 12 months after discharge from hospital**

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Compulsory Treatment (95% CI)
>90% Weight for Height 12-mo after discharge - young people	41 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.32 (0.63 to 2.74)	379 per 1000	121 more per 1000 (from 140 fewer to 660 more)
Intermediate Outcome 12-mo after discharge - young people Clinically underweight and either receiving ongoing OP treatment or prematurely disengaged with services	41 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 1.61 (0.55 to 4.7)	207 per 1000	126 more per 1000 (from 93 fewer to 766 more)
Patients alive 12-mo after discharge - young people	41 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,3} due to risk of bias, imprecision	RR 1.05 (0.9 to 1.22)	931 per 1000	47 more per 1000 (from 93 fewer to 205 more)
Readmitted to Hospital 12-mo after discharge - young people	41 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,2} due to risk of bias, imprecision	RR 0.46 (0.02 to 8.96)	69 per 1000	37 fewer per 1000 (from 68 fewer to 549 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Compulsory Treatment (95% CI)
*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).					
CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up					
1 Ayton 2009: high selection bias (group allocation likely to affect outcome, no attempt to balance design, baseline not comparable); high performance bias (compulsory group treated significantly longer than voluntary group, sig more in compulsory group required nasogastric feeding). 2 CI crosses both 0.75 and 1.25 (Risk Ratio). 3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).					

1 **Table 371: Summary table of findings for compulsory treatment versus voluntary treatment in adults with anorexia nervosa at discharge**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Compulsory Treatment (95% CI)
BMI at discharge	346 (3 studies) 5.7 years	⊕⊖⊖⊖ VERY LOW ^{1,2,3,4} due to risk of bias, imprecision		Not calculable for SMD values	The mean BMI at discharge in the intervention groups was 0.04 standard deviations higher (0.19 lower to 0.27 higher)
Weight Gain	96 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean weight gain in the intervention groups was 0.23 standard deviations higher (0.22 lower to 0.68 higher)
Duration of hospital stay	250 (2 studies)	⊕⊖⊖⊖ VERY LOW ^{2,3,5} due to risk of bias, imprecision		Not calculable for SMD values	The mean duration of hospital stay in the intervention groups was 0.46 standard deviations higher (0.18 to 0.73 higher)
Refeeding Syndrome	96 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,5} due to risk of bias, imprecision	RR 2.24 (1.1 to 4.56)	171 per 1000	213 more per 1000 (from 17 more to 610 more)

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Compulsory Treatment (95% CI)
Locked Ward	96 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 29.62 (4.02 to 218.18)	14 per 1000	409 more per 1000 (from 43 more to 1000 more)
Required Tube Feeding	96 (1 study)	⊕⊖⊖⊖ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 2.94 (1.48 to 5.82)	157 per 1000	305 more per 1000 (from 75 more to 757 more)
Achieved Target Weight	88 (1 study)	⊕⊖⊖⊖ VERY LOW ^{3,5} due to risk of bias, imprecision	RR 0.65 (0.27 to 1.57)	411 per 1000	144 fewer per 1000 (from 300 fewer to 234 more)
Required >1 Specialist Medical Consultation	88 (1 study)	⊕⊖⊖⊖ VERY LOW ^{3,5} due to risk of bias, imprecision	RR 1.29 (1.06 to 1.56)	726 per 1000	211 more per 1000 (from 44 more to 407 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Carney 2006: high selection bias (group allocation likely to affect study outcome, no attempt made to balance design, groups not comparable at baseline); high performance bias (Voluntary group not likely to be on locked ward nor subject to tube feeding).

2 Ramsay 1999/Ward 2015: high selection bias (allocation to group likely to affect study outcome, no attempt to balance design, groups not comparable at baseline).

3 Griffiths 1997: high selection bias (group allocation likely to affect study outcome, no attempt made to balance design, socioeconomic status of compulsory group significantly higher than voluntary group); low performance bias (compulsory group had significantly longer treatment).

4 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

5 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

1 **Table 372: Summary table of findings for compulsory treatment versus voluntary treatment in adults with anorexia nervosa at follow up from discharge**
2

Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects	
				Risk with Voluntary Treatment	Risk difference with Compulsory Treatment (95% CI)
Patient Deaths FU	245 (2 studies)	⊕⊕⊕⊕ VERY LOW ^{1,2,3} due to risk of bias, imprecision	RR 5.66 (1.49 to 21.54)	13 per 1000	62 more per 1000 (from 6 more to 272 more)
Patient Deaths 20-yr FU	157 (1 study)	⊕⊕⊕⊕ VERY LOW ^{1,4} due to risk of bias, imprecision	RR 1.68 (0.82 to 3.43)	128 per 1000	87 more per 1000 (from 23 fewer to 312 more)

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; ITT: Intention to treat; FU: Follow up

1 Ramsay 1999/Ward 2015: high selection bias (allocation to group likely to affect study outcome, no attempt to balance design, groups not comparable at baseline).

2 Griffiths 1997: high selection bias (group allocation likely to affect study outcome, no attempt made to balance design, socioeconomic status of compulsory group significantly higher than voluntary group); low performance bias (compulsory group had significantly longer treatment).

3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

3 **Table 373: Logistic regression predicting dropout from inpatient care (Vandereycken 2009)**

	Total Period	Drop out <1 month	Drop out <2 months	Drop out <3 months	Drop out <4 months
Compulsory versus voluntary	0.19	5.73*	0.76	0.41	0.78
Duration of illness	0.68	0.29	1.18	0.22	0.36
Inpatient treatments	0.1	0.78	0.13	0.72	0.78
Outpatient treatments	1.93	4.31*	0.97	0.1	0.11

1 **Table 374: Regression analysis on factors predicting likelihood of compulsory treatment (Carney 2008)**

	Multiple regression OR	Significance
Age		NS
Age 20-29		NS
Previous admissions	1.29	0.0225
Type of eating disorder		NS
Psychiatric co-morbidities	1.75	0.0315
BMI on admission		NS
Re-feeding syndrome		NS
Days in treatment		NS
Tube feeding		NS
Locked ward	23.45	0.0235

2 Abbreviations: NS, not significant; OR, odds ratio

3 **Table 375: Regression analysis on the effect of perceived coercion on outcome in hospital (Schreyer 2015)**

Predictors	B co-efficient	OR	Hospital outcome
Perceived coercion	NS		Inpatient length of stay
Extraversion	NS		Inpatient length of stay
Admission BMI	NS		Inpatient length of stay
Perceived coercion	NS		Inpatient rate of weight gain
Perceived coercion	NS		Final discharge BMI
Admission BMI	NS		Final discharge BMI
Perceived coercion	$\beta=4.20^*$	0.92	Successful transition to partial hospital vs early drop out
Drive for thinness	$\beta =8.79^{**}$	1.08	Successful transition to partial hospital vs early drop out
Admission BMI	$\beta =7.37^{**}$	1.28	Successful transition to partial hospital vs early drop out
Perceived coercion	NS	0.99	Achieved target weight
Admission BMI	$\beta =23.1^{**}$	1.48	Achieved target weight

4 Abbreviations: β = beta coefficient; NS = not significant

1 **Table 376: Summary on the quality of the studies that conducted a regression analysis on compulsory treatment**

	1.1 Is the source population or source area well described?	1.2 Is the eligible population or area representative of the source population or area?	1.3 Do the selected participants or areas represent the eligible population or area?	2.1 Selection of exposure (and comparison) group. How was selection bias minimized?	2.2 Was the selection of explanatory variables based on a sound theoretical basis?	2.3 Was the contamination acceptably low?	2.4 How well were likely confounding factors identified and controlled?	2.5 Is the setting applicable to the UK?	3.1 Were the outcome measures and procedures reliable?	3.2 Were the outcome measurements complete?	3.3 Were all the important outcomes assessed?	3.4 Was there a similar follow up time in exposure and comparison groups?	3.5 Was follow up time meaningful?	4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?	4.2 Were multiple explanatory variables considered in the analyses?	4.3 Were the analytical methods appropriate?	4.6 Was the precision of association given or calculable? Is association meaningful?	5.1 Are the study results internally valid (i.e. unbiased)?	5.2 Are the findings generalizable to the source population (i.e. externally valid)?	Overall Average
Carney 2008	(+)	(+)	(+)	NR	(++)	NR	(+)	(+)	(++)	(++)	(-)	(++)	(++)	(+)	(-)	(++)	(++)	(+)	(+)	(+) LOW
Schreyer 2015	(+)	(+)	(+)	NR	(++)	NR	(+)	(-)	(++)	(++)	(-)	(++)	(++)	(+)	(+)	(++)	(++)	(+)	(+)	(+) LOW
Vandereycken 2009	(+)	(+)	(+)	NR	(++)	NR	(-)	(+)	(++)	(++)	(-)	(++)	(++)	(+)	(+)	(++)	(++)	(+)	(+)	(+) LOW

2 Abbreviations: ++ Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter; +Some
3 of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions may be likely to alter; -, (-) Few or no checklist
4 criteria have been fulfilled and the conclusions are likely or very likely to alter; NR, not reported

5

1 **10.2.3 Economic evidence**

2 No economic evidence on the cost effectiveness of compulsory treatment was identified by
3 the systematic search of the economic literature undertaken for this guideline. Details on the
4 methods used for the systematic search of the economic literature are described in Chapter
5 3.

6 **10.2.4 Clinical evidence statements**

7 **10.2.4.1 Compulsory treatment versus voluntary treatment in young people with any eating 8 disorder at discharge**

9 Very low quality evidence from one observational study (n=47) showed compulsory treatment
10 is more effective on BMI, the number of people achieving regular menstruation and
11 depression compared with voluntary treatment.

12 Very low quality evidence from one observational study (n=47) showed compulsory treatment
13 is more effective on change in Morgan-Russell-scores compared with voluntary treatment but
14 there was some uncertainty.

15 Very low quality evidence from one observational study (n=50) showed no difference in the
16 effect of compulsory treatment on the number of people who disengaged from family therapy
17 during treatment and the number of people who were prematurely discharged compared with
18 voluntary treatment.

19 Very low quality evidence from one observational study (n=50) showed compulsory treatment
20 is less effective on general functioning and the number of people who required nasogastric
21 feeding compared with voluntary treatment.

22 **10.2.4.2 Compulsory treatment versus voluntary treatment in young people with any eating 23 disorder at follow up**

24 Very low quality evidence from one observational study (n=41) showed no difference in the
25 effect of compulsory treatment on the number of people who achieve greater than 90%
26 weight for height compared with voluntary treatment.

27 Very low quality evidence from one observational study (n=41) showed compulsory treatment
28 may be more effective on the number of people who are still alive, although there was some
29 uncertainty.

30 Very low quality evidence from one observational study (n=41) showed compulsory treatment
31 may be less effective on the number of people who are either clinically underweight or are
32 prematurely discharged, and on the number of people who are readmitted to hospital
33 compared with voluntary treatment, although there was some uncertainty.

34 **10.2.4.3 Compulsory treatment versus voluntary treatment in adults with any eating disorder at 35 discharge**

36 Very low quality evidence from one observational study (n=397) showed no difference in the
37 effect of compulsory treatment on BMI and the number of people who achieving greater than
38 85% average body weight compared with voluntary treatment.

39 Very low quality evidence from one observational study (n=397) showed compulsory
40 treatment is more effective on weight gain compared with voluntary treatment.

1 Very low quality evidence from one observational study (n=397) showed compulsory
2 treatment may be more effective on weight gain compared with voluntary treatment, although
3 there was some uncertainty.

4 Very low quality evidence from one observational study (n=397) showed compulsory
5 treatment may be less effective on the number of people achieving either more than 85%
6 average body weight or a BMI of more than 18 kg/m² compared with voluntary treatment,
7 although there was some uncertainty.

8 Very low quality evidence from one observational study (n=397) showed compulsory
9 treatment is less effective on length of treatment compared with voluntary treatment.

10 **10.2.4.4 Compulsory treatment versus voluntary treatment in adults with anorexia nervosa at** 11 **discharge**

12 Very low quality evidence from three observational studies (n=346) showed no difference in
13 the effect of compulsory treatment on BMI compared with voluntary treatment.

14 Very low quality evidence from one observational study (n=96) showed no difference in the
15 effect of compulsory treatment on weight gain compared with voluntary treatment.

16 Very low quality evidence from two observational studies (n=250) showed compulsory
17 treatment is less effective on duration of hospital stay compared with voluntary treatment.

18 Very low quality evidence from one observational study (n=96) showed compulsory treatment
19 is less effective on the number of people experiencing refeeding syndrome, the number of
20 people who were put on a locked ward and the number of people who required tube feeding
21 compared with voluntary treatment.

22 Very low quality evidence from one observational study (n=88) showed no difference in the
23 effect of compulsory treatment on the number of people who achieved their target weight
24 compared with voluntary treatment.

25 Very low quality evidence from one observational study (n=88) showed compulsory treatment
26 is less effective on the number of people required more than one specialist medical
27 consultation compared with voluntary treatment.

28 **10.2.4.5 Compulsory treatment versus voluntary treatment in adults with anorexia nervosa at** 29 **follow up**

30 Very low quality of evidence from two observational studies (n=245) showed that there are
31 more patient deaths at 5 years follow up compared with voluntary treatment.

32 Very low quality of evidence from one observational study (n=157) showed compulsory
33 treatment may be less effective on the number of people who died at long-term follow up
34 (mean of 19.3 years [range: 14.4-26.3] from admission date) compared with voluntary
35 treatment, although there was some uncertainty.

36 **10.2.4.6 Regression analysis predicting dropouts from treatment if compulsory versus** 37 **voluntary treatment**

38 Low quality evidence from one observational study (n=174) investigated the hypothesis that
39 the provision of choice will result in more self-chosen and fewer rebellious dropouts. The
40 results showed fewer dropouts within one month in those who had voluntary treatment
41 compared with compulsory treatment after adjusting for duration of illness, previous inpatient
42 and outpatient treatments.

1 **10.2.4.7 Regression analysis on the factors associated with the likelihood of compulsory**
2 **treatment**

3 Low quality evidence from one observational study (n=96) aimed to explore the
4 circumstances that lead clinicians to use legal coercion in the management of patients with
5 severe AN. The results showed patients are more likely to be admitted for compulsory
6 treatment if they had previous admissions and psychiatric comorbidities after controlling for
7 age, type of eating disorder, BMI at admission, re-feeding syndrome, days in treatment, tube
8 feeding and locked ward. None of the latter variables were associated with being more likely
9 to have compulsory treatment.

10 **10.2.4.8 Regression analysis on the impact of perceived coercion on outcomes from hospital.**

11 Low quality evidence from one observational study (n=204) investigated the hypothesis that
12 a perceived coercion at admission is associated with poorer hospital outcomes. A regression
13 analysis partially supported the hypothesis. The results showed an increased likelihood of
14 dropout prior to successful transition to partial hospitalisation after controlling for EDI-drive
15 for thinness and BMI.

16 Low quality evidence from one observational study (n=204) showed higher perceived
17 coercion was not associated with inpatient length of stay after adjusting for admission BMI or
18 extraversion.

19 Low quality evidence from one observational study (n=204) showed higher perceived
20 coercion was not associated with achieving target weight after adjusting for admission BMI

21 Low quality evidence from one observational study (n=204) showed higher perceived
22 coercion was not associated with discharge BMI after adjusting for admission BMI.

23 **10.2.5 Economic evidence statements**

24 No economic evidence on the cost effectiveness of compulsory treatment was available.

25 **10.2.6 Recommendations and link to evidence**

26 **Using the Mental Health Act and compulsory treatment**

<p>140. If a person's physical health is at serious risk due to their eating disorder, they do not consent to treatment, and they can only be treated safely in an inpatient setting, follow the legal framework for compulsory treatment in the Mental Health Act 1983.</p> <p>141. If a child or young person lacks capacity, their physical health is at serious risk and they do not, or lack the capacity to, consent to treatment, ask their parents or carers to consent on their behalf and if necessary, use an appropriate legal framework for compulsory treatment (such as the Mental Health Act 1983/2007 or the Children Act 1989).</p> <p>142. Feeding people without their consent should only be done by multidisciplinary teams who are competent to do so.</p>	<p>For this review, the following outcomes were considered critical: remission, disorder specific symptoms (e.g. binge eating frequency) are of greatest concern.</p>
<p>Relative value of different outcomes</p>	

	<p>Other outcomes that are important measures include all-cause mortality, adverse events, quality of life, resource use and relapse.</p> <p>Other outcomes of concern that are of lesser importance but clearly important outcomes include, general psychopathology, body weight, general functioning, eating disorder psychopathology, family functioning and service user experience, body weight, consent, family functioning, general functioning, physical indicators and service utilisation measures (e.g. admission hospital.)</p>
<p>Trade-off between clinical benefits and harms</p>	<p>No direct evidence was identified on what factors/indicators should be considered when assessing whether a person with an eating disorder should be admitted for compulsory treatment. As such indirect evidence was included in this review to help the committee generate a recommendation.</p> <p>Observational studies</p> <p>An observational study explored how successful inpatient care was for people with any eating disorder who were admitted for compulsory treatment compared to those admitted for voluntary treatment. In adults, no difference was found at discharge for any outcome including weight and the number who achieved a target body weight between compulsory and voluntary treatment. However, the rate of weight gain was greater in those who were admitted for compulsory treatment (though there was some uncertainty), but this may in part be a function of the fact that they stayed longer in hospital.</p> <p>In young people, favourable results were found for weight at discharge, Morgan-Russell scores (although there was some uncertainty), resumption of menses, depression and general functioning in those who were admitted for compulsory treatment compared with voluntary admission. However, more patients required nasogastric feeding. No difference was found in the number of patients who disengaged from family therapy nor in the number of those who were prematurely discharged. At long-term follow up (12 months after discharge from an inpatient unit), more people were either clinically underweight and receiving ongoing outpatient treatment or were prematurely discharged from services, and more people were readmitted to hospital (although there was some uncertainty). However, the mode of treatment (compulsory or voluntary) made no difference in the number of people who achieved a target body weight.</p> <p>Regression analyses</p> <p>A regression analysis showed that, after controlling for duration of illness, inpatient and outpatient treatments, dropouts from inpatient treatment within one month were significantly lower if patients were admitted under voluntary conditions compared with compulsory treatment.</p> <p>One study explored the circumstances that lead clinicians to use legal coercion in the management of patients with severe anorexia nervosa. The results showed patients were more likely to be admitted for compulsory treatment if they had previous admissions and psychiatric comorbidities after controlling for age, type of eating disorder. BMI at admission, re-feeding syndrome, days in treatment, tube feeding and whether they were put on a secured ward were associated with compulsory admission</p> <p>Another regression analysis on people admitted for compulsory care showed a higher perceived coercion was associated with a decreased likelihood of successful transition to partial hospitalisation after adjusting for EDI-drive for thinness and BMI. The analysis also showed that higher perceived coercion was not associated with length of inpatient stay after adjusting for admission BMI or extraversion. It was also not associated with achieving a target weight after adjusting for admission BMI, or discharge BMI after adjusting for admission BMI.</p>

Trade-off between net health benefits and resource use	The committee expressed the view that this is an issue covered by legislation (safety issue), and therefore economic analysis is not relevant.
Quality of evidence	<p>No evidence was identified that explored what factors predicted the need for compulsory treatment. The studies found that conducted a regression analysis on compulsory treatment did not directly answer the question. They investigated whether: a patient was more likely to drop out from inpatient care; factors associated with patients who undergo compulsory treatment (not necessarily what factors they should be admitted for); and the impact of compulsory treatment on outcomes from hospital.</p> <p>The evidence from these studies was low quality for the reasons including that they either: did not fully explore all explanatory variables, the size of the studies was relatively small ranging from 96 to 204 participants, provided indirect evidence or; they were not conducted in the UK.</p> <p>Observational studies were included in this review and presented to the committee in case they proved useful. All of the outcomes were graded very low quality since they were observational and there were no reasons identified to justify upgrading the quality (e.g.. a large effect size or dose response).</p>
Other considerations	<p>No direct evidence was identified on what factors need to be considered before admitting a patient for compulsory admission. Therefore, the committee developed these recommendations by informal consensus using their expertise and informed by their knowledge of the Mental Health Act 1983 and Children Act 1989.</p> <p>For children and young people, the Children Act 1989 means that duty can be allocated to local authorities, courts, parents and other agencies in the UK to ensure children are safeguarded and their welfare is promoted. It makes provisions for instances when parents and families do not co-operate with statutory bodies.</p> <p>In the case of eating disorders the compulsory treatment would mean admitting a critically ill person who is refusing treatment to an inpatient unit for acute medical stabilisation or refeeding. This applies to adults, children and young people. In the case of children and young people under 16, if they lack capacity, and they refuse treatment then the parents and carers can be asked to consent on their behalf.. The committee agreed it is important that feeding people without their consent should be only be done by teams competent in doing so.</p> <p>The committee noted that for nasogastric feeding to be performed, it will almost always be necessary for the person to be detained under the Mental Health Act 1983, although occasionally someone may request this treatment. If the person is detained under Section 2 or Section 3, nasogastric feeding does not require a second opinion, although there will be circumstances in which it will be good practice to obtain one.</p> <p>Given the committee's concerns about a lack of understanding on the part of healthcare professionals they decided to make a number of recommendations, which make clear the position of eating disorders in relation to the Mental Health Act, the Children's Act and Gillick competence.</p> <p>The committee discussed whether specific mention should be made of community treatment orders given that they are covered by the Mental Health Act. However, it was noted that there was no evidence for their efficacy (at least in the context of eating disorders) and indeed some evidence (in people with psychosis) that they are not effective (Burns et al., 2013).</p>

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1 12 Glossary

Term	Definition
Abstract	Summary of a study, which may be published alone or as an introduction to a full scientific paper.
Amenorrhea	An abnormal absence of menstruation.
Arm (of a clinical study)	Subsection of individuals within a study who receive one particular intervention, for example placebo arm.
Association	Statistical relationship between 2 or more events, characteristics or other variables. The relationship may or may not be causal.
Attrition bias	Systematic differences between comparison groups for withdrawal or exclusion of participants from a study.
AUC	Area under the curve
Available case analysis (ACA)	Analysis of data that is available for participants at the end of follow up.
Baseline	The initial set of measurements at the beginning of a study (after run-in period where applicable) with which subsequent results are compared.
Before-and-after study	A study that investigates the effects of an intervention by measuring particular characteristics of a population both before and after taking the intervention, and assessing any change that occurs.
Bias	Influences on a study that can make the results look better or worse than they really are. Bias can occur by chance, deliberately or as a result of systematic errors in the design and execution of a study. It can also occur at different stages in the research process, for example during the collection, analysis, interpretation, publication or review of research data. For examples see Confounding factor, Performance bias, Publication bias Selection bias.
Carer (caregiver)	Someone who looks after family, partners or friends in need of help because they are ill, frail or have a disability.
Case-control study	A study to find out the cause(s) of a disease or condition. This is done by comparing a group of patients who have the disease or condition (cases) with a group of people who do not have it (controls) but who are otherwise as similar as possible (in characteristics thought to be unrelated to the causes of the disease or condition). This means the researcher can look for aspects of their lives that differ to see if they may cause the condition. Such studies are retrospective because they look back in time from the outcome to the possible causes of a disease or condition.
Case series	Report of a number of cases of a given disease, usually covering the course of the disease and the response to treatment. There is no comparison (control) group of patients.
Clinical audit	A systematic process for setting and monitoring standards of clinical care. Whereas 'guidelines' define what the best clinical practice should be, 'audit' investigates whether best practice is being carried out. Clinical audit can be described as a cycle or spiral. Within the cycle there are stages that follow a systematic process of establishing best practice, measuring care against specific criteria, taking action to improve care and monitoring to sustain improvement. The spiral suggests that as the process continues, each cycle aspires to a higher level of quality.
Clinical effectiveness	How well a specific test or treatment works when used in the 'real world' (for example when used by a doctor with a patient at home), rather than in a carefully controlled clinical trial. Trials that assess clinical effectiveness are sometimes called management trials. Clinical effectiveness is not the same as efficacy.

Term	Definition
Clinical efficacy	The extent to which an intervention is active when studied under controlled research conditions.
Clinician	A healthcare professional who provides patient care. For example a doctor, nurse or physiotherapist.
Cochrane Review	The Cochrane Library consists of a regularly updated collection of evidence-based medicine databases including the Cochrane Database of Systematic Reviews (reviews of RCTs prepared by the Cochrane Collaboration).
Cohort study	A study with 2 or more groups of people – cohorts – with similar characteristics. One group receives a treatment, is exposed to a risk factor or has a particular symptom and the other group does not. The study follows their progress over time and records what happens.
Comorbidity	A disease or condition that someone has in addition to the health problem being studied or treated.
Concealment of allocation	The process used to ensure that the person deciding to enter a participant into an RCT does not know the comparison group into which that individual will be allocated. This is distinct from blinding and is aimed at preventing selection bias. Some attempts at concealing allocation are more prone to manipulation than others and the method of allocation concealment is used as an assessment of the quality of a trial.
Confidence interval (CI)	<p>There is always some uncertainty in research. This is because a small group of patients is studied to predict the effects of a treatment on the wider population. The confidence interval is a way of expressing how certain we are about the findings from a study, using statistics. It gives a range of results that is likely to include the 'true' value for the population. The CI is usually stated as '95% CI', which means that the range of values has a 95 in 100 chance of including the 'true' value. For example, a study may state that "based on our sample findings, we are 95% certain that the 'true' population blood pressure is not higher than 150 and not lower than 110". In such a case the 95% CI would be 110 to 150.</p> <p>A wide confidence interval indicates a lack of certainty about the true effect of the test or treatment – often because a small group of patients has been studied. A narrow confidence interval indicates a more precise estimate (for example if a large number of patients have been studied).</p>
Confounding factor	Something that influences a study and can result in misleading findings if it is not understood or appropriately dealt with. For example, a study of heart disease may look at a group of people who exercise regularly and a group who do not exercise. If the ages of the people in the 2 groups are different, then any difference in heart disease rates between the 2 groups could be because of age rather than exercise. Therefore age is a confounding factor.
Continuous outcome	Data with a potentially infinite number of possible values within a given range. Height, weight and blood pressure are examples of continuous variables.
Control group	A group of people in a study who do not receive the treatment or test being studied. Instead, they may receive the standard treatment (sometimes called 'usual care') or a dummy treatment (placebo). The results for the control group are compared with those for a group receiving the treatment being tested. The aim is to check for any differences. Ideally, the people in the control group should be as similar as possible to those in the treatment group, to make it as easy as possible to detect any effects due to the treatment.
Cost–benefit analysis (CBA)	Cost-benefit analysis is one of the tools used to carry out an economic evaluation. The costs and benefits are measured using the same

Term	Definition
	monetary units (for example UK pounds) to see whether the benefits exceed the costs.
Cost–consequence analysis (CCA)	Cost-consequence analysis is one of the tools used to carry out an economic evaluation. This compares the costs (such as treatment and hospital care) with the consequences (such as health outcomes) of a test or treatment with a suitable alternative. Unlike cost–benefit analysis or cost-effectiveness analysis, it does not attempt to summarise outcomes in a single measure (such as the quality adjusted life year) or in financial terms. Instead, outcomes are shown in their natural units (some of which may be monetary) and it is left to decision-makers to determine whether, overall, the treatment is worth carrying out.
Cost-effectiveness analysis (CEA)	Cost-effectiveness analysis is one of the tools used to carry out an economic evaluation. The benefits are expressed in non-monetary terms related to health, such as symptom-free days, heart attacks avoided, deaths avoided or life years gained (that is, the number of years by which life is extended as a result of the intervention).
Cost-effectiveness model	An explicit mathematical framework which is used to represent clinical decision problems and incorporate evidence from a variety of sources in order to estimate the costs and health outcomes.
Cost–utility analysis (CUA)	Cost–utility analysis is one of the tools used to carry out an economic evaluation. The benefits are assessed in terms of both quality and duration of life, and expressed as quality adjusted life years (QALYs). See also Utility.
COX proportional hazard model	In survival analysis, a statistical model that asserts that the effect of the study factors (for example the intervention of interest) on the hazard rate (the risk of occurrence of an event) in the study population is multiplicative and does not change over time.
Credible interval (CrI)	The Bayesian equivalent of a confidence interval.
Decision analysis	An explicit quantitative approach to decision-making under uncertainty, based on evidence from research. This evidence is translated into probabilities, and then into diagrams or decision trees which direct the clinician through a succession of possible scenarios, actions and outcomes.
Dichotomous outcomes	Outcome that can take one of 2 possible values, such as dead/alive, smoker/non-smoker, present/not present (also called binary data).
Discounting	Costs and perhaps benefits incurred today have a higher value than costs and benefits occurring in the future. Discounting health benefits reflects individual preference for benefits to be experienced in the present rather than the future. Discounting costs reflects individual preference for costs to be experienced in the future rather than the present.
Dominance	A health economics term. When comparing tests or treatments, an option that is both less effective and costs more is said to be 'dominated' by the alternative.
Drop-out	A participant who withdraws from a trial before the end.
Economic evaluation	An economic evaluation is used to assess the cost effectiveness of healthcare interventions (that is, to compare the costs and benefits of a healthcare intervention to assess whether it is worth doing). The aim of an economic evaluation is to maximise the level of benefits – health effects – relative to the resources available. It should be used to inform and support the decision-making process; it is not supposed to replace the judgement of healthcare professionals. There are several types of economic evaluation: cost–benefit analysis, cost–consequence analysis, cost-effectiveness analysis, cost-minimisation analysis and cost–utility analysis. They use similar methods

Term	Definition
	to define and evaluate costs, but differ in the way they estimate the benefits of a particular drug, programme or intervention.
Effect (as in effect measure, treatment effect, estimate of effect, effect size)	A measure that shows the magnitude of the outcome in 1 group compared with that in a control group. For example, if the absolute risk reduction is shown to be 5% and it is the outcome of interest, the effect size is 5%. The effect size is usually tested, using statistics, to find out how likely it is that the effect is a result of the treatment and has not just happened by chance.
Effectiveness	How beneficial a test or treatment is under usual or everyday conditions.
Efficacy	How beneficial a test, treatment or public health intervention is under ideal conditions (for example in a laboratory).
Ego-syntonic beliefs	Beliefs, values, and feelings consistent with one's sense of self
Epidemiological study	The study of a disease within a population, defining its incidence and prevalence and examining the roles of external influences (for example infection, diet) and interventions.
EQ-5D (EuroQol 5 dimensions)	A standardised instrument used to measure health-related quality of life. It provides a single index value for health status.
Equivalence study	A trial designed to determine whether the response to 2 or more treatments differs by an amount that is clinically unimportant. This is usually demonstrated by showing that the true treatment difference is likely to lie between a lower and an upper equivalence level of clinically acceptable differences.
Evidence	Information on which a decision or guidance is based. Evidence is obtained from a range of sources including RCTs, observational studies, expert opinion (of clinical professionals or patients).
Exclusion criteria (clinical study)	Criteria that define who is not eligible to participate in a clinical study.
Exclusion criteria (literature review)	Explicit standards used to decide which studies should be excluded from consideration as potential sources of evidence.
Extended dominance	If Option A is both more clinically effective than Option B and has a lower cost per unit of effect when both are compared with a do-nothing alternative, then Option A is said to have extended dominance over Option B. Option A is therefore more cost effective and should be preferred, other things remaining equal.
Extrapolation	An assumption that the results of studies of a specific population will also hold true for another population with similar characteristics.
False negative	A diagnostic test result that incorrectly indicates that an individual does not have the disease of interest, when they do actually have it.
False positive	A diagnostic test result that incorrectly indicates that an individual has the disease of interest, when they actually do not have it.
Fixed-effect model	In meta-analysis, a model that calculates a pooled effect estimate using the assumption that all observed variation between studies is caused by random sample variability. Studies are assumed to be estimating the same overall effect.
Follow up	Observation over a period of time of an individual, group or initially defined population whose appropriate characteristics have been assessed in order to observe changes in health status or health-related variables.
Forest plot	A graphical representation of the individual results of each study included in a meta-analysis together with the combined meta-analysis result. The plot also allows readers to see the heterogeneity among the results of the studies. The results of individual studies are shown as squares centred on each study's point estimate. A horizontal line runs through each square to show each study's confidence interval. The overall estimate from the meta-analysis and its confidence interval are

Term	Definition
	shown at the bottom, represented as a diamond. The centre of the diamond represents the pooled point estimate, and its horizontal tips represent the confidence interval.
Generalisability	The extent to which the results of a study hold true for groups that did not participate in the research.
Gold standard	A method, procedure or measurement that is widely accepted as being the best available to test for or treat a disease.
GRADE, GRADE profile	A system developed by the GRADE Working Group to address the short-comings of present grading systems in healthcare. The GRADE system uses a common, sensible and transparent approach to grading the quality of evidence. The results of applying the GRADE system to clinical trial data are displayed in a table known as a GRADE profile.
Guided self-help	This term is used interchangeably with self-help with support
Harms	Adverse effects of an intervention.
Hazard ratio	A hazard is the rate at which events happen, so that the probability of an event happening in a short time interval is the length of time multiplied by the hazard. Although the hazard may vary with time, the assumption in proportional hazard models for survival analysis is that the hazard in one group is a constant proportion of the hazard in the other group. This proportion is the hazard ratio.
Health economics	Study or analysis of the cost of using and distributing healthcare resources.
Health-related quality of life (HRQoL)	A measure of the effects of an illness to see how it affects someone's day-to-day life.
Heterogeneity	The term is used in meta-analyses and systematic reviews to describe when the results of a test or treatment (or estimates of its effect) differ
Imprecision	Results are imprecise when studies include relatively few patients and few events and thus have wide confidence intervals around the estimate of effect.
Incidence	The incidence of a disease is the rate at which new cases occur in a population during a specified period.
Inclusion criteria (clinical study)	Specific criteria that define who is eligible to participate in a clinical study.
Inclusion criteria (literature review)	Explicit criteria used to decide which studies should be considered as potential sources of evidence.
Incremental cost	The extra cost linked to using one test or treatment rather than another. Or the additional cost of doing a test or providing a treatment more frequently.
Incremental cost effectiveness ratio (ICER)	The difference in the mean costs in the population of interest divided by the differences in the mean outcomes in the population of interest for one treatment compared with another.
Incremental net benefit (INB)	The value (usually in monetary terms) of an intervention net of its cost compared with a comparator intervention. The INB can be calculated for a given cost-effectiveness (willingness to pay) threshold. If the threshold is £20,000 per QALY gained then the INB is calculated as: (£20,000×QALYs gained) minus incremental cost.
Indirectness	The available evidence is different to the review question being addressed, in terms of population, intervention, comparison and outcome (PICO).
Intention-to-treat analysis (ITT)	An assessment of the people taking part in a clinical trial, based on the group they were initially (and randomly) allocated to. This is regardless of whether or not they dropped out, fully complied with the treatment or switched to an alternative treatment. Intention-to-treat analyses are often used to assess clinical effectiveness because they mirror actual practice:

Term	Definition
	that is, not everyone complies with treatment and the treatment people receive may be changed according to how they respond to it.
Intervention	In medical terms this could be a drug treatment, surgical procedure, diagnostic or psychological therapy. Examples of public health interventions could include action to help someone to be physically active or to eat a more healthy diet.
Kappa statistic	A statistical measure of inter-rater agreement that takes into account the agreement occurring by chance
Length of stay	The total number of days a patient stays in hospital.
Licence	See Product licence.
Life years gained	Mean average years of life gained per person as a result of the intervention compared with an alternative intervention.
Likelihood ratio	The likelihood ratio combines information about the sensitivity and specificity. It tells you how much a positive or negative result changes the likelihood that a patient would have the disease. The likelihood ratio of a positive test result (LR+) is sensitivity divided by (1 minus specificity).
Loss to follow up	Patients who have withdrawn from the clinical trial at the point of follow up.
Markov model	A method for estimating long-term costs and effects for recurrent or chronic conditions, based on health states and the probability of transition between them within a given time period (cycle).
Mean	An average value, calculated by adding all the observations and dividing by the number of observations.
Mean difference	In meta-analysis, a method used to combine measures on continuous scales (such as weight), where the mean, standard deviation and sample size in each group are known. The weight given to the difference in means from each study (for example how much influence each study has on the overall results of the meta-analysis) is determined by the precision of its estimate of effect.
Median	The value of the observation that comes half-way when the observations are ranked in order.
Meta-analysis	A method often used in systematic reviews. Results from several studies of the same test or treatment are combined to estimate the overall effect of the treatment.
Minimal important difference (MID)	Threshold for clinical importance which represents the minimal important difference for benefit or for harm; for example the threshold at which drug A is less effective than drug B by an amount that is clinically important to patients.
Monte Carlo	A technique used to approximate the probability of certain outcomes by running multiple simulations using random variables.
Multivariate model	A statistical model for analysis of the relationship between 2 or more predictors, (independent) variables and the outcome (dependent) variable.
Net monetary benefit (NMB)	The value (usually in monetary terms) of an intervention net of its cost. The NMB can be calculated for a given cost-effectiveness (willingness to pay) threshold. If the threshold is £20,000 per QALY gained then the NMB is calculated as: (£20,000×QALYs gained) minus cost.
Network meta-analysis	Meta-analysis in which multiple treatments (that is, 3 or more) are being compared using both direct comparisons of interventions within RCTs and indirect comparisons across trials based on a common comparator.
Non-inferiority trial	A trial designed to determine whether the effect of a new treatment is not worse than a standard treatment by more than a pre-specified amount. A one-sided version of an equivalence trial.

Term	Definition
Number needed to treat (NNT)	The average number of patients who need to be treated to get a positive outcome. For example, if the NNT is 4, then 4 patients would have to be treated to ensure 1 of them gets better. The closer the NNT is to 1, the better the treatment. For example, if you give a stroke prevention drug to 20 people before 1 stroke is prevented, the number needed to treat is 20.
Observational study	Individuals or groups are observed or certain factors are measured. No attempt is made to affect the outcome. For example, an observational study of a disease or treatment would allow 'nature' or usual medical care to take its course. Changes or differences in one characteristic (for example whether or not people received a specific treatment or intervention) are studied without intervening. There is a greater risk of selection bias than in experimental studies.
Odds ratio (OR)	<p>Odds are a way to represent how likely it is that something will happen (the probability) and compares the probability of something in one group with the probability of the same thing in another.</p> <p>An odds ratio of 1 between 2 groups would show that the probability of the event (for example a person developing a disease, or a treatment working) is the same for both. An odds ratio greater than 1 means the event is more likely in the first group. An odds ratio less than 1 means that the event is less likely in the first group.</p> <p>Sometimes probability can be compared across more than 2 groups – in this case, one of the groups is chosen as the 'reference category' and the odds ratio is calculated for each group compared with the reference category. For example, to compare the risk of dying from lung cancer for non-smokers, occasional smokers and regular smokers, non-smokers could be used as the reference category. Odds ratios would be worked out for occasional smokers compared with non-smokers and for regular smokers compared with non-smokers.</p> <p>See also Confidence interval, Relative risk.</p>
Opportunity cost	The loss of other healthcare programmes displaced by investment in or introduction of another intervention. This may be best measured by the health benefits that could have been achieved had the money been spent on the next best alternative healthcare intervention.
Outcome	The impact that a test, treatment, policy, programme or other intervention has on a person, group or population. Outcomes from interventions to improve the public's health could include changes in knowledge and behaviour related to health, societal changes (for example a reduction in crime rates) and a change in people's health and wellbeing or health status. In clinical terms, outcomes could include the number of patients who fully recover from an illness or the number of hospital admissions, and an improvement or deterioration in someone's health, functional ability, symptoms or situation. Researchers should decide what outcomes to measure before a study begins.
p value	The p value is a statistical measure that indicates whether or not an effect is statistically significant. For example, if a study comparing 2 treatments found that one seems more effective than the other, the p value is the probability of obtaining these results by chance. By convention, if the p value is below 0.05 (that is, there is less than a 5% probability that the results occurred by chance) it is considered that there probably is a real difference between treatments. If the p value is 0.001 or less (less than a 1% probability that the results occurred by chance), the result is seen as highly significant. If the p value shows that there is likely to be a difference between treatments, the confidence interval describes how big the difference in effect might be.
Performance bias	Systematic differences between intervention groups in care provided apart from the intervention being evaluated. Blinding of study

Term	Definition
	participants (both the recipients and providers of care) is used to protect against performance bias.
Placebo	A fake (or dummy) treatment given to participants in the control group of a clinical trial. It is indistinguishable from the actual treatment (which is given to participants in the experimental group). The aim is to determine what effect the experimental treatment has had over and above any placebo effect caused because someone has received (or thinks they have received) care or attention.
Placebo effect	A beneficial (or adverse) effect produced by a placebo and not due to any property of the placebo itself.
Post-hoc analysis	Statistical analyses that are not specified in the trial protocol and are generally suggested by the data.
Power (statistical)	The ability to demonstrate an association when one exists. Power is related to sample size; the larger the sample size, the greater the power and the lower the risk that a possible association could be missed.
Prevalence	The prevalence of a disease is the proportion of a population that are cases at a point in time.
Primary care	Healthcare delivered outside hospitals. It includes a range of services provided by GPs, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians.
Primary outcome	The outcome of greatest importance, usually the one in a study that the power calculation is based on.
Product licence	An authorisation from the Medicines and Healthcare Products Regulatory Agency (MHRA) to market a medicinal product.
Prognosis	A probable course or outcome of a disease. Prognostic factors are patient or disease characteristics that influence the course. Good prognosis is associated with low rate of undesirable outcomes; poor prognosis is associated with a high rate of undesirable outcomes.
Prospective study	A research study in which the health or other characteristic of participants is monitored (or 'followed up') for a period of time, with events recorded as they happen. This contrasts with retrospective studies.
Protocol (review)	A document written prior to commencing a review that details exactly how evidence to answer a review question will be obtained and synthesised. It defines in detail the population of interest, the interventions, the comparators/controls and the outcomes of interest (PICO).
Publication bias	Publication bias occurs when researchers publish the results of studies showing that a treatment works well and don't publish those showing it did not have any effect. If this happens, analysis of the published results will not give an accurate idea of how well the treatment works. This type of bias can be assessed by a funnel plot.
Quality of life	See Health-related quality of life.
Quality adjusted life year (QALY)	A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality-of-life. One QALY is equal to 1 year of life in perfect health. QALYS are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a scale of 0 to 1). It is often measured in terms of the person's ability to perform the activities of daily life, and freedom from pain and mental disturbance.
Random effect model	In meta-analysis, a model that calculates a pooled effect estimate using the assumption that each study is estimating a different true treatment effect due to real differences between studies. Observed variation in

Term	Definition
	effects are therefore caused by a combination of random sample variability (within-study variation) and heterogeneity between studies (between-study variation). The overall effects is an average of the estimated true study effects.
Randomisation	Assigning participants in a research study to different groups without taking any similarities or differences between them into account. For example, it could involve using a random numbers table or a computer-generated random sequence. It means that each individual (or each group in the case of cluster randomisation) has the same chance of receiving each intervention.
Randomised controlled trial (RCT)	A study in which a number of similar people are randomly assigned to 2 (or more) groups to test a specific drug or treatment. One group (the experimental group) receives the treatment being tested, the other (the comparison or control group) receives an alternative treatment, a dummy treatment (placebo) or no treatment at all. The groups are followed up to see how effective the experimental treatment was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce bias.
Reference standard	The test that is considered to be the best available method to establish the presence or absence of the outcome – this may not be the one that is routinely used in practice.
Relative risk (RR)	The ratio of the risk of disease or death among those exposed to certain conditions compared with the risk for those who are not exposed to the same conditions (for example the risk of people who smoke getting lung cancer compared with the risk for people who do not smoke). If both groups face the same level of risk, the relative risk is 1. If the first group had a relative risk of 2, subjects in that group would be twice as likely to have the event happen. A relative risk of less than 1 means the outcome is less likely in the first group. Relative risk is sometimes referred to as risk ratio.
Reporting bias	See Publication bias.
Resource implication	The likely impact in terms of finance, workforce or other NHS resources.
Retrospective study	A research study that focuses on the past and present. The study examines past exposure to suspected risk factors for the disease or condition. Unlike prospective studies, it does not cover events that occur after the study group is selected.
Review question	The plan or set of steps to be followed in a study. A protocol for a systematic review describes the rationale for the review, the objectives and the methods that will be used to locate, select and critically appraise studies, and to collect and analyse data from the included studies.
Secondary care	Care provided in hospitals.
Secondary outcome	An outcome used to evaluate additional effects of the intervention deemed a priori as being less important than the primary outcomes.
Selection bias	Selection bias occurs if: <ul style="list-style-type: none"> • The characteristics of the people selected for a study differ from the wider population from which they have been drawn; or • There are differences between groups of participants in a study in terms of how likely they are to get better.
Self-help	This term is used interchangeably with self-help without support
Self-help with support	This term was used interchangeably with guided self-help
Sensitivity	How well a test detects the thing it is testing for. If a diagnostic test for a disease has high sensitivity, it is likely to pick up all cases of the disease in people who have it (that is, give a 'true positive' result). But if a test is too sensitive it will sometimes also give a positive result in people who

Term	Definition
	<p>don't have the disease (that is, give a 'false positive'). For example, if a test were developed to detect if a woman is 6 months pregnant, a very sensitive test would detect everyone who was 6 months pregnant but would probably also include those who are 5 and 7 months pregnant. If the same test were more specific (sometimes referred to as having higher specificity), it would detect only those who are 6 months pregnant and someone who was 5 months pregnant would get a negative result (a 'true negative'). But it would probably also miss some people who were 6 months pregnant (that is, give a 'false negative').</p> <p>Breast screening is a 'real-life' example. The number of women who are recalled for a second breast screening test is relatively high because the test is very sensitive. If it were made more specific, people who don't have the disease would be less likely to be called back for a second test but more women who have the disease would be missed.</p>
Sensitivity analysis	<p>A means of representing uncertainty in the results of an analysis. Uncertainty may arise from missing data, imprecise estimates or methodological controversy. Sensitivity analysis also allows for exploring the generalisability of results to other settings. The analysis is repeated using different assumptions to examine the effect on the results.</p> <ul style="list-style-type: none"> • One-way simple sensitivity analysis (univariate analysis) – each parameter is varied individually in order to isolate the consequences of each parameter on the results of the study. • Multi-way simple sensitivity analysis (scenario analysis) – 2 or more parameters are varied at the same time and the overall effect on the results is evaluated. • Threshold sensitivity analysis – the critical value of parameters above or below which the conclusions of the study will change are identified. • Probabilistic sensitivity analysis – probability distributions are assigned to the uncertain parameters and are incorporated into evaluation models based on decision analytical techniques (for example Monte Carlo simulation).
Significance (statistical)	<p>A result is deemed statistically significant if the probability of the result occurring by chance is less than 1 in 20 ($p < 0.05$).</p>
Specificity	<p>The proportion of true negatives that are correctly identified as such. For example, in diagnostic testing the specificity is the proportion of non-cases correctly diagnosed as non-cases. In terms of literature searching a highly specific search is generally narrow and aimed at picking up the key papers in a field and avoiding a wide range of papers.</p> <p>See also Sensitivity.</p>
Stakeholder	<p>An organisation with an interest in a topic on which NICE is developing a clinical guideline or piece of public health guidance. Organisations that register as stakeholders can comment on the draft scope and the draft guidance. Stakeholders may be:</p> <ul style="list-style-type: none"> • manufacturers of drugs or equipment • national patient and carer organisations • NHS organisations • organisations representing healthcare professionals.
Standard deviation (SD)	<p>A measure of the spread or dispersion of a set of observations, calculated as the average difference from the mean value in the sample.</p>
Subgroup analysis	<p>An analysis in which the intervention effect is evaluated in a defined subset of the participants in a trial, or in complementary subsets.</p>
Systematic review	<p>A review in which evidence from scientific studies has been identified, appraised and synthesised in a methodical way according to predetermined criteria. It may include a meta-analysis.</p>

Term	Definition
Time horizon	The time span over which costs and health outcomes are considered in a decision analysis or economic evaluation.
Treatment allocation	Assigning a participant to a particular arm of a trial.
True negative	A diagnostic test result that correctly indicates that an individual does not have the disease of interest when they actually do not have it.
True positive	A diagnostic test result that correctly indicates that an individual has the disease of interest when they do actually have it.
Univariate	Analysis which separately explores each variable in a data set.
Utility	In health economics, a utility is the measure of the preference or value that an individual or society places upon a particular health state. It is generally a number between 0 (representing death) and 1 (perfect health). The most widely used measure of benefit in cost-utility analysis is the quality-adjusted life year, but other measures include disability-adjusted life years (DALYs) and healthy year equivalents (HYEs).

1 13 Abbreviations

ABW	Average body weight
AN	Anorexia nervosa
ANIS	Anorexia nervosa inventory for self-rating
ARFID	Avoidant/Restrictive Food Intake Disorder
AS	Anteroposterior
BED	Binge eating disorder
BITE	Bulimic investigatory test Edinburgh
BMD	Bone mineral density
BMI	Body mass index
BN	Bulimia nervosa
BT	Behavioural therapy
BT	Behavioural therapy
CAMHS	Child and adolescent mental health services
CAT	Cognitive analytic therapy
CBT	Cognitive behavioural therapy
CDI	Clinical diagnostic interview
CI	Confidence interval
COC	Combined oral contraceptive pill
CPA	Care programme approach
CRT	Cognitive remediation therapy
DAWBA	Development and well-being assessment
DBT	Dialectical behaviour therapy
DHEA	Dehydroepiandrosterone
DM,	Diabetes mellitus
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAT	Eating attitudes test
ECHO	Experienced carers helping others
ED	Eating disorder
EDA-5	The eating disorder assessment for DSM-5
EDE	Eating disorder examination
EDI	Eating disorder interview
EDI-C	Eating disorder inventory for children
EDNOS	Eating disorder not otherwise stated
ESM	Emotional and social mind training
ESP	Eating disorders screen for primary care
FBT	Family-Based Treatment
FN	Femoral neck
FPP	Focal psychodynamic psychotherapy
FT	Family therapy
FU	Follow up
GAF	Global assessment of functioning
GP	General practice

GRADE	Grading of recommendations, assessment, development and evaluation
GSH or gSH	Guided self-help
HRT	Hormone replacement therapy
ICAT	Integrative cognitive-affective therapy
IFT –	intensive family coaching
IFW	Individual family work
IGF	Insulin-like growth factor
IP	Inpatient
IPT	Interpersonal therapy
IPT	Interpersonal psychotherapy
ITT	Intention to treat
LS	Lumbar spine
MANTRA	Maudsely anorexia treatment for adults
MARISPAN	Management of really sick patients with anorexia nervosa
MD	Mean difference
MHA	Mental health act.
MINI	Mini-international neuropsychiatric interview
N	Number
NA	Not available
NDRI	Norepinephrine-dopamine reuptake Inhibitor
Non-Sp	Non-specialist
NR	Not reported
NRI	Norepinephrine reuptake inhibitor
OAD	Overcoming anorexia online
OSFED	Other specified feeding or eating disorder
PE	Psychoeducation
QUADAS	Quality assessment of diagnostic accuracy studies
RCT	Randomised control trial
ROC	Receiver operating characteristics
RR	Relative risk
rTMS	Repetitive transcranial magnetic stimulation
SATA	Substance abuse treatment agent
SCAN	Schedules for clinical assessment in neuropsychiatry
SCID-I	Structured clinical interview for axis I disorders
SCOFF	Sick control one fat food
Se	Sensitivity
SEED	Severe and enduring anorexia nervosa
SFT-AN	Systematic family therapy for anorexia nervosa
SH	Self help
SIAB-EX	Structured Interview for anorexic and bulimic Syndromes for expert rating
SIAB-S	Structured Interview for anorexic and bulimic syndromes- self-rated questionnaire
SMD	Standard mean difference
SNRI	Serotonin norepinephrine reuptake inhibitor.

SOS	Speed of sound
Sp	Specialist
Sp	Specificity
SPT-BN	Supportive psychotherapy for young people bulimia nervosa
SSCM	Specialist supportive clinical management
SSRI	Selective serotonin reuptake inhibitor
TAU	Treatment as usual
TCA	Tricyclic antidepressants
Vs.	Versus
WLC	Wait list control

14 Recommendations

1. Be aware that eating disorders present in a range of settings, including:
 - primary and secondary health care (including acute hospitals)
 - social care
 - education
 - work.
2. Although eating disorders can develop at any age, be aware that the risk in young men and women is highest between 13 and 17 years of age.
3. Do not use screening tools (for example, SCOFF) as the sole method to determine whether or not people have an eating disorder.
4. People with eating disorders should be assessed and receive treatment at the earliest opportunity.
5. Early treatment is particularly important for those with or at risk of severe emaciation and such patients should be prioritised for treatment.
6. When assessing for an eating disorder or deciding whether to refer people for assessment, take into account any of the following that apply:
 - an unusually low or high BMI or body weight for their age
 - rapid weight loss
 - dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals
 - family members or carers report a change in eating behaviour
 - social withdrawal, particularly from situations that involve food
 - other mental health problems
 - a disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)
 - problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
 - menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
 - physical signs of:
 - malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor
 - compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise
 - abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition
 - unexplained electrolyte imbalance or hypoglycaemia
 - atypical dental wear (such as erosion)

- 1 • whether they take part in activities associated with a high risk of
2 eating disorders (for example, professional sport, fashion,
3 dance, or modelling).
- 4 7. Be aware that, in addition to the points in recommendation 4, children and
5 young people with an eating disorder may also present with faltering
6 growth (for example, a low weight or height for their age) or delayed
7 puberty.
- 8 8. Do not use single measures such as BMI or duration of illness to
9 determine whether to offer treatment for an eating disorder.
- 10 9. Professionals in primary and secondary mental health or acute settings
11 should assess the following in people with a suspected eating disorder:
- 12 • their physical health, including checking for any physical effects
13 of malnutrition or compensatory behaviours such as vomiting
- 14 • the presence of mental health problems commonly associated
15 with eating disorders, including depression, anxiety, self-harm
16 and obsessive compulsive disorder
- 17 • the possibility of alcohol or substance misuse.
- 18 • the need for emergency care in people whose physical health is
19 compromised or who have a suicide risk.
- 20 10. Be aware that people with an eating disorder may:
- 21 • find it difficult or distressing to discuss it with healthcare
22 professionals, staff and other service users
- 23 • be vulnerable to stigma and shame
- 24 • need information and interventions tailored to their age and level
25 of development.
- 26 11. Ensure that all people with an eating disorder and their parents or carers
27 (as appropriate) have equal access to treatments (including through self-
28 referral) for eating disorders, regardless of:
- 29 • age
- 30 • gender or gender identity (including people who are transgender)
- 31 • sexual orientation
- 32 • socioeconomic status
- 33 • religion, belief, culture, family origin or ethnicity
- 34 • where they live and who they live with
- 35 • any physical or other mental health problems or disabilities.
- 36 12. Healthcare professionals assessing people with an eating disorder
37 (especially children and young people) should be alert throughout
38 assessment and treatment to signs of bullying, teasing, abuse (emotional,
39 physical and sexual) and neglect. For guidance on when to suspect child
40 maltreatment, see the NICE guideline on child maltreatment.
- 41 13. When assessing a person with a suspected eating disorder, find out what
42 they and their family members or carers (as appropriate) know about
43 eating disorders and address any misconceptions.
- 44 14. Offer people with an eating disorder and their family members or carers
45 (as appropriate) education and information on:

- 1 health services). These should be near to their home, and have the
2 capacity to provide appropriate educational activities during extended
3 admissions.
- 4 33. When a person is admitted to inpatient care for medical stabilisation,
5 specialist eating disorder or liaison psychiatry services should:
- 6 • keep in contact with the inpatient team to advise on care and
7 management, both during the admission and when planning
8 discharge
- 9 • keep the person's family members or carers involved
- 10 • consider starting or continuing psychological treatments for the
11 eating disorder.
- 12 34. Inpatient or day patient services should collaborate with other teams
13 (including the community team) and the person's family members or
14 carers (as appropriate), to help with treatment and transition.
- 15 35. Develop a care plan for each person with an eating disorder who is
16 admitted to inpatient care. The care plan should:
- 17 • give clear objectives and outcomes for the admission
- 18 • be developed in collaboration with the person, their family
19 members or carers (as appropriate), and the community-based
20 eating disorder service
- 21 • set out how they will be discharged, how they will move back to
22 community-based care, and what this care should be.
- 23 36. Whether or not the person is medically stable, within 1 month of
24 admission, review with them, their parents or carers (as appropriate) and
25 the referring team, whether inpatient care should be continued or stepped
26 down to a less intensive setting.
- 27 37. As part of the review:
- 28 • assess whether enough progress has been made towards the
29 objectives agreed at admission
- 30 • agree a schedule for further reviews, with reviews happening at
31 least monthly take into account the risk that people with an
32 eating disorder can become institutionalised by a long
33 admission, and that a lack of change in their condition could
34 indicate that inpatient treatment is harmful
- 35 • consider seeking an independent second opinion if healthcare
36 professionals have different views about the benefit of continued
37 inpatient care..
- 38 38. When prescribing medication for people with an eating disorder and
39 comorbid mental or physical health conditions, take into account the
40 impact malnutrition and compensatory behaviours can have on
41 medication effectiveness and the risk of side effects.
- 42 39. When prescribing for people with an eating disorder and a comorbidity,
43 assess how the eating disorder will affect medication adherence (for
44 example, for medication that can affect body weight).
- 45 40. When prescribing for people with an eating disorder, take into account the
46 risks of medication that can compromise physical health due to pre-
47 existing medical complications.

- 1 41. Offer ECG monitoring for people with an eating disorder who are taking
2 medication that could compromise cardiac functioning (including
3 medication that could cause electrolyte imbalance, bradycardia below 40
4 beats per minute, hypokalaemia, or a prolonged QT interval).
- 5 42. Assess fluid and electrolyte balance in people with an eating disorder who
6 are believed to be engaging in compensatory behaviours, such as
7 vomiting, taking laxatives or diuretics, or water loading.
- 8 43. Assess whether ECG monitoring is needed in people with an eating
9 disorder, based on the following risk factors:
- 10 • rapid weight loss
 - 11 • excessive exercise
 - 12 • severe purging behaviours, such as laxative or diuretic use or
13 vomiting
 - 14 • bradycardia
 - 15 • hypotension
 - 16 • excessive caffeine (including from energy drinks)
 - 17 • prescribed or non-prescribed medications
 - 18 • muscular weakness
 - 19 • electrolyte imbalance
 - 20 • previous abnormal heart rhythm.
- 21 Management for all eating disorders
- 22 44. Provide acute medical care (including emergency admission) for people
23 with an eating disorder who have severe electrolyte imbalance, severe
24 malnutrition, severe dehydration or signs of incipient organ failure.
- 25 45. For people with an eating disorder who need supplements to restore
26 electrolyte balance, offer these orally unless the person has problems
27 with gastrointestinal absorption or the electrolyte disturbance is severe.
- 28 46. For people with an eating disorder and continued unexplained electrolyte
29 imbalance, assess whether it could be caused by another condition.
- 30 47. Encourage people with an eating disorder who are vomiting to:
- 31 • have regular dental and medical reviews
 - 32 • avoid brushing teeth immediately after vomiting
 - 33 • rinse with non-acid mouthwash after vomiting
 - 34 • avoid highly acidic foods and drinks.
- 35 48. Advise people with an eating disorder who are misusing laxatives or
36 diuretics:
- 37 • that laxatives and diuretics do not reduce calorie absorption and
38 so do not help with weight loss.
 - 39 • to gradually reduce and stop laxative or diuretic use.
- 40 49. Advise people with an eating disorder who are exercising excessively to
41 stop doing so.
- 42 50. For guidance on identifying, assessing and managing overweight and
43 obesity, see the NICE guideline on obesity.

- 1 51. GPs should offer a physical and mental health review at least annually to
2 people with anorexia nervosa who are not receiving ongoing treatment for
3 their eating disorder. The review should include:
- 4 • weight or BMI (adjusted for age if appropriate)
 - 5 • blood pressure
 - 6 • relevant blood tests
 - 7 • any problems with daily functioning
 - 8 • assessment of risk (related to both physical and mental health)
 - 9 • an ECG, for people with purging behaviours and/or significant
10 weight changes
 - 11 • a discussion of treatment options.
- 12 52. Monitor growth and development in children and young people with
13 anorexia nervosa who have not completed puberty (for example, not
14 reached menarche or final height).
- 15 53. Provide advice and education to women with an eating disorder who plan
16 to conceive, to increase the likelihood of conception and to reduce the
17 risk of miscarriage. This may include information on the importance of:
- 18 • maintaining good mental health and wellbeing
 - 19 • ensuring adequate nutrient intake and a healthy body weight
 - 20 • stopping behaviours such as binge eating, vomiting, laxatives
21 and excessive exercise.
- 22 54. Nominate a dedicated professional (such as a GP or midwife) to monitor
23 and support pregnant women with an eating disorder during pregnancy
24 and in the post-natal period, because of:
- 25 • concerns they may have specifically about gaining weight
 - 26 • possible health risks to the mother and child.
 - 27 • the high risk of mental health problems in the perinatal period
- 28 55. For women who are pregnant or in the perinatal period and have an
29 eating disorder:
- 30 • offer treatment for their eating disorder as covered in chapters 6-
31 9.
 - 32 • provide monitoring and education during pregnancy as
33 recommended in the NICE guideline on antenatal and postnatal
34 mental health.
- 35 56. For guidance on providing advice to pregnant women about healthy
36 eating and feeding their baby, see the NICE guideline on maternal and
37 child nutrition.
- 38 57. Consider more intensive prenatal care for pregnant women with current or
39 remitted anorexia nervosa, to ensure adequate prenatal nutrition and fetal
40 development.
- 41 58. Provide support and care for all people with anorexia nervosa in contact
42 with specialist services, whether or not they are having a specific
43 intervention. Support should:
- 44 • include psychoeducation about the disorder

- 1 • include monitoring of weight, mental and physical health, and any
2 risk factors
- 3 • be multidisciplinary and coordinated between services
- 4 • involve the person's family members or carers (as appropriate).
- 5 59. When treating anorexia nervosa, be aware that:
- 6 • helping people to reach a healthy body weight or BMI for their
7 age is a key goal **and**
- 8 • weight gain is key in supporting other psychological, physical and
9 quality of life changes that are needed for improvement or
10 recovery.
- 11 60. When weighing people with anorexia nervosa, consider sharing the
12 results with them and (if appropriate) their family members or carers.
- 13 People with anorexia nervosa who are not having treatment
- 14 61. For people with anorexia who are not having treatment (for example
15 because it has not helped or because they have declined it) and who do
16 not have severe or complex problems:
- 17 • discharge them to primary care
- 18 • tell them they can ask their GP to refer them again for treatment
19 at any time.
- 20 62. For people with anorexia who have declined or do not want treatment and
21 who have severe or complex problems, eating disorder services should
22 provide support as covered in recommendation 56.
- 23 63. For adults with anorexia nervosa, consider one of:
- 24 • individual eating-disorder-focused cognitive behavioural therapy
25 (CBT-ED)
- 26 • Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- 27 • specialist supportive clinical management (SSCM).
- 28 Explain to the person what the treatments involve to help them choose which
29 they would prefer.
- 30 64. Individual CBT-ED programmes for adults with anorexia nervosa should:
- 31 • typically consist of up to 40 sessions over 40 weeks, with twice-
32 weekly sessions in the first 2 or 3 weeks
- 33 • aim to reduce the risk to physical health and any other symptoms
34 of the eating disorder
- 35 • encourage healthy eating and reaching a healthy body weight
- 36 • cover nutrition, cognitive restructuring, mood regulation, social
37 skills, body image concern, self-esteem, and relapse prevention
- 38 • create a personalised treatment plan based on the processes
39 that appear to be maintaining the eating problem
- 40 • explain the risks of malnutrition and being underweight
- 41 • enhance self-efficacy
- 42 • include self-monitoring of dietary intake and associated thoughts
43 and feelings

- 1 • include homework, to help the person practice in their daily life
2 what they have learned.
- 3 65. MANTRA for adults with anorexia nervosa should:
- 4 • typically consist of 20 sessions, with:
- 5 o weekly sessions for the first 10 weeks, and a flexible schedule
6 after this
- 7 o up to 10 extra sessions for people with complex problems
- 8 • base treatment on the MANTRA workbook
- 9 • motivate the person and encourage them to work with the
10 practitioner
- 11 • be flexible in how the modules of MANTRA are delivered and
12 emphasised
- 13 • when the person is ready, cover nutrition, symptom
14 management, and behaviour change
- 15 • encourage the person to develop a 'non-anorexic identity'
- 16 • involve family members or carers to help the person:
- 17 o understand their condition and the problems it causes and the
18 link to the wider social context
- 19 o change their behaviour.
- 20 66. SSCM for adults with anorexia nervosa should:
- 21 • typically consist of 20 or more weekly sessions (depending on
22 severity)
- 23 • assess, identify, and regularly review key problems
- 24 • aim to develop a positive relationship between the person and
25 the practitioner
- 26 • aim to help people recognise the link between their symptoms
27 and their abnormal eating behaviour
- 28 • aim to restore weight
- 29 • provide psychoeducation, and nutritional education and advice
- 30 • include physical health monitoring
- 31 • establish a weight range goal
- 32 • encourage reaching a healthy body weight and healthy eating
- 33 • allow the person to decide what else should be included as part
34 of their therapy.
- 35 67. If individual CBT-ED, MANTRA, or SSCM is unacceptable,
36 contraindicated or ineffective for adults with anorexia nervosa, consider:
- 37 • one of these 3 treatments that the person has not had before **or**
38 eating-disorder-focused focal psychodynamic therapy (FPT).
- 39 68. FPT for adults with anorexia nervosa should:
- 40 • typically consist of up to 40 sessions over 40 weeks
- 41 • make a patient-centred focal hypothesis that is specific to the
42 individual and addresses:

- 1 o what the symptoms mean to the person
- 2 o how the symptoms affect the person
- 3 o how the symptoms influence the person's relationships with
- 4 others and with the therapist
- 5 • in the first phase, focus on developing the therapeutic alliance
- 6 between the therapist and person with anorexia nervosa,
- 7 addressing pro-anorexic behaviour and ego-syntonic beliefs
- 8 (beliefs, values and feelings consistent with the person's sense
- 9 of self) and building self-esteem
- 10 • in the second phase, focus on relevant relationships with other
- 11 people and how these affect eating behaviour
- 12 • in the final phase, focus on transferring the therapy experience to
- 13 situations in everyday life and address any concerns the person
- 14 has about what will happen when treatment ends.
- 15 First-line psychological treatment for children and young people
- 16 69. Consider anorexia-nervosa-focused family therapy for children and young
- 17 people (FT-AN), delivered as single-family therapy or a combination of
- 18 single- and multi-family therapy. Give children and young people the
- 19 option to have some single-family sessions:
 - 20 • separately from their family members or carers and
 - 21 • together with their family members or carers.
- 22 70. FT-AN for children and young people with anorexia nervosa should:
 - 23 • typically consist of 18–20 sessions over 1 year
 - 24 • review the needs of the person 4 weeks after treatment begins
 - 25 and then every 3 months, to establish how regular sessions
 - 26 should be and how long treatment should last
 - 27 • emphasise the role of the family in helping the person to recover
 - 28 • not blame the person or their family members or carers
 - 29 • include psychoeducation about nutrition and the effects of
 - 30 malnutrition
 - 31 • support the parents or carers to take a central role in helping the
 - 32 person manage their eating early in treatment and emphasise
 - 33 that this is a temporary role
 - 34 • in the first phase, aim to establish a good therapeutic alliance
 - 35 with the person, their parents or carers and other family
 - 36 members
 - 37 • in the second phase, support the person (with help from their
 - 38 parents or carers) to establish a level of independence
 - 39 appropriate for their level of development
 - 40 • in the final phase:
 - 41 o focus on plans for when treatment ends (including any concerns
 - 42 the person and their family have) and on relapse prevention
 - 43 o address how the person can get support if treatment is stopped.
- 44 71. Consider support for family members who are not involved in the family
- 45 therapy, to help them cope with distress caused by the condition.

- 1 72. Consider giving children and young people with anorexia nervosa
2 additional appointments separate from their family members or carers.
- 3 73. Assess whether family members or carers (as appropriate) need support if
4 the child or young person with anorexia nervosa is having therapy on their
5 own.
- 6 74. If FT-AN is unacceptable, contraindicated or ineffective for children or
7 young people with anorexia nervosa, consider individual CBT-ED or
8 adolescent-focused psychotherapy for anorexia nervosa (AFP-AN).
- 9 75. Individual CBT-ED for children and young people with anorexia nervosa
10 should:
- 11 • typically consist of up to 40 sessions over 40 weeks, with:
 - 12 ○ twice-weekly sessions in the first 2 or 3 weeks
 - 13 ○ 8–12 additional brief family sessions with the person and their
14 parents or carers (as appropriate)
 - 15 • in family sessions and in individual sessions, include
16 psychoeducation about nutrition and the effects of malnutrition
 - 17 • in family sessions:
 - 18 ○ identify anything in the person’s home life that could make it
19 difficult for them to change their behaviour, and find ways to
20 address this
 - 21 ○ discuss meal plans
 - 22 • aim to reduce the risk to physical health and any other symptoms
23 of the eating disorder
 - 24 • encourage reaching a healthy body weight and healthy eating
 - 25 • cover nutrition, relapse prevention, cognitive restructuring, mood
26 regulation, social skills, body image concern and self-esteem
 - 27 • create a personalised treatment plan based on the processes
28 that appear to be maintaining the eating problem
 - 29 • take into account the person’s specific development needs
 - 30 • explain the risks of malnutrition and being underweight
 - 31 • enhance self-efficacy
 - 32 • include self-monitoring of dietary intake and associated thoughts
33 and feelings
 - 34 • include homework, to help the person practice what they have
35 learned in their daily life
 - 36 • address how the person can get support if treatment is stopped.
- 37 76. AFP-AN for children and young people should:
- 38 • typically consist of 32–40 individual sessions over 12–18 months,
39 with:
 - 40 ○ more regular sessions early on, to help the person build a
41 relationship with the practitioner and motivate them to change
42 their behaviour
 - 43 ○ 8–12 additional family sessions with the person and their parents
44 or carers (as appropriate)

- 1 • review the needs of the person 4 weeks after treatment begins
- 2 and then every 3 months, to establish how regular sessions
- 3 should be and how long treatment should last
- 4 • in family sessions and in individual sessions, include
- 5 psychoeducation about nutrition and the effects of malnutrition
- 6 • focus on the person's self-image, emotions and interpersonal
- 7 processes, and how these affect their eating disorder
- 8 • develop a formulation of the person's psychological issues and
- 9 how they use anorexic behaviour as a coping strategy
- 10 • address fears about weight gain, and emphasise that weight gain
- 11 and healthy eating is a critical part of therapy
- 12 • find alternative strategies for the person to manage stress
- 13 • in later stages of treatment, explore issues of identity and build
- 14 independence
- 15 • towards end of treatment, focus on transferring the therapy
- 16 experience to situations in everyday life
- 17 • in family sessions, help parents or carers support the person to
- 18 change their behaviour
- 19 • address how the person can get support if treatment is stopped.
- 20 77. Be aware that the family members or carers of a person with an eating
- 21 disorder may experience severe distress. Offer family members or carers
- 22 assessments of their own needs as treatment progresses (see NICE's
- 23 guideline on supporting adult carers), including:
- 24 • what impact the eating disorder has on them and their mental
- 25 health
- 26 • what support they need, including practical support and
- 27 emergency plans if the person with the eating disorder is at high
- 28 medical or psychiatric risk.
- 29 78. If appropriate, provide written information for family members or carers
- 30 who do not attend assessment or treatment meetings with the person with
- 31 an eating disorder.
- 32 79. Do not offer medication as the sole treatment for anorexia nervosa.
- 33 80. Only offer dietary counselling as part of a multidisciplinary approach.
- 34 81. Encourage people with anorexia nervosa to take an age-appropriate oral
- 35 multi-vitamin and multi-mineral supplement until their diet includes
- 36 enough to meet their dietary reference values.
- 37 82. Include family members or carers (as appropriate) in any dietary
- 38 education or meal planning for children and young people with anorexia
- 39 nervosa who are having therapy on their own.
- 40 83. Offer supplementary dietary advice to children and young people with
- 41 anorexia nervosa and their family or carers (as appropriate) to help them
- 42 meet their dietary needs for growth and development (particularly during
- 43 puberty)
- 44 84. Do not offer a physical therapy (such as transcranial magnetic stimulation,
- 45 acupuncture, weight training, yoga or warming therapy) as part of the
- 46 treatment for eating disorders.

- 1 85. Bone mineral density results should be interpreted and explained to
2 people with anorexia nervosa by a professional with the knowledge and
3 competencies to do this.
- 4 86. Before deciding whether to measure bone density, discuss with the
5 person and their family members or carers why it could be useful.
- 6 87. Explain to people with anorexia nervosa that the main way of preventing
7 and treating low bone mineral density is reaching and maintaining a
8 healthy body weight or BMI for their age.
- 9 88. Consider a bone mineral density scan:
 - 10 • after 1 year of underweight in children and young people, or
11 earlier if they have bone pain or recurrent fractures
 - 12 • after 2 years of underweight in adults, or earlier if they have bone
13 pain or recurrent fractures.
- 14 89. Use measures of bone density that correct for bone size (such as bone
15 mineral apparent density [BMAD]) in children and young people with
16 faltering growth.
- 17 90. Consider repeat bone mineral density scans in people with ongoing
18 persistent underweight, especially when using or deciding whether to use
19 hormonal treatment.
- 20 91. Do not repeat bone mineral density scans for people with anorexia
21 nervosa more frequently than once per year, unless they develop bone
22 pain or recurrent fractures.
- 23 92. Do not routinely offer oral or transdermal oestrogen therapy to treat low
24 bone mineral density in children or young people with anorexia nervosa.
- 25 93. Seek specialist paediatric or endocrinological advice before starting any
26 hormonal treatment for low bone mineral density. Coordinate any
27 treatment with the eating disorders team.
- 28 94. Consider transdermal 17 β estradiol (with cyclic progesterone) for young
29 women (13–17 years) with anorexia nervosa who have long-term low
30 body weight and low bone mineral density with a bone age over 15.
- 31 95. Consider incremental physiological doses of oestrogen in young women
32 (13–17 years) with anorexia nervosa who have delayed puberty, long-
33 term low body weight and low bone mineral density with a bone age
34 under 15.
- 35 96. Consider bisphosphonates for women (18 years and over) with anorexia
36 nervosa who have long-term low body weight and low bone mineral
37 density. Discuss the benefits and risks (including risk of teratogenic
38 effects) with women before starting treatment.
- 39 97. Advise people with anorexia nervosa and osteoporosis or related bone
40 disorders to avoid high-impact physical activities and activities that
41 significantly increase the chance of falls or fractures.
- 42 98. For guidance on osteoporosis risk assessment, see the NICE guideline on
43 assessing the risk of fragility fractures in osteoporosis.
- 44 99. Seek specialist paediatric or endocrinology advice for delayed physical
45 development or faltering growth in children and young people with an
46 eating disorder.
- 47 100. Ensure that staff of day patient, inpatient, or acute services who treat
48 eating disorders are trained to recognise the symptoms of refeeding
49 syndrome and how to manage it.

- 1 101. Use a standard operating procedure for refeeding that emphasises the
2 need to avoid under-nutrition and refeeding syndrome. Refer to existing
3 national guidance, such as MARSIPAN and junior MARSIPAN.
- 4 102. Eating disorder specialists and other healthcare teams should collaborate
5 to support effective treatment of physical or mental health comorbidities in
6 people with an eating disorder.
- 7 103. When collaborating, teams should use outcome measures for both the
8 eating disorder and the physical and mental health comorbidities, to
9 monitor the effectiveness of treatments for each condition and the
10 potential impact they have on each other.
- 11 104. When deciding which order to treat an eating disorder and a comorbid
12 mental health condition (in parallel, as part of the same treatment plan or
13 one after the other), take the following into account:
- 14 • the severity and complexity of the eating disorder and
15 comorbidity
 - 16 • the person's level of functioning
 - 17 • the preferences of the person with the eating disorder and (if
18 appropriate) those of their family or carers.
- 19 105. Refer to the NICE guidelines on specific mental health problems for
20 further guidance on treatment.
- 21 106. See Section 7.8.6 for relevant recommendations
- 22 107. See Section 7.8.6 for relevant recommendations
- 23 108. Explain to all people with bulimia nervosa that psychological treatments
24 have a limited effect on body weight.
- 25 109. Consider bulimia-nervosa-focused guided self-help for adults with bulimia
26 nervosa.
- 27 110. Bulimia-nervosa-focused guided self-help programmes for adults with
28 bulimia nervosa should:
- 29 • use cognitive behavioural self-help materials for eating disorders
 - 30 • supplement the self-help programme with brief supportive
31 sessions (for example 4 to 9 sessions lasting 20 minutes each
32 over 16 weeks, running weekly at first).
- 33 111. If bulimia-nervosa-focused guided self-help is unacceptable,
34 contraindicated, or ineffective after 4 weeks of treatment, consider
35 individual eating-disorder-focused cognitive behavioural therapy (CBT-
36 ED).
- 37 112. Individual CBT-ED for adults with bulimia nervosa should:
- 38 • typically consist of up to 20 sessions over 20 weeks, and
39 consider twice-weekly sessions in the first phase
 - 40 • in the first phase focus on:
 - 41 ○ engagement and education
 - 42 ○ establishing a pattern of regular eating, and providing
43 encouragement, advice and support while people do this
 - 44 • follow by addressing the eating disorder psychopathology (for
45 example, the extreme dietary restraint, the concerns about body
46 shape and weight, and the tendency to binge eat in response to
47 difficult thoughts and feelings)

- 1 • provide psychoeducation about eating disorders and how
2 symptoms are maintained, while encouraging the person to
3 gradually establish regular eating habits
- 4 • develop a case formulation with the person
- 5 • teach the person to monitor their thoughts, feelings and
6 behaviours
- 7 • set goals and encourage the person to address problematic
8 thoughts, beliefs and behaviours with problem-solving
- 9 • use relapse prevention strategies to prepare for and mitigate
10 potential future setbacks
- 11 • in sessions with parents and carers, provide education about
12 eating disorders, identify family factors that stop the person from
13 changing their behaviour, and discuss how the family can
14 support the person's recovery.
- 15 118. Do not offer medication as the sole treatment for bulimia nervosa.
- 16 119. For people with an eating disorder and diabetes, the eating disorder and
17 diabetes teams should:
- 18 • collaborate to explain the importance of physical health
19 monitoring to the person
- 20 • agree who has responsibility for monitoring physical health
- 21 • collaborate on managing mental and physical health
22 comorbidities
- 23 • use a low threshold for monitoring blood glucose and blood
24 ketones
- 25 • use outcome measurements to monitor the effectiveness of
26 treatments for each condition and the potential impact they have
27 on each other.
- 28 120. When treating eating disorders in people with diabetes:
- 29 • explain to the person (and if needed their diabetes team) that
30 they may need to monitor their blood glucose and blood ketones
31 more closely during treatment
- 32 • consider involving their family members and carers (as
33 appropriate) in treatment to help them with blood glucose
34 control.
- 35 121. Address insulin misuse as part of any psychological treatment for eating
36 disorders in people with diabetes.
- 37 122. Offer people with an eating disorder who are misusing insulin the
38 following treatment plan:
- 39 • a gradual increase in the amount of carbohydrates in their diet (if
40 medically safe), so that insulin can be started at a lower dose
- 41 • a gradual increase in insulin doses to avoid a rapid drop in blood
42 glucose levels, which can increase risk of retinopathy and
43 neuropathy
- 44 • adjusted total glycaemic load and carbohydrate distribution to
45 meet their individual needs and prevent rapid weight gain
- 46 • psychoeducation about the problems caused by misuse of
47 diabetes medication

- 1 • diabetes educational interventions, if the person has any gaps in
2 their knowledge.
- 3 123. For people with suspected hypoglycaemia, test for blood glucose:
- 4 • before all supervised meals and snacks
- 5 • when using the hypoglycaemia treatment algorithm
- 6 • after correction doses.
- 7 124. For people with suspected hyperglycaemia or hypoglycaemia, and people
8 with normal blood glucose levels who are misusing insulin, healthcare
9 professionals should test for blood ketones:
- 10 • when using the hypoglycaemia treatment algorithm
- 11 • after correction doses.
- 12 125. For people with bulimia nervosa and diabetes, consider monitoring of:
- 13 • glucose toxicity
- 14 • insulin resistance
- 15 • ketoacidosis
- 16 • oedema.
- 17 126. When diabetes control is challenging:
- 18 • do not attempt to rapidly treat hyperglycaemia (for example with
19 increased insulin doses), because this increases the risk of
20 retinopathy and neuropathy
- 21 • regularly monitor blood potassium levels
- 22 • do not stop insulin altogether, because this puts the person at
23 high risk of ketoacidosis.
- 24 127. For more guidance on managing diabetes, including that for fluid
25 replacement in young people, refer to the NICE guidelines on type 1 and
26 type 2 diabetes in children and young people, type 1 diabetes in adults,
27 and type 2 diabetes in adults.
- 28 128. For people with an eating disorder who are misusing substances, or over
29 the counter or prescribed medication, provide treatment for the eating
30 disorder unless the substance misuse is interfering with this treatment.
- 31 129. If substance misuse or medication is interfering with treatment, consider a
32 multidisciplinary approach with substance misuse services.
- 33 130. Explain to people with binge eating disorder that psychological treatments
34 aimed at treating binge eating have a limited effect on body weight and
35 that weight loss is not a therapy target in itself. Refer to the NICE
36 guideline on obesity identification, assessment and management for
37 guidance on weight loss and bariatric surgery.
- 38 First-line psychological treatment for adults
- 39 131. Offer a binge-eating-disorder-focused guided self-help programme to
40 adults with binge eating disorder.
- 41 132. Binge-eating-disorder-focused guided self-help programmes for adults
42 should:
- 43 • use cognitive behavioural self-help materials
- 44 • focus on adherence to the self-help programme

- 1 • supplement the self-help programme with brief supportive
2 sessions (for example, 4 to 9 sessions lasting 20 minutes each
3 over 16 weeks, running weekly at first)
- 4 • focus exclusively on helping the person follow the programme.
- 5 133. If guided self-help is unacceptable, contraindicated, or ineffective after 4
6 weeks, offer group eating-disorder-focused cognitive behavioural therapy
7 (CBT-ED).
- 8 134. Group CBT-ED programmes for adults with binge eating disorder should:
- 9 • typically consist of 16 weekly 90-minute group sessions over 4
10 months
- 11 • focus on psychoeducation, self-monitoring of the eating
12 behaviour and helping the person analyse their problems and
13 goals
- 14 • include making a daily food intake plan and identifying binge
15 eating cues
- 16 • include body exposure training and helping the person to identify
17 and change negative beliefs about their body
- 18 • help with avoiding relapses and coping with current and future
19 risks and triggers.
- 20 135. If an individual refuses group CBT-ED, or such treatment is not available,
21 consider individual CBT-ED for BED.
- 22 136. Individual CBT-ED for adults with binge eating disorder should:
- 23 • typically consist of 16–20 sessions
- 24 • develop a formulation of the person’s psychological issues, to
25 determine how dietary and emotional factors contribute to their
26 binge eating
- 27 • based on the formulation:
- 28 ○ advise people to eat regular meals and snacks to avoid feeling
29 hungry
- 30 ○ address the emotional triggers for their binge eating, using
31 cognitive restructuring, behavioural experiments and exposure
- 32 • include weekly monitoring of binge eating behaviours, dietary
33 intake and weight
- 34 • share the weight record with the person
- 35 • address body-image issues if present
- 36 • explain to the person that although CBT-ED does not aim at
37 weight loss, stopping binge eating can have this effect in the
38 long term
- 39 • advise the person not to try to lose weight (for example by
40 dieting) during treatment, because this is likely to trigger binge
41 eating.
- 42 137. For children and young people with binge eating disorder, offer the same
43 treatments recommended for adults with binge eating disorder.
- 44 138. Do not offer medication as the sole treatment for binge eating disorder.
- 45 139. For people with OSFED, consider using the treatments for the eating
46 disorder it most closely resembles.

- 1 140. If a person's physical health is at serious risk due to their eating disorder,
2 they do not consent to treatment, and they can only be treated safely in
3 an inpatient setting, follow the legal framework for compulsory treatment
4 in the Mental Health Act 1983.
- 5 141. If a child or young person lacks capacity, their physical health is at
6 serious risk and they do not, or lack the capacity to, consent to treatment,
7 ask their parents or carers to consent on their behalf and if necessary,
8 use an appropriate legal framework for compulsory treatment (such as
9 the Mental Health Act 1983/2007 or the Children Act 1989).
- 10 142. Feeding people without their consent should only be done by
11 multidisciplinary teams who are competent to do so.
- 12

15 Research recommendations

- Research recommendation: What is the effectiveness of stepped care for psychological treatment of eating disorders for people of any age?
- Research recommendation: What physical parameters (for example, blood pressure and ECGs) are most informative in the risk management of people with anorexia nervosa?
- Research recommendation: What are the effective interventions for the treatment of anorexia nervosa?
- Research recommendation: What factors are associated with the maintenance of benefit after successful treatment for anorexia nervosa?
- Research recommendation: What is the effectiveness of psychological interventions for treatment of eating disorders in men?
- Research recommendation: What is effectiveness of peer-support interventions for people with eating disorders and their families or carers?
- Research recommendation: What is the effectiveness of psychological interventions for the families or carers of people with eating disorders?
- Research recommendation: What is the effectiveness of psychotropic medications, alone or in conjunction with treatment as usual, on the symptoms of eating disorders?
- Research recommendation: Does exercise in addition to a recommended psychotherapy add any benefit to those with bulimia nervosa or binge eating disorder?
- Research recommendation: What is the impact of underweight in children and young people with eating disorders in early life on the critical periods of growth and development?
- Research recommendation: What is the validity of bone measures in children and young people with anorexia nervosa who have recovered weight, compared to those who have not, in predicting fractures later in adult life?
- Research recommendation: Does testosterone confer any benefit in a. in improving bone density in men, and b. growth and pubertal delay in young men?
- Research recommendation: What is the impact of comorbidities on treatment outcomes for eating disorders, and what approaches are effective in managing these comorbidities?
- Research recommendation: What is the incidence, and differences in the complication rate, of diabetic ketoacidosis in people with eating disorders?
- Research recommendation: What are the effects of eating disorders on long-term complications of type I and type II diabetes?
- Research recommendation: What is the comparative effectiveness of psychological treatments for eating disorders of reduced duration and reduced intensity compared to standard treatment?
- Research recommendation: How effective are family therapies compared with CBT-ED in children and young people with eating disorders?
- Research recommendation: Compare the clinical and cost effectiveness of individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) with guided self-help and group CBT-ED for (i) adults and (ii) children and young people with binge eating disorder.
- Research recommendation: Compare the clinical and cost effectiveness of individual eating-disorder-focused CBT-ED with guided self-help and group CBT-ED for children and young people with binge eating disorder.
- Research recommendation: What is the clinical and cost effectiveness of psychological treatments for children and young people with binge eating disorder?

16 Appendices

2 The appendices are contained in separate documents:

3 Appendix A: Scope

4 Appendix B: Declarations of interest

5 Appendix C: Special advisors

6 Appendix D: Stakeholders

7 Appendix E: Researchers contacted

8 Appendix F: Review questions

9 Appendix G: Research recommendations

10 Appendix H: Search strategies

11 Appendix I: HE search strategies

12 Appendix J: Excluded studies list

13 Appendix K: Flow charts

14 Appendix L: Grade evidence profiles

15 Appendix M: Forest plots

16 Appendix N: Bulimia nervosa TSU report

17 Appendix O: HE evidence check lists

18 Appendix P: HE evidence tables

19 Appendix Q: HE evidence profiles

20 Appendix R: NMA methodology and results

21 Appendix S: Clinical evidence of interventions for people with BN and BED

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