National Institute for Health and Care Excellence

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Eating disorders: recognition and treatment

Appendix L - GRADE evidence profiles

NICE Guideline

Methods, evidence and recommendations

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Final

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

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Appendix L:GRADE evidence profiles

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L.1 What are the utility, validity and reliability of the instruments, tools and methods used for case identification in eating disorders?

No GRADE tables were generated. Quality of the outcomes is included in the relevant chapter.

L.2 What is the validity and reliability of the instruments, tools and methods used to assess and monitor eating disorders?

No GRADE tables were generated. Quality of the outcomes is included in the relevant chapter.

L.3 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?

L.3.1 Individual therapy for anorexia nervosa

Table 1: Full GRADE profile for CBT-ED versus another intervention for young people and adults with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute	Quality	Importance
Weight - Adults (Better indicated by higher values)												
2	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	99	199	-	SMD 0.17 higher (0.07	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
										lower to 0.42 higher)		
EDE-Restraint - Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency 4	no serious indirectness	serious5	none	19	37	-	SMD 0.13 lower (0.69 lower to 0.44 higher)	LOW	IMPORTANT
EDE-Eating concerns- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3,5	none	19	37	-	SMD 0.31 lower (0.87 lower to 0.25 higher)	LOW	IMPORTANT
EDE-Weight concerns- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	19	37	-	SMD 0.39 higher (0.17 lower to 0.95 higher)	LOW	IMPORTANT
EDE-Shape concerns- Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**AN CBT-ED**	**Another intervention**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	37	-	SMD 0.09 lower (0.65 lower to 0.46 higher)	LOW	IMPORTANT
EDI - Drive for thinness- Adults (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious5	none	19	37	-	SMD 0.07 lower (0.63 lower to 0.48 higher)	LOW	IMPORTANT
EDI - Body dissatisfaction- Adults (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious5	none	19	37	-	SMD 0.2 lower (0.76 lower to 0.35 higher)	LOW	IMPORTANT
EDI - Bulimia- Adults (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious5	none	19	37	-	SMD 0.21 lower (0.76 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
										to 0.35 higher)		
EDI Total - Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	80	162	-	SMD 0.08 lower (0.35 lower to 0.19 higher)	LOW	IMPORTANT
General psychopathology- Adults (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	serious9	serious5	none	80	162	-	SMD 0.25 lower (0.52 lower to 0.02 higher)	LOW	IMPORTANT
Depression Adults (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious5	none	19	37	-	SMD 0.20 lower (0.76 lower to 0.35 higher)	LOW	IMPORTANT
Relapse												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious12	none	4/18 (22.2%)	8/15 (53.3%)	RR 0.42 (0.16 to 1.12)	309 fewer per 1000 (from 448 fewer to 64 more)	LOW	IMPORTANT
Remission ITT- Adults												
2	randomised trials	serious1	serious13	serious14	serious15	none	19/98 (19.4%)	18/177 (10.2%)	RR 1.78 (0.93 to 3.39)	99 more per 1000 (34 fewer to 488 more)	VERY LOW	CRITICAL
BMI-Adolescents FU (Better indicated by higher values)												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious5	none	50	48	-	SMD 0.29 lower (0.69 lower to 0.11 higher)	LOW	CRITICAL
BMI - Adults FU (Better indicated by higher values)												
2	randomised trials	serious1	serious13	serious2	serious15	none	97	188	-	SMD 0.05	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
										lower (0.29 lower to 0.2 higher)	Y LOW	
EDE-Shape concerns - Adults FU (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious3	none	18	26	-	SMD 0.31 lower (1.33 lower to 0.71 higher)	LOW	IMPORTANT
EDE-Eating concerns- Adults FU (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious3	none	17	26	-	SMD 0.16 lower (0.78 lower to 0.45 higher)	LOW	IMPORTANT
EDE-Restraint - Adults FU (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	none	17	26	-	SMD 0.36 lower (0.97 lower to 0.26 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
EDE-Weight concerns - Adults FU (Better indicated by lower values)												
1	randomised trials	serious[17]	no serious inconsistency	no serious indirectness	serious[6]	none	17	26	-	SMD 0.02 lower (0.63 lower to 0.59 higher)	LOW	IMPORTANT
EDI - Body dissatisfaction- Adults FU (Better indicated by lower values)												
1	randomised trials	serious[17]	no serious inconsistency	no serious indirectness	serious[5]	none	17	26	-	SMD 0.32 lower (0.94 lower to 0.29 higher)	LOW	IMPORTANT
EDI - Buliimia - Adults FU (Better indicated by lower values)												
1	randomised trials	serious[17]	no serious inconsistency	no serious indirectness	serious[6]	none	17	26	-	SMD 0.43 higher (0.19 lower to 1.06 higher)	LOW	IMPORTANT
EDI - Drive for thinness - Adults FU (Better indicated by lower values)												
1	randomised trials	serious[17]	no serious inconsistency	no serious indirectness	serious[6]	none	17	26	-	SMD 0.25 higher (0.37	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.87 higher)		
EDI Total Adults - FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	80	162	-	SMD 0.07 higher (0.19 lower to 0.34 higher)	VERY LOW	IMPORTANT
EDI-Total Adolescents FU (Better indicated by lower values)												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious5	none	42	40	-	SMD 0.17 lower (0.6 lower to 0.27 higher)	LOW	CRITICAL
Depression Adults FU (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious6	none	17	26	-	SMD 0.13 lower (0.48 lower to 0.75 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	none	17	26	-	SMD 0.04 lower (0.65 to 0.57 lower)	LOW	IMPORTANT
General psychopathology Adults FU (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	serious9	serious3	none	80	162	-	SMD 0.03 higher (0.24 lower to 0.3 higher)	LOW	IMPORTANT
Remission- Adolescents FU ITT												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious15	none	10/55 (18.2%)	8/55 (14.5%)	RR 1.25 (0.53 to 2.93)	36 more per 1000 (from 68 fewer to 281 more)	LOW	CRITICAL
Remission -Adults FU ITT												
1	randomised trials	serious1	serious2,13	serious2	very serious18	none	16/80 (20%)	38/162 (23.5%)	RR 0.85 (0.51	35 fewer per 1000	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN CBT-ED	Another intervention	Relative (95% CI)	Absolute		
									to 1.43)	(from 115 fewer to 101 more)		

[1] It was unclear if allocation concealment was performed. High drop outs >20% were reported. Only assessors were blind in all studies.
[2] In Zipfel, 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, 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)

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Table 2: Full GRADE profile for psychiatric counselling compared with another intervention in adults with anorexia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Psychiatric Counselling	Other	Relative (95% CI)	Absolute		
Remission_ITT_Adults												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	0/19 (0%)	9/85 (10.6 %)	RR 1.10 (0.95 to 1.28)	11 more per 1000 (from 5 fewer to 30 more)	LOW	CRITICAL
All cause mortality Adults												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	0/22 (0%)	1/62 (1.6%)	RR 1.01 (0.9 to 1.13)	0 more per 1000 (from 2 fewer to 2 more)	LOW	IMPORTANT

[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)

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1 **Table 3: Full GRADE profile for supportive therapy versus another intervention for young people with anorexia nervosa.**

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**AN Supportive therapy**	**Another intervention_Adolescents**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Weight (percentile) Adolescents (Better indicated by Higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	11	10	-	SMD 0.98 lower (1.9 to 0.07 lower)	LOW	CRITICAL
Did not achieve remission ITT Adolescents												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	1/11 (9.1%)	6/10 (60%)	RR 2.27 (1.04 to 4.97)	762 more per 1000 (from 24 more to 1000 more)	LOW	CRITICAL
Weight (percentile) Adolescents FU (Better indicated by Higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	9	10	-	SMD 0.57 lower (1.5 lower to 0.35 Higher)	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Supportive therapy	Another intervention_Adolescents	Relative (95% CI)	Absolute		
Remission ITT- Adolescents FU												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	6/11 (54.5%)	4/10 (40%)	See comment	144 more per 1000 (from 184 fewer to 984 more)	LOW	CRITICAL

[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)

Table 4: Full GRADE profile for adolescent focused therapy versus another intervention in young people with AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Adolescent focused therapy	Other	Relative (95% CI)	Absolute		
BMI Adolescents (Better indicated by Higher values)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious3	none	69	70	-	SMD 0.43 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**AN Adolescent focused therapy**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										(0.77 to 0.09 lower)		
Remission ITT Adolescents												
2	randomised trials	serious1, 2	serious	no serious indirectness	serious4	none	43/78 (55.1%)	56/80 (70%)	RR 0.79 (0.61 to 1.01)	147 fewer per 1000 (from 273 fewer to 7 more)	LOW	CRITICAL
BMI Adolescents FU (Better indicated by Higher values)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious3	none	66	63	-	SMD 0.18 lower (0.53 lower to 0.16 Higher)	LOW	CRITICAL
Remission ITT- Adolescents FU												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious5	none	49/78 (62.8%)	47/80 (58.8 %)	See comment	41 more per 1000 (from 100	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Adolescent focused therapy	Other	Relative (95% CI)	Absolute		
										fewer to 217 more)		

[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)

Table 5: Full GRADE profile for psychodynamic general versus another intervention for adults with AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Psychodynamic General	another intervention_Adults	Relative (95% CI)	Absolute		
BMI Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	80	162	-	SMD 0.17 lower (0.44 lower to 0.09 Higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**AN Psychodynamic General**	**another intervention_Adults**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
EDI Total - Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	80	162	-	SMD 0.02 lower (0.29 lower to 0.24 Higher)	VERY LOW	IMPORTANT
All cause mortality- Adults												
2	randomised trials	serious 4	no serious inconsistency	serious5	very serious6	none	0/43 (0%)	2/41 (4.9%)	RR 1.05 (0.94 to 1.18)	2 more per 1000 (from 3 fewer to 9 more)	VERY LOW	CRITICAL
General psychopathology- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious	serious7	none	80	162	-	SMD 0.08 Higher (0.19 lower to 0.35	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**AN Psychodynamic General**	**another intervention_Adults**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										Higher)		
Remission_Adults_ITT												
2	randomised trials	serious 8	no serious inconsistency	serious2, 5	serious6	none	19/123 (15.4%)	18/203 (8.9%)	**RR 1.73 (0.95 to 3.14)**	65 more per 1000 (from 4 fewer to 190 more)	VERY LOW	CRITICAL
Weight (BMI and kg)- Adult FU (Better indicated by Higher values)												
2	randomised trials	serious 8	no serious inconsistency	serious2, 5	serious3	none	100	193	-	SMD 0.09 Higher (0.14 lower to 0.33 Higher)	VERY LOW	CRITICAL
EDE Bulimia- Adults FU												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	very serious9	none	2/14 (14.3%)	3/16 (18.8%)	RR 0.76 (0.15 to 3.92)	45 fewer per 1000 (from 159	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Psychodynamic General	another intervention_Adults	Relative (95% CI)	Absolute		
										fewer to 548 more)		
EDI - Total- Adults FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	80	162	-	SMD 0.07 lower (0.35 lower to 0.19 Higher)	VERY LOW	IMPORTANT
Morgan Russell ED- Adults FU (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious7	none	14	16	-	SMD 0.32 Higher (0.4 lower to 1.04 Higher)	LOW	CRITICAL
General psychopathology - Adults FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	80	162	-	SMD 0.00 lower (0.27 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Psychodynamic General	another intervention_Adults	Relative (95% CI)	Absolute		
										to 0.27 Higher)		
Remission FU_- Adults ITT												
2	randomised trials	serious 10	no serious inconsistency	serious2	serious9	none	34/94 (36.2%)	31/178 (17.4%)	RR 2.00 (1.33 to 3.03)	174 more per 1000 (from 57 more to 354 more)	VERY LOW	CRITICAL

[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%
[2] In Zipfel, 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] Unclear methods of randomisation and if allocation concealment was performed. High dropouts reported >20%. Unclear if either patient, investigator or assessor were blind.
[5] In Dare, a number of patients were hospitalised during the treatment: 10% Family therapy, 14% focal psychodynamic, 9% focal psychodynamic CAT, 26% treatment as usual - counselling
[6] 95% CI crossed 1 MID (1.25)
[7] 95% CI crossed 1 MID (0.5)
[8] Unclear if allocation concealment was performed or if assessors were blind. High dropouts reported .>20%
[9] 95% CI crossed 2 MIDs (0.75 and 1.25)
[10] Unclear if allocation concealment was performed or if participants, investigators or assessors were blind. High dropouts reported .>20%

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1 **Table 6: Full GRADE profile for interpersonal therapy versus another intervention in adults with AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANIPT	another intervention	Relative (95% CI)	Absolute		
BMI- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	21	35	-	SMD 0.13 lower (0.68 lower to 0.41 Higher)	LOW	CRITICAL
EDE-Restraint- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	21	35	-	SMD 0.99 Higher (0.41 to 1.57 Higher)	LOW	IMPORTANT
EDE-Eating concerns- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	21	35	-	SMD 0.49 Higher (0.06 lower to 1.04 Higher)	LOW	IMPORTANT
EDE-Weight concerns- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	21	35	-	SMD 0.2 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANIPT	another intervention	Relative (95% CI)	Absolute		
										(0.75 lower to 0.34 Higher)		
EDE-Shape concerns- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	21	35	-	SMD 0.25 Higher (0.29 lower to 0.8 Higher)	LOW	IMPORTANT
General Function (GAF)- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	21	35	-	SMD 0.5 lower (1.06 lower to 0.05 Higher)	LOW	IMPORTANT
Depression (Hamilton)- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	21	35	-	SMD 0.4 Higher (0.15 lower to 0.95 Higher)	LOW	CRITICAL
EDI - Drive for thinness- Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANIPT	another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	17	31	-	SMD 0.17 lower (0.76 lower to 0.43 Higher)	LOW	IMPORTANT
EDI - Bulimia- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	17	31	-	SMD 0.36 Higher (0.24 lower to 0.96 Higher)	LOW	IMPORTANT
EDI - Body dissatisfaction- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2,3	none	17	31	-	SMD 0.01 Higher (0.59 lower to 0.6 Higher)	VERY LOW	IMPORTANT
BMI - Follow-up- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	14	29	-	SMD 0.10 Higher (0.54	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANIPT	another intervention	Relative (95% CI)	Absolute		
										lower to 0.75 Higher)		
EDE-Shape concerns Follow-up- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	14	29	-	SMD 0.18 Higher (0.47 lower to 0.82 Higher)	LOW	IMPORTANT
EDE-Eating concerns Follow-up- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	14	29	-	SMD 0.17 lower (0.81 lower to 0.47 Higher)	LOW	IMPORTANT
EDE-Restraint Follow-up- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	14	29	-	SMD 0.28 lower (0.93 lower to 0.37 Higher)	LOW	IMPORTANT
EDE-Weight concerns Follow-up- Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**ANIPT**	**another intervention**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2,3	none	14	29	-	SMD 0.1 lower (0.74 lower to 0.54 Higher)	VERY LOW	IMPORTANT
EDI - Drive for thinness - FU- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	14	29	-	SMD 0.54 lower (1.19 lower to 0.11 Higher)	LOW	IMPORTANT
EDI - Bulimia - FU- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	14	29	-	SMD 0.21 lower (0.85 lower to 0.44 Higher)	LOW	IMPORTANT
EDI - Body dissatisfaction - FU- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	14	29	-	SMD 0.14 Higher (0.5 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANIPT	another intervention	Relative (95% CI)	Absolute		
										to 0.78 Higher)		
Depression (Hamilton) Follow-up- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2,3	none	14	29	-	SMD 0.08 lower (0.72 lower to 0.56 Higher)	VERY LOW	IMPORTANT
General Function (GAF) Follow-up- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2,3	none	14	29	-	SMD 0.08 Higher (0.56 lower to 0.72 Higher)	VERY LOW	CRITICAL

[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)

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1 **Table 7: Full GRADE profile of SSCM versus another intervention in adults with AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
BMI- Adults (Better indicated by higher values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	125	144	-	SMD 0.04 lower (0.28 lower to 0.21 higher)	LOW	CRITICAL
EDE-Restraint- Adults (Better indicated by lower values)												
2	randomised trials	serious1	serious inconsistency9	no serious indirectness	serious2	none	86	112	-	SMD 0.58 lower (1.41 lower to 0.24 higher)	VERY LOW	IMPORTANT
EDE-Eating concerns- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2, 3	none	86	112	-	SMD 0.04 higher (0.33 lower to 0.24 higher)	LOW	IMPORTANT
EDE-Weight concerns- Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	86	112	-	SMD 0.07 lower (0.36 lower to 0.22 higher)	LOW	IMPORTANT
EDE-Shape concerns- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	86	112	-	SMD 0.11 lower (0.39 lower to 0.18 higher)	LOW	IMPORTANT
EDE - Global- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	107	106	-	SMD 0.00 lower (0.27 lower to 0.27 higher)	LOW	IMPORTANT
EDI - Drive for thinness- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	16	40	-	SMD 0.29 lower (0.88	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
										lower to 0.29 higher)		
EDI - Body dissatisfaction- Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	none	16	40	-	SMD 0.14 higher (0.44 lower to 0.72 higher)	LOW	IMPORTANT
EDI - Bulimia- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	16	40	-	SMD 0.09 lower (0.67 lower to 0.49 higher)	LOW	IMPORTANT
Depression - Adults (Better indicated by lower values)												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	123	146	-	SMD 0.15 lower (0.4 lower to 0.09 higher)	LOW	IMPORTANT
General Function (GAF)- Adults (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	16	40	-	SMD 0.83 higher (0.22 to 1.43 higher)	LOW	IMPORTANT
Remission_ ITT- Adults												
2	randomised trials	serious1,6	no serious inconsistency	no serious indirectness	very serious7	none	11/107 (10.3%)	9/109 (8.3%)	RR 1.22 (0.52 to 2.82)	18 more per 1000 (from 40 fewer to 150 more)	VERY LOW	CRITICAL
BMI - Follow-up- Adults (Better indicated by higher values)												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	135	151	-	SMD 0.09 lower (0.32 lower to 0.15 higher)	LOW	CRITICAL
EDE-Weight concerns Follow-up- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2,5	none	86	103	-	SMD 0.16 higher	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
										(0.13 lower to 0.46 higher)		
EDE-Shape concerns Follow-up- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	82	103	-	SMD 0.04 higher (0.25 lower to 0.34 higher)	LOW	IMPORTANT
EDE-Restraint Follow-up- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	82	103	-	SMD 0.20 higher (0.09 lower to 0.5 higher)	LOW	IMPORTANT
EDE-Eating concerns Follow-up- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	82	103	-	SMD 0.24 higher (0.06 lower to 0.53 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
EDE-Global FU- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	107	106	-	SMD 0.13 higher (0.14 lower to 0.4 higher)	LOW	IMPORTANT
EDI - Body dissatisfaction - FU- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	12	31	-	SMD 0.2 higher (0.47 lower to 0.87 higher)	LOW	IMPORTANT
EDI - Buliimia - Follow-up- Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	12	31	-	SMD 0.15 lower (0.82 lower to 0.52 higher)	LOW	IMPORTANT
EDI - Drive for thinness - Follow-up- Adults (Better indicated by lower values)												
1	randomised trials	very serious1	no serious inconsistency	no serious indirectness	serious5	none	12	31	-	SMD 0.44 higher	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
										(0.24 lower to 1.12 higher)		
Depression Follow-up- Adults (Better indicated by lower values)												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	119	137	-	SMD 0.02 lower (0.27 lower to 0.023 higher)	LOW	IMPORTANT
Bulimia- Adults												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	very serious7	none	3/16 (18.8 %)	2/14 (14.3 %)	RR 1.31 (0.25 to 6.76)	44 more per 1000 (from 107 fewer to 823 more)	VERY LOW	IMPORTANT
General Function (GAF) Follow-up- Adults (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2, 5	none	12	31	-	SMD 0.05 lower (0.72 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	ANSSCM		Relative (95% CI)	Absolute		
										0.62 higher)		
Remission FU_ITT- Adults												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious7	none	23/123 (18.7%)	28/120 (23.3%)	RR 0.80 (0.49 to 1.3)	47 fewer per 1000 (from 119 fewer to 70 more)	VERY LOW	CRITICAL

[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 dropouts were reported >20%
9 Heterogeneity >50%

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1 **Table 8: Full GRADE profile of MANTRA versus another intervention for adults with AN**

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**AN MANTRA**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
BMI Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	106	107	-	SMD 0.08 Higher (0.18 lower to 0.35 Higher)	LOW	CRITICAL
EDI - Total Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	106	107	-	SMD 0.00 Higher (0.27 lower to 0.27 Higher)	LOW	IMPORTANT
Depression- Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	106	107	-	SMD 0.01 lower (0.28 lower to 0.26 Higher)	LOW	IMPORTANT
Remission ITT- Adults												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**ANMANTRA**	**Other**	**Relative (95% CI)**	**Absolute**		
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	9/106 (8.5%)	11/107 (10.3%)	RR 0.82 (0.35 to 1.91)	19 fewer per 1000 (from 67 fewer to 94 more)	LOW	CRITICAL
BMI FU- Adults (Better indicated by Higher values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious5	none	106	107	-	SMD 0.11 Higher (0.16 lower to 0.37 Higher)	VERY LOW	CRITICAL
Depression FU- Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	106	107	-	SMD 0.01 Higher (0.25 lower to 0.28 Higher)	LOW	IMPORTANT
EDI - Total Adults FU (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	106	107	-	SMD 0.13 lower (0.4 lower to 0.14 Higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN MANTRA	Other	Relative (95% CI)	Absolute		
Remission ITT FU- Adults												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	22/106 (20.8%)	18/109 (16.5 %)	RR 1.22 (0.7 to 2.14)	36 more per 1000 (from 50 fewer to 188 more)	LOW	CRITICAL

[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)

Table 9: Full GRADE profile for inpatient CBT-ED compared with another inpatient CBT-ED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Inpatient CBT-ED (1)		Relative (95% CI)	Absolute		
BMI Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	37	35	-	SMD 0.09 lower (0.56 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Inpatient CBT-ED (1)		Relative (95% CI)	Absolute		
										0.37 Higher)		
EDE-Restraint Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	37	35	-	SMD 0 Higher (0.46 lower to 0.46 Higher)	LOW	IMPORTANT
EDE-Eating concerns Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	37	35	-	SMD 0.09 Higher (0.37 lower to 0.56 Higher)	LOW	IMPORTANT
EDE-Weight concerns Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	37	35	-	SMD 0.07 lower (0.54 lower to 0.39 Higher)	LOW	IMPORTANT
EDE-Shape concerns Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	37	35	-	SMD 0.06 Higher (0.4 lower to 0.52 Higher)	LOW	IMPORTANT
General psychiatric features Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Inpatient CBT-ED (1)		Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	37	35	-	SMD 0.3 Higher (0.16 lower to 0.77 Higher)	LOW	IMPORTANT
BMI - Adults FU (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	34	34	-	SMD 0.04 Higher (0.43 lower to 0.52 Higher)	LOW	CRITICAL
General psychiatric features - Adults FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	34	34	-	SMD 0.14 Higher (0.33 lower to 0.62 Higher)	LOW	IMPORTANT
EDE-Restraint Adults FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	34	34	-	SMD 0.06 lower (0.54 lower to 0.42 Higher)	LOW	IMPORTANT
EDE-Eating concerns Adults FU (Better indicated by lower values)												
1	randomised trials	serious	no serious inconsistency	no serious indirectness	serious3	none	34	34	-	SMD 0 Higher (0.48 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Inpatient CBT-ED (1)		Relative (95% CI)	Absolute	Quality	Importance
										to 0.48 Higher)		
EDE-Weight concerns Adults FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	34	34	-	SMD 0.2 Higher (0.27 lower to 0.68 Higher)	LOW	IMPORTANT
EDE-Shape concerns Adults FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	34	34	-	SMD 0 Higher (0.48 lower to 0.48 Higher)	LOW	IMPORTANT

1 [1] Unclear if allocation concealment was performed. It was also unclear if investigators, participants were blind, however, the assessors were blind.
2 [2] 95% CI crossed 1 MID (-0.5)
3 [3] For a continuous outcome, there were fewer than 400 participants
4 [4] 95% CI crossed 1 MID (0.5)

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1 **Table 10: Full GRADE profile of CBT versus another intervention for severe AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Severe AN CBT**	**Other**	**Relative (95% CI)**	**Absolute**		
BMI- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.00 Higher (0.49 lower to 0.49 Higher)	LOW	CRITICAL
Depression- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.24 lower (0.74 lower to 0.25 Higher)	LOW	IMPORTANT
EDE- Global- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.39 lower (0.89 lower to 0.11 Higher)	LOW	IMPORTANT
Quality of life- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.28 lower (0.78 lower to 0.22 Higher)	LOW	CRITICAL
BMI FU- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	31	32	-	SMD 0.11 Higher	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Severe AN CBT	Other	Relative (95% CI)	Absolute	Quality	Importance
										(0.38 lower to 0.61 Higher)		
Depression FU- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.27 lower (0.77 lower to 0.22 Higher)	LOW	IMPORTANT
EDE- Global FU- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.57 lower (1.08 lower to 0.07 Higher)	LOW	IMPORTANT
Quality of life FU- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.14 lower (0.64 lower to 0.35 Higher)	LOW	CRITICAL

[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)

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1 **Table 11: Full GRADE profile for SSCM versus another intervention for severe AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Severe SSCM	Other	Relative (95% CI)	Absolute		
BMI- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	32	31	-	SMD 0.00 Higher (0.49 lower to 0.49 Higher)	LOW	CRITICAL
EDE-Global- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	32	31	-	SMD 0.39 Higher (0.11 lower to 0.99 Higher)	LOW	IMPORTANT
Quality of life- Adults (Better indicated by Higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	32	31	-	SMD 0.28 Higher (0.22 lower to 0.78 Higher)	LOW	CRITICAL
Depression- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	32	31	-	SMD 0.24 Higher (0.25 lower to 0.74 Higher)	LOW	IMPORTANT
BMI FU- Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Severe SSCM	Other	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	32	31	-	SMD 0.11 lower (0.61 lower to 0.38 Higher)	LOW	CRITICAL
EDE-Global FU- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	32	31	-	SMD 0.57 Higher (0.07 to 1.08 Higher)	LOW	IMPORTANT
Quality of life FU- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	32	31	-	SMD 0.14 Higher (0.35 lower to 0.64 Higher)	LOW	CRITICAL
Depression FU- Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	32	31	-	SMD 0.27 Higher (0.22 lower to 0.77 Higher)	LOW	IMPORTANT

[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)

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L.3.21 Individual therapy for bulimia nervosa

2 **Table 12: Full GRADE profile for CBT-ED versus another intervention for people with bulimia nervosa at end of treatment.**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute	Quality	Importance
Purges - Adolescents (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	43	43	-	SMD 0.33 higher (0.1 lower to 0.75 higher)	LOW	CRITICAL
Purges - Adults (Better indicated by lower values)												
5	randomised trials	serious3	very serious4	no serious indirectness	serious5	none	180	179	-	SMD 0.59 lower (0.8 to 0.37 lower)	VERY LOW	CRITICAL
Binges objective Adolescent (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	43	43	-	SMD 0.23 higher (0.2 lower to 0.65 higher)	LOW	CRITICAL
Binges objective Adults (Better indicated by lower values)												
10	randomised trials	serious7	serious8	no serious indirectness	no serious imprecision	none	309	380	-	SMD 0.25 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute		
										(0.41 to 0.1 lower)		
Vomiting episodes Adults (Better indicated by lower values)												
7	randomised trials	serious7	very serious4	no serious indirectness	serious5	none	217	267	-	SMD 0.32 lower (0.51 to 0.13 lower)	VERY LOW	CRITICAL
Laxatives use/ fornight (Better indicated by lower values)												
2	randomised trials	serious9	no serious inconsistency	serious10	serious2	none	90	118	-	SMD 0.27 higher (0.01 lower to 0.55 higher)	VERY LOW	IMPORTANT
Symptom checklist (SCL-90-R) (Better indicated by lower values)												
3	randomised trials	serious11	serious8	no serious indirectness	serious5	none	122	139	-	SMD 0.31 lower (0.56 to 0.06 lower)	VERY LOW	CRITICAL
Quality of life (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious2	none	39	41	-	SMD 0.25 higher (0.19 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute		
										to 0.69 higher)		
Depression - young people (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	58	52	-	SMD 0.43 higher (0 to 0.86 higher)	LOW	CRITICAL
Depression - Adults (Better indicated by lower values)												
10	randomised trials	serious13	serious8	no serious indirectness	no serious imprecision	none	266	366	-	SMD 0.31 lower (0.47 to 0.14 lower)	LOW	CRITICAL
EDE- Total score - young people (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	58	52	-	SMD 0.28 higher (0.15 lower to 0.7 higher)	LOW	CRITICAL
EDE - Total score - Adults (Better indicated by lower values)												
5	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious5	none	210	209	-	SMD 0.6 lower (0.81 to 0.39 lower)	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute		
EDE-dietary restraint (Better indicated by lower values)												
10	randomised trials	serious15	very serious4	no serious indirectness	serious5	none	343	382	-	SMD 0.63 lower (0.78 to 0.47 lower)	VERY LOW	IMPORTANT
EDE-shape concern (Better indicated by lower values)												
10	randomised trials	serious15	very serious4	no serious indirectness	no serious imprecision	none	343	382	-	SMD 0.08 higher (0.07 lower to 0.23 higher)	VERY LOW	CRITICAL
EDE-weight concern (Better indicated by lower values)												
10	randomised trials	serious15	very serious4	no serious indirectness	no serious imprecision	none	343	382	-	SMD 0.13 lower (0.29 lower to 0.02 higher)	VERY LOW	CRITICAL
EDE-eating concern (Better indicated by lower values)												
5	randomised trials	serious16	serious8	no serious indirectness	no serious imprecision	none	238	239	-	SMD 0.16 lower (0.34 lower to 0.02 higher)	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute		
EDI- Bulimia (Better indicated by lower values)												
4	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	none	98	144	-	SMD 0.3 lower (0.57 to 0.04 lower)	LOW	CRITICAL
EDI - Drive for thinness (Better indicated by lower values)												
4	randomised trials	serious17	serious4	no serious indirectness	serious18	none	98	145	-	SMD 0 lower (0.27 lower to 0.27 higher)	VERY LOW	CRITICAL
EDI - Body Dissatisfaction (Better indicated by lower values)												
4	randomised trials	serious17	serious4	no serious indirectness	serious18	none	103	97	-	SMD 0.05 lower (0.35 lower to 0.24 higher)	VERY LOW	CRITICAL
Global Clinical Score (Better indicated by lower values)												
3	randomised trials	serious19	no serious inconsistency	no serious indirectness	serious5	none	46	65	-	SMD 0.15 lower (0.54 lower to 0.24 higher)	LOW	CRITICAL
General psychopathology (PSE) (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious20	no serious inconsistency	no serious indirectness	serious5	none	11	11	-	SMD 0.77 lower (1.64 lower to 0.1 higher)	LOW	CRITICAL
Remission - Adolescents												
2	randomised trials	serious21	no serious inconsistency	serious22	serious23	none	29/102 (28.4 %)	21/113 (18.6%)	RR 1.54 (0.96 to 2.47)	100 more per 1000 (from 7 fewer to 273 more)	VERY LOW	CRITICAL
Remission - Adults												
7	randomised trials	serious24	no serious inconsistency	no serious indirectness	serious25	none	108/340 (31.8 %)	68/391 (17.4%)	RR 1.87 (1.43 to 2.46)	151 more per 1000 (from 75 more to 254 more)	LOW	CRITICAL
Bulimic Inventory Test Edinburgh (Better indicated by lower values)												
1	randomised trials	serious26	no serious inconsistency	no serious indirectness	serious5	none	24	23	-	SMD 0.77 lower (1.37 to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention	Relative (95% CI)	Absolute		
										0.18 lower)		

1 *1 The participants and investigators were not blind but the assessors were.*
2 *2 95% CI crossed 1 MID (0.5)*
3 *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*
4 *studies >20%,*
5 *4 Heterogeneity reported, I2 >80%*
6 *5 95% CI crossed 1 MID (-0.5)*
7 *6 Unclear randomization method; neither the investigators, assessors nor participants were blind.*
8 *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*
9 *were reported by Fairburn.*
10 *8 Heterogeneity detected I2 >50%*
11 *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*
12 *were reported by Fairburn and Freeman.*
13 *10 <50% bulimia nervosa.*
14 *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*
15 *of drop outs were reported >20% in Agras 2000.*
16 *12 Unclear if allocation concealment was performed. Unclear if assessor, investigators and patients was blind.*
17 *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*
18 *were reported Theils and Agras.*
19 *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*
20 *studies a high number of drop outs were reported >20%*
21 *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*
22 *(>20%) were reported by Treasure, Theils and Fairburn*
23 *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*
24 *blind and high drop out rates were reported in half the studies >20%.*
25 *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.*
26 *18 Fewer than 400 patients for optimal sample size.*
27 *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*
28 *drop outs >20% and one study it was unclear if assessor was blind.*
29 *20 It was unclear how randomisation sequence was generated and if allocation concealment was conducted.*
30 *21 Unclear randomization method; no participant, investigator nor assessor blinding.*
31 *22 Sample in one study consists of 61 bulimia nervosa and 24 EDNOS*
32 *23 95% CI crossed 1 MID (1.25)*

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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 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%

Table 13: Full GRADE profile for CBT-ED versus another intervention for people with bulimia nervosa at follow-up.

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention Follow-up	Relative (95% CI)	Absolute		
Purges Follow-up - Adolescents (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	40	29	-	SMD 0 higher (0.48 lower to 0.48 higher)	LOW	CRITICAL
Purges Follow-up - Adults (Better indicated by lower values)												
3	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	102	106	-	SMD 0.15 lower (0.42 lower to 0.13 higher)	LOW	CRITICAL
Binge episodes follow-up - Adolescents (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	40	29	-	SMD 0.06 lower (0.54 lower to 0.42 higher)	LOW	CRITICAL
Binge episodes Follow-up - Adults (Better indicated by lower values)												
5	randomised trials	serious5	very serious6	no serious indirectness	serious2	none	148	146	-	SMD 0.19 lower (0.38 lower to	VERY LOW	

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention Follow-up	Relative (95% CI)	Absolute		
										0.04 higher)		
Vomiting Follow-up - Adults (Better indicated by lower values)												
3	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious4	none	83	79	-	SMD 0.19 lower (0.51 lower to 0.12 higher)	LOW	
Laxatives Follow-up - Adults (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious2	none	49	49	-	SMD 0.02 lower (0.42 lower to 0.37 higher)	LOW	CRITICAL
Symptom checklist Follow-up - Adults (Better indicated by lower values)												
3	randomised trials	serious9	very serious10	no serious indirectness	serious4	none	121	115	-	SMD 0.41 lower (0.68 to 0.14 lower)	VERY LOW	CRITICAL
Quality of life FU (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious12	none	25	27	-	SMD 0.08 higher (0.47 lower to 0.62 higher)	LOW	CRITICAL
Depression - FU - Adults (Better indicated by lower values)												
9	randomised trials	serious13	no serious inconsistency	no serious indirectness	no serious imprecision	none	199	211	-	SMD 0.14 lower (0.34 lower to	MODERATE	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention Follow-up	Relative (95% CI)	Absolute		
										0.05 higher)		
EDE - Total score Follow-up - Adults (Better indicated by lower values)												
3	randomised trials	serious14,15	no serious inconsistency	no serious indirectness	serious2	none	154	153	-	SMD 0.11 lower (0.34 lower to 0.11 higher)	LOW	CRITICAL
EDE - Restraint FU - Adults (Better indicated by lower values)												
3	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious2	none	63	63	-	SMD 0.12 lower (0.47 lower to 0.23 higher)	LOW	CRITICAL
EDE - Shape concern FU - Adults (Better indicated by lower values)												
3	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious2	none	63	63	-	SMD 0.01 lower (0.36 lower to 0.34 higher)	LOW	CRITICAL
EDE - Weight concern FU - Adults (Better indicated by lower values)												
3	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious2	none	63	63	-	SMD 0.08 lower (0.43 lower to 0.27 higher)	LOW	CRITICAL
EDE - Eating concern FU - Adults (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious4	none	25	27	-	SMD 0.25 lower (0.8 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention Follow-up	Relative (95% CI)	Absolute		
										0.29 higher)		
Global clinical score FU - Adults (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious4	none	11	11	-	SMD 0.81 lower (1.69 lower to 0.07 higher)	LOW	CRITICAL
General psychopathology - FU - Adults (Better indicated by lower values)												
2	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious4	none	25	24	-	SMD 0.5 lower (1.07 lower to 0.07 higher)	LOW	CRITICAL
Bulimic inventory test edinburgh (Better indicated by lower values)												
1	randomised trials	serious18,19	no serious inconsistency	no serious indirectness	serious4	none	24	23	-	SMD 0.21 lower (0.78 lower to 0.37 higher)	LOW	
EDI - Bulimia FU - Adults (Better indicated by lower values)												
1	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious4	none	16	31	-	SMD 0.47 lower (1.09 lower to 0.15 higher)	LOW	CRITICAL
EDI - Drive for thinness FU - Adults (Better indicated by lower values)												
1	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious12	none	16	31	-	SMD 0.12 higher (0.5 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	another intervention Follow-up	Relative (95% CI)	Absolute		
										0.73 higher)		
EDI - Body Dissatisfaction FU - Adults (Better indicated by lower values)												
1	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious4	none	14	13	-	SMD 0.36 lower (1.12 lower to 0.4 higher)	LOW	CRITICAL
Remission FU - young people												
2	randomised trials	serious1	no serious inconsistency	serious20	very serious21,22	none	28/102 (27.5%)	41/113 (36.3%)	RR 0.85 (0.56 to 1.3)	54 fewer per 1000 (from 160 fewer to 109 more)	VERY LOW	CRITICAL
Remission FU - Adults												
5	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious22	none	105/303 (34.7%)	84/326 (25.8%)	RR 1.37 (1.08 to 1.74)	95 more per 1000 (from 21 more to 191 more)	LOW	CRITICAL

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 I2 >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.

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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 irf 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)

Table 14: Full GRADE profile of interpersonal therapy versus another intervention for BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN IPT	another intervention	Relative (95% CI)	Absolute	**Quality**	**Importance**
EDE - Total (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	124	123	-	SMD 0.52 higher (0.27 to 0.77 higher)	LOW	IMPORTANT
EDE - Restraint (Better indicated by lower values)												
3	randomised trials	serious3	very serious4	no serious indirectness	serious2	none	146	163	-	SMD 0.71 higher	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN IPT	another intervention	Relative (95% CI)	Absolute		
										(0.02 lower to 1.43 higher)		
EDE - Weight concerns (Better indicated by lower values)												
3	randomised trials	serious3	very serious4	no serious indirectness	serious5	none	146	163	-	SMD 0.63 higher (0.53 lower to 1.79 higher)	VERY LOW	IMPORTANT
EDE - Shape concerns (Better indicated by lower values)												
3	randomised trials	serious3	very serious4	no serious indirectness	serious5	none	146	163	-	SMD 0.14 lower (1.06 lower to 0.78 higher)	VERY LOW	IMPORTANT
EDE - Eating concerns (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	124	123	-	SMD 0.47 higher (0.22 to 0.73 higher)	LOW	IMPORTANT
Symptom checklist (SCL-90-R) (Better indicated by lower values)												
2	randomised trials	serious1, 6	no serious inconsistency	no serious indirectness	serious5	none	86	105	-	SMD 0.11 higher	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN IPT	another intervention	Relative (95% CI)	Absolute		
										(0.19 lower to 0.4 higher)		
Social adjustment scale (Better indicated by lower values)												
3	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	97	116	-	SMD 0.33 higher (0.06 lower to 0.61 higher)	LOW	IMPORTANT
Purges (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious2	none	64	65	-	SMD 0.42 higher (0.07 to 0.77 higher)	LOW	IMPORTANT
Self induced vomiting (Better indicated by lower values)												
2	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	80	98	-	SMD 0.64 higher (0.33 to 0.96 higher)	LOW	IMPORTANT
Bulimic episodes (objective) (Better indicated by lower values)												
2	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	none	49	49	-	SMD 0.29 higher (0.01	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN IPT	another intervention	Relative (95% CI)	Absolute		
										lower to 0.6 higher)		
Depression (Better indicated by lower values)												
3	randomised trials	serious6	serious8	no serious indirectness	serious2	none	93	109	-	SMD 0.22 higher (0.41 lower to 0.85 higher)	VERY LOW	IMPORTANT
Laxative taking (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious9	none	58	58	-	SMD 0.37 lower (0.73 lower to 0 higher)	LOW	IMPORTANT
Remission_ITT												
3	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious10	none	21/200 (10.5 %)	77/225 (34.2%)	RR 0.33 (0.21 to 0.5)	229 fewer per 1000 (from 171 fewer to 270 fewer)	LOW	CRITICAL
General clinical score (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN IPT	another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious2	none	11	11	-	SMD 0.94 higher (0.05 to 1.83 higher)	LOW	CRITICAL
Remission_ITT < 5 years												
4	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious10	none	11/25 (44%)	14/50 (28%)	RR 1.56 (0.83 to 2.93)	157 more per 1000 (from 48 fewer to 540 more)	LOW	CRITICAL
Remission_ITT > 5 years												
2	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious10	none	37/175 (21.1 %)	52/175 (29.7%)	RR 0.71 (0.49 to 1.03)	86 fewer per 1000 (from 152 fewer to 9 more)	LOW	CRITICAL

[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%

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[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.

Table 15: Full GRADE profile for interpersonal therapy versus another intervention for BN at follow up

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN IPT**	**another intervention Follow-up**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
EDE - Total FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	113	114	-	SMD 0.22 higher (0.04 lower to 0.48 higher)	LOW	IMPORTANT
EDE - Restraint FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	130	134	-	SMD 0.33 higher (0.08 to 0.57 higher)	LOW	IMPORTANT
EDE - Weight concerns FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN IPT**	**another intervention Follow-up**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	130	134	-	SMD 0.11 higher (0.13 lower to 0.35 higher)	LOW	IMPORTANT
EDE - Shape concerns FU (Better indicated by lower values)												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness		none	130	134	-	SMD 0.03 higher (0.21 lower to 0.27 higher)	LOW	IMPORTANT
EDE - Eating concerns FU (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	113	114	-	SMD 0.15 higher (0.11 lower to 0.41 higher)	LOW	IMPORTANT
Symptom checklist (SCL-90-R) FU (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	81	85	-	SMD 0.02 lower (0.32 lower to 0.29 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN IPT**	**another intervention Follow-up**	**Relative (95% CI)**	**Absolute**		
Social adjustment scale FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	81	85	-	SMD 0.15 higher (0.15 lower to 0.46 higher)	LOW	IMPORTANT
Purges FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	64	65	-	SMD 0.18 higher (0.16 lower to 0.53 higher)	LOW	CRITICAL
Bulimic episodes (objective) FU (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious	none	49	49	-	SMD 0.02 higher (0.37 lower to 0.42 higher)	LOW	CRITICAL
Self induced vomiting FU (Better indicated by lower values)												
2	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious2	none	66	69	-	SMD 0.05 higher (0.28 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN IPT	another intervention Follow-up	Relative (95% CI)	Absolute		
										0.39 higher)		
Laxative taking FU (Better indicated by lower values)												
1	randomised trials	serious 5	no serious inconsistency	no serious indirectness	serious2	none	49	49	-	SMD 0.02 higher (0.37 lower to 0.42 higher)	LOW	IMPORTANT
Depression (Becks) FU (Better indicated by lower values)												
3	randomised trials	serious 4	serious6	no serious indirectness	serious2	none	66	69	-	SMD 0.10 higher (0.22 lower to 2.05 higher)	VERY LOW	IMPORTANT
Remission F_ITT												
3	randomised trials	serious 4	very serious6	no serious indirectness	serious7	none	48/200 (24%)	66/225 (29.3%)	RR 0.84 (0.61 to 1.15)	47 fewer per 1000 (from 114 fewer to 44 more)	VERY LOW	CRITICAL

1 [1] It was unclear if allocation concealment was conducted. Across studies, investigators, participants or assessors were not blind. High dropout rates were
2 detected >20%.

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[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 drop out rates were detected >20%
[6] Heterogeneity was detected >50%
[7] 95% CI crossed 1 MID (0.75)

Table 16: Full GRADE profile for ICAT versus another intervention for BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN ICAT	another intervention	Relative (95% CI)	Absolute	Quality	Importance
EDE - Total score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	40	40	-	SMD 0.11 lower (0.55 lower to 0.33 Higher)	LOW	IMPORTANT
Purges (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	40	40	-	SMD 0.05 Higher (0.39 lower to 0.49 Higher)	LOW	CRITICAL
Binges (objective) (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNICAT	another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	40	40	-	SMD 0.06 Higher (0.37 lower to 0.5 Higher)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	40	40	-	SMD 0.08 lower (0.52 lower to 0.36 Higher)	LOW	IMPORTANT

1 [1] It was unclear whether the participants, investigators or the assessors were blind.
2 [2] 95% CI crossed 1 MID (-0.5)
3 [3] fewer than 400 participants
4 [4] 95% CI crossed 1 MID (0.5)

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1 **Table 17: Full GRADE profile for ICAT versus another intervention for BN at follow-up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNICAT	another intervention FU	Relative (95% CI)	Absolute		
EDE - Total score FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	40	40	-	SMD 0.19 lower (0.63 lower to 0.25 Higher)	LOW	IMPORTANT
Purges FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious	none	40	40	-	SMD 0.09 lower (0.53 lower to 0.35 Higher)	LOW	CRITICAL
Binges (objective) FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	40	40	-	SMD 0.25 lower (0.69 lower to 0.19 Higher)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BNICAT**	**another intervention FU**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	40	40	-	SMD 0.14 Higher (0.3 lower to 0.58 Higher)	LOW	IMPORTANT

1 [1] It was unclear whether the participants, investigators or the assessors were blind.
2 [2] 95% CI crossed 1 MID (-0.5)
3 [3] 95% CI crossed 1 MID (0.5)

4 **Table 18: Full GRADE profile for CBT-ED versus another CBT-ED for people with BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute		
Symptom check list - 90 (Better indicated by lower values)												
3	randomised trials	serious1	serious2	no serious indirectness	serious3	none	148	143	-	SMD 0.03 lower (0.26 lower to 0.2 higher)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute	**Quality**	**Importance**
5	randomised trials	serious4	serious2	no serious indirectness	serious3	none	154	152	-	SMD 0.08 lower (0.31 lower to 0.14 higher)	VERY LOW	IMPORTANT
Social adjustment score (Better indicated by lower values)												
2	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious6	none	71	71	-	SMD 0.21 lower (0.54 lower to 0.12 higher)	LOW	IMPORTANT
Bingeing (objective) (Better indicated by lower values)												
4	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious3	none	121	121	-	SMD 0.20 lower (0.43 lower to 0.03 higher)	LOW	CRITICAL
Vomiting (Better indicated by lower values)												
2	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious3	none	61	61	-	SMD 0.09 lower (0.45 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute		
										0.26 higher)		
Laxatives (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious6	none	37	35	-	SMD 0.23 lower (0.7 lower to 0.23 higher)	LOW	IMPORTANT
Purging (last 2 weeks) (Better indicated by lower values)												
2	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious6	none	59	55	-	SMD 0.11 lower (0.48 lower to 0.26 higher)	LOW	CRITICAL
Remission_ITT												
4	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious10	none	83/163 (50.9 %)	72/158 (45.6 %)	RR 1.13 (0.91 to 1.41)	59 more per 1000 (from 41 fewer to 187 more)	LOW	CRITICAL
EDI- Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious11	none	37	35	-	SMD 0.14 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute		
										(0.32 lower to 0.6 higher)		
LOW												
LOW	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious3	none	61	61	-	SMD 0.02 lower (0.37 lower to 0.34 higher)	LOW	IMPORTANT
EDI- Body dissatisfaction (Better indicated by lower values)												
2	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious3	none	61	61	-	SMD 0.02 higher (0.34 lower to 0.37 higher)	LOW	IMPORTANT
EDI- Total (Better indicated by lower values)												
3	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious3	none	161	158	-	SMD 0.01 higher (0.21 lower to 0.23 higher)	LOW	IMPORTANT
EDE - Total (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute		
4	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious3	none	183	178	-	SMD 0.04 lower (0.25 lower to 0.17 higher)	LOW	IMPORTANT
Global Function (GAFS) (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious11	none	37	35	-	SMD 0.36 higher (0.1 lower to 0.83 higher)	LOW	CRITICAL
General psychiatric features (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious3	none	77	72	-	SMD 0.16 higher (0.16 lower to 0.48 higher)	LOW	CRITICAL
Bingeing episodes (28 d)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious10	none	26/77 (33.8 %)	18/72 (25%)	RR 1.35 (0.81 to 2.24)	88 more per 1000 (from 47 fewer to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute		
										310 more)		
Vomiting episodes (28 d)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious10	none	28/77 (36.4%)	24/72 (33.3%)	RR 1.09 (0.7 to 1.69)	30 more per 1000 (from 100 fewer to 230 more)	LOW	CRITICAL
Purging (28 d)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious10	none	30/77 (39%)	25/72 (34.7%)	RR 1.12 (0.74 to 1.71)	42 more per 1000 (from 90 fewer to 247 more)	LOW	CRITICAL
Laxative misuse												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious10	none	9/77 (11.7%)	8/72 (11.1%)	RR 1.05 (0.43 to 2.58)	6 more per 1000 (from 63 fewer to 176 more)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious3	none	24	26	-	SMD 0.55 higher (0.02	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2)	Relative (95% CI)	Absolute		
										lower to 1.11 higher)		
Depression >18 binges month (Better indicated by lower values)												
4	randomised trials	serious4	serious	no serious indirectness	serious3	none	130	126	-	SMD 0.20 lower (0.45 lower to 0.04 higher)	VERY LOW	IMPORTANT

[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 drop outs 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 ! MID (-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 19: Full GRADE profile for CBT-ED versus another CBT-ED for people with BN at follow-up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2) - Follow-up	Relative (95% CI)	Absolute	Quality	Importance
Depression Follow-up (Better indicated by lower values)												
4	randomised trials	serious 1	serious2	no serious indirectness	serious3	none	142	138	-	SMD 0.00 Higher (0.23 lower to 0.24 Higher)	VERY LOW	CRITICAL
Symptom check list - 90 Follow-up (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	137	132	-	SMD 0.09 Higher (0.15 lower to 0.33 Higher)	LOW	IMPORTANT
Bingeing episodes (28 d) FU												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	23/77 (29.9 %)	19/72 (26.4%)	RR 1.13 (0.68 to 1.9)	34 more per 1000 (from 84 fewer to 237 more)	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT-ED (1)**	**CBT-ED (2) - Follow-up**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Vomiting (28 d) Follow-up												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious6	none	29/77 (37.7 %)	23/72 (31.9%)	RR 1.18 (0.76 to 1.84)	57 more per 1000 (from 77 fewer to 268 more)	LOW	
Laxative misuse												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious7	none	9/77 (11.7 %)	6/72 (8.3%)	RR 1.4 (0.53 to 3.74)	33 more per 1000 (from 39 fewer to 228 more)	LOW	
Purging (28 d) Follow-up												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious6	none	31/77 (40.3 %)	24/72 (33.3%)	RR 1.21 (0.79 to 1.85)	70 more per 1000 (from 70 fewer to 283 more)	LOW	
Bingeing Follow-up (Better indicated by lower values)												
4	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	142	138	-	SMD 0.01 lower (0.25 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2) - Follow-up	Relative (95% CI)	Absolute	Quality	Importance
										0.22 Higher)		
Laxatives Follow-up (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious9	none	37	35	-	SMD 0.12 lower (0.58 lower to 0.34 Higher)	LOW	CRITICAL
Vomiting Follow-up (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	116	116	-	SMD 0.1 Higher (0.16 lower to 0.35 Higher)	LOW	CRITICAL
Purging (last 2 weeks) Follow-up (Better indicated by lower values)												
2	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious3	none	59	52	-	SMD 0.09 Higher (0.29 lower to 0.46 Higher)	LOW	IMPORTANT
General psychiatric features - FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT-ED (1)**	**CBT-ED (2) - Follow-up**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious3	none	77	72	-	SMD 0.05 Higher (0.28 lower to 0.37 Higher)	LOW	CRITICAL
Global Function (GAFS) (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious10	none	37	35	-	SMD 0.51 Higher (0.04 to 0.98 Higher)	LOW	IMPORTANT
Social adjustment score Follow-up (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious10	none	84	86	-	SMD 0.44 Higher (0.14 to 0.75 Higher)	LOW	IMPORTANT
EDI- Bulimia Follow-up (Better indicated by lower values)												
2	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious9	none	61	61	-	SMD 0.21 lower (0.57 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED (1)	CBT-ED (2) - Follow-up	Relative (95% CI)	Absolute	Quality	Importance
										0.15 Higher)		
EDI- Body dissatisfaction Follow-up (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious3	none	61	61	-	SMD 0.10 Higher (0.25 lower to 0.46 Higher)	LOW	CRITICAL
EDI- Drive for thinness Follow-up (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious10	none	37	35	-	SMD 0.26 Higher (0.2 lower to 0.73 Higher)	LOW	CRITICAL
EDI- Total Follow-up (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	161	158	-	SMD 0.02 lower (0.24 lower to 0.2 Higher)	LOW	
EDE - Total - Follow-up (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT-ED (1)**	**CBT-ED (2) - Follow-up**	**Relative (95% CI)**	**Absolute**		
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	122	115	-	SMD 0.10 lower (0.35 lower to 0.16 Higher)	LOW	IMPORTANT
Remission - FU _ ITT												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	39/73 (53.4 %)	29/71 (40.8%)	RR 1.30 (0.93 to 1.83)	123 more per 1000 (from 29 fewer to 339 more)	LOW	CRITICAL

[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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1 **Table 20: Full GRADE profile for behavioural therapy versus another intervention for BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	another intervention	Relative (95% CI)	Absolute		
Bulimic episodes (Better indicated by lower values)												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	64	119	-	SMD 0.10 lower (0.41 lower to 0.21 higher)	LOW	CRITICAL
Depression (Better indicated by lower values)												
5	randomised trials	serious1	serious3	no serious indirectness	serious2	none	64	121	-	SMD 0.36 higher (0.25 lower to 0.98 higher)	VERY LOW	IMPORTANT
Laxative use (no. tablets) (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	none	30	62	-	SMD 0.33 lower (0.77 lower to 0.11 higher)	LOW	IMPORTANT
Vomiting (Better indicated by lower values)												
3	randomised trials	serious1	very serious6	no serious indirectness	serious2	none	62	98	-	SMD 0.52 lower (0.86 to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	another intervention	Relative (95% CI)	Absolute		
										0.18 lower)		
Symptom Checklist (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious7	none	19	43	-	SMD 0.89 lower (0.31 lower to 1.46 higher)	LOW	CRITICAL
EDE - Dietary restraint (Better indicated by lower values)												
2	randomised trials	serious1	very serious6	no serious indirectness	serious7	none	32	57	-	SMD 0.92 higher (0.60 lower to 2.43 higher)	VERY LOW	IMPORTANT
EDE - Attitudes towards weight (Better indicated by lower values)												
2	randomised trials	serious1	very serious6	no serious indirectness	very serious8	none	32	57	-	SMD 2.23 higher (0.68 lower to 5.15 higher)	VERY LOW	IMPORTANT
VERY LOW												
VERY LOW	randomised trials	serious1	very serious6	no serious indirectness	serious7	none	32	57	-	SMD 1.87 higher (0.47	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	another intervention	Relative (95% CI)	Absolute		
										lower to 4.21 higher)		
EDI - Bulimia (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	46	93	-	SMD 0.42 lower (0.78 to 0.06 lower)	LOW	IMPORTANT
EDI - Drive for thinness (Better indicated by lower values)												
2	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious8	none	46	93	-	SMD 1.64 lower (2.05 to 1.22 lower)	LOW	IMPORTANT
EDI - Body dissatisfaction (Better indicated by lower values)												
2	randomised trials	serious10	serious3	no serious indirectness	serious5	none	73	76	-	SMD 1.21 lower (2.27 to 0.16 lower)	VERY LOW	IMPORTANT
Social adjustment scale (Better indicated by lower values)												
1	randomised trials	serious1	serious3	no serious indirectness	serious5	none	19	43	-	SMD 0.48 higher (0.47 lower	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	another intervention	Relative (95% CI)	Absolute		
										to 1.44 higher)		
Remission - ITT												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious8	none	15/40 (37.5 %)	24/66 (36.4%)	RR 1.01 (0.6 to 1.69)	4 more per 1000 (from 145 fewer to 251 more)	VERY LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	19	22	-	SMD 1.81 lower (2.55 to 1.07 lower)	LOW	CRITICAL
Vomiting >5 years or .18 binges/mo (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	43	76	-	SMD 0.18 lower (0.56 lower to 0.20 higher)	LOW	CRITICAL

[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%

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[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.

Table 21: Full GRADE profile for BT versus another intervention for BN at follow-up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN BT	another intervention Follow-up	Relative (95% CI)	Absolute		
Vomiting or purging FU (Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 1.00 higher (0.19 to 1.80 higher)	LOW	IMPORTANT
Bulimic episodes FU (Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.93 higher (0.13 to 1.73 higher)	LOW	CRITICAL
EDE - Dietary restraint FU (Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious3	none	13	14	-	SMD 0.45 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	another intervention Follow-up	Relative (95% CI)	Absolute		
										(0.32 lower to 1.21 higher)		
EDE- Shape concerns FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.35 higher (0.42 lower to 1.11 higher)	LOW	IMPORTANT
EDE - Weight concerns FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	13	14	-	SMD 0.07 higher (0.69 lower to 0.82 higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
2	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious3	none	29	45	-	SMD 0.04 higher (0.44 lower to 0.53 higher)	LOW	IMPORTANT
EDI - Drive for thinness FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	another intervention Follow-up	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	16	31	-	SMD 0.78 lower (1.41 to 0.15 lower)	LOW	IMPORTANT
EDI- Body dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	13	14	-	SMD 0.36 higher (0.40 lower to 1.12 higher)	LOW	IMPORTANT
EDI - Bulimia FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	16	31	-	SMD 0.34 lower (0.96 lower to 0.28 higher)	LOW	IMPORTANT
Remission FU_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	5/25 (20 %)	20/50 (40%)	RR 0.50 (0.21 to 1.18)	20 fewer per 100 (from 32 fewer to 7 more)	LOW	CRITICAL

1 [1] It was unclear how randomisation sequence was generated or if allocation concealment was conducted. Assessors were blind but it was unclear if
2 investigators or participants were blind. High drop outs were reported >20%

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[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)

Table 22: Full GRADE profile for BT versus wait list controls for BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BNBT	WLC	Relative (95% CI)	Absolute	Quality	Importance
Binge frequency (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	30	20	-	SMD 1.11 lower (1.72 to 0.5 lower)	LOW	CRITICAL
Self-induced vomiting (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	30	20	-	SMD 0.76 lower (1.34 to 0.17 lower)	LOW	CRITICAL
Laxative use (no. tablets) (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	30	20	-	SMD 0.75 lower (1.33 to 0.16 lower)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	Very serious4	none	16	18	-	SMD 0.04 Higher (0.64 lower to 0.71 Higher)	VERY LOW	IMPORTANT

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[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)

Table 23: Full GRADE profile for hybrid versus another intervention for BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN other/hybrid	another intervention	Relative (95% CI)	Absolute	Quality	Importance
Binge Eating (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	42	44	-	SMD 0.21 lower (0.63 lower to 0.21 Higher)	LOW	CRITICAL
Symptom check list - 90 (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	42	44	-	SMD 0 Higher (0.42 lower to 0.42 Higher)	LOW	CRITICAL
Depression - Becks (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	42	44	-	SMD 0.3 lower (0.73 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN other/hybrid	another intervention	Relative (95% CI)	Absolute		
										to 0.12 Higher)		
EDI - 1-6 ED symptoms (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	42	44	-	SMD 0.07 lower (0.49 lower to 0.35 Higher)	LOW	IMPORTANT
Binge Eating - Follow-up (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	42	44	-	SMD 0.36 lower (0.79 lower to 0.07 Higher)	LOW	CRITICAL
Symptom check list - 90 Follow-up (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	42	44	-	SMD 0 Higher (0.42 lower to 0.42 Higher)	LOW	CRITICAL
Depression - Becks Follow-up (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN other/hybrid**	**another intervention**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	42	44	-	SMD 0.16 lower (0.58 lower to 0.26 Higher)	LOW	IMPORTANT
EDI -1-6 Follow-up (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	42	44	-	SMD 0.18 lower (0.6 lower to 0.25 Higher)	LOW	IMPORTANT

[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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1 **Table 24: Full GRADE profile for CBT-ED versus wait list control for BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT-ED**	**WLC**	**Relative (95% CI)**	**Absolute**		
Laxative use (no. tablets) (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	20	-	SMD 0.36 lower (0.68 to 0.05 lower)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
3	randomised trials	serious3	very serious4	no serious indirectness	serious2	none	63	50	-	SMD 1.35 lower (1.79 to 0.91 lower)	VERY LOW	CRITICAL
Purge frequency (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious2	none	10	11	-	SMD 2.00 lower (3.08 to 0.91 lower)	LOW	CRITICAL
Vomiting (Better indicated by lower values)												
2	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	53	39	-	SMD 1.56 lower (2.03 to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	WLC	Relative (95% CI)	Absolute		
										1.08 lower)		
Overall severity (Better indicated by lower values)												
2	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious7	none	124	70	-	SMD 1.92 lower (2.28 to 1.56 lower)	LOW	IMPORTANT
EDI - Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious2	none	19	22	-	SMD 0.37 lower (0.99 lower to 0.25 Higher)	LOW	IMPORTANT
EDI - Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious2	none	19	22	-	SMD 1.02 lower (1.68 to 0.36 lower)	LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	19	22	-	SMD 1.48 Higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	WLC	Relative (95% CI)	Absolute		
										(2.18 to 0.78 lower)		
Symptom checklist - 90 items (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious2	none	103	51	-	SMD 0.71 lower (1.05 to 0.36 lower)	LOW	CRITICAL
General pyschiatric features (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	72	51	-	SMD 0.81 lower (1.18 to 0.43 lower)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious7	none	17	18	-	SMD 1.43 lower (2.18 to 0.67 lower)	LOW	IMPORTANT
Vomiting episodes												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious11	none	52/103	30/50 (60%)	RR 0.84 (0.62	96 fewer per 1000 (from	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	WLC	Relative (95% CI)	Absolute		
							(50.5 %)		to 1.13)	228 fewer to 78 more)		
Purging												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious11	none	55/103 (53.4 %)	33/51 (64.7 %)	RR 0.82 (0.63 to 1.08)	116 fewer per 1000 (from 239 fewer to 52 more)	LOW	
Laxative misuse												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious11	none	17/103 (16.5 %)	13/51 (25.5 %)	RR 0.65 (0.34 to 1.23)	89 fewer per 1000 (from 168 fewer to 59 more)	LOW	
EDE - Shape concern (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious7	none	21	19	-	SMD 2.44 lower (3.28 to 1.6 lower)	LOW	IMPORTANT
EDE - Weight concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN CBT-ED	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious7	none	21	19	-	SMD 2.44 lower (3.28 to 1.6 lower)	LOW	IMPORTANT
Bulimic episodes												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious11	none	44/103 (42.7%)	27/51 (52.9%)	RR 0.81 (0.57 to 1.13)	101 fewer per 1000 (from 228 fewer to 69 more)	LOW	
EDE - Dietary Restraint (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious7	none	21	19	-	SMD 1.52 lower (2.24 to 0.81 lower)	LOW	IMPORTANT
Did not achieve remission ITT												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious11	none	9/54 (16.7%)	2/27 (7.4%)	RR 0.90 (0.77 to 1.06)	7 fewer per 1000 (from 17 fewer to 4 more)	LOW	CRITICAL

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[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 dropouts 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 dropouts were reported >20%.
[6] It was unclear if allocation concealment was conducted or if either the participants, investigators or assessors were blind. High dropouts 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 dropouts 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 dropouts 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 dropouts 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.

Table 25: Full GRADE profile for DBT versus another intervention for BN

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BNDBT**	**another intervention**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Negative mood regulation score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	14	15	-	SMD 0.33 lower (1.07 lower to 0.4 Higher)	LOW	IMPORTANT
Depression- Becks (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BNDBT**	**another intervention**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	14	15	-	SMD 0.91 lower (1.68 to 0.14 lower)	LOW	IMPORTANT
Emotional eating - anger/anxiety/depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	14	15	-	SMD 0.7 lower (1.46 lower to 0.07 Higher)	LOW	IMPORTANT

[1] It was unclear if either participants, investigators or assessors were blind.
[2] 95% CI crossed 1 MID (-0.5)

Table 26: Full GRADE profile for psychodynamic general versus another intervention for BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Psychodynamic General	another intervention	Relative (95% CI)	Absolute		
Binge eating (28/d) (Better indicated by lower values)												
2	randomised trials	serious1,2	very serious3	no serious indirectness	serious4	none	57	59	-	SMD 1.02 higher (0.60	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Psychodynamic General	another intervention	Relative (95% CI)	Absolute	Quality	**Importance**
										lower to 2.65 higher)		
Vomiting/purging episodes (28d) (Better indicated by lower values)												
2	randomised trials	serious1,2	very serious3	no serious indirectness	serious5	none	59	61	-	SMD 1.46 higher (0.05 lower to 2.97 higher)	VERY LOW	CRITICAL
EDE - Attitudes towards weight (Better indicated by lower values)												
2	randomised trials	serious1,2	very serious3	no serious indirectness	very serious6	none	59	61	-	SMD 0.02 higher (1.25 lower to 1.30 higher)	VERY LOW	IMPORTANT
EDE - Dietary restraint (Better indicated by lower values)												
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious5	none	59	61	-	SMD 0.75 higher (0.38 to 1.12 higher)	LOW	IMPORTANT
EDE - Attitudes towards shape (Better indicated by lower values)												
2	randomised trials	serious1,2	very serious3	no serious indirectness	serious4	none	59	61	-	SMD 0.71 lower (3.56	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Psychodynamic General	another intervention	Relative (95% CI)	Absolute	Quality	**Importance**
										lower to 2.13 higher)		
EDI - Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	25	25	-	SMD 0.53 higher (0.04 lower to 1.09 higher)	LOW	IMPORTANT
EDI -Bulimia (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	24	25	-	SMD 0.61 higher (0.03 to 1.18 higher)	LOW	IMPORTANT
EDI - Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	24	25	-	SMD 0.24 higher (0.33 lower to 0.8 higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious4	none	34	36	-	SMD 0.78 lower (1.27	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Psychodynamic General	another intervention	Relative (95% CI)	Absolute	Quality	**Importance**
										to 0.29 lower)		
General psychopathology (Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	34	36	-	SMD 0.36 higher (0.11 lower to 0.83 higher)	LOW	IMPORTANT

[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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L.3.3 Individual therapy for binge eating disorder

Table 27: Full GRADE profile for hybrid versus another hybrid for adults with binge eating disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge Hybrid	other Hybrid	Relative (95% CI)	Absolute	Quality	Importance
Global clinical score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	30	30	-	SMD 1.09 lower (1.64 to 0.55 lower)	LOW	CRITICAL
% weight loss (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	30	30	-	SMD 0.34 Higher (0.17 lower to 0.85 Higher)	LOW	CRITICAL

[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)

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1 **Table 28: Full GRADE profile for CBT-ED versus another intervention for BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention	Relative (95% CI)	Absolute		
BMI Adolescents (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	13	-	SMD 0.02 higher (0.75 lower to 0.79 higher)	LOW	CRITICAL
Depression Adolescents (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	13	13	-	SMD 1.08 lower (1.91 to 0.25 lower)	LOW	CRITICAL
Depression Adults (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	71	70	-	SMD 0.00 higher (33 lower to 0.33 higher)	LOW	CRITICAL
EDE - Dietary restraint Adolescents (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	13	13	-	SMD 0.65 lower (1.44 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention	Relative (95% CI)	Absolute		
										0.15 higher)		
EDE- Dietary restraint Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	109	144	-	SMD 0.52 lower (0.78 to 0.26 lower)	LOW	IMPORTANT
EDE - Eating concerns Adolescents (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	13	13	-	SMD 1.41 lower (2.29 to 0.54 lower)	LOW	IMPORTANT
EDE- Eating concerns Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	110	146	-	SMD 0.51 lower (0.76 to 0.25 lower)	LOW	IMPORTANT
EDE - Shape concerns Adolescents (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	13	13	-	SMD 0.11 higher (0.66 lower to 0.88 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention	Relative (95% CI)	Absolute		
EDE- Shape concerns Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	110	146	-	SMD 0.56 lower (0.80 to 0.28 lower)	LOW	IMPORTANT
EDE-Weight concerns Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	110	146	-	SMD 0.07 higher (0.18 lower to 0.32 higher)	LOW	IMPORTANT
EDE - Weight concerns Adolescents (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	13	13	-	SMD 0.30 lower (1.07 lower to 0.48 higher)	LOW	IMPORTANT
EDE- Global score Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	137	209	-	SMD 0.99 lower (1.24 to 0.74 lower)	LOW	IMPORTANT
Social adjustment - Adolescents (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	13	13	-	SMD 0.52 lower (1.3 lower to 0.27 higher)	LOW	IMPORTANT
Binge eating Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	109	144	-	SMD 0.05 higher (0.20 lower to 0.30 higher)	LOW	CRITICAL
Remission Adolescents_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	10/13 (76.9 %)	5/13 (38.5%)	RR 2.00 (0.95 to 4.23)	385 more per 1000 (from 19 fewer to 1000 more)	LOW	CRITICAL
Remission Adults												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious7	none	13/38 (34.2 %)	40/74 (54.1%)	RR 0.63 (0.39 to 1.03)	200 fewer per 1000 (from	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention	Relative (95% CI)	Absolute		
										330 fewer to 16 more)		

[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)

Table 29: Full GRADE table for CBT-ED versus another intervention for people with BED at follow-up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention FU	Relative (95% CI)	Absolute		
BMI FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	137	209	-	SMD 0.19 lower (0.41 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention FU	Relative (95% CI)	Absolute		
										0.03 higher)		
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	70	-	SMD 0.00 higher (0.33 lower to 0.33 higher)	LOW	IMPORTANT
Binge eating FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	131	127	-	SMD 0.10 higher (0.15 lower to 0.34 higher)	LOW	CRITICAL
EDE- Global scale FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	137	209	-	SMD 1.02 lower (1.27 to 0.77 lower)	LOW	IMPORTANT
EDE- Dietary restraint FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention FU	Relative (95% CI)	Absolute		
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	102	129	-	SMD 0.39 lower (0.66 to 0.13 lower)	LOW	IMPORTANT
EDE- Weight concerns FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	102	129	-	SMD 1.53 lower (1.86 to 1.20 lower)	LOW	IMPORTANT
EDE- Shape concerns FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	102	129	-	SMD 1.67 lower (2.0 to 1.33 lower)	LOW	IMPORTANT
EDE- Eating concerns FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	102	129	-	SMD 1.28 lower (1.59 to 0.97 lower)	LOW	IMPORTANT
Remission FU												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge CBT-ED	another intervention FU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	16/30 (53.3 %)	36/57 (63.2%)	RR 0.84 (0.57 to 1.24)	101 fewer per 1000 (from 272 fewer to 152 more)	LOW	CRITICAL

[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)

Table 30: Full GRADE profile for interpersonal therapy versus another intervention for adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge IPT	Another intervention	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Binge IPT**	**Another intervention**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	75	130	-	SMD 0.02 Higher (0.26 lower to 0.31 Higher)	LOW	CRITICAL
Binge eating (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	75	130	-	SMD 0.05 lower (0.33 lower to 0.24 Higher)	LOW	CRITICAL
Remission ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	65/75 (86.7 %)	106/130 (81.5%)	RR 1.05 (0.94 to 1.2)	41 more per 1000 (from 49 fewer to 163 more)	LOW	CRITICAL
BMI FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	75	130	-	SMD 0.01 Higher (0.27 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge IPT	Another intervention	Relative (95% CI)	Absolute		
										0.3 Higher)		
Binge eating FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	75	130	-	SMD 0.07 lower (0.35 lower to 0.22 Higher)	LOW	CRITICAL

1 [1] It was unclear how the random sequence was generated or if allocation concealment was performed. It was unclear if participants and investigators were
2 blind to treatment, however, assessors were blind. High dropout rates were reported >20%
3 [2] For a continuous outcome, there were fewer than 400 participants.
4 [3] For a dichotomous outcome, there were fewer than 300 events.

5 :

6 **Table 31: Full GRADE profile for DBT versus wait list control for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge DBT	Waiting List	Relative (95% CI)	Absolute		
Binge eating (objective (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	14	-	SMD 0.14 lower (1.2	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge DBT	Waiting List	Relative (95% CI)	Absolute		
										lower to 0.22 Higher)		
Vomiting episodes (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	14	-	SMD 0.72 lower (1.44 lower to 0 Higher)	LOW	CRITICAL
EDE-Global Score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	14	-	SMD 1.02 lower (1.77 to 0.27 lower)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	14	-	SMD 0.90 lower (1.63 to 0.16 lower)	LOW	IMPORTANT

[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)

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1 **Table 32: Full GRADE profile for BT compared with another intervention in adults with BED at end of treatment and follow-up.**

2

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bnge BT	Another intervention	Relative (95% CI)	Absolute		
Bulimic episodes (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	36	76	-	SMD 0.03 higher (0.37 lower to 0.42 higher)	LOW	CRITICAL
Purging (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	36	76	-	SMD 0.19 higher (0.21 lower to 0.58 higher)	LOW	IMPORTANT
Symptom checklist (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	36	76	-	SMD 0.16 higher (0.24 lower to 0.55 higher)	LOW	IMPORTANT
EDE-Dietary restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	36	76	-	SMD 0.01 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bnge BT	Another intervention	Relative (95% CI)	Absolute		
										(0.38 lower to 0.41 higher)		
EDE-weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	36	76	-	SMD 0.06 lower (0.46 lower to 0.33 higher)	LOW	IMPORTANT
EDE-shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	36	76	-	SMD 0.06 lower (0.46 to 0.33 higher)	LOW	IMPORTANT
EDE-eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	36	76	-	SMD 0.26 higher (0.14 lower to 0.65 higher)	LOW	IMPORTANT
EDI-bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	36	76	-	SMD 0.18 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bnge BT	Another intervention	Relative (95% CI)	Absolute		
										(0.57 lower to 0.22 higher)		
EDI-body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	36	76	-	SMD 0.16 lower (0.55 lower to 0.24 higher)	LOW	IMPORTANT
EDI-drive for thinness (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	36	76	-	SMD 0.18 lower (0.58 lower to 0.22 higher)	LOW	IMPORTANT
Remission												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	20/72 (27.8 %)	33/76 (43.4%)	RR 0.64 (0.41 to 1.01)	156 fewer per 1000 (from 256 fewer to 4 more)	LOW	CRITICAL
Bulimic episodes FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BngeBT	Another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	28	58	-	SMD 0.11 lower (0.56 lower to 0.34 higher)	LOW	CRITICAL
Purging FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	28	59	-	SMD 0.34 higher (0.12 lower to 0.79 higher)	LOW	IMPORTANT
Symptom checklist FU (Better indicated by lower values)												
1	randomised trials	serious1				none	28	59	-	SMD 0.29 higher (0.16 lower to 0.74 higher)	LOW	IMPORTANT
EDE-Dietary restraint FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	28	59	-	SMD 0.07 lower (0.52 lower to 0.38 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BngeBT	Another intervention	Relative (95% CI)	Absolute		
EDE-weight concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	28	59	-	SMD 0.08 lower (0.53 lower to 0.37 higher)	LOW	IMPORTANT
EDE-shape concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	28	59	-	SMD 0.03 higher (0.42 lower to 0.49 higher)	LOW	IMPORTANT
EDE-eating concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	28	59	-	SMD 0.16 lower (0.61 lower to 0.29 higher)	LOW	IMPORTANT
EDI-bulimia FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	28	59	-	SMD 0.29 lower (0.74 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BngeBT	Another intervention	Relative (95% CI)	Absolute		
										0.17 higher)		
EDI-body dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	59	-	SMD 0.05 lower (0.50 lower to 0.40 higher)	LOW	IMPORTANT
EDI-drive for thinness FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	28	59	-	SMD 0.20 lower (0.65 lower to 0.25 higher)	LOW	IMPORTANT
Remission FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	19/36 (52.8 %)	33/76 (43.4%)	RR 1.22 (0.81 to 1.82)	96 more per 1000 (from 82 fewer to 356 more)	LOW	CRITICAL

[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

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[3] 95% CI crossed 1 MID (0.5)
[4] 95% CI crossed 1 MID (-0.5)
[5] 95% CI crossed 1 MID (1.25)

Table 33: Full GRADE profile for hybrid versus another hybrid in people with BED

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Binge Hybrid	other Hybrid	Relative (95% CI)	Absolute	Quality	Importance
Global clinical score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	30	30	-	SMD 1.09 lower (1.64 to 0.55 lower)	LOW	CRITICAL
% weight loss (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	30	30	-	SMD 0.34 higher (0.17 lower to 0.85 higher)	LOW	CRITICAL

[1] Unclear if allocation concealment was performed. Unclear if the participants, assessors or investigators were blind.
[2] 95% CI crossed 2 MIDs (-0.5 and 0.5)
[3] 95% CI crossed 1 MID (0.5)

Table 34: Full GRADE profile for CBT-general versus another intervention in adults with BED

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED CBT-General vs another intervention**	**BED**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Purging (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	38	101	-	SMD 0.16 lower (0.56 lower to 0.23 higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.14 lower (0.53 lower to 0.25 higher)	LOW	IMPORTANT
EDE-Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	38	74	-	SMD 0.22 higher (0.17 lower to 0.61 higher)	LOW	IMPORTANT
EDE-Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.21 higher (0.18	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED CBT-General vs another intervention**	**BED**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										lower to 0.5 higher)		
EDE-Eating concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	38	74	-	SMD 0.11 lower (0.51 lower to 0.28 higher)	LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	38	74	-	SMD 0.01 higher (0.38 lower to 0.4 higher)	LOW	IMPORTANT
EDI-Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	38	74	-	SMD 0.33 higher (0.06 lower to 0.72 higher)	LOW	IMPORTANT
EDI-Drive for thinness (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED CBT-General vs another intervention**	**BED**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	38	74	-	SMD 0.74 higher (0.15 lower to 0.64 higher)	LOW	IMPORTANT
EDI- Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.07 higher (0.33 lower to 0.46 higher)	LOW	IMPORTANT
SCL-90-R Global severity index (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.07 lower (0.46 lower to 0.32 higher)	LOW	IMPORTANT
Remission IT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	20/36 (55.6%)	33/76 (43.4 %)	RR 1.28 (0.87 to 1.89)	122 more per 1000 (from	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED CBT-General vs another intervention**	**BED**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										56 fewer to 386 more)		
Purging FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	58	-	SMD 0.23 lower (0.68 lower to 0.22 higher)	LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	29	58	-	SMD 0.05 lower (0.5 lower to 0.4 higher)	LOW	IMPORTANT
EDE-Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.24 higher (0.2 lower to 0.69 higher)	LOW	IMPORTANT
EDE-Shape concern FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT-General vs another intervention	BED	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.34 higher (0.11 lower to 0.78 higher)	LOW	IMPORTANT
EDE-Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.16 higher (0.29 lower to 0.6 higher)	LOW	IMPORTANT
EDE- Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.14 higher (0.58 lower to 0.57 higher)	LOW	IMPORTANT
EDI-Body dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.32 higher (0.13 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT-General vs another intervention	BED	Relative (95% CI)	Absolute		
										0.76 higher)		
EDI-Drive for thinness FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.32 higher (0.13 lower to 0.77 higher)	LOW	IMPORTANT
EDI- Bulimia FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.29 higher (0.16 lower to 0.74 higher)	LOW	IMPORTANT
SCL-90-R Global severity index FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	29	58	-	SMD 0.00 higher (0.64 lower to 0.64 higher)	LOW	IMPORTANT
Remission IT FU												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT-General vs another intervention	BED	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	34/38 (89.5%)	35/74 (47.3 %)	RR 1.89 (1.45 to 2.46)	421 more per 1000 (from 213 more to 691 more)	LOW	CRITICAL

1 1 It was unclear how randomisation was conducted or if allocation concealment was performed. Assessors were blind but it was unclear if investigators or
2 participants were blind. High drop outs were reported >20%.
3 2 95% CI crossed 1 MID (-0.5)
4 3 For a continuous outcome there were fewer than 400 participants
5 4 95% CI crossed 1 MID (0.5)
6 5 95% CI Crossed 1 MID (1.25)

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L.3.41 Individual therapy for EDNOS

2 **Table 35: Full GRADE profile for hybrid versus group hybrid for adults with ENDOS**

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**EDNOS Individual hybrid**	**Group hybrid**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	17	18	-	SMD 0.11 lower (0.77 lower to 0.56 Higher)	VERY LOW	IMPORTANT
General psychopathology (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious	none	17	18	-	SMD 0.13 lower (0.79 lower to 0.54 Higher)	VERY LOW	IMPORTANT
Dietary restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	17	18	-	SMD 0.08 Higher (0.58 lower to 0.74 Higher)	VERY LOW	IMPORTANT
EDI Total (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**EDNOS Individual hybrid**	**Group hybrid**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	17	18	-	SMD 0.29 Higher (0.38 lower to 0.96 Higher)	LOW	IMPORTANT
Remission ITT												
1	randomised trials	serious1	no serious inconsistency	serious4	very serious5	none	6/17 (35.3%)	8/18 (44.4%)	RR 0.79 (0.35 to 1.81)	93 fewer per 1000 (from 289 fewer to 360 more)	VERY LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	17	18	-	SMD 0.55 Higher (0.12 lower to 1.23 Higher)	LOW	IMPORTANT
General pyschopathology FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	17	18	-	SMD 0.33 Higher (0.33 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	EDNOS Individual hybrid	Group hybrid	Relative (95% CI)	Absolute	Quality	Importance
										1 Higher)		
Dietary restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	17	18	-	SMD 0.14 Higher (0.52 lower to 0.81 Higher)	LOW	IMPORTANT
EDI Total FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	17	18	-	SMD 0.57 Higher (0.11 lower to 1.23 Higher)	LOW	IMPORTANT
Remission ITT FU												
1	randomised trials	serious 1	no serious inconsistency	serious4	serious6	none	13/17 (76.5%)	17/18 (94.4 %)	RR 0.81 (0.61 to 1.08)	179 fewer per 1000 (from 368 fewer to 76 more)	VERY LOW	CRITICAL

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[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)

Table 36: Full GRADE profile for CBT-general versus another intervention for adults with BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute	Quality	Importance
Purging (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	38	101	-	SMD 0.16 lower (0.56 lower to 0.23 Higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.14 lower (0.53 lower to 0.25 Higher)	LOW	IMPORTANT
EDE-Weight concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	38	74	-	SMD 0.22 Higher (0.17 lower to 0.61 Higher)	LOW	IMPORTANT
EDE-Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.21 Higher (0.18 lower to 0.5 Higher)	LOW	IMPORTANT
EDE-Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	38	74	-	SMD 0.11 lower (0.51 lower to 0.28 Higher)	LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	38	74	-	SMD 0.01 Higher (0.38	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute		
										lower to 0.4 Higher)		
EDI-Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	38	74	-	SMD 0.33 Higher (0.06 lower to 0.72 Higher)	LOW	IMPORTANT
EDI-Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	38	74	-	SMD 0.74 Higher (0.15 lower to 0.64 Higher)	LOW	IMPORTANT
EDI- Bulimia (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.07 Higher (0.33 lower to 0.46 Higher)	LOW	IMPORTANT
SCL-90-R Global severity index (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	74	-	SMD 0.07 lower (0.46 lower to 0.32 Higher)	LOW	IMPORTANT
Remission IT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	20/36 (55.6%)	33/76 (43.4 %)	RR 1.28 (0.87 to 1.89)	122 more per 1000 (from 56 fewer to 386 more)	LOW	CRITICAL
Purging FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	29	58	-	SMD 0.23 lower (0.68 lower to 0.22 Higher)	LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	29	58	-	SMD 0.05 lower (0.5 lower to 0.4 Higher)	LOW	IMPORTANT
EDE-Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.24 Higher (0.2 lower to 0.69 Higher)	LOW	IMPORTANT
EDE-Shape concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.34 Higher (0.11 lower to 0.78 Higher)	LOW	IMPORTANT
EDE-Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.16 Higher (0.29	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute		
										lower to 0.6 Higher)		
EDE- Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.14 Higher (0.58 lower to 0.57 Higher)	LOW	IMPORTANT
EDI-Body dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.32 Higher (0.13 lower to 0.76 Higher)	LOW	IMPORTANT
EDI-Drive for thinness FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.32 Higher (0.13 lower to 0.77 Higher)	LOW	IMPORTANT
EDI- Bulimia FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-General vs another intervention	BN	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	29	58	-	SMD 0.29 Higher (0.16 lower to 0.74 Higher)	LOW	IMPORTANT
SCL-90-R Global severity index FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	29	58	-	SMD 0.00 Higher (0.64 lower to 0.64 Higher)	LOW	IMPORTANT
Remission IT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	34/38 (89.5%)	35/74 (47.3 %)	RR 1.89 (1.45 to 2.46)	421 more per 1000 (from 213 more to 691 more)	LOW	CRITICAL

[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)

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[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)

L.3.54 Group therapy for bulimia nervosa

Table 37: Full GRADE profile for group BT (ED) versus another BT (ED) for adults with BN

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group BT (ED)**	**BT.2 (ED)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Vomiting (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	12	11	-	SMD 0.06 lower (0.87 lower to 0.76 Higher)	VERY LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	11	-	SMD 0.35 Higher (0.48 lower to 1.17 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious4	none	4/15 (26.7%)	4/15 (26.7%)	RR 1.00 (0.31 to 3.28)	0 fewer per 1000 (from 184	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT (ED)	BT.2 (ED)	Relative (95% CI)	Absolute		
										fewer to 608 more)		
Vomiting FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	12	12	-	SMD 0.65 lower (1.48 lower to 0.17 Higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	11	-	SMD 0.47 Higher (0.36 lower to 1.3 Higher)	LOW	IMPORTANT
Remission_ITT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious4	none	5/15 (33.3%)	2/15 (13.3 %)	RR 2.50 (0.57 to 10.93)	200 more per 1000 (from 57 fewer to 1000 more)	VERY LOW	CRITICAL

[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.

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[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)

Table 38: Full GRADE profile for group CBT-ED versus wait list controls for adults with BN

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group CBT-ED**	**WLC**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Bingeing frequency (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	29	25	-	SMD 0.43 lower (0.97 lower to 0.12 Higher)	LOW	CRITICAL
Purges (per week) (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	14	14	-	SMD 0.33 lower (1.08 lower to 0.42 Higher)	LOW	IMPORTANT
Vomiting (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	12	12	-	SMD 0.9 lower (1.74 to 0.05 lower)	LOW	IMPORTANT
Depression (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT-ED	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	12	-	SMD 1.81 lower (2.79 to 0.84 lower)	LOW	IMPORTANT
EDI- Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	11	-	SMD 0.66 lower (1.46 lower to 0.15 Higher)	LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	11	-	SMD 0.38 lower (1.17 lower to 0.4 Higher)	LOW	IMPORTANT
EDI- Body Dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	15	11	-	SMD 0.67 lower (1.47 lower to 0.13 Higher)	LOW	IMPORTANT
No_Remission_ITT												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT-ED	WLC	Relative (95% CI)	Absolute		
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	5/26 (19.2%)	1/26 (3.8 %)	RR 0.86 (0.72 to 1.04)	5 fewer per 1000 (from 11 fewer to 2 more)	LOW	CRITICAL
No_Remission_ITT FU												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	10/30 (33.3%)	2/29 (6.9 %)	RR 0.72 (0.55 to 0.94)	19 fewer per 1000 (from 4 fewer to 31 fewer)	LOW	CRITICAL

[1] It was unclear how randomisation was performed or if allocation concealment was performed. Neither the participants, 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)

Table 39: Full GRADE profile for group CBT-ED versus another intervention for adults with BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT (ED)	Other Intervention	Relative (95% CI)	Absolute		
Bingeing frequency (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group CBT (ED)**	**Other Intervention**	**Relative (95% CI)**	**Absolute**		
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	101	105	-	SMD 0.08 higher (0.19 lower to 0.36 higher)	LOW	IMPORTANT
EDI- Drive for thinness (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	101	105	-	SMD 0.15 higher (0.13 lower to 0.42 higher)	LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
3	randomised trials	serious 1	Serious4	no serious indirectness	Serious5	none	101	105	-	SMD 0.14 higher (0.44 lower to 0.72 higher)	VERY LOW	IMPORTANT
EDI- Body Dissatisfaction (Better indicated by lower values)												
3	randomised trials	serious 1	serious4	no serious indirectness	serious5	none	101	105	-	SMD 0.16 higher (0.33 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT (ED)	Other Intervention	Relative (95% CI)	Absolute		
										0.66 higher)		
EDI-Global (Better indicated by lower values)												
2	randomised trials	serious 6	serious4	no serious indirectness	serious3	none	73	72	-	SMD 0.07 lower (0.57 lower to 0.42 higher)	VERY LOW	IMPORTANT
EDE-Total (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious2	none	60	60	-	SMD 0.13 higher (0.23 lower to 0.49 higher)	LOW	IMPORTANT
Clinical impairment (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious3	none	0	-	-	SMD 1.02 lower (1.54 to 0.51 lower)	LOW	IMPORTANT
Symptom checklist (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious2	none	60	60	-	SMD 0.07 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT (ED)	Other Intervention	Relative (95% CI)	Absolute		
										(0.27 lower to 0.43 higher)		
Depression (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	98	113	-	SMD 0.07 higher (0.21 lower to 0.34 higher)	LOW	IMPORTANT
Anxiety (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious2	none	60	60	-	SMD 0.11 lower (0.47 lower to 0.25 higher)	LOW	IMPORTANT
Vomiting (Better indicated by lower values)												
2	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious5	none	38	53	-	SMD 0.45 higher (0.02 to 0.87 higher)	LOW	IMPORTANT
Laxatives (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group CBT (ED)**	**Other Intervention**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious5	none	26	30	-	SMD 0.55 higher (0.02 to 1.09 higher)	LOW	IMPORTANT
No_Remission_ITT												
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious10	none	3/41 (7.3%)	1/40 (2.5%)	RR 0.95 (0.86 to 1.05)	1 fewer per 1000 (from 3 fewer to 1 more)	LOW	CRITICAL
Binging frequency FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	105	100	-	SMD 0.07 higher (0.21 lower to 0.34 higher)	LOW	CRITICAL
EDI- Body Dissatisfaction FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	105	100	-	SMD 0.25 lower (0.53 lower to 0.02 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group CBT (ED)**	**Other Intervention**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
EDI - Bulimia FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	105	100	-	SMD 0.06 lower (0.33 lower to 0.22 higher)	LOW	IMPORTANT
EDI-Global FU (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious	none	37	37	-	SMD 0.1 lower (0.15 to 0.05 lower)	LOW	IMPORTANT
EDI- Drive for thinness FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	105	100	-	SMD 0.11 lower (0.39 lower to 0.16 higher)	LOW	IMPORTANT
EDE-Total FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious2	none	60	60	-	SMD 0.03 lower (0.39 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT (ED)	Other Intervention	Relative (95% CI)	Absolute		
										0.32 higher)		
Vomiting FU (Better indicated by lower values)												
2	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious5	none	42	49	-	SMD 0.38 higher (0.05 lower to 0.81 higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	102	108	-	SMD 0.04 lower (0.31 lower to 0.24 higher)	LOW	IMPORTANT
Laxatives FU (Better indicated by lower values)												
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious5	none	30	25	-	SMD 0.59 higher (0.05 to 1.13 higher)	LOW	IMPORTANT
Anxiety FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious3	none	60	60	-	SMD 0.41 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group CBT (ED)	Other Intervention	Relative (95% CI)	Absolute		
										(0.78 to 0.05 lower)		
Symptom checklist FU (Better indicated by lower values)												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious2	none	60	60	-	SMD 0.14 lower (0.49 lower to 0.22 higher)	LOW	IMPORTANT
Remission_ITT FU												
2	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious11	none	7/56 (12.5 %)	14/70 (20%)	RR 0.70 (0.32 to 1.56)	60 fewer per 1000 (from 136 fewer to 112 more)	LOW	CRITICAL
Clinical impairment FU (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious2	none	37	37	-	SMD 2.29 lower (3.43 to 1.15 lower)	LOW	IMPORTANT

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[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 drop out 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)

Table 40: Full GRADE profile for group BT-ED versus wait list controls for adults with BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT(ED)	WLC	Relative (95% CI)	Absolute		
Bingeing frequency (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	15	11	-	SMD 0.15 Higher (0.63 lower to 0.93 Higher)	VERY LOW	CRITICAL
Vomiting (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT(ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	23	12	-	SMD 1.22 lower (1.99 to 0.45 lower)	LOW	IMPORTANT
EDI- Drive for thinnes (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	15	11	-	SMD 0.39 lower (1.17 lower to 0.4 Higher)	LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	15	11	-	SMD 0.2 Higher (0.58 lower to 0.98 Higher)	VERY LOW	IMPORTANT
EDI- Body Dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	15	11	-	SMD 0.73 lower (1.54 lower to 0.08 Higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT(ED)	WLC	Relative (95% CI)	Absolute		
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	23	12	-	SMD 1.37 lower (2.17 to 0.58 lower)	LOW	IMPORTANT
Did not achieve remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	8/30 (26.7%)	0/14 (0%)	RR 0.77 (0.6 to 0.99)	-	LOW	CRITICAL
Remission_ITT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Very serious6	none	7/30 (23.3%)	4/14 (28.6 %)	RR 1.07 (0.73 to 1.58)	20 more per 1000 (from 77 fewer to 166 more)	VERY LOW	CRITICAL

[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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1 **Table 41: Full GRADE profile for group BT-ED versus another intervention for adults with BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT (ED)	Other Group	Relative (95% CI)	Absolute		
Bingeing frequency (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	15	-	SMD 0.33 Higher (0.39 lower to 1.06 Higher)	LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious4	none	24	12	-	SMD 0.27 lower (0.97 lower to 0.43 Higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious5	none	23	12	-	SMD 0.16 Higher (0.54 lower to 0.86 Higher)	LOW	IMPORTANT
EDI- Drive for thinnes (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group BT (ED)**	**Other Group**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	15	-	SMD 0.25 Higher (0.47 lower to 0.97 Higher)	LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious5	none	15	15	-	SMD 0.51 Higher (0.22 lower to 1.24 Higher)	VERY LOW	IMPORTANT
EDI- Body Dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious5	none	15	15	-	SMD 0.08 lower (0.79 lower to 0.64 Higher)	VERY LOW	IMPORTANT
Did not achieve remission												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious6	none	8/30 (26.7 %)	1/30 (3.3%)	RR 0.76 (0.61 to 0.96)	8 fewer per 1000 (from 1 fewer to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT (ED)	Other Group	Relative (95% CI)	Absolute		
										13 fewer)		
Bingeing frequency FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	25	33	-	SMD 0.01 lower (0.53 lower to 0.52 Higher)	LOW	CRITICAL
Vomiting FU (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious4	none	24	12	-	SMD 0.38 lower (1.08 lower to 0.33 Higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
2	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.13 Higher (0.39 lower to 0.65 Higher)	LOW	IMPORTANT
EDI - Drive for thinnes FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Group BT (ED)**	**Other Group**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	15	-	SMD 0.24 Higher (0.48 lower to 0.96 Higher)	LOW	IMPORTANT
EDI - Bulimia FU (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	very serious5	none	15	15	-	SMD 0.02 Higher (0.69 lower to 0.74 Higher)	VERY LOW	IMPORTANT
EDI- Body Dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	15	-	SMD 0.35 Higher (0.37 lower to 1.07 Higher)	LOW	IMPORTANT
EDE- Shape concern FU (Better indicated by lower values)												
1	no methodology chosen					none	10	18	-	SMD 0 Higher (0.77 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT (ED)	Other Group	Relative (95% CI)	Absolute		
										0.77 Higher)		
EDE- Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	10	18	-	SMD 0.34 Higher (0.44 lower to 1.12 Higher)	LOW	IMPORTANT
EDE- Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious5	none	10	10	-	SMD 0 Higher (0.88 lower to 0.88 Higher)	VERY LOW	IMPORTANT
EDE- Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	very serious5	none	10	18	-	SMD 0 Higher (0.77 lower to 0.77 Higher)	VERY LOW	IMPORTANT
Remission_ITT FU												
2	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious7	none	14/40 (35%)	19/33 (57.6 %)	RR 0.85 (0.53	86 fewer per 1000 (from	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group BT (ED)	Other Group	Relative (95% CI)	Absolute		
									to 1.35)	271 fewer to 202 more)		

1 [1] Unclear methods of randomisation and allocation concealment. Neither the participants, investigators nor assessors were blinded.
2 [2] 95% CI crossed 1 MID (0.5)
3 [3] Unclear how randomisation was performed or if allocation concealment was conducted. It was unclear if either the participants, investigators or assessors
4 were blind. High dropouts >20% were reported in some groups.
5 [4] 95% CI crossed 1 MID (-0.5)
6 [5] 95% CI crossed 2 MIDs (0.5 and -0.5)
7 [6] 95% CI crossed 1 MID (0.75)
8 [7] 95% CI crossed 2 MIDs (0.75 and 1.25)

9 **Table 42: Full GRADE profile for group psychoeducation versus another intervention for adults with BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group pyschoeducation vs.Other	Control	Relative (95% CI)	Absolute		
Bingeing (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	25	-	SMD 0.2 Higher (0.33 lower to 0.74	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group pyschoeducation vs.Other	Control	Relative (95% CI)	Absolute		
										Higher)		
Vomiting (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	25	-	SMD 0.44 Higher (0.11 lower to 0.98 Higher)	LOW	IMPORTANT
Remission_ITT												
1	observational studies	Serious 1	no serious inconsistency	no serious indirectness	very serious3	none	6/35 (17.1%)	9/30 (30%)	RR 0.57 (0.23 to 1.42)	129 fewer per 1000 (from 231 fewer to 126 more)	VERY LOW	CRITICAL
EDI-Drive for thinness (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	25	-	SMD 0.62 Higher (0.08 to 1.17 Higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group pyschoeducation vs.Other	Control	Relative (95% CI)	Absolute		
EDI-Bulimia (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	25	-	SMD 0.5 Higher (0.05 lower to 1.04 Higher)	LOW	IMPORTANT
EDI-Body dissatisfaction (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	25	-	SMD 0.12 Higher (0.41 lower to 0.66 Higher)	LOW	IMPORTANT

[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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1 **Table 43: Full GRADE profile for group CBT (varied intensity and focus) versus another group CBT (control) for adults with BN**

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT (varied intensity and focus)**	**CBT (control low)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Binging episodes (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	109	34	-	SMD 0.37 lower (0.76 lower to 0.02 Higher)	LOW	CRITICAL
Laxative use (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	109	34	-	SMD 0.10 Higher (0.29 lower to 0.49 Higher)	LOW	IMPORTANT
Vomiting episodes (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	109	34	-	SMD 0.4 lower (0.79 to 0.01 lower)	LOW	IMPORTANT
EDI - Drive for thinness (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT (varied intensity and focus)**	**CBT (control low)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	109	34	-	SMD 0.49 lower (0.88 to 0.1 lower)	LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	109	34	-	SMD 0.85 lower (1.25 to 0.45 lower)	LOW	IMPORTANT
EDI - Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	109	34	-	SMD 0.03 lower (0.41 lower to 0.36 Higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	109	34	-	SMD 0.1 Higher (0.29 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN CBT (varied intensity and focus)**	**CBT (control low)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										0.48 Higher)		
Anxiety (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	109	34	-	SMD 0.11 Higher (0.27 lower to 0.5 Higher)	LOW	IMPORTANT
Did not achieve remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	73/109 (67%)	18.2%	RR 0.42 (0.3 to 0.57)	106 fewer per 1000 (from 78 fewer to 127 fewer)	LOW	CRITICAL

[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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1 **Table 44: Full GRADE profile for group emotional and mind training versus another intervention for adults with BN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group Emotional and MInd Training	Other	Relative (95% CI)	Absolute	Quality	Importance
EDE-Global (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	37	37	-	SMD 0.1 lower (0.59 lower to 0.39 Higher)	LOW	IMPORTANT
EDE-Global FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	37	37	-	SMD 0.1 Higher (0.05 to 0.15 Higher)	LOW	IMPORTANT
Clinical impairment (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 1.02 Higher (0.51 to 1.54 Higher)	LOW	CRITICAL
Clinical impairment FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Serious3	none	37	37	-	SMD 2.29 Higher (1.15 to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group Emotional and MInd Training	Other	Relative (95% CI)	Absolute		
										3.43 Higher)		

[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)

Table 45: Full GRADE profile for group support versus another intervention for adults with BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Group Support	Other	Relative (95% CI)	Absolute		
Change in depression scores (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	24	76	-	SMD 0.06 Higher (0.4 lower to 0.52 Higher)	**LOW**	IMPORTANT

[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)

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L.3.6 Group therapy for binge eating disorder

Table 46: Full GRADE profile for group mindfulness compared with another group for adults BED.

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Mindfulness	Other Group	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	53	50	-	SMD 0.07 Higher (0.32 lower to 0.45 Higher)	LOW	IMPORTANT
Binge eating days (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	53	50	-	SMD 0.06 lower (0.45 lower to 0.32 Higher)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	53	50	-	SMD 0.1 lower (0.49 lower to 0.29 Higher)	LOW	IMPORTANT
BMI FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Mindfulness	Other Group	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	53	50	-	SMD 0.12 Higher (0.26 lower to 0.51 Higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	53	50	-	SMD 0.06 lower (0.45 lower to 0.32 Higher)	LOW	IMPORTANT
Binge eating days FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	53	50	-	SMD 0.26 lower (0.64 lower to 0.13 Higher)	LOW	CRITICAL

[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)

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1 **Table 47: Full GRADE profile for group mindfulness versus wait list controls for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Mindfulness	Wait list control	Relative (95% CI)	Absolute		
Binge eating days (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	53	47	-	SMD 1.08 lower (1.5 to 0.66 lower)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	53	47	-	SMD 0.85 lower (1.26 to 0.44 lower)	LOW	IMPORTANT
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	53	47	-	SMD 0.19 Higher (0.2 lower to 0.59 Higher)	LOW	IMPORTANT
Binge eating scale (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	53	47	-	SMD 1.24 lower (1.67 to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Mindfulness	Wait list control	Relative (95% CI)	Absolute		
										0.81 lower)		
Binge eating days FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	53	47	-	SMD 1.02 lower (1.44 to 0.6 lower)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	53	47	-	SMD 0.44 lower (0.83 to 0.04 lower)	LOW	IMPORTANT
BMI FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	53	47	-	SMD 0.2 Higher (0.19 lower to 0.59 Higher)	LOW	IMPORTANT
Binge eating scale FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	53	47	-	SMD 1.39 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Mindfulness	Wait list control	Relative (95% CI)	Absolute		
										(1.83 to 0.95 lower)		

[1] [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] [2] For a continuous outcome, there were fewer than 400 participants.
[3] [3] 95% CI crossed 1 MID (-0.5)
[4] [4] 95% CI crossed 1 MID (0.5)

Table 48: Full GRADE profile for group CBT-ED compared with another intervention for adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute		
Weight (Better indicated by lower values)												
6	randomised trials	serious1	serious2	no serious indirectness	serious3	none	252	278	-	SMD 0.23 higher (0.03 lower to 0.49 higher)	VERY LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
9	randomised trials	serious 1	no serious inconsistency	no serious indirectness	no serious imprecision	none	384	411	-	SMD 0.13 lower	MODERATE	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute		
										(0.27 lower to 0.01 higher)		
Depression (Better indicated by lower values)												
7	randomised trials	serious 1	no serious inconsistency	no serious indirectness	no serious imprecision	none	279	309	-	SMD 0.03 higher (0.13 lower to 0.19 higher)	MODERATE	IMPORTANT
Anxiety (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	32	21	-	SMD 0.13 lower (0.69 lower to 0.42 higher)	LOW	IMPORTANT
EDE Global clinical score (Better indicated by lower values)												
2	randomised trials	serious 1	very serious6	no serious indirectness	very serious7	none	115	151	-	SMD 1.08 higher (0.79 to 1.37 higher)	VERY LOW	IMPORTANT
EDE- Shape concerns (Better indicated by lower values)												
3	randomised trials	serious 8	serious2	no serious indirectness	serious9	none	124	117	-	SMD 0.14 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										(0.4 lower to 0.11 higher)		
EDE-Dietary restraint (Better indicated by lower values)												
4	randomised trials	serious8	very serious6	no serious indirectness	serious9	none	194	190	-	SMD 0.02 higher (0.19 lower to 0.22 higher)	VERY LOW	IMPORTANT
EDE-Weight concern (Better indicated by lower values)												
4	randomised trials	serious8	serious2	no serious indirectness	serious9	none	194	190	-	SMD 0.19 lower (0.39 lower to 0.02 higher)	VERY LOW	IMPORTANT
EDE-Eating concern (Better indicated by lower values)												
4	randomised trials	serious8	very serious6	no serious indirectness	serious9	none	194	190	-	SMD 0.18 higher (0.03 lower to 0.38 higher)	VERY LOW	IMPORTANT
Global symptom score (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 10	no serious inconsistency	no serious indirectness	serious9	none	78	80	-	SMD 0.06 higher (0.25 lower to 0.37 higher)	LOW	IMPORTANT
Remission_ITT												
4	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious11	none	120/191 (62.8 %)	107/213 (50.2 %)	RR 1.22 (1.03 to 1.45)	111 more per 1000 (from 15 more to 226 more)	LOW	CRITICAL
Weight FU (Better indicated by lower values)												
6	randomised trials	serious 1	no serious inconsistency	no serious indirectness	no serious imprecision	none	243	271	-	SMD 0.09 higher (0.08 lower to 0.27 higher)	MODERATE	IMPORTANT
Bingeing FU (Better indicated by lower values)												
7	randomised trials	serious 1	no serious inconsistency	no serious indirectness	no serious imprecision	none	310	341	-	SMD 0.03 lower (0.19 lower	MODERATE	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute		
										to 0.12 higher)		
Depression FU (Better indicated by lower values)												
6	randomised trials	serious 1	no serious inconsistency	no serious indirectness	no serious imprecision	none	275	312	-	SMD 0.04 higher (0.13 lower to 0.2 higher)	MODERATE	IMPORTANT
Anxiety FU (Better indicated by lower values)												
2	randomised trials	serious 8	very serious6	no serious indirectness	serious5	none	93	92	-	SMD 0.86 higher (0.55 to 1.17 higher)	VERY LOW	IMPORTANT
EDE Global clinical score FU (Better indicated by lower values)												
3	randomised trials	serious 1	very serious6	no serious indirectness	serious3	none	115	151	-	SMD 1.01 higher (0.73 to 1.3 higher)	VERY LOW	IMPORTANT
EDE-Dietary restraint FU (Better indicated by lower values)												
4	randomised trials	serious 8	serious2	no serious indirectness	no serious imprecision	none	174	176	-	SMD 0.16 higher (0.05 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute		
										to 0.37 higher)		
EDE- Shape concerns FU (Better indicated by lower values)												
4	randomised trials	serious 8	very serious6	no serious indirectness	serious3	none	174	176	-	SMD 0.74 higher (0.5 to 0.98 higher)	VERY LOW	IMPORTANT
EDE-Weight concern FU (Better indicated by lower values)												
5	randomised trials	serious 8	very serious6	no serious indirectness	no serious imprecision	none	237	303	-	SMD 0.24 higher (0.05 to 0.43 higher)	VERY LOW	IMPORTANT
EDE-Eating concern FU (Better indicated by lower values)												
5	randomised trials	serious 8	very serious6	no serious indirectness	serious3	none	237	303	-	SMD 0.26 higher (0.08 to 0.45 higher)	VERY LOW	IMPORTANT
Global symptom index FU (Better indicated by lower values)												
1	randomised trials	serious 10	no serious inconsistency	no serious indirectness	serious9	none	67	71	-	SMD 0.13 higher (0.2 lower to 0.47 higher)	□□□□ LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
Remission FU_ITT												
3	randomised trials	serious 1	serious2	no serious indirectness	serious12	none	91/146 (62.3 %)	73/133 (54.9 %)	RR 1.25 (0.85 to 1.85)	137 more per 1000 (from 82 fewer to 467 more)	VERY LOW	CRITICAL

[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 drop outs 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)

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1 **Table 49: Full GRADE profile for CBT-ED versus wait list control for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Wait list control	Relative (95% CI)	Absolute		
Weight (BMI) (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious1	none	91	90	-	SMD 0.14 higher (0.15 lower to 0.43 higher)	LOW	IMPORTANT
Binge eating days (Better indicated by lower values)												
2	randomised trials	serious 2	very serious3	no serious indirectness	very serious4	none	72	69	-	SMD 0.36 lower (1.45 lower to 0.72 higher)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
3	randomised trials	serious 2	serious3	no serious indirectness	serious5	none	91	69	-	SMD 0.19 higher (0.5 lower to 0.11 higher)	VERY LOW	IMPORTANT
BMI-FU (Better indicated by lower values)												
2	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious1	none	63	67	-	SMD 0.12 higher (0.22 lower to 0.47 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group CBT (ED)	Wait list control	Relative (95% CI)	Absolute	Quality	Importance
Depression FU (Better indicated by lower values)												
2	randomised trials	serious 6	very serious3	no serious indirectness	very serious4	none	69	68	-	SMD 0.04 higher (1.06 lower to 1.15 higher)	VERY LOW	IMPORTANT
Binge eating days FU (Better indicated by lower values)												
2	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious5	none	63	67	-	SMD 0.62 lower (0.97 to 0.26 lower)	LOW	CRITICAL

[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 invesetigators and assessors were blinded. High drop outs were reported >20%.

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1 **Table 50: Full GRADE profile for group BT-ED versus wait list controls for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group BT(ED)**	**WLC**	**Relative (95% CI)**	**Absolute**		
Bingeing frequency (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	34	38	-	SMD 0.24 lower (0.7 lower to 0.23 Higher)	LOW	CRITICAL
EDE- Total (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	34	38	-	SMD 0.1 Higher (0.37 lower to 0.56 Higher)	LOW	IMPORTANT
Anxiety (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	34	38	-	SMD 0.03 lower (0.49 lower to 0.44 Higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	34	38	-	SMD 0.5 lower (0.97 to 0.03 lower)	LOW	IMPORTANT
Remission_ITT												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group BT(ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	10/50 (20%)	10/50 (20 %)	RR 1.00 (0.46 to 2.19)	0 fewer per 1000 (from 108 fewer to 238 more)	VERY LOW	CRITICAL

1 [1] It was unclear if allocation concealment was performed, Neither the participants, investigators or assessors were blind.
2 [2] 95% CI crossed 1 MID (-0.5)
3 [3] 95% CI crossed 1 MID (0.5)
4 [4] For a continuous outcome, there were fewer than 400 participants.
5 [5] 95% CI crossed 2 MIDs (0.75 and 1.25)

6 **Table 51: Full GRADE profile for group BT-ED versus another group for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group BT (ED)	Other Group	Relative (95% CI)	Absolute		
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.21 lower (0.61 lower to 0.19 Higher)	LOW	IMPORTANT
BMI (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group BT (ED)	Other Group	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.18 lower (0.58 lower to 0.22 Higher)	LOW	IMPORTANT
Weight loss (pounds) (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	50	48	-	SMD 0.18 Higher (0.22 lower to 0.57 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	32/50 (64%)	18/51 (35.3%)	RR 1.81 (1.18 to 2.78)	286 more per 1000 (from 64 more to 628 more)	LOW	CRITICAL
EDE-Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.54 lower (0.95 to 0.14 lower)	LOW	IMPORTANT
EDE-Dietary restraint (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group BT (ED)**	**Other Group**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.54 lower (0.94 to 0.14 lower)	LOW	IMPORTANT
EDE- Shape concerns (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.32 lower (0.72 lower to 0.07 Higher)	LOW	IMPORTANT
EDE-Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.38 lower (0.78 lower to 0.02 Higher)	LOW	IMPORTANT
BMI FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	49	39	-	SMD 0.14 lower (0.56 lower to 0.28 Higher)	LOW	IMPORTANT
Weight loss (pounds) FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group BT (ED)**	**Other Group**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	49	39	-	SMD 0.05 Higher (0.37 lower to 0.47 Higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	49	39	-	SMD 0.03 Higher (0.39 lower to 0.46 Higher)	LOW	IMPORTANT
EDE-Dietary restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	49	39	-	SMD 0.6 lower (1.03 to 0.17 lower)	LOW	IMPORTANT
EDE-Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	49	39	-	SMD 0.4 lower (0.82 lower to 0.03 Higher)	LOW	IMPORTANT
EDE- Shape concerns FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group BT (ED)**	**Other Group**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	49	39	-	SMD 0.12 lower (0.54 lower to 0.3 Higher)	LOW	IMPORTANT
EDE-Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	49	39	-	SMD 0.18 Higher (0.24 lower to 0.6 Higher)	LOW	IMPORTANT
Remission_ITT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	31/50 (62%)	22/51 (43.1%)	RR 1.44 (0.98 to 2.11)	190 more per 1000 (from 9 fewer to 479 more)	LOW	CRITICAL

[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)

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1 **Table 52: Full GRADE profile for group CBT-ED (body exposure) versus CBT-ED (cognitive) for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT (body exposure).	CBT (cognitive).	Relative (95% CI)	Absolute		
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0 higher (0.8 lower to 0.8 higher)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	12	-	SMD 0.41 lower (1.22 lower to 0.4 higher)	LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious4	none	12	12	-	SMD 0 higher (0.8 lower to 0.8 higher)	VERY LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.19 higher (0.62	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT (body exposure).	CBT (cognitive).	Relative (95% CI)	Absolute		
										lower to 0.99 higher)		
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	12	-	SMD 0.38 lower (1.19 lower to 0.43 higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.01 higher (0.79 lower to 0.81 higher)	VERY LOW	IMPORTANT
Bingeing episodes (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.27 lower (1.07 lower to 0.53 higher)	VERY LOW	CRITICAL
Remission_ITT												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT (body exposure).	CBT (cognitive).	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	4/14 (28.6%)	9/14 (64.3%)	RR 0.44 (0.18 to 1.11)	360 fewer per 1000 (from 527 fewer to 71 more)	LOW	CRITICAL
EDE- Restraint FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.08 lower (0.88 lower to 0.72 higher)	VERY LOW	IMPORTANT
EDE- Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0 higher (0.8 lower to 0.8 higher)	VERY LOW	IMPORTANT
EDE- Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.18 higher	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT (body exposure).	CBT (cognitive).	Relative (95% CI)	Absolute		
										(0.62 lower to 0.98 higher)	LOW	
EDE- Shape concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	12	12	-	SMD 0.45 higher (0.37 lower to 1.26 higher)	LOW	IMPORTANT
BMI FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.25 lower (1.05 lower to 0.56 higher)	VERY LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	12	12	-	SMD 0.2 higher (0.61 lower to 1 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED CBT (body exposure).	CBT (cognitive).	Relative (95% CI)	Absolute		
Bingeing episodes FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious7	none	12	12	-	SMD 0.43 higher (0.38 lower to 1.24 higher)	VERY LOW	CRITICAL
Remission_ITT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious7	none	6/14 (42.9%)	8/14 (57.1%)	RR 0.75 (0.35 to 1.6)	143 fewer per 1000 (from 371 fewer to 343 more)	VERY LOW	CRITICAL

[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 in Bulik assessors were blind. High drop outs 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 ! MID (-0.05).

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[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.

Table 53: Full GRADE profile for group interpersonal therapy versus another intervention for adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group IPT (ED)	Other	Relative (95% CI)	Absolute		
Bingeing (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	80	78	-	SMD 0.16 Higher (0.15 lower to 0.48 Higher)	LOW	CRITICAL
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	59/81 (72.8%)	64/81 (79%)	RR 0.92 (0.77 to 1.1)	63 fewer per 1000 (from 182 fewer to 79 more)	LOW	CRITICAL
Depression (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group IPT (ED)**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
2	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	98	96	-	SMD 0.22 lower (0.5 lower to 0.06 Higher)	LOW	IMPORTANT
EDE-Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	80	78	-	SMD 0.59 Higher (0.27 to 0.91 Higher)	LOW	IMPORTANT
EDE-Shape concern (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious2	none	80	78	-	SMD 0.08 Higher (0.23 lower to 0.39 Higher)	LOW	IMPORTANT
EDE-Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	80	78	-	SMD 0.12 Higher (0.19 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group IPT (ED)	Other	Relative (95% CI)	Absolute		
										0.44 Higher)		
EDE-Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	80	78	-	SMD 0.08 Higher (0.23 lower to 0.39 Higher)	LOW	IMPORTANT
Global symptom index (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	80	78	-	SMD 0.06 lower (0.37 lower to 0.25 Higher)	LOW	IMPORTANT
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	80	78	-	SMD 0.06 lower (0.37 lower to 0.26 Higher)	LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group IPT (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	67	-	SMD 0.14 lower (0.48 lower to 0.19 Higher)	LOW	CRITICAL
EDE-Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	71	67	-	SMD 0.25 Higher (0.09 lower to 0.58 Higher)	LOW	IMPORTANT
EDE-Shape concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	67	-	SMD 0 Higher (0.33 lower to 0.33 Higher)	LOW	IMPORTANT
EDE-Eating concernt FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	67	-	SMD 0 Higher (0.33 lower to 0.33 Higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group IPT (ED)**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
EDE-Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	67	-	SMD 0 Higher (0.33 lower to 0.33 Higher)	LOW	IMPORTANT
Global symptom index FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	67	-	SMD 0.13 lower (0.47 lower to 0.2 Higher)	LOW	IMPORTANT
Remission FU_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	50/81 (61.7%)	48/81 (59.3%)	RR 1.04 (0.81 to 1.34)	24 more per 1000 (from 113 fewer to 201 more)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	71	67	-	SMD 0.1 lower (0.43 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group IPT (ED)	Other	Relative (95% CI)	Absolute		
										0.24 Higher)		
BMI FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	71	67	-	SMD 0.17 lower (0.5 lower to 0.16 Higher)	LOW	IMPORTANT

[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)

Table 54: Full GRADE profile for group counselling versus another intervention for adults with BED at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Counselling	another intervention	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group Counselling**	**another intervention**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	39	49	-	SMD 0.14 Higher (0.28 lower to 0.56 Higher)	LOW	IMPORTANT
EDE - Dietary restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	48	50	-	SMD 0.54 Higher (0.14 to 0.94 Higher)	LOW	IMPORTANT
EDE- Shape concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	48	50	-	SMD 0.32 Higher (0.07 lower to 0.72 Higher)	LOW	IMPORTANT
EDE- Weight concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	48	50	-	SMD 0.38 Higher (0.02 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Counselling	another intervention	Relative (95% CI)	Absolute		
										to 0.78 Higher)		
EDE - Eating concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	48	50	-	SMD 0.54 Higher (0.14 to 0.95 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	Serious 4	none	17/51 (33.3%)	2/50 (4%)	RR 8.33 (2.03 to 34.21)	293 more per 1000 (from 41 more to 1000 more)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	48	50	-	SMD 0.21 Higher (0.19 lower to 0.61 Higher)	LOW	IMPORTANT
Weight loss (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Counselling	another intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	48	50	-	SMD 0.18 lower (0.57 lower to 0.22 Higher)	LOW	IMPORTANT
Patient's preference for treatment (Better indicated by Higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	48	50	-	SMD 0.37 lower (0.77 lower to 0.03 Higher)	LOW	IMPORTANT

[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

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1 **Table 55: Full GRADE profile for group counselling versus another intervention for adults with BED at follow-up.**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Counselling	another intervention FU	Relative (95% CI)	Absolute		
BMI FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	39	49	-	SMD 0.14 Higher (0.28 lower to 0.56 Higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	39	49	-	SMD 0.03 lower (0.46 lower to 0.39 Higher)	LOW	IMPORTANT
EDE - Dietary restraint FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	39	49	-	SMD 0.6 Higher (0.17 to 1.03 Higher)	LOW	IMPORTANT
EDE- Shape concerns FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	39	49	-	SMD 0.12 Higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Counselling	another intervention FU	Relative (95% CI)	Absolute		
										(0.3 lower to 0.54 Higher)		
EDE- Weight concerns FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	39	49	-	SMD 0.4 Higher (0.03 lower to 0.82 Higher)	LOW	IMPORTANT
EDE - Eating concerns FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	39	49	-	SMD 0.18 lower (0.6 lower to 0.24 Higher)	LOW	IMPORTANT
Remission_ITT FU												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	22/51 (43.1%)	31/50 (62%)	RR 0.70 (0.47 to 1.02)	186 fewer per 1000 (from 329 fewer	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Counselling	another intervention FU	Relative (95% CI)	Absolute		
										to 12 more)		
Weight loss FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	48	50	-	SMD 0.18 lower (0.57 lower to 0.22 Higher)	LOW	IMPORTANT

[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)

Table 56: Full GRADE profile for group diet counselling versus another group intervention for adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Diet	Other Group	Relative (95% CI)	Absolute		
Weight (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group Diet**	**Other Group**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	97	145	-	SMD 0.54 lower (0.81 to 0.28 lower)	□□□□ LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	96	145	-	SMD 0.24 higher (0.02 lower to 0.5 higher)	□□□□ LOW	CRITICAL
EDE- Shape concern (Better indicated by lower values)												
2	randomised trials	serious 1	serious4	no serious indirectness	serious3	none	39	46	-	SMD 0.26 higher (0.17 lower to 0.7 higher)	□□□□ VERY LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
2	randomised trials	serious 1	very serious5	no serious indirectness	serious3	none	39	46	-	SMD 0.19 higher (0.24 lower to	□□□□ VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Diet	Other Group	Relative (95% CI)	Absolute		
										0.63 higher)		
EDE-Eating concern (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency 4	no serious indirectness	serious3	none	39	46	-	SMD 0.26 higher (0.17 lower to 0.7 higher)	□□□□ LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
2	randomised trials	serious 1	serious4	no serious indirectness	serious3	none	39	46	-	SMD 0.14 higher (0.29 lower to 0.57 higher)	□□□□ VERY LOW	IMPORTANT
Depression (Better indicated by lower values)												
4	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	123	204	-	SMD 0.19 higher (0.03 lower to 0.42 higher)	□□□□ LOW	IMPORTANT
Global EDE (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group Diet**	**Other Group**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious3	none	45	80	-	SMD 0.17 higher (0.2 lower to 0.54 higher)	□□□□ LOW	IMPORTANT
Remission_ITT												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious8	none	31/97 (32%)	73/145 (50.3 %)	RR 0.64 (0.46 to 0.88)	181 fewer per 1000 (from 60 fewer to 272 fewer)	□□□□ LOW	CRITICAL
Weight FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	84	145	-	SMD 0.17 lower (0.44 lower to 0.1 higher)	□□□□ LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	96	145	-	SMD 0.21 higher (0.05 lower to	□□□□ LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Diet	Other Group	Relative (95% CI)	Absolute		
										0.47 higher)		
EDE- Shape concern FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	34	37	-	SMD 0.03 lower (0.5 lower to 0.44 higher)	□□□□ LOW	IMPORTANT
EDE- Weight concern FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	34	37	-	SMD 0.11 higher (0.36 lower to 0.59 higher)	□□□□ LOW	IMPORTANT
EDE-Eating concern FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	34	37	-	SMD 0.06 lower (0.53 lower to 0.41 higher)	□□□□ LOW	IMPORTANT
EDE- Restraint FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group Diet**	**Other Group**	**Relative (95% CI)**	**Absolute**		
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	34	37	-	SMD 0.16 lower (0.63 lower to 0.3 higher)	□□□□ LOW	IMPORTANT
Global EDE FU (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious3	none	45	80	-	SMD 0.17 higher (0.19 lower to 0.54 higher)	□□□□ LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	82	123	-	SMD 0.03 lower (0.32 lower to 0.25 higher)	□□□□ LOW	IMPORTANT
Remission-ITT FU												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious8	none	23/52 (44.2 %)	43/65 (66.2 %)	RR 0.67 (0.47 to 0.95)	218 fewer per 1000 (from 33 fewer to	□□□□ LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Diet	Other Group	Relative (95% CI)	Absolute		
										351 fewer)		
EDE- Shape concern < 18 binges per month (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious2	none	23	25	-	SMD 0.13 lower (0.69 lower to 0.44 higher)	□□□□ LOW	IMPORTANT
EDE- Shape concern > 18 binges per month (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious3	none	16	21	-	SMD 0.83 higher (0.15 to 1.51 higher)	□□□□ LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	23	25	-	SMD 0.29 lower (0.86 lower to 0.28 higher)	□□□□ LOW	IMPORTANT
EDE- Restraint > 18 binges per month (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency 4	no serious indirectness	serious3	none	16	21	-	SMD 0.90 higher	□□□□ LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Diet	Other Group	Relative (95% CI)	Absolute		
										(0.21 to 1.58 higher)		

[1] Across studies it was unclear in somehow randomisation was performed and in all studies if allocation concealment was performed. Across the studies, either it was unclear of 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)

Table 57: Full GRADE profile for group self-help (ED) versus another group for adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	80	154	-	SMD 0.19 lower (0.46 lower to 0.08 Higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.30 Higher (0.01 to 0.6 Higher)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	13	31	-	SMD 0.23 Higher (0.43 lower to 0.89 Higher)	LOW	IMPORTANT
EDE Q Global Scoare (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.33 Higher (0.03 to 0.62 Higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
EDE Q Restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.46 Higher (0.16 to 0.76 Higher)	LOW	IMPORTANT
EDE Q Eating Concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.31 Higher (0.01 to 0.6 Higher)	LOW	IMPORTANT
EDE Q Shape Concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.22 Higher (0.08 lower to 0.52 Higher)	LOW	IMPORTANT
EDE Q Weight Concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.27 Higher (0.03 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
										0.57 Higher)		
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	57	110	-	SMD 0.00 lower (0.32 lower to 0.32 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	9/16 (56.3%)	7/35 (20%)	RR 2.83 (1.29 to 6.23)	366 more per 1000 (from 58 more to 1000 more)	LOW	CRITICAL
BMI FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Serious3	none	79	152	-	SMD 0.08 lower (0.35 lower to 0.2 Higher)	LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	67	123	-	SMD 0.10 lower (0.4 lower to 0.19 Higher)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	13	31	-	SMD 0.23 Higher (0.43 lower to 0.89 Higher)	LOW	IMPORTANT
EDE Q Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.46 Higher (0.16 to 0.76 Higher)	LOW	IMPORTANT
EDE Q Eating Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.08 lower (0.38 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
										0.22 Higher)		
EDE Q Shape Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.07 Higher (0.23 lower to 0.37 Higher)	LOW	IMPORTANT
EDE Q Weight Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.07 Higher (0.23 lower to 0.37 Higher)	LOW	IMPORTANT
EDE Q Global Scoare FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.06 Higher (0.24 lower to 0.35 Higher)	LOW	IMPORTANT
Quality of life FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH(ED)	Other Group	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	57	110	-	SMD 0.02 Higher (0.3 lower to 0.34 Higher)	LOW	IMPORTANT
Remission_ITT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious7	none	3/16 (18.8%)	10/35 (28.6 %)	RR 0.67 (0.22 to 2.09)	94 fewer per 1000 (from 223 fewer to 311 more)	VERY LOW	CRITICAL

[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)

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1 **Table 58: Full GRADE profile for group guided self-help (ED) versus another group for adults with BED**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH(ED)	Other Group	Relative (95% CI)	Absolute	Quality	Importance
BMI (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	77	157	-	SMD 0.16 Higher (0.11 lower to 0.44 Higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	60	123	-	SMD 0.35 lower (0.66 to 0.04 lower)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	17	27	-	SMD 0.53 lower (1.15 lower to 0.09 Higher)	LOW	IMPORTANT
EDE Q Global Score (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH(ED)	Other Group	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	60	130	-	SMD 0.07 Higher (0.24 lower to 0.38 Higher)	LOW	IMPORTANT
EDE Q Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	60	130	-	SMD 0.22 lower (0.52 lower to 0.09 Higher)	LOW	IMPORTANT
EDE Q Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	60	130	-	SMD 0.08 lower (0.39 lower to 0.22 Higher)	LOW	IMPORTANT
EDE Q Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	60	130	-	SMD 0.26 Higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Group Guided SH(ED)**	**Other Group**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										(0.05 lower to 0.57 Higher)		
EDE Q Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	60	130	-	SMD 0.09 Higher (0.21 lower to 0.4 Higher)	LOW	IMPORTANT
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	56	120	-	SMD 0.01 Higher (0.31 lower to 0.32 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious5	none	4/19 (21.1%)	12/32 (37.5 %)	RR 0.57 (0.21 to 1.52)	161 fewer per 1000 (from 296 fewer to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH(ED)	Other Group	Relative (95% CI)	Absolute	Quality	Importance
										195 more)		
BMI FU (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	77	154	-	SMD 0.02 lower (0.29 lower to 0.26 Higher)	LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	67	123	-	SMD 0.23 Higher (0.02 lower to 0.48 Higher)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	17	24	-	SMD 0.49 lower (1.13 lower to 0.14 Higher)	LOW	IMPORTANT
EDE Q Global Score FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH(ED)	Other Group	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	60	130	-	SMD 0.40 lower (0.71 to 0.09 lower)	LOW	IMPORTANT
EDE Q Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	60	130	-	SMD 0.21 Higher (0.1 lower to 0.52 Higher)	LOW	IMPORTANT
EDE Q Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	60	130	-	SMD 0.29 Higher (0.02 lower to 0.6 Higher)	LOW	IMPORTANT
EDE Q Weight concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	123	-	SMD 0.07 Higher (0.23	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH(ED)	Other Group	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.37 Higher)		
EDE Q Shape concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	60	130	-	SMD 0.42 Higher (0.11 to 0.73 Higher)	LOW	IMPORTANT
Quality of life FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	56	111	-	SMD 0.01 Higher (0.31 lower to 0.33 Higher)	LOW	IMPORTANT
Remission_ITT FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	7/19 (36.8%)	6/32 (18.8%)	RR 1.97 (0.78 to 4.99)	182 more per 1000 (from 41 fewer to 748 more)	LOW	CRITICAL

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[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 MIDs (-0.5)
[4] 95% CI crossed 1 MIDs (0.5)
[5] 95% CI crossed 2 MIDs (0.75 and 1.25)
[6] 95% CI crossed 1 MIDs (1.25)

Table 59: Full GRADE profile for group self-help (ED) versus wait list controls for adults with BED

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	69	-	SMD 0.09 Higher (0.25 lower to 0.42 Higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	67	69	-	SMD 0.41 lower (0.75 lower to 0.07 Higher)	LOW	CRITICAL
EDE-Q Global Score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	69	-	SMD 0.00 Higher (0.34 lower to 0.34 Higher)	LOW	IMPORTANT
EDE-Q Restraint (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH (ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	69	-	SMD 0.08 Higher (0.26 lower to 0.42 Higher)	LOW	IMPORTANT
EDE-Q Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	69	-	SMD 0.09 Higher (0.25 lower to 0.42 Higher)	LOW	IMPORTANT
EDE-Q Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	69	-	SMD 0.00 Higher (0.34 lower to 0.34 Higher)	LOW	IMPORTANT
EDE-Q Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	67	69	-	SMD 0.00 Higher (0.34 lower to 0.34 Higher)	LOW	IMPORTANT
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	67	69	-	SMD 0.08 Higher (0.27 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group SH (ED)	WLC	Relative (95% CI)	Absolute		
										to 0.45 Higher)		

[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)

Table 60: Full GRADE profile for group guided self-help (ED) versus wait list controls for adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	60	69	-	SMD 0.26 Higher (0.09 lower to 0.61 Higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	60	69	-	SMD 0.83 lower (1.19 to	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
										0.47 lower)		
EDE-Q Global Score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	seriousᵌ	none	60	69	-	SMD 0.22 lower (0.57 lower to 0.13 Higher)	LOW	IMPORTANT
EDE-Q Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	seriousᵌ	none	60	69	-	SMD 0.34 lower (0.69 to 0.01 lower)	LOW	IMPORTANT
EDE-Q Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	seriousᵌ	none	60	69	-	SMD 0.18 lower (0.53 lower to 0.17 Higher)	LOW	IMPORTANT
EDE-Q Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	seriousᵎ	none	60	69	-	SMD 0.09 lower (0.43 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Guided SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
										0.26 Higher)		
EDE-Q Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	60	69	-	SMD 0.00 Higher (0.35 lower to 0.35 Higher)	LOW	IMPORTANT
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	60	69	-	SMD 0.09 Higher (0.28 lower to 0.47 Higher)	LOW	IMPORTANT

[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

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1 **Table 61: Full GRADE profile for group psychoeducation versus another group for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Psychoeducation	Other Group	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	77	157	-	SMD 0.02 Higher (0.25 lower to 0.29 Higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	63	127	-	SMD 0.05 Higher (0.25 lower to 0.35 Higher)	LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	14	30	-	SMD 0.48 Higher (0.17 lower to 1.13 Higher)	LOW	IMPORTANT
EDE-Q Global Score (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Psychoeducation	Other Group	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	126	127	-	SMD 0.45 lower (0.7 to 0.2 lower)	LOW	IMPORTANT
EDE-Q Restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.22 lower (0.52 lower to 0.09 Higher)	LOW	IMPORTANT
EDE-Q Eating Concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.22 lower (0.52 lower to 0.09 Higher)	LOW	IMPORTANT
EDE-Q Shape Concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.30 lower (0.6	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Psychoeducation	Other Group	Relative (95% CI)	Absolute		
										lower to 0.01 Higher)		
EDE-Q Weight Concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.55 lower (0.86 to 0.24 lower)	LOW	IMPORTANT
Did not Achieve Remission_ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	3/16 (18.8%)	13/35 (37.1%)	RR 1.32 (0.94 to 1.85)	119 more per 1000 (from 22 fewer to 316 more)	LOW	CRITICAL
Quality of life (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	63	113	-	SMD 0.01 lower (0.32 lower to 0.3	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Psychoeducation	Other Group	Relative (95% CI)	Absolute		
										Higher)		
BMI FU (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	87	156	-	SMD 0.06 Higher (0.21 lower to 0.33 Higher)	LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	63	127	-	SMD 0.03 Higher (0.27 lower to 0.34 Higher)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	12	29	-	SMD 1.01 lower (1.83 to 0.18 lower)	LOW	IMPORTANT
EDE-Q Global Score FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Psychoeducation	Other Group	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.37 lower (0.67 to 0.06 lower)	LOW	IMPORTANT
EDE-Q Restraint FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.29 lower (0.59 lower to 0.02 Higher)	LOW	IMPORTANT
EDE-Q Eating Concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	63	127	-	SMD 0.20 lower (0.51 lower to 0.1 Higher)	LOW	IMPORTANT
EDE-Q Shape Concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	63	127	-	SMD 0.37 lower (0.68	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Group Psychoeducation	Other Group	Relative (95% CI)	Absolute		
										to 0.07 lower)		
EDE-Q Weight Concern FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	63	127	-	SMD 0.51 lower (0.82 to 0.2 lower)	LOW	IMPORTANT
Quality of life FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	54	113	-	SMD 0.03 lower (0.35 lower to 0.3 Higher)	LOW	IMPORTANT
Did not Achieve Remission_ITT FU												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	3/16 (18.8%)	10/35 (28.6%)	RR 1.13 (0.83 to 1.55)	37 more per 1000 (from 49 fewer to 157 more)	LOW	CRITICAL

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[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)

L.3.7 Self-help for anorexia nervosa

Table 62: Full GRADE profile for internet guided self-help versus another intervention for adults with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Internet GSH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
EDI - Total (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	106	113	-	SMD 0.27 lower (0.53 lower to 0 Higher)	LOW	IMPORTANT
EDI- Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	106	113	-	SMD 0.17 lower (0.44 lower to 0.09 Higher)	LOW	IMPORTANT
EDI- Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	106	113	-	SMD 0.15 lower (0.42 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Internet GSH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										0.11 Higher)		
EDI- Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	106	113	-	SMD 0.24 lower (0.51 lower to 0.02 Higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	106	113	-	SMD 0.2 lower (0.46 lower to 0.07 Higher)	LOW	IMPORTANT
Global Clinical Score (PSR) (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	119	120	-	SMD 0.21 lower (0.47 lower to 0.04 Higher)	LOW	CRITICAL
Bulimic symptoms (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	106	120	-	SMD 0.26 lower (0.52	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Internet GSH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0 Higher)		
Morgan-Russell Menstrual Function (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	119	120	-	SMD 0.18 lower (0.44 lower to 0.07 Higher)	LOW	CRITICAL
General psychopathology (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	119	120	-	SMD 0.1 lower (0.35 lower to 0.15 Higher)	LOW	IMPORTANT
General psychopathology FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	92	116	-	SMD 0.07 lower (0.34 lower to 0.21 Higher)	LOW	CRITICAL
Morgan-Russell Menstrual Function FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	92	116	-	SMD 0.07 Higher (0.2 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Internet GSH (ED)	Other	Relative (95% CI)	Absolute		
										to 0.35 Higher)		
Bulimic symptoms FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	92	116	-	SMD 0.21 lower (0.48 lower to 0.07 Higher)	LOW	CRITICAL

[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.

L.3.84 Self-help for bulimia nervosa

Table 63: Full GRADE profile for guided self-help (ED) versus another intervention for adults with BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
Binge eating (Better indicated by lower values)												
6	randomised trials	serious1	serious2	serious3	no serious imprecision 4	none	189	199	-	SMD 0.18 lower (0.38	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										lower to 0.02 higher)		
Purging (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	serious6	serious7	none	41	39	-	SMD 0.34 higher (0.1 lower to 0.78 higher)	VERY LOW	CRITICAL
Excessive exercising (Better indicated by lower values)												
3	randomised trials	serious8	no serious inconsistency	serious6	serious4	none	86	101	-	SMD 0.02 higher (0.27 lower to 0.31 higher)	VERY LOW	IMPORTANT
Vomiting (Better indicated by lower values)												
5	randomised trials	serious1	no serious inconsistency	serious3	serious4	none	98	92	-	SMD 0.18 lower (0.4 lower to 0.05 higher)	VERY LOW	CRITICAL
Laxative use (Better indicated by lower values)												
5	randomised trials	serious1	no serious inconsistency	no serious indirectness 3	serious9	none	116	127	-	SMD 0.33 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										(0.58 to 0.07 lower)		
Bulimic Inventory Index (Better indicated by lower values)												
2	randomised trials	serious10	serious2	no serious indirectness	serious7	none	54	58	-	SMD 0.29 higher (0.09 lower to 0.67 higher)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
2	randomised trials	serious11	no serious inconsistency	serious6	serious4	none	72	73	-	SMD 0.02 higher (0.31 lower to 0.35 higher)	VERY LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
3	randomised trials	serious11	no serious inconsistency	serious6	serious4	none	95	97	-	SMD 0.00 lower (0.29 lower to 0.28 higher)	VERY LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
3	randomised trials	serious11	no serious inconsistency	serious6	serious4	none	95	97	-	SMD 0.12 lower	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										(0.41 lower to 0.16 higher)	Y LOW	
EDE- Restraint (Better indicated by lower values)												
3	randomised trials	serious11	no serious inconsistency	serious6	serious4	none	95	97	-	SMD 0.03 higher (0.25 lower to 0.32 higher)	VERY LOW	IMPORTANT
EDE-Global (Better indicated by lower values)												
3	randomised trials	serious11	serious2	serious6	serious4	none	85	74	-	SMD 0.10 lower (0.41 lower to 0.22 higher)	VERY LOW	IMPORTANT
EDI Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious9	none	30	25	-	SMD 0.62 lower (1.16 to 0.09 lower)	LOW	IMPORTANT
EDI Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious4	none	30	26	-	SMD 0.48 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										(1.01 lower to 0.06 higher)		
EDI Bulimia (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious9	none	30	26	-	SMD 0.71 lower (1.25 to 0.17 lower)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
5	randomised trials	serious13	serious2	serious3	serious4	none	142	138	-	SMD 0.25 higher (0.01 to 0.49 higher)	VERY LOW	IMPORTANT
Remission - Adults_ITT												
4	randomised trials	serious11	no serious inconsistency	serious3	very serious14	none	36/232 (15.5 %)	36/222 (16.2 %)	RR 1.01 (0.66 to 1.53)	2 more per 1000 (from 55 fewer to 86 more)	VERY LOW	CRITICAL
Bulimic Inventory Index FU (Better indicated by lower values)												
1	randomised trials	serious15	no serious inconsistency	no serious indirectness	serious14	none	23	24	-	SMD 0.77 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										(0.18 to 1.37 higher)		
Bingeing FU (Better indicated by lower values)												
4	randomised trials	serious16	serious3	no serious indirectness	serious4	none	126	144	-	SMD 0.04 higher (0.2 lower to 0.28 higher)	VERY LOW	CRITICAL
Purging FU (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	serious6	serious7	none	27	25	-	SMD 0.40 higher (0.15 lower to 0.95 higher)	VERY LOW	CRITICAL
Vomiting FU (Better indicated by lower values)												
3	randomised trials	serious16	serious6	serious6	serious9	none	47	48	-	SMD 0.25 lower (0.66 lower to 0.16 higher)	VERY LOW	CRITICAL
Excessive Exercising FU (Better indicated by lower values)												
2	randomised trials	serious17	no serious inconsistency	very serious6	serious4	none	72	87	-	SMD 0.02 lower	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										(0.33 lower to 0.3 higher)	Y LOW	
Laxative use FU (Better indicated by lower values)												
3	randomised trials	serious16	no serious inconsistency	serious6	serious9	none	98	118	-	SMD 0.29 lower (0.56 lower to 0.02 higher)	VERY LOW	CRITICAL
Depression FU (Better indicated by lower values)												
3	randomised trials	serious18	no serious inconsistency	serious3	serious9	none	75	79	-	SMD 0.19 lower (0.5 lower to 0.13 higher)	VERY LOW	IMPORTANT
EDE- Eating concern FU (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	serious6	serious4	none	27	25	-	SMD 0.25 higher (0.29 lower to 0.8 higher)	VERY LOW	IMPORTANT
EDE- Shape concern FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
2	randomised trials	serious19	no serious inconsistency	serious6	serious4	none	50	49	-	SMD 0.08 lower (0.48 lower to 0.32 higher)	VERY LOW	IMPORTANT
EDE- Weight concern FU (Better indicated by lower values)												
2	randomised trials	serious19	no serious inconsistency	serious6	serious4	none	50	49	-	SMD 0.09 higher (0.31 lower to 0.48 higher)	VERY LOW	IMPORTANT
EDE- Restraint FU (Better indicated by lower values)												
2	randomised trials	serious19	no serious inconsistency	serious6	serious4	none	50	49	-	SMD 0.04 higher (0.36 lower to 0.43 higher)	VERY LOW	IMPORTANT
Satisfaction with life FU (Better indicated by higher values)												
1	randomised trials	serious5	no serious inconsistency	serious6	serious9	none	27	25	-	SMD 0.08 lower (0.62 lower to 0.47 higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
EDI Body dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious7	none	25	30	-	SMD 0.1 higher (0.43 lower to 0.63 higher)	LOW	IMPORTANT
EDI Drive for thinness FU (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious7	none	25	30	-	SMD 0.23 higher (0.3 lower to 0.77 higher)	LOW	IMPORTANT
EDI Bulimia FU (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious9	none	25	30	-	SMD 0.23 lower (0.76 lower to 0.31 higher)	LOW	IMPORTANT
Remission FU - Adults												
4	randomised trials	serious11	no serious inconsistency	serious3	serious20	none	45/232 (19.4%)	50/222 (22.5%)	RR 0.85 (0.59 to 1.14)	34 fewer per 1000 (from 92	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										fewer to 32 more)		

1 *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*
2 *to treatment allocation, and in most studies it was unclear if the the assessors and investigators were blind. High drop out rates were reported across studies.*
3 *2 Heterogeneity was detected I2 >50%.*
4 *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.*
5 *4 For a continuous outcome, there were fewer than 400 participants.*
6 *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*
7 *reported >20%,*
8 *6 A mixed population of BN and EDNOS was used, however, the BN made up the higher number.*
9 *7 95% CI crossed 1 MID (0.5).*
10 *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,*
11 *assessors were blind in all studies but Schmidt. High drop outs were reported >20%.*
12 *9 95% CI crossed 1 MID (-0.5).*
13 *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 in Durand 2003,*
14 *but it was unclear in participants were blind. In Thiels it was unclear if any were blind. High drop outs were reported >20%,*
15 *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*
16 *were reported >20*
17 *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,*
18 *investigator or assessor was performed. High drop outs were detected >20%.*
19 *13 It was unclear in all studies except Theils 1998 (where it was not performed) if allocation concealment was performed. Across all studies it was unclear if patients were*
20 *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%.*
21 *14 95% CI crossed 2 MIDs (0.75 and 1.25)*
22 *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%.*
23 *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*
24 *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%.*
25 *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*
26 *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%.*
27 *18 It was unclear in Bailer and Mitchell if allocation concealment was conducted but it was no performed in Thiels 1988. It was unclear across all studies if the participants,*
28 *investigators or assessors were blind, except Mitchell 2008 the assessors were blind. High drop outs were reported >20%.*
29 *19 It was unclear in Mitchell if allocation concealment was conducted but it was no performed in Thiels 1988. It was unclear if the participants, investigators or assessors were*
30 *blind, except Mitchell 2008 the assessors were blind. High drop outs were reported >20%.*
31 *20 95% CI crossed 1 MID (0.75).*

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1 **Table 64: Full GRADE profile for guided self-help (ED) versus wait list controls for adults with bulimia nervosa**

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Guided SH (ED)**	**WLC**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Bingeing (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	55	56	-	SMD 0.46 lower (0.84 to 0.08 lower)	VERY LOW	CRITICAL
Vomiting (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	74	77	-	SMD 0.32 lower (0.64 lower to 0.01 higher)	LOW	CRITICAL
Use of laxatives (Better indicated by lower values)												
2	randomised trials	serious1	very serious4	no serious indirectness	serious3	none	74	77	-	SMD 0.55 lower (1.80 lower to 0.69 higher)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
3	randomised trials	serious1	serious2	no serious indirectness	serious3	none	109	111	-	SMD 0.53 lower (0.8 to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
										0.26 lower)		
Purging (Better indicated by lower values)												
2	randomised trials	serious1	very serious4	serious2	serious3	none	89	89	-	SMD 0.95 lower (1.27 to 0.63 lower)	VERY LOW	CRITICAL
EDI Drive for thinness (Better indicated by lower values)												
2	randomised trials	serious5	serious6	serious2	serious3	none	89	89	-	SMD 0.80 lower (1.1 to 0.49 lower)	VERY LOW	IMPORTANT
EDI Body dissatisfaction (Better indicated by lower values)												
2	randomised trials	serious5	no serious inconsistency	serious2	serious3	none	89	89	-	SMD 0.81 lower (1.12 to 0.51 lower)	VERY LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	serious2	serious3	none	35	34	-	SMD 0.15 lower (0.62 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
										0.32 higher)		
EDE- Weight concern (Better indicated by lower values)												
2	randomised trials	serious5	serious6	serious2	serious7	none	89	89	-	SMD 0.82 lower (1.13 to 0.51 lower)	VERY LOW	IMPORTANT
EDE-Restraint (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	serious2	serious3	none	35	34	-	SMD 0.31 lower (0.78 lower to 0.17 higher)	VERY LOW	CRITICAL
EDE - Eating concern (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	serious2	serious3	none	35	34	-	SMD 1.19 lower (1.71 to 0.68 lower)	VERY LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
2	randomised trials	serious5	serious6	serious2	serious3	none	89	89	-	SMD 0.70 lower (1.01 to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
										0.4 lower)		
EDE-Global (Better indicated by lower values)												
2	randomised trials	serious9	no serious inconsistency	serious2	serious3	none	89	89	-	SMD 1.31 lower (1.64 to 0.99 lower)	VERY LOW	IMPORTANT
Quality of life (Better indicated by higher values)												
2	randomised trials	serious5	no serious inconsistency	serious2	serious3	none	89	89	-	SMD 0.59 higher (0.29 to 0.89 higher)	VERY LOW	CRITICAL
Clinical Symptom Index (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	74	77	-	SMD 0.38 lower (0.71 to 0.06 lower)	LOW	CRITICAL
Did not achieve remission_ITT												
2	randomised trials	serious10	no serious inconsistency	serious11	serious12	none	21/112 (18.8%)	6/86 (7%)	RR 0.86 (0.77 to 0.96)	10 fewer per 1000 (from 3 fewer to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
										16 fewer)		
Remission FU_ITT												
1	randomised trials	serious13	no serious inconsistency	serious11	serious14	none	13/58 (22.4 %)	7/31 (22.6 %)	RR 0.99 (0.44 to 2.23)	2 fewer per 1000 (from 126 fewer to 278 more)	VERY LOW	CRITICAL
Purging (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious7	none	35	34	-	SMD 2.07 lower (2.66 to 1.47 lower)	VERY LOW	CRITICAL
Purging (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious7	none	54	34	-	SMD 0.49 lower (0.87 to 0.11 lower)	LOW	CRITICAL
EDE- Shape concern (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	serious2	serious7	none	35	34	-	SMD 1.05 lower (1.56 to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
										0.54 lower)		
EDE- Shape concern >18 binges month (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious3	none	54	55	-	SMD 0.51 lower (0.89 to 0.13 lower)	LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	serious2	serious7	none	35	34	-	SMD 1.29 lower (1.81 to 0.77 lower)	VERY LOW	IMPORTANT
EDE- Weight concern >18 binges month (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious3	none	54	55	-	SMD 0.56 lower (0.95 to 0.18 lower)	LOW	IMPORTANT

[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%.
[2] Ljotsson 2007 contained a mixture of BED (52%) and BN (48%)
[3] 95% CI crossed 1 MID (-0.5).
[4] Heterogeneity was detected I2 >80%.

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[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%.
[6] Heterogeneity was detected I2 >50%.
[7] For a continuous outcome, there were fewer than 400 participants.
[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%.
[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%.
[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%.
[11] Palmer 2002 contained a mixed population of EDNOS (20%) and BN (80%)
[12] For a dichotomous outcome, there were fewer than 300 events.
[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%.
[14] 95% CI crossed 1 MID (1.25).

Table 65: Full GRADE profile for self-help compared with another intervention for adults with BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help	Other	Relative (95% CI)	Absolute	Quality	Importance
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	28	-	SMD 0.52 lower (1.05 lower to 0.01 Higher)	LOW	IMPORTANT
EDE Global (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help	Other	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	17	-	SMD 0.82 lower (1.55 to 0.1 lower)	LOW	IMPORTANT
EDE Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	28	-	SMD 0.20 lower (0.73 lower to 0.32 Higher)	LOW	IMPORTANT
EDE Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	28	-	SMD 0.45 lower (0.98 lower to 0.08 Higher)	LOW	IMPORTANT
EDE Shape Concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	28	-	SMD 0.39 Higher (0.14 lower to 0.92 Higher)	LOW	IMPORTANT
EDE Weight Concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	28	-	SMD 0.47 lower (1 lower to 0.06 Higher)	LOW	IMPORTANT

[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 1 MID (-0.5)

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1 **Table 66: Full GRADE profile for self-help versus wait list control for adults with BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help	WLC	Relative (95% CI)	Absolute		
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	28	28	-	SMD 0.02 Higher (0.5 lower to 0.54 Higher)	VERY LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	28	28	-	SMD 0.07 lower (0.59 lower to 0.45 Higher)	LOW	IMPORTANT
EDE-Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	28	28	-	SMD 0.08 lower (0.6 lower to 0.44 Higher)	LOW	IMPORTANT
EDE-Weight concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Self-help**	**WLC**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	28	28	-	SMD 0.00 Higher (0.52 lower to 0.52 Higher)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	28	28	-	SMD 0.0 Higher (0.52 lower to 0.52 Higher)	VERY LOW	IMPORTANT
Did not achieve remission_ITT												
1	randomised trials	serious 4	no serious inconsistency	serious5	serious6	none	2/32 (6.3%)	0/31 (0%)	RR 0.94 (0.84 to 1.04)	-	VERY LOW	CRITICAL
Remission_ITT_FU												
1	randomised trials	serious 4	no serious inconsistency	serious5	very serious7	none	7/32 (21.9 %)	7/31 (22.6 %)	RR 0.97 (0.38 to 2.44)	7 fewer per 1000 (from 140 fewer to 325 more)	VERY LOW	CRITICAL

1 [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
2 reported >20%

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[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)

Table 67: Full GRADE profile for self-help (ED) versus any other intervention for people with BN

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Self-help (ED)**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Bingeing (Better indicated by lower values)												
3	randomised trials	serious1	serious2	serious3	very serious4	none	91	71	-	SMD 0.18 higher (0.52 lower to 0.88 higher)	VERY LOW	CRITICAL
Purging (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious6	none	35	35	-	SMD 0.49 higher (0.02 to 0.97 higher)	LOW	CRITICAL
Use of laxatives (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	serious3	serious8	none	16	17	-	SMD 0.10 higher (0.58	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	Other	Relative (95% CI)	Absolute		
										lower to 0.78 higher)		
Vomiting (Better indicated by lower values)												
2	randomised trials	serious1	very serious9	serious3	serious10	none	58	38	-	SMD 0.85 higher (0.41 to 1.29 higher)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious10	none	28	28	-	SMD 0.52 higher (0.01 lower to 1.05 higher)	LOW	CRITICAL
Exercising (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	serious3	very serious4	none	16	17	-	SMD 0.1 higher (0.58 lower to 0.79 higher)	VERY LOW	IMPORTANT
Remission_ITT												
2	randomised trials	serious12	no serious inconsistency	serious13	very serious14	none	11/87 (12.6 %)	12/86 (14%)	RR 0.74	36 fewer per 1000 (from 95	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	Other	Relative (95% CI)	Absolute		
									(0.32 to 1.7)	fewer to 98 more)		
EDE-Global (Better indicated by lower values)												
2	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious10	none	76	56	-	SMD 0.2 higher (0.15 lower to 0.55 higher)	LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
2	randomised trials	serious15	no serious inconsistency	no serious indirectness	serious10	none	69	49	-	SMD 0.23 higher (0.14 lower to 0.61 higher)	LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious10	none	28	28	-	SMD 0.45 higher (0.08 lower to 0.98 higher)	LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
2	randomised trials	serious15	no serious inconsistency	no serious indirectness	serious10	none	69	49	-	SMD 0.2 higher (0.18	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	Other	Relative (95% CI)	Absolute		
										lower to 0.57 higher)		
EDE- Restraint (Better indicated by lower values)												
2	randomised trials	serious15	very serious9	no serious indirectness	serious10	none	69	49	-	SMD 0.71 higher (0.32 to 1.1 higher)	VERY LOW	IMPORTANT
Purging FU (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious8	none	35	35	-	SMD 0 higher (0.47 lower to 0.47 higher)	LOW	CRITICAL
Bingeing FU (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	serious3	serious10	none	54	57	-	SMD 0.23 higher (0.14 lower to 0.61 higher)	VERY LOW	CRITICAL
Vomiting FU (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	serious3	very serious4	none	18	22	-	SMD 0.07 higher	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	Other	Relative (95% CI)	Absolute		
										(0.55 lower to 0.69 higher)		
Excessive exercising FU (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	serious3	very serious4	none	17	20	-	SMD 0.09 higher (0.55 lower to 0.74 higher)	VERY LOW	IMPORTANT
Use of laxatives FU (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	serious3	serious10	none	18	21	-	SMD 0.22 higher (0.41 lower to 0.85 higher)	VERY LOW	CRITICAL
EDE-Global FU (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious6	none	35	35	-	SMD 0.14 lower (0.61 lower to 0.33 higher)	LOW	IMPORTANT
Remission FU												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	Other	Relative (95% CI)	Absolute		
1	randomised trials	serious12	no serious inconsistency	serious13	very serious4	none	7/32 (21.9 %)	13/58 (22.4 %)	RR 0.98 (0.43 to 2.2)	4 fewer per 1000 (from 128 fewer to 269 more)	VERY LOW	CRITICAL

[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 drop outs were reported .>20%.
[2] Heterogeneity detected I2 >50%.
[3] Schmidt 2006 included a mixed population of BN and ENDOS
[4] 95% CI crossed 2 MIDs (-0.5 and 0.5).
[5] It was unclear if allocation concealment was performed. It was also unclear if participants, investigators and assessors were blind. High drop outs 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 drop outs were reported .>20%.
[8] For a continuous outcome there were fewer than 400 participants.
[9] Heterogeneity was detected I2>80%
[10] 95% CI crossed 1 MID (0.5).
[11] Allocation concealment was performed and assessors were blind. However, participants were not blind and it was unclear if investigators were. High drop outs were detected >20%.
[12] It was unclear if allocation concealment was performed. It was also unclear if either the participants, assessors or investigators were blind. High drop outs 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 drop outs were reported >20%.
[16] Allocation concealment was performed in Carter 2003. The participants were not blind but the assessors were. High drop outs 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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2 **Table 68: Full GRADE profile for internet self-help (ED) versus another intervention for people with BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	Other	Relative (95% CI)	Absolute		
Bingeing (Better indicated by lower values)												
2	randomised trials	serious 1	serious2	no serious indirectness	serious3	none	105	87	-	SMD 0.26 lower (0.55 lower to 0.03 higher)	VERY LOW	CRITICAL
Purging (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	35	35	-	SMD 0.49 lower (0.97 to 0.02 lower)	LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious5	none	70	52	-	SMD 0.14 higher (0.22 lower to 0.5 higher)	LOW	CRITICAL
EDE-Q (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BN Internet SH (ED)**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious7	none	35	35	-	SMD 0.36 lower (0.84 lower to 0.11 higher)	LOW	IMPORTANT
Laxative use (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	70	52	-	SMD 0.16 higher (0.2 lower to 0.52 higher)	LOW	CRITICAL
Excessive exercise (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious3	none	70	52	-	SMD 0.08 higher (0.28 lower to 0.44 higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious8	none	12/83 (14.5%)	11/72 (15.3%)	RR 0.95 (0.44 to 2.01)	8 fewer per 1000 (from 86 fewer to	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										154 more)		
Binging FU (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	105	87	-	SMD 0.21 lower (0.49 lower to 0.08 higher)	LOW	CRITICAL
Remission FU_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious8	none	21/83 (25.3%)	11/72 (15.3%)	RR 1.66 (0.86 to 3.2)	101 more per 1000 (from 21 fewer to 336 more)	VERY LOW	CRITICAL
EDE-Q FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious5	none	35	35	-	SMD 0.14 higher (0.33 lower to 0.61 higher)	LOW	IMPORTANT
Purging FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious3	none	35	35	-	SMD 0 higher (0.47	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.47 higher)		
Vomiting FU (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious3	none	70	52	-	SMD 0.04 lower (0.4 lower to 0.32 higher)	LOW	CRITICAL
Laxative use FU (Better indicated by lower values)												
1	randomised trials	Serious s4	no serious inconsistency	no serious indirectness	serious5	none	70	52	-	SMD 0.18 higher (0.18 lower to 0.54 higher)	LOW	CRITICAL
Excessive exercise FU (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious3	none	70	52	-	SMD 0.01 lower (0.37 lower to 0.35 higher)	LOW	IMPORTANT
Bingeing (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	Other	Relative (95% CI)	Absolute		
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious7	none	105	87	-	SMD 0.69 higher (1.17 to 0.2 lower)	LOW	CRITICAL
Bingeing >18 month (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious3	none	70	52	-	SMD 0.03 lower (0.3 lower to 0.33 higher)	LOW	CRITICAL

[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 drop outs 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 drop outs were reported >20%.
[7] 95% CI crossed 1 MID (-0.5)

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1 **Table 69: Full GRADE profile for internet self-help (ED) versus wait list controls for BN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
Bingeing (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	71	66	-	SMD 0.41 lower (0.75 to 0.07 lower)	VERY LOW	CRITICAL
Purging (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	71	66	-	SMD 0.37 lower (0.71 to 0.04 lower)	VERY LOW	CRITICAL
Vomiting (Better indicated by lower values)												
2	randomised trials	serious 1	very serious4	serious2	serious3	none	71	66	-	SMD 0.09 Higher (0.25 lower to 0.43 Higher)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious 5	no serious inconsistency	serious2	serious6	none	36	31	-	SMD 1.09 lower (1.6 to 0.57 lower)	VERY LOW	CRITICAL
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 5	no serious inconsistency	serious2	serious7	none	36	31	-	SMD 0.7 Higher	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
										(0.19 to 1.2 Higher)	VERY LOW	
Remission Not Achieved												
1	randomised trials	serious 5	no serious inconsistency	serious2	serious8	none	7/38 (18.4%)	1/38 (2.6 %)	RR 0.84 (0.71 to 0.98)	4 fewer per 1000 (from 1 fewer to 8 fewer)	VERY LOW	CRITICAL
EDE-Q (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	serious2	serious6	none	71	66	-	SMD 0.71 lower (1.05 to 0.36 lower)	VERY LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious 5	no serious inconsistency	serious2	serious6	none	36	31	-	SMD 0.88 lower (1.38 to 0.38 lower)	VERY LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
1	randomised trials	serious 5	no serious inconsistency	serious2	serious6	none	36	31	-	SMD 1.18 lower (1.7 to 0.66 lower)	VERY LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 5	no serious inconsistency	serious2	serious6	none	36	31	-	SMD 0.88 lower (1.38 to 0.38 lower)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
1	randomised trials	serious 5	no serious inconsistency	serious2	serious6	none	36	31	-	SMD 0.94 lower (1.45 to 0.43 lower)	VERY LOW	IMPORTANT

[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 ENDOS (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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1 **Table 70: Full GRADE profile for self-help (ED) versus wait list controls for adults with BN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
Bingeing (Better indicated by lower values)												
2	randomised trials	serious1	very serious2	no serious indirectness	serious3	none	76	54	-	SMD 1.23 lower (3.95 lower to 1.49 higher)	⨁◯◯◯ VERY LOW	CRITICAL
Purging (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	none	35	35	-	SMD 0.2 higher (0.27 lower to 0.67 higher)	⨁◯◯◯ LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious5,6	none	41	19	-	SMD 0.00 higher (0.54 lower to 0.54 higher)	⨁◯◯◯ VERY LOW	CRITICAL
EDE-Q (Better indicated by lower values)												
2	randomised trials	serious4	very serious2	no serious indirectness	very serious3	none	76	54	-	SMD 1.25 lower (3.41 lower to 0.92 higher)	⨁◯◯◯ VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
Depression (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious5	none	28	29	-	SMD 0.47 higher (0.06 lower to 1 higher)	⨁◯◯◯ LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious 8	no serious inconsistency	no serious indirectness	very serious9	none	9/55 (16.4%)	2/27 (7.4%)	RR 2.21 (0.51 to 9.52)	90 more per 1000 (from 36 fewer to 631 more)	⨁◯◯◯ VERY LOW	CRITICAL
EDE- Restraint (Better indicated by lower values)												
2	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious10	none	69	48	-	SMD 0.07 higher (0.31 lower to 0.44 higher)	⨁◯◯◯ LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
2	randomised trials	serious 8	no serious inconsistency	no serious indirectness	serious6	none	69	48	-	SMD 0.74 lower (1.18 to 0.29 lower)	⨁◯◯◯ LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Self-help (ED)	WLC	Relative (95% CI)	Absolute		
2	randomised trials	serious[8]	no serious inconsistency	no serious indirectness	serious[10]	none	69	48	-	SMD 0.55 lower (0.97 to 0.13 lower)	□□□□ LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
1	randomised trials	serious[7]	no serious inconsistency	no serious indirectness	serious[5]	none	28	29	-	SMD 0.42 higher (0.1 lower to 0.95 higher)	□□□□ LOW	IMPORTANT

[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 drop outs 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 drop outs 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 drop outs 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 71: Full GRADE profile for text messaging versus wait list controls for BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BN Text messaging	WLC	Relative (95% CI)	Absolute		
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	42/82 (51.2%)	30/83 (36.1 %)	RR 1.42 (0.99 to 2.02)	152 more per 1000 (from 4 fewer to 369 more)	VERY LOW	

[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)

L.3.97 Self-help for binge eating disorder

Table 72: Full GRADE profile for guided self-help (ED) versus another intervention for BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Guided SH (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
Bingeing (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Guided SH (ED)**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
7	randomised trials	serious 1	no serious inconsistency	no serious indirectness 2	no serious imprecision	none	251	239	-	SMD 0.28 lower (0.47 to 0.09 lower)	MODERATE	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious2	serious4	none	45	45	-	SMD 0.81 lower (1.24 to 0.38 lower)	VERY LOW	CRITICAL
Use of laxatives (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious2	serious4	none	45	45	-	SMD 0.21 higher (0.21 lower to 0.62 higher)	VERY LOW	CRITICAL
BMI (Better indicated by lower values)												
7	randomised trials	serious 1	no serious inconsistency	no serious indirectness	no serious imprecision	none	327	363	-	SMD 0.04 higher (0.11 lower to 0.2 higher)	MODERATE	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Guided SH (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
Depression (Better indicated by lower values)												
5	randomised trials	serious 5	no serious inconsistency	serious6	no serious imprecision	none	218	176	-	SMD 0.29 lower (0.5 to 0.08 lower)	LOW	IMPORTANT
Remission_ITT												
9	randomised trials	serious 7	serious8	no serious indirectness 6	serious9	none	151/351 (43%)	75/310 (24.2 %)	RR 1.76 (1.42 to 2.19)	184 more per 1000 (from 102 more to 288 more)	VERY LOW	CRITICAL
EDE-Global severity (Better indicated by lower values)												
4	randomised trials	serious 7	no serious inconsistency	serious2	serious10	none	159	230	-	SMD 0.14 lower (0.35 lower to 0.07 higher)	VERY LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
7	randomised trials	serious 7	serious8	serious2,6	serious4	none	359	381	-	SMD 0.27 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										(0.53 to 0.02 lower)		
EDE- Weight concern (Better indicated by lower values)												
7	randomised trials	serious 7	serious8	serious2,6	serious4	none	359	381	-	SMD 0.22 lower (0.52 lower to 0.08 higher)	VERY LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
7	randomised trials	serious 7	serious8	serious2,6	serious4	none	359	381	-	SMD 0.37 lower (0.6 to 0.13 lower)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
6	randomised trials	serious 7	very serious11	serious6	serious10	none	284	366	-	SMD 0.27 lower (0.43 to 0.11 lower)	VERY LOW	IMPORTANT
Excessive exercise (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious2	very serious4	none	45	45	-	SMD 0.28 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED)	Other	Relative (95% CI)	Absolute	Quality	Importance
										(0.7 lower to 0.13 higher)		
Satisfaction with life (Better indicated by lower values)												
2	randomised trials	serious 12	no serious inconsistency	no serious indirectness	no serious imprecision	none	110	174	-	SMD 0.12 higher (0.13 lower to 0.36 higher)	MODERATE	CRITICAL
Bingeing FU (Better indicated by lower values)												
4	randomised trials	serious 13	no serious inconsistency	no serious indirectness	serious10	none	111	189	-	SMD 0.09 higher (0.15 lower to 0.33 higher)	LOW	CRITICAL
BMI FU (Better indicated by lower values)												
4	randomised trials	serious 7	no serious inconsistency	serious6	serious10	none	164	245	-	SMD 0.02 higher (0.18 lower to 0.22 higher)	VERY LOW	CRITICAL
EDE- Weight concern FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Guided SH (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
3	randomised trials	serious 14	serious8	serious6	serious10	none	147	221	-	SMD 0.12 higher (0.31 lower to 0.56 higher)	VERY LOW	IMPORTANT
EDE- Restraint FU (Better indicated by lower values)												
3	randomised trials	serious 14	serious8	serious6	serious10	none	147	221	-	SMD 0.12 lower (0.52 lower to 0.27 higher)	VERY LOW	IMPORTANT
EDE- Shape concern FU (Better indicated by lower values)												
3	randomised trials	serious 14	serious8	serious6	serious10	none	147	221	-	SMD 0.00 higher (0.42 lower to 0.42 higher)	VERY LOW	IMPORTANT
EDE- Eating concern FU (Better indicated by lower values)												
3	randomised trials	serious 14	serious8	serious6	serious10	none	147	221	-	SMD 0.06 lower (0.47 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED)	Other	Relative (95% CI)	Absolute		
										to 0.36 higher)		
EDE-Q-Global score-FU (Better indicated by lower values)												
2	randomised trials	serious	no serious inconsistency	no serious indirectness	serious10	none	95	165	-	SMD 0.32 lower (0.58 to 0.06 lower)	LOW	IMPORTANT
Remission FU_ITT												
3	randomised trials	serious 7	no serious inconsistency	serious6	serious15	none	58/106 (54.7 %)	46/123 (37.4 %)	RR 1.40 (1.06 to 1.85)	150 more per 1000 (from 22 more to 318 more)	VERY LOW	CRITICAL
Quality of life FU (Better indicated by lower values)												
1	randomised trials	serious 16	no serious inconsistency	no serious indirectness	serious10	none	56	111	-	SMD 0.01 higher (0.31 lower to 0.33 higher)	LOW	CRITICAL
Depression FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Guided SH (ED)**	**Other**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
2	randomised trials	serious 13	no serious inconsistency	serious6	serious4	none	70	80	-	SMD 0.39 lower (0.71 to 0.06 lower)	VERY LOW	CRITICAL

[1] Across studies it was unclear if allocation concealment was conducted (or adequately). In Peterson 2001 neither the investigator or 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 bland. 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

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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%.

Table 73: Full GRADE profile for guided self-help (ED) versus wait list controls for adults with BED

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
Bingeing (Better indicated by lower values)												
3	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	94	124	-	SMD 0.85 lower (1.14 to 0.56 lower)	LOW	CRITICAL
BMI (Better indicated by lower values)												
2	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious4	none	94	94	-	SMD 0.17 higher (0.12 lower to 0.46 higher)	LOW	CRITICAL
EDE- Weight concern (Better indicated by lower values)												
2	randomised trials	serious 1	serious5	no serious indirectness	serious2	none	124	124	-	SMD 0.48 lower (1.04 lower to 0.08 higher)	VERY LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
2	randomised trials	serious 1	serious5	no serious indirectness	serious2	none	124	124	-	SMD 0.58 lower (1.16 lower to 0 higher)	VERY LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
2	randomised trials	serious 1	serious5	no serious indirectness	serious2	none	153	99	-	SMD 0.43 lower (0.96 lower to 0.11 higher)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
2	randomised trials	serious 1	very serious6	no serious indirectness	serious2	none	124	124	-	SMD 0.90 lower (1.83 lower to 0.03 higher)	VERY LOW	IMPORTANT
v												
2	randomised trials	serious 1	very serious6	no serious indirectness	serious2	none	124	124	-	SMD 0.71 lower (1.34 to 0.08 lower)	VERY LOW	IMPORTANT
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious8	none	56	53	-	SMD 0.09 higher	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
										(0.28 lower to 0.47 higher)		
Did not achieve Remission												
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious10	none	17/34 (50%)	2/25 (8 %)	RR 0.54 (0.38 to 0.78)	37 fewer per 1000 (from 18 fewer to 50 fewer)	LOW	CRITICAL

[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 unclear if participants were. In Carter, participants, assessors and investigators were not blind. High drop outs 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 drop outs 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 drop outs were detected >20%.
[8] 95% CI crossed 1 MID (0.5).
[9] Allocation concealment was conducted but neither the participants, investigators nor assessors were blind. It was unclear how many participants were randomised.
[10] For a dichotomous outcome, there were fewer than 300 participants.

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1 **Table 74: Full GRADE profile for self-help (ED) versus another intervention for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	Other	Relative (95% CI)	Absolute		
Bingeing (Better indicated by lower values)												
6	randomised trials	serious1	no serious inconsistency	no serious indirectness	no serious imprecision	none	204	271	-	SMD 0.25 Higher (0.06 to 0.43 Higher)	MODERATE	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	45	45	-	SMD 0.81 Higher (0.38 to 1.24 Higher)	LOW	CRITICAL
Use of laxatives (Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious4	none	45	45	-	SMD 0.21 lower (0.62 lower to 0.21 Higher)	LOW	CRITICAL
BMI (Better indicated by lower values)												
4	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	189	228	-	SMD 0.13 lower (0.33	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	Other	Relative (95% CI)	Absolute		
										lower to 0.06 Higher)		
Depression (Better indicated by lower values)												
4	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	111	125	-	SMD 0.07 Higher (0.19 lower to 0.33 Higher)	LOW	CRITICAL
Remission_ITT												
6	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	71/165 (43%)	89/180 (49.4 %)	RR 0.84 (0.68 to 1.04)	79 fewer per 1000 (from 158 fewer to 20 more)	LOW	CRITICAL
EDE- Restraint (Better indicated by lower values)												
4	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious3	none	167	222	-	SMD 0.39 Higher (0.19 to 60 Higher)	LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Self-help (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
4	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious5	none	167	222	-	SMD 0.24 Higher (0.04 to 0.44 Higher)	LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
4	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious3	none	167	222	-	SMD 0.30 Higher (0.1 to 0.51 Higher)	LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
4	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious3	none	167	222	-	SMD 0.34 Higher (0.14 to 0.55 Higher)	LOW	IMPORTANT
EDE- Global severity (Better indicated by lower values)												
5	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious3	none	191	246	-	SMD 0.30 Higher (0.11 to 0.5 Higher)	LOW	IMPORTANT
Excessive exercise (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Self-help (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	45	45	-	SMD 0.28 Higher (0.13 lower to 0.7 Higher)	LOW	CRITICAL
Satisfaction with life (Better indicated by lower values)												
2	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious5	none	111	173	-	SMD 0.11 higher (0.11 lower to 0.35 Higher)	LOW	CRITICAL
Bingeing FU (Better indicated by lower values)												
3	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious5	none	79	148	-	SMD 0.06 lower (0.34 lower to 0.21 Higher)	LOW	CRITICAL
BMI FU (Better indicated by lower values)												
3	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious5	none	114	182	-	SMD 0.10 lower (0.34 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	Other	Relative (95% CI)	Absolute		
										to 0.14 Higher)		
Depression FU (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious11	none	12	25	-	SMD 0.18 Higher (0.51 lower to 0.88 Higher)	LOW	CRITICAL
Remission FU_ITT												
2	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious6	none	21/59 (35.6 %)	27/59 (45.8 %)	RR 0.78 (0.5 to 1.2)	101 fewer per 1000 (from 229 fewer to 92 more)	LOW	CRITICAL
EDE- Restraint FU (Better indicated by lower values)												
2	randomised trials	serious13	no serious inconsistency	no serious indirectness	serious14	none	102	157	-	SMD 0.20 Higher (0.05 lower to 0.45 Higher)	LOW	IMPORTANT
EDE- Shape concern FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**BED Self-help (ED)**	**Other**	**Relative (95% CI)**	**Absolute**		
2	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious5	none	102	157	-	SMD 0.07 Higher (0.18 lower to 0.32 Higher)	LOW	IMPORTANT
EDE- Weight concern FU (Better indicated by lower values)												
2	randomised trials	serious12	serious15	no serious indirectness	serious5	none	102	157	-	SMD 0.04 Higher (0.22 lower to 0.29 Higher)	VERY LOW	IMPORTANT
EDE- Eating concern FU (Better indicated by lower values)												
2	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious5	none	102	157	-	SMD 0.01 Higher (0.24 lower to 0.27 Higher)	LOW	IMPORTANT
EDE-Q Global Score FU (Better indicated by lower values)												
2	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious5	none	102	158	-	SMD 0.08 Higher (0.17 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	Other	Relative (95% CI)	Absolute		
										to 0.33 Higher)		
Quality of life FU (Better indicated by lower values)												
1	randomised trials	serious[1,2]	no serious inconsistency	no serious indirectness	serious[5]	none	57	110	-	SMD 0.02 Higher (0.3 lower to 0.34 Higher)	LOW	CRITICAL

[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.

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[1] High dropouts were reported >20%.
[2] [11] 95% CI crossed 2 MIDs (-0.5 and 0.5)
[3] [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
[4] unclear if participants were blind. In Carter, participants, assessors and participants were not blind. High dropouts were reported >20%.
[5] [13] It was unclear if allocation concealment was conducted (except in Carter). In Peterson 2001, it was unclear if either the participants, investigator or
[6] assessors were blind. In Carter, participants, assessors and investigators were not blind.
[7] [14] For a dichotomous outcome, there were fewer than 300 events.
[8] [15] Heterogeneity was detected I2 >50%

[9] **Table 75: Full GRADE profile for self-help (ED) versus wait list controls for BED**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
Bingeing (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	102	94	-	SMD 0.40 lower (0.68 to 0.11 lower)	LOW	CRITICAL
BMI (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	102	103	-	SMD 0.01 Higher (0.27 lower to 0.28 Higher)	LOW	CRITICAL
Remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4,5	none	15/35 (42.9%)	2/25 (8%)	RR 5.36 (1.34 to 21.36)	349 more per 1000 (from 27 more to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	WLC	Relative (95% CI)	Absolute		
										1000 more)		
EDE- Restraint (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	102	94	-	SMD 0.05 lower (0.33 lower to 0.23 Higher)	LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
2	randomised trials	serious 1	Serious5	no serious indirectness	serious3	none	102	94	-	SMD 0.19 lower (0.47 lower to 0.09 Higher)	VERY LOW	IMPORTANT
EDE- Weight concern (Better indicated by lower values)												
2	randomised trials	serious 1	Serious5	no serious indirectness	serious3	none	102	94	-	SMD 0.14 lower (0.42 lower to 0.15 Higher)	VERY LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
2	randomised trials	serious 1	very serious6	no serious indirectness	serious3	none	102	94	-	SMD 0.25 lower (0.54 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Self-help (ED)	WLC	Relative (95% CI)	Absolute		
										0.04 Higher)		
EDE-Q- Global severity (Better indicated by lower values)												
2	randomised trials	serious 1	Serious5	no serious indirectness	serious3	none	102	94	-	SMD 0.20 lower (0.49 lower to 0.08 Higher)	VERY LOW	IMPORTANT
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	57	53	-	SMD 0.08 Higher (0.29 lower to 0.45 Higher)	LOW	CRITICAL

1 [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
2 unclear if participants were blind. In Carter, participants, assessors, investigators were not blind. High dropouts were reported >20%.
3 [2] 95% CI crossed 1 MID (-0.5)
4 [3] For a continuous outcome, there were fewer than 400 participants.
5 [4] For a dichotomous outcome, there were fewer than 300 events.
6 [5] Heterogeneity detected I2 >50%
7 6 Heterogeneity detected, I2 >80%

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1 **Table 76: Full GRADE profile for internet self-help (ED) compared with wait list controls for adults with BED**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
Bingeing - Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	59	59	-	SMD 0.03 lower (0.4 lower to 0.34 Higher)	LOW	CRITICAL
BMI - Adolescents (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious4	none	46	47	-	SMD 0.21 lower (0.62 lower to 0.2 Higher)	LOW	CRITICAL
BMI - Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	59	59	-	SMD 0.38 Higher (0.02 to 0.75 Higher)	LOW	CRITICAL
Depression - Adolescents (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious4	none	46	47	-	SMD 0.32 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
										(0.72 lower to 0.09 Higher)		
Depression - Adults (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.38 lower (0.84 lower to 0.08 Higher)	LOW	IMPORTANT
EDI Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.38 lower (0.84 lower to 0.08 Higher)	LOW	IMPORTANT
EDI Bulimia (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.85 lower (1.33 to 0.37 lower)	LOW	IMPORTANT
EDI Body dissatisfaction (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	37	37	-	SMD 0.01 Higher (0.44 lower to 0.47 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious7	none	13/37 (35.1%)	3/37 (8.1%)	RR 4.33 (1.35 to 13.96)	270 more per 1000 (from 28 more to 1000 more)	LOW	
EDE-Total (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.38 lower (0.84 lower to 0.08 Higher)	LOW	IMPORTANT
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	37	37	-	SMD 0.01 lower (0.47 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
										0.45 Higher)		
EDE- Shape concern (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.3 lower (0.76 lower to 0.15 Higher)	LOW	IMPORTANT
Global severity index (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious2	none	37	37	-	SMD 0.44 lower (0.9 lower to 0.02 Higher)	LOW	
Quality of life (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious2	none	37	37	-	SMD 0.01 lower (0.46 lower to 0.45 Higher)	LOW	CRITICAL
Bingeing FU - Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	52	57	-	SMD 0.05 Higher (0.33 lower to 0.42 Higher)	LOW	CRITICAL
BMI FU - Adolescents (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious4	none	46	47	-	SMD 0.27 lower (0.67 lower to 0.14 Higher)	LOW	CRITICAL
BMI FU - Adults (Better indicated by lower values)												
2	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	52	57	-	SMD 0.33 Higher (0.05 lower to 0.71 Higher)	LOW	CRITICAL
Depression FU - Adolescents (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	no serious indirectness	serious5	none	46	47	-	SMD 0.17 Higher (0.24 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute	Quality	Importance
										0.58 Higher)		
Depression FU - Adults (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.4 lower (0.86 lower to 0.06 Higher)	LOW	IMPORTANT
EDE- Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.08 Higher (0.37 lower to 0.54 Higher)	LOW	IMPORTANT
EDE- Shape concern FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.23 lower (0.69 lower to 0.23 Higher)	LOW	IMPORTANT
EDE-Total FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.3 lower (0.76 lower to 0.16 Higher)	LOW	IMPORTANT
EDI Drive for thinness FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.44 lower (0.9 lower to 0.02 Higher)	LOW	IMPORTANT
EDI Bulimia FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.32 lower (0.78 lower to 0.14 Higher)	LOW	IMPORTANT
EDI Body dissatisfaction FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious5	none	37	37	-	SMD 0.13 Higher (0.33 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet SH (ED)	WLC	Relative (95% CI)	Absolute		
										0.58 Higher)		
Global severity index- FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious4	none	37	37	-	SMD 0.33 lower (0.79 lower to 0.13 Higher)	LOW	CRITICAL
Quality of life-FU (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious5	none	37	37	-	SMD 0.12 Higher (0.33 lower to 0.58 Higher)	LOW	CRITICAL
Remission FU_ITT												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious8	none	16/37 (43.2%)	8/37 (21.6 %)	RR 2 (0.98 to 4.09)	216 more per 1000 (from 4 fewer to 668 more)	LOW	CRITICAL

[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 bind at baseline measurement it was unclear if participants or investigators were blind. High dropouts were reported >20%.

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[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)

Table 77: Full GRADE profile for guided self-help (ED) versus another guided self-help in adults with BED

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED) vs.Guided SH	Control	Relative (95% CI)	Absolute		
Bingeing (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	38	-	SMD 0.48 lower (0.94 to 0.02 lower)	LOW	CRITICAL
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	38	-	SMD 0.19 lower (0.64 lower to 0.27 Higher)	LOW	CRITICAL
Depression (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED) vs.Guided SH	Control	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	38	-	SMD 0.25 lower (0.71 lower to 0.2 Higher)	LOW	IMPORTANT
Remission_ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	22/37 (59.5%)	9/38 (23.7%)	RR 2.51 (1.34 to 4.71)	358 more per 1000 (from 81 more to 879 more)	LOW	CRITICAL
EDE- Restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	38	-	SMD 0.38 lower (0.84 lower to 0.08 Higher)	LOW	IMPORTANT
EDE- Shape concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	38	-	SMD 0.12 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Guided SH (ED) vs.Guided SH	Control	Relative (95% CI)	Absolute		
										(0.57 lower to 0.33 Higher)		
EDE- Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	37	38	-	SMD 0 Higher (0.45 lower to 0.45 Higher)	LOW	IMPORTANT
EDE- Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	37	38	-	SMD 0.44 lower (0.9 lower to 0.02 Higher)	LOW	IMPORTANT

[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.

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1 **Table 78: Full GRADE profile for internet versus another intervention for adults with BED**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BED Internet	Other	Relative (95% CI)	Absolute	Quality	Importance
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	22	22	-	SMD 0.22 Higher (0.38 lower to 0.81 Higher)	LOW	CRITICAL
Binge eating (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	22	22	-	SMD 0.45 Higher (0.15 lower to 1.05 Higher)	LOW	CRITICAL
BMI FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	15	13	-	SMD 0.16 Higher (0.58 lower to 0.9 Higher)	LOW	CRITICAL
Binge eating FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	13	-	SMD 0.39 Higher (0.36 lower to 1.15 Higher)	LOW	CRITICAL

2 [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
3 investigators were blind. High dropouts were detected >20%.

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[2] 95% CI crossed 1 MID (0.5)
[3] 95% CI crossed 2 MIDs (-0.5 and 0.5)

L.3.10 Self-help for any eating disorder

Table 79: Full GRADE profile for internet self-help versus wait list controls for any eating disorder

Quality assessment							No of patients		E
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED Internet SH	WLC	R (S
EDE-Q Total score (Better indicated by lower values)									
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	36	42	-
EDE-Restraint (Better indicated by lower values)									
2	randomised trials	serious[3]	serious[4]	no serious indirectness	serious[5]	none	139	151	-
EDE-Eating concern (Better indicated by lower values)									
2	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[5]	none	139	151	-
EDE-Weight concern (Better indicated by lower values)									
2	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[5]	none	139	151	-
EDE-Shape concern (Better indicated by lower values)									
2	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[5]	none	139	151	-
BMI (Better indicated by lower values)									

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Quality assessment							No of patients		E
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED Internet SH	WLC	R (9
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious5	none	103	109	-
Depression (Better indicated by lower values)									
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	36	42	-
Vomiting (Better indicated by lower values)									
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious5	none	103	109	-

[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 I2 >50%
[5] For a continuous variable, there were fewer than 400 participants.

Table 80: Full GRADE profile for guided self-help (ED) versus wait list controls for any eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
EDE-Q Total score (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.68 lower (1.13 to 0.23 lower)	LOW	IMPORTANT
EDE-Restraint (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.49 lower (0.93 to 0.05 lower)	LOW	IMPORTANT
EDE-Eating concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.6 lower (1.05 to 0.15 lower)	LOW	IMPORTANT
EDE-Shape concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.59 lower (1.03 to 0.14 lower)	LOW	IMPORTANT
EDE-Weight concern (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.6 lower (1.05 to 0.15 lower)	LOW	IMPORTANT
BMI (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	42	39	-	SMD 0.18 Higher (0.26 lower to 0.61 Higher)	LOW	CRITICAL
Binge eating (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.07 lower (0.5 lower to 0.37 Higher)	LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.12 lower (0.55 lower to 0.32 Higher)	LOW	CRITICAL
Laxative use (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	39	-	SMD 0.15 lower (0.59 lower to 0.29 Higher)	LOW	CRITICAL
Exercise frequency (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	42	39	-	SMD 0.02 Higher (0.42 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED Guided SH (ED)	WLC	Relative (95% CI)	Absolute		
										to 0.45 Higher)		

[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

L.3.115 Family therapy for people with anorexia nervosa

Table 81: Full GRADE profile for family therapy-ED and TAU versus TAU in young people with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	TAU	Relative (95% CI)	Absolute		
Remission (ITT) (assessed with: Morgan-Russell Good or Intermediate outcome)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	12/30 (40%)	5/30 (16.7%)	RR 2.4 (0.96 to 5.98)	233 more per 1000 (from 7 fewer to 830 more)	MODERATE	CRITICAL
BMI (raw) (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	TAU	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	30	30	-	SMD 0.1 higher (0.41 lower to 0.6 higher)	MODERATE	CRITICAL
#>=BMI 10th Percentile (age-sex corrected)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	16/30 (53.3%)	8/29 (27.6%)	RR 1.93 (0.98 to 3.81)	257 more per 1000 (from 6 fewer to 775 more)	MODERATE	CRITICAL
EDI Total (Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	30	29	-	SMD 0.03 higher (0.48 lower to 0.54 higher)	MODERATE	IMPORTANT
Global Functioning (measured with: Global Outcome Assessment Scale; Better indicated by lower values)												
1	randomised trials	no serious risk	no serious inconsistency	no serious indirectness	serious1	none	30	29	-	SMD 0.22 higher (0.29	MODERATE	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	TAU	Relative (95% CI)	Absolute		
		of bias								lower to 0.74 higher)		
Amenorrheic patients												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	11/30 (36.7%)	19/29 (65.5%)	RR 0.56 (0.33 to 0.96)	288 fewer per 1000 (from 26 fewer to 439 fewer)	MODERATE	IMPORTANT
Hospitalizations to EoT												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious2	none	10/30 (33.3%)	14/29 (48.3%)	RR 0.69 (0.37 to 1.3)	150 fewer per 1000 (from 304 fewer to 145 more)	LOW	IMPORTANT

1 1 CI crosses either 0.75 or 1.25 (Risk Ratio), or either -0.5 or -0.5 (SMD).
2 2 CI crosses both 0.75 and 1.25 (Risk Ratio).

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Table 82: Full GRADE profile for family therapy-ED versus any other type of family intervention in adults with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute	Quality	Importance
BMI (follow-up 36 months; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	22	25	-	SMD 0.43 lower (1.01 lower to 0.15 higher)	LOW	CRITICAL
SEED Anorexia Severity Scale (follow-up 36 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	10	15	-	SMD 0.2 higher (0.61 lower to 1 higher)	VERY LOW	CRITICAL
SEED Bulimia Severity Scale (follow-up 36 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	10	15	-	SMD 0.48 higher (0.34 lower to 1.29 higher)	LOW	CRITICAL
Carer Quality of Life (follow-up 36 months; measured with: GHQ-12 Short Form; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	40	-	SMD 0.08 higher (0.37 lower to 0.53 higher)	LOW	IMPORTANT
Carer Family Functioning (follow-up 36 months; measured with: Level of Expressed Emotion; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	33	33	-	SMD 0.13 higher (0.35 lower to 0.61 higher)	LOW	IMPORTANT
Carer Experience of Caregiving Inventory (ECI) Negative (follow-up 36 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	35	40	-	SMD 0.43 lower (0.89 lower to 0.03 higher)	LOW	IMPORTANT
Carer Experience of Caregiving Inventory (ECI) Positive (follow-up 36 months; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	35	40	-	SMD 0.53 lower (0.99 to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
										0.06 lower)		

1 1 Whitney 2012: Unclear whether baseline properties of two arms similar. No participant nor assessor blinding.
2 2 CI crosses either 0.5 or -0.5 (SMD).
3 3 CI crosses both 0.5 and -0.5 (SMD).

4 **Table 83: Full GRADE profile for family therapy-ED versus any other type of family intervention in adults with anorexia nervosa at**
5 **follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
BMI FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	21	23	-	SMD 0.41 higher (0.19 lower to 1 higher)	LOW	CRITICAL
SEED Anorexia Severity Scale FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	15	14	-	SMD 0.24 lower (0.97 lower to 0.49 higher)	LOW	CRITICAL
SEED Bulimia Severity Scale FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	15	14	-	SMD 0.12 higher (0.61 lower to 0.85 higher)	VERY LOW	CRITICAL
Carer Quality of Life FU (measured with: GHQ-12 Short Form; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	32	-	SMD 0.16 lower (0.63 lower to 0.32 higher)	LOW	IMPORTANT
Carer Family Functioning FU (measured with: Level of Expressed Emotion; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	29	-	SMD 0.11 lower (0.62	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
										lower to 0.41 higher)		
Carer Experience of Caregiving Inventory (ECI) Negative FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.38 lower (0.88 lower to 0.12 higher)	LOW	IMPORTANT
Carer Experience of Caregiving Inventory (ECI) Positive FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.23 lower (0.73 lower to 0.26 higher)	LOW	IMPORTANT

1 1 Whitney 2012: Unclear whether baseline properties of two arms similar. No participant nor assessor blinding.
2 2 CI crosses either 0.5 or -0.5 (SMD).
3 3 CI crosses both 0.5 and -0.5 (SMD).

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Table 84: Full GRADE profile for family therapy-ED versus any other type of family intervention in young people with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
% of Ideal Body Weight (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	12	13	-	SMD 0.62 lower (1.43 lower to 0.19 higher)	LOW	CRITICAL
EDI Bulimia (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	12	13	-	SMD 0.54 lower (1.34 lower to 0.26 higher)	LOW	IMPORTANT
EDI Drive for Thinness (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	12	13	-	SMD 0.13 lower (0.91 lower to 0.66 higher)	VERY LOW	IMPORTANT
EDI Body Dissatisfaction (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	12	13	-	SMD 0.2 lower (0.99 lower to 0.59 higher)	VERY LOW	IMPORTANT
General Psychopathology (measured with: BSI GSI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	12	13	-	SMD 0 higher (0.78 lower to 0.78 higher)	VERY LOW	IMPORTANT
Depression (measured with: CDI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	12	13	-	SMD 0.5 lower (1.3 lower to 0.3 higher)	LOW	IMPORTANT
Family Functioning (measured with: FAM-III; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	12	13	-	SMD 0.43 lower (1.23 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Any other type of family intervention	Relative (95% CI)	Absolute		
										to 0.37 higher)		

1 1 Geist 2000: Unclear randomization method, allocation concealment, no participant blinding, unclear assessor blinding.
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 CI crosses both 0.74 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

4 **Table 85: Full GRADE profile for general family and any individual therapy versus any nutritional intervention in adults with anorexia**
5 **nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	General Family Therapy	Any nutritional intervention	Relative (95% CI)	Absolute		
Weight (kg) (follow-up 12 months; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	15	15	-	SMD 0.13 lower (0.85 lower to 0.59 higher)	VERY LOW	CRITICAL
Regular Menstruation (follow-up 12 months)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	General Family Therapy	Any nutritional intervention	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	3/15 (20%)	3/15 (20%)	RR 1 (0.24 to 4.18)	0 fewer per 1000 (from 152 fewer to 636 more)	VERY LOW	IMPORTANT
Amenorrheic patients (follow-up 12 months)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	8/15 (53.3%)	10/15 (66.7%)	RR 0.8 (0.44 to 1.45)	133 fewer per 1000 (from 373 fewer to 300 more)	VERY LOW	IMPORTANT
Global Clinical Score (follow-up 12 months; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	15	15	-	SMD 1.95 higher (1.06 to 2.84 higher)	LOW	IMPORTANT

1 1 Hall 1987: Randomization method and allocation concealment unclear. Control arm dropout rate was 27%.
2 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
3 3 <400 participants.

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Table 86: Full GRADE profile for family therapy-ED versus general family therapy in young people with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	General Family Therapy	Relative (95% CI)	Absolute		
Remission (ITT) (follow-up 12 months; assessed with: % of patients achieving ≥ 95% IBW1)												
1	randomised trials	serious 2	no serious inconsistency	no serious indirectness	serious3	none	26/82 (31.7%)	20/82 (24.4%)	RR 1.3 (0.79 to 2.14)	73 more per 1000 (from 51 fewer to 278 more)	LOW	CRITICAL
% of Ideal Body Weight (follow-up 12 months; Better indicated by higher values)												
1	randomised trials	serious 2	no serious inconsistency	no serious indirectness	serious4	none	78	80	-	SMD 0.16 higher (0.15 lower to 0.47 higher)	LOW	CRITICAL
EDE Global (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 2	no serious inconsistency	no serious indirectness	serious3	none	78	80	-	SMD 0.26 lower (0.58 lower to 0.05 higher)	LOW	IMPORTANT
Yale-Brown-Cornell Eating Disorder Scale (follow-up 12 months; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	General Family Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious 2	no serious inconsistency	no serious indirectness	serious4	none	78	80	-	SMD 0.18 lower (0.49 lower to 0.13 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious 2	no serious inconsistency	no serious indirectness	serious4	none	78	80	-	SMD 0.09 higher (0.22 lower to 0.4 higher)	LOW	IMPORTANT
Quality of Life (follow-up 12 months; measured with: Quality of Life and Enjoyment Scale (Short-Form); Better indicated by higher values)												
1	randomised trials	serious 2	no serious inconsistency	no serious indirectness	serious4	none	78	80	-	SMD 0.15 lower (0.46 lower to 0.16 higher)	LOW	IMPORTANT

1 1 Combines data for 'full remission' and 'partial remission'.
2 2 Agras 2014: dropout rate for both arms>20% (Family Therapy 26%, Systematic Family Therapy 25%).
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 4 <400 participants.

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1 **Table 87: Full GRADE profile for family therapy-ED versus general family therapy in young people with anorexia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	General Family Therapy	Relative (95% CI)	Absolute		
Remission FU (ITT) (assessed with: % of patients achieving ≥ 95% IBW)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	32/82 (39%)	31/82 (37.8%)	RR 1.03 (0.7 to 1.52)	11 more per 1000 (from 113 fewer to 197 more)	VERY LOW	CRITICAL
% of Ideal Body Weight FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	78	80	-	SMD 0.16 higher (0.15 lower to 0.47 higher)	LOW	CRITICAL
EDE Global FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious	none	78	80	-	SMD 0.26 lower (0.58 lower to 0.05 higher)	LOW	IMPORTANT
Yale-Brown-Cornell Eating Disorder Scale FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	General Family Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	78	80	-	SMD 0.18 lower (0.49 lower to 0.13 higher)	LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	78	80	-	SMD 0.09 higher (0.22 lower to 0.4 higher)	LOW	IMPORTANT
Quality of Life FU (measured with: Quality of Life and Enjoyment Scale (Short-Form); Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	78	80	-	SMD 0.15 lower (0.46 lower to 0.16 higher)	LOW	IMPORTANT

1 1 Agras 2014: dropout rate for both arms>20% (Family Therapy 26%, Systematic Family Therapy 25%).
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 <400 participants.

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Table 88: Full GRADE profile for multi-family therapy-ED versus family therapy-ED in young people with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute	Quality	Importance
Remission (ITT) (follow-up 6 months)												
1	randomised trials	no serious risk of bias	no serious inconsistency	serious1	serious2	none	65/85 (76.5%)	48/82 (58.5%)	RR 1.31 (1.05 to 1.62)	181 more per 1000 (from 29 more to 363 more)	LOW	CRITICAL
BMI - Change Scores (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.39 higher (0.09 to 0.7 higher)	LOW	CRITICAL
%mBMI - Change Scores (follow-up 6 weeks; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.45 higher (0.14 to 0.75 higher)	LOW	CRITICAL
EDE Restraint - Change scores (follow-up 6 weeks; Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.38 higher	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute		
										(0.08 to 0.69 higher)	VERY LOW	
EDE Eating Concerns - Change scores (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	serious1	serious4	none	85	82	-	SMD 0.12 higher (0.18 lower to 0.43 higher)	VERY LOW	IMPORTANT
EDE Shape Concerns - Change scores (follow-up 6 weeks; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.42 higher (0.11 to 0.72 higher)	VERY LOW	IMPORTANT
EDE Weight Concerns - Change scores (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.35 higher (0.04 to 0.65 higher)	VERY LOW	IMPORTANT
Depression - Change scores (follow-up 6 weeks; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious 3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.28 higher (0.02 lower to 0.59 higher)	VERY LOW	IMPORTANT
Carer - Experience of Caregiving - Positive - Change scores (follow-up 6 months; Better indicated by higher values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious4	none	85	82	-	SMD 0.15 higher (0.16 lower to 0.45 higher)	VERY LOW	IMPORTANT
Carer - Experience of Caregiving - Negative - Change scores (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious4	none	85	82	-	SMD 0.09 lower (0.39 lower to 0.22 higher)	VERY LOW	IMPORTANT
Service user experience - young person (follow-up 6 months; assessed with: Client Satisfaction Questionnaire score 27-32)												
1	randomised trials	serious 3	no serious inconsistency	serious1	very serious5	none	13/42 (31%)	13/37 (35.1%)	RR 0.88 (0.47 to 1.65)	42 fewer per 1000 (from 186 fewer to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute		
										228 more)		
Service user experience - carer (follow-up 6 months; assessed with: Client Satisfaction Questionnaire score 27-32)												
1	randomised trials	serious	no serious inconsistency	serious1	very serious5	none	29/49 (59.2%)	27/47 (57.4%)	RR 1.03 (0.73 to 1.45)	17 more per 1000 (from 155 fewer to 259 more)	VERY LOW	IMPORTANT

1 1 Sample consists of 120 AN and 40 Restricting EDNOS participants.
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 Eisler 2016: no participant nor investigator blinding.
4 4 <400 participants (continuous outcome).
5 5 CI crosses both 0.75 and 1.25 (Risk Ratio).

6
7

8 **Table 89: Full GRADE profile for multi-family therapy-ED versus family therapy-ED in young people with anorexia nervosa at follow**
9 **up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute		
Remission FU (ITT)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	serious1	serious2	none	66/85 (77.6%)	47/82 (57.3%)	RR 1.35 (1.09 to 1.69)	201 more per 1000 (from 52 more to 395 more)	LOW	CRITICAL
BMI FU - Change Scores (Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.67 higher (0.35 to 0.98 higher)	LOW	CRITICAL
%mBMI FU - Change Scores (Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.4 higher (0.09 to 0.71 higher)	LOW	CRITICAL
EDE Restraint FU - Change scores (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.37 higher (0.06 to 0.67 higher)	VERY LOW	IMPORTANT
EDE Eating Concerns FU - Change scores (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multi-Family Therapy	Family Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious 3	no serious inconsistency	very serious1	serious4	none	85	82	-	SMD 0.17 higher (0.13 lower to 0.48 higher)	VERY LOW	IMPORTANT
EDE Shape Concerns FU - Change scores (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.42 higher (0.12 to 0.73 higher)	VERY LOW	IMPORTANT
EDE Weight Concerns FU - Change scores (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious2	none	85	82	-	SMD 0.35 higher (0.05 to 0.66 higher)	VERY LOW	IMPORTANT
Depression FU - Change scores (Better indicated by lower values)												
1	randomised trials	serious 3	no serious inconsistency	serious1	serious4	none	85	82	-	SMD 0.2 higher (0.11 lower to 0.5 higher)	VERY LOW	IMPORTANT

1 1 Sample consists of 120 AN and 40 Restricting EDNOS participants.

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1 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
2 3 Eisler 2016: no participant nor investigator blinding.
3 4 <400 participants (continuous outcome).

4 **Table 90: Family therapy-ED versus any individual therapy at end of treatment in young people with anorexia nervosa**
5

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Individual Therapy	Relative (95% CI)	Absolute	Quality	Importance
Remission (ITT) (follow-up 5 years; assessed with: See footnote.1)												
3	randomised trials	serious2,3,4	serious5	no serious indirectness	serious6	none	65/90 (72.2%)	45/89 (50.6%)	RR 1.45 (0.82 to 2.59)	228 more per 1000 (from 91 fewer to 804 more)	VERY LOW	CRITICAL
BMI or Weight (follow-up 5 years; Better indicated by higher values)												
3	randomised trials	serious2,3,4	no serious inconsistency	no serious indirectness	serious6	none	80	80	-	SMD 0.51 higher (0.19 to 0.82 higher)	LOW	CRITICAL
Morgan-Russell Average Score (follow-up 5 years; range of scores: 0-12; Better indicated by higher values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious7	none	10	11	-	SMD 1.92 higher (0.85	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Individual Therapy	Relative (95% CI)	Absolute	Quality	Importance
										to 2.99 higher)		
EDE Global (follow-up 12 months; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious6	none	51	52	-	SMD 0.45 lower (0.84 to 0.05 lower)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: Beck Depression Inventory; range of scores: 0-63; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious6	none	19	16	-	SMD 0.35 higher (0.32 lower to 1.02 higher)	LOW	IMPORTANT
Carer Family Functioning - Conflict (follow-up 12 months; measured with: PARQ Mother + Father; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious6	none	36	29	-	SMD 0.04 lower (0.53 lower to 0.44 higher)	LOW	IMPORTANT
Carer Family Functioning - Communication (measured with: McMaster Family Assessment Device; range of scores: 1-4; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Individual Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious6	none	39	45	-	SMD 0.48 lower (0.92 to 0.05 lower)	LOW	IMPORTANT
Carer Family Functioning - Behaviour Control (measured with: McMaster Family Assessment Device; range of scores: 1-4; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious6	none	39	45	-	SMD 0.59 lower (1.03 to 0.16 lower)	LOW	IMPORTANT

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 adolescent 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.

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1 **Table 91: Full GRADE profile for family therapy-ED versus any individual therapy at follow up in young people with anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Individual Therapy	Relative (95% CI)	Absolute		
Remission FU (ITT) (follow-up 5 years; assessed with: See footnote.)												
3	randomised trials	serious1,2,3,4	no serious inconsistency	no serious indirectness	serious5	none	56/90 (62.2%)	55/89 (61.8%)	RR 1.01 (0.8 to 1.27)	6 more per 1000 (from 124 fewer to 167 more)	LOW	CRITICAL
BMI or Weight FU (follow-up 5 years; Better indicated by higher values)												
3	randomised trials	serious2,3,4	no serious inconsistency	no serious indirectness	serious5	none	73	77	-	SMD 0.24 higher (0.08 lower to 0.56 higher)	LOW	CRITICAL
EDE Global FU (follow-up 12 months; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	44	49	-	SMD 0.23 lower (0.63 lower to 0.18 higher)	LOW	IMPORTANT
Depression FU (follow-up 12 months; measured with: Beck Depression Inventory; range of scores: 0-63; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Individual Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious5	none	19	16	-	SMD 0.87 higher (0.17 to 1.57 higher)	LOW	IMPORTANT
Carer Family Functioning FU (follow-up 12 months; measured with: PARQ Mother +Father; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious5	none	36	29	-	SMD 0.03 higher (0.46 lower to 0.52 higher)	LOW	IMPORTANT

1 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
2 remission Ps and/or all Ps achieving 95% or greater IBW though who have elevated EDE scores (similar to Morgan-Russell intermediate outcome). Robin
3 1999: Morgan-Russell Good or Intermediate outcome (data from Eisler, I. (2005). The empirical and theoretical base of family therapy and multiple family
4 day therapy for adolescent anorexia nervosa. Journal of Family Therapy, 27, 104-131). Russell 1987: Morgan-Russell Good or Intermediate outcomes.
5 2 Lock 2010: No participant blinding.
6 3 Robin 1999: inadequate randomization method, unclear allocation concealment, participant and assessor blinding, dropout data not provided.
7 4 Russell 1987/Eisler 1997: Unclear randomization method, allocation method, participant blinding, dropout rate both arms>20% (Family Therapy 40%,
8 Individual Therapy 64%).
9 5 CI crosses 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 92: Full GRADE profile for family therapy-ED versus any individual therapy in adults with anorexia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Individual Therapy	Relative (95% CI)	Absolute		
All-cause Mortality												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	22/22 (100%)	61/62 (98.4%)	RR 1.01 (0.9 to 1.13)	10 more per 1000 (from 98 fewer to 128 more)	LOW	IMPORTANT
Recovered												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	19/22 (86.4%)	56/62 (90.3%)	RR 0.94 (0.78 to 1.14)	54 fewer per 1000 (from 199 fewer to 126 more)	LOW	CRITICAL

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.

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Table 93: Full GRADE profile for family therapy-ED 1 versus family therapy-ED 2 in young people with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
Full Remission (ITT) (follow-up 12 months; assessed with: Morgan-Russell Good outcome; >=95% mBMI and EDE global <= 1.59)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious3	none	17/74 (23%)	32/72 (44.4%)	RR 0.52 (0.32 to 0.85)	213 fewer per 1000 (from 67 fewer to 302 fewer)	LOW	CRITICAL
BMI (follow-up 12 months; Better indicated by higher values)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious3	none	74	72	-	SMD 0.34 lower (0.67 to 0.02 lower)	LOW	CRITICAL
% of Average Body Weight (change scores) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	21	-	SMD 0.42 lower (1.05 lower to 0.21 higher)	LOW	CRITICAL
Morgan-Russell Outcome-Average (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	21	-	SMD 0.29 higher (0.34 lower to 0.91 higher)	LOW	IMPORTANT
EDE Global (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	55	51	-	SMD 0.23 higher (0.16 lower to 0.61 higher)	LOW	IMPORTANT
EDE Restraint (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	55	51	-	SMD 0.21 higher (0.17 lower to 0.59 higher)	LOW	IMPORTANT
EDE Eating Concerns (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	55	51	-	SMD 0.13 higher (0.26 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
										0.51 higher)		
EDE Weight Concerns (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	55	51	-	SMD 0.26 higher (0.12 lower to 0.64 higher)	LOW	IMPORTANT
EDE Shape Concerns (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	55	51	-	SMD 0.25 higher (0.13 lower to 0.63 higher)	LOW	IMPORTANT
Hospitalized during treatment												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious3	none	13/55 (23.6%)	6/51 (11.8%)	RR 2.01 (0.83 to 4.89)	119 more per 1000 (from 20 fewer to 458 more)	LOW	IMPORTANT
Depression (measured with: Scale analogous to Morgan-Russell; CDI; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious4	none	74	72	-	SMD 0.12 lower (0.44 lower to 0.21 higher)	LOW	IMPORTANT

1 1 Eisler 2000: unclear randomization method, allocation concealment, participant blinding.
2 2 Le Grange 2016: no participant nor investigator blinding.
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 4 <400 participants.

5 **Table 94: Full GRADE profile for family therapy-ED 1 (conjoint family therapy) versus family therapy-ED 2 in young people with**
6 **anorexia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
Full Remission (ITT) 12-mo FU (assessed with: >=95% mBMI and EDE global <= 1.59)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	16/55 (29.1%)	19/51 (37.3%)	RR 0.78 (0.45 to 1.35)	82 fewer per 1000 (from 205 fewer to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
										130 more)		
BMI 12-mo FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	55	51	-	SMD 0.23 lower (0.61 lower to 0.15 higher)	LOW	CRITICAL
EDE Global 12-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	55	51	-	SMD 0.19 higher (0.19 lower to 0.57 higher)	LOW	IMPORTANT
EDE Restraint 12-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	55	51	-	SMD 0.2 higher (0.18 lower to 0.58 higher)	LOW	IMPORTANT
EDE Eating Concerns 12-mo FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED1	Family Therapy-ED2	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	55	51	-	SMD 0.12 higher (0.26 lower to 0.5 higher)	LOW	IMPORTANT
EDE Weight Concerns 12-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	55	51	-	SMD 0.13 higher (0.25 lower to 0.51 higher)	LOW	IMPORTANT
EDE Shape Concerns 12-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	55	51	-	SMD 0.2 higher (0.18 lower to 0.58 higher)	LOW	IMPORTANT
Depression 12-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	55	51	-	SMD 0.42 higher (0.04 to 0.81 higher)	LOW	IMPORTANT

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1 1 Le Grange 2016: no participant nor investigator blinding.
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 <400 participants.

4 **Table 95: Full GRADE profile for long-term family therapy-ED versus short-term family therapy-ED in young people with anorexia**
5 **nervosa at end of treatment**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED Long-Term	Family Therapy-ED Short-Term	Relative (95% CI)	Absolute	Quality	Importance
BMI (follow-up mean 3.96 years; Better indicated by higher values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	42	44	-	SMD 0.22 higher (0.2 lower to 0.65 higher)	MODERATE	CRITICAL
EDE Restraint (follow-up mean 3.96 years; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious1	none	42	44	-	SMD 0.24 lower (0.67 lower to 0.18 higher)	LOW	IMPORTANT
EDE Weight Concerns (follow-up mean 3.96 years; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious1	none	42	44	-	SMD 0.42 lower (0.85 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED Long-Term	Family Therapy-ED Short-Term	Relative (95% CI)	Absolute		
										to 0.01 higher)		
EDE Eating Concerns (follow-up mean 3.96 years; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious1	none	42	44	-	SMD 0.36 lower (0.79 lower to 0.06 higher)	LOW	IMPORTANT
EDE Shape Concerns (follow-up mean 3.96 years; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious1	none	42	44	-	SMD 0.29 lower (0.72 lower to 0.13 higher)	LOW	IMPORTANT
Yale-Brown-Cornell Eating Disorder Scale (follow-up mean 3.96 years; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious1	none	42	44	-	SMD 0.54 lower (0.97 to 0.11 lower)	LOW	IMPORTANT

1 1 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
2 2 Lock 2005/2006: Participant not blind, assessor blinding unclear.

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Table 96: Full GRADE profile for long-term family therapy-ED versus short-term family therapy-ED in young people with anorexia nervosa at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED Long-term	Family Therapy-ED Short-term	Relative (95% CI)	Absolute	Quality	Importance
BMI (raw) FU (Better indicated by higher values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	34	37	-	SMD 0.08 higher (0.39 lower to 0.54 higher)	MODERATE	CRITICAL
BMI>20 FU												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious2	none	20/34 (58.8%)	24/37 (64.9%)	RR 0.91 (0.63 to 1.31)	58 fewer per 1000 (from 240 fewer to 201 more)	LOW	CRITICAL
# >90% Ideal BW FU												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious3	none	31/34 (91.2%)	32/37 (86.5%)	RR 1.05 (0.89 to 1.24)	43 more per 1000 (from 95 fewer	MODERATE	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED Long-term	Family Therapy-ED Short-term	Relative (95% CI)	Absolute		
										to 208 more)		
Resumed Menstruation FU												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious2	none	18/34 (52.9%)	20/37 (54.1%)	RR 0.98 (0.63 to 1.51)	11 fewer per 1000 (from 200 fewer to 276 more)	LOW	IMPORTANT
Amenorrheic patients FU												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious2	none	1/34 (2.9%)	3/37 (8.1%)	RR 0.36 (0.04 to 3.32)	52 fewer per 1000 (from 78 fewer to 188 more)	LOW	IMPORTANT
EDE Eating Concerns FU (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	very serious2	none	15	20	-	SMD 0.06 lower (0.73 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED Long-term	Family Therapy-ED Short-term	Relative (95% CI)	Absolute		
										to 0.61 higher)		
EDE Restraint FU (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious1	none	15	20	-	SMD 0.39 lower (1.06 lower to 0.29 higher)	LOW	IMPORTANT
EDE Weight Concerns FU (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious1	none	15	20	-	SMD 0.32 lower (1 lower to 0.35 higher)	LOW	IMPORTANT
EDE Shape Concerns FU (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious1	none	15	20	-	SMD 0.39 lower (1.07 lower to 0.28 higher)	LOW	IMPORTANT

1 1 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
2 2 CI crosses both 0.75 and 1.25 (Risk Ratio).

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1 3 <300 events.
2 4 Lock 2005/2006: Participant not blind, assessor blinding unclear.

3 **Table 97: Full GRADE profile for family therapy with family meal versus family therapy without family meal in young people with**
4 **anorexia nervosa at end of treatment**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy with Family Meal	Family Therapy without Family Meal	Relative (95% CI)	Absolute	**Quality**	**Importance**
Remission (follow-up 6 months; assessed with: Morgan-Russell Good or Intermediate outcome)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	10/11 (90.9%)	5/12 (41.7%)	RR 2.18 (1.09 to 4.37)	492 more per 1000 (from 38 more to 1000 more)	LOW	CRITICAL
Weight (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	11	12	-	SMD 0.31 lower (1.13 lower to 0.52 higher)	VERY LOW	CRITICAL
% EBW (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	11	12	-	SMD 0.41 higher (0.42 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy with Family Meal	Family Therapy without Family Meal	Relative (95% CI)	Absolute		
										1.23 higher)		
Morgan-Russell Outcome - Average score (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	11	12	-	SMD 0.15 lower (0.97 lower to 0.67 higher)	VERY LOW	IMPORTANT
EDI-2 (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	11	12	-	SMD 0.6 higher (0.24 lower to 1.44 higher)	LOW	IMPORTANT
General Psychopathology (follow-up 6 months; measured with: SCL90-R GSI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	11	12	-	SMD 0.92 higher (0.05 to 1.79 higher)	LOW	IMPORTANT
Menstruation resumed (follow-up 6 months)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy with Family Meal	Family Therapy without Family Meal	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	8/10 (80%)	3/11 (27.3%)	RR 2.93 (1.06 to 8.08)	526 more per 1000 (from 16 more to 1000 more)	LOW	IMPORTANT

1 1 Herscovici 2015: unclear allocation concealment; no participant, investigator nor assessor blinding; EDI-2 and SCL-90-R GSI score significantly lower in
2 FT group.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

5 **Table 98: Full GRADE profile for family therapy with family meal versus family therapy without family meal in young people with**
6 **anorexia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy with Family Meal	Family Therapy without Family Meal	Relative (95% CI)	Absolute		
Remission 6-mo FU (assessed with: Morgan-Russell Good or Intermediate outcome)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	8/11 (72.7%)	6/12 (50%)	RR 1.45 (0.74	225 more per 1000	VER	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy with Family Meal	Family Therapy without Family Meal	Relative (95% CI)	Absolute	Quality	Importance
									to 2.85)	(from 130 fewer to 925 more)	Y LOW	
Weight 6-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	11	10	-	SMD 0.23 lower (1.09 lower to 0.63 higher)	VERY LOW	CRITICAL
% EBW 6-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	11	10	-	SMD 0.43 higher (0.44 lower to 1.3 higher)	LOW	CRITICAL
Morgan-Russell Outcome - Average score 6-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	11	10	-	SMD 0.05 higher (0.81 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy with Family Meal	Family Therapy without Family Meal	Relative (95% CI)	Absolute	Quality	Importance
										0.9 higher)		
EDI-2 6-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	11	10	-	SMD 0.54 higher (0.34 lower to 1.41 higher)	LOW	IMPORTANT
General Psychopathology 6-mo FU (measured with: SCL90-R GSI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	11	10	-	SMD 0.78 higher (0.13 lower to 1.66 higher)	LOW	IMPORTANT
Menstruation resumed 6-mo FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	7/9 (77.8%)	4/11 (36.4%)	RR 2.14 (0.91 to 5.04)	415 more per 1000 (from 33 fewer to 1000 more)	LOW	IMPORTANT

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1 1 Herscovici 2015: unclear allocation concealment; no participant, investigator nor assessor blinding; EDI-2 and SCL-90-R GSI score significantly lower in
2 FT group.
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

L.3.125 Family therapy for people with bulimia nervosa

6 **Table 99: Full GRADE profile for family therapy-ED versus any individual therapy in adolescents with bulimia nervosa at end of**
7 **treatment.**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute	Quality	Importance
Remission (follow-up 12 months)												
3	randomised trials	serious1,2,3	no serious inconsistency	serious4	serious5	none	40/134 (29.9%)	40/161 (24.8%)	RR 1.27 (0.87 to 1.86)	67 more per 1000 (from 32 fewer to 214 more)	VERY LOW	CRITICAL
Binge Frequency (follow-up 12 months; Better indicated by lower values)												
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious6	none	79	78	-	SMD 0.09 lower (0.4 lower to 0.23 higher)	LOW	CRITICAL
Abstinence from vomiting (assessed with: EATATE)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious3	no serious inconsistency	serious4	very serious7	none	9/32 (28.1%)	10/31 (32.3%)	RR 0.87 (0.41 to 1.85)	42 fewer per 1000 (from 190 fewer to 274 more)	VERY LOW	IMPORTANT
Purge Frequency (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	43	43	-	SMD 0.33 lower (0.75 lower to 0.1 higher)	LOW	IMPORTANT
Vomit Frequency (follow-up 6 months; measured with: EDE; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	36	35	-	SMD 0.64 lower (1.12 to 0.16 lower)	LOW	IMPORTANT
EDE Global (follow-up 12 weeks; range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious5	none	62	93	-	SMD 0.38 lower (0.69 to 0.06 lower)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute		
EDE Restraint (follow-up 6 months; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	36	35	-	SMD 0.51 lower (0.98 to 0.04 lower)	LOW	IMPORTANT
EDE Shape Concern (follow-up 6 months; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	36	35	-	SMD 0.54 lower (1.01 to 0.07 lower)	LOW	IMPORTANT
EDE Weight Concern (follow-up 6 weeks; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	36	35	-	SMD 0.48 lower (0.95 to 0.01 lower)	LOW	IMPORTANT
Yale-Brown-Cornell Eating Disorder Scale (follow-up 12 weeks; range of scores: 0-76; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	43	43	-	SMD 0.36 lower (0.78 lower to 0.07 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: BDI; range of scores: 0-63; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute		
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious5	none	79	78	-	SMD 0.28 lower (0.6 lower to 0.03 higher)	LOW	IMPORTANT
Hospitalized during treatment phase (follow-up 12 months)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	1/51 (2%)	12/58 (20.7%)	RR 0.09 (0.01 to 0.7)	188 fewer per 1000 (from 62 fewer to 205 fewer)	LOW	IMPORTANT
Service User Experience (follow-up 6 months; measured with: Helping Relationship Questionnaire; range of scores: 0-33; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	35	33	-	SMD 0.06 higher (0.42 lower to 0.53 higher)	LOW	IMPORTANT

1 *1 Le Grange 2007: Unclear randomization method and allocation concealment, no participant, investigator nor assessor blinding.*
2 *2 Le Grange 2015: Unclear randomization method and allocation concealment, no participant nor investigator blinding.*
3 *3 Schmidt 2007: Unclear randomization and allocation concealment, No participant nor investigator blinding.*
4 *4 Schmidt 2007: Sample consists of 61 bulimia nervosa and 24 EDNOS*
5 *5 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).*
6 *6 <300 events (dichotomous outcome) or <400 participants (continuous outcome).*

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1 *7 CI crosses both 0.75 and 1.25 (Risk Ratio).*

2 **Table 100: Full GRADE profile for Family therapy-ED versus any individual therapy in adolescents with bulimia nervosa at follow up**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute	Quality	Importance
Remission FU												
2	randomised trials	serious1, 2	no serious inconsistency	serious3	serious4	none	37/93 (39.8%)	31/122 (25.4%)	RR 1.69 (1.11 to 2.57)	175 more per 1000 (from 28 more to 399 more)	VERY LOW	CRITICAL
Binge Frequency FU (Better indicated by lower values)												
2	randomised trials	serious1, 5	no serious inconsistency	no serious indirectness	serious6	none	63	74	-	SMD 0.1 lower (0.44 lower to 0.24 higher)	LOW	CRITICAL
Abstinence from vomiting FU (assessed with: EATATE)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	very serious7	none	15/29 (51.7%)	14/25 (56%)	RR 0.92 (0.56 to 1.51)	45 fewer per 1000 (from 246 fewer to 286 more)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute		
Purge Frequency FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	29	40	-	SMD 0 higher (0.48 lower to 0.48 higher)	LOW	IMPORTANT
Vomit Frequency FU (measured with: EDE; Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious4	none	34	34	-	SMD 0.17 lower (0.65 lower to 0.3 higher)	LOW	IMPORTANT
EDE Global FU (range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1, 5	no serious inconsistency	no serious indirectness	serious4	none	63	74	-	SMD 0.38 lower (0.72 to 0.04 lower)	LOW	IMPORTANT
EDE Restraint FU (follow-up 6 weeks; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious4	none	34	34	-	SMD 0.38 lower (0.86 lower to 0.1 higher)	LOW	IMPORTANT
EDE Shape Concern FU (follow-up 6 months; range of scores: 0-6; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious4	none	34	34	-	SMD 0.58 lower (1.06 to 0.09 lower)	LOW	IMPORTANT
EDE Weight Concern FU (follow-up 6 months; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious4	none	34	34	-	SMD 0.46 lower (0.94 lower to 0.02 higher)	LOW	IMPORTANT
Yale-Brown-Cornell Eating Disorder Scale FU (follow-up 12 months; range of scores: 0-76; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	29	40	-	SMD 0.37 lower (0.85 lower to 0.11 higher)	LOW	IMPORTANT
Depression FU (follow-up 12 months; measured with: BDI; range of scores: 0-63; Better indicated by lower values)												
2	randomised trials	serious1, 5	no serious inconsistency	no serious indirectness	serious6	none	63	74	-	SMD 0.1 lower (0.43 lower to 0.24 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Other intervention	Relative (95% CI)	Absolute		
Service User Experience FU (follow-up 6 months; measured with: Helping Relationship Questionnaire; range of scores: 0-33; Better indicated by higher values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious4	none	36	35	-	SMD 0.41 lower (0.88 lower to 0.06 higher)	LOW	IMPORTANT

1 Le Grange 2015: Unclear randomization method and allocation concealment, no participant nor investigator blinding.
2 Schmidt 2007: Unclear randomization and allocation concealment, No participant nor investigator blinding.
3 Schmidt 2007: Sample consists of 61 bulimia nervosa and 24 EDNOS
4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
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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L.3.131 Family therapy for binge eating disorder

2 **Table 101: Full GRADE profile for family therapy-ED versus wait list control in adults with binge eating disorder**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Waiting List Control	Relative (95% CI)	Absolute	Quality	Importance
Weight (kg) (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	31	-	SMD 0.08 higher (0.42 lower to 0.58 higher)	LOW	IMPORTANT
Binge Frequency (follow-up 6 months; measured with: EDE-Q OBE; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Serious2	none	31	31	-	SMD 0.56 lower (1.07 to 0.05 lower)	LOW	CRITICAL
Depression (follow-up 6 months; measured with: Beck Depression Inventory (BDI); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Serious2	none	31	31	-	SMD 0.52 lower (1.02 to 0.01 lower)	LOW	IMPORTANT
Family Functioning (follow-up 6 months; measured with: Dyadic Adjustment Scale; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Waiting List Control	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Serious2	none	31	31	-	SMD 0.04 lower (0.54 lower to 0.46 higher)	LOW	IMPORTANT

1 1 Gorin 2003: Dropout rate>20% (34% for whole sample), inadequate randomization method (used blocks by binge eating frequency), unclear allocation
2 concealment, participant and assessor blinding.
3 2 CI crosses either 0.5 or -0.5 (SMD).

4 **Table 102: Full GRADE profile for family therapy-ED versus any other intervention in adults with binge eating disorder at end of**
5 **treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Group CBT	Relative (95% CI)	Absolute		
Weight (kg) (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.2 higher (0.29 lower to 0.7 higher)	LOW	IMPORTANT
Binge Frequency (follow-up 6 months; measured with: EDE-Q OBE; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Group CBT	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.24 higher (0.26 lower to 0.73 higher)	LOW	CRITICAL
Depression (follow-up 6 months; measured with: Beck Depression Inventory (BDI); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.31 lower (0.81 lower to 0.19 higher)	LOW	IMPORTANT
Family Functioning (follow-up 6 months; measured with: Level of Expressed Emotion (LEE); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.09 lower (0.59 lower to 0.4 higher)	LOW	IMPORTANT

1 1 Gorin 2003: Dropout rate>20% (34% for whole sample), inadequate randomization method (used blocks by binge eating frequency), unclear allocation
2 concealment, participant and assessor blinding.
3 2 CI crosses either 0.5 or -0.5 (SMD).

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1 **Table 103: Full GRADE profile for family therapy-ED versus any other intervention in adults with binge eating disorder at follow up**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family Therapy-ED	Group CBT	Relative (95% CI)	Absolute	Quality	Importance
Weight (kg) FU (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.22 higher (0.28 lower to 0.71 higher)	LOW	IMPORTANT
Binge Frequency FU (follow-up 6 months; measured with: EDE-Q OBE; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.52 higher (0.01 to 1.02 higher)	LOW	CRITICAL
Depression FU (follow-up 6 months; measured with: Beck Depression Inventory (BDI); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	32	-	SMD 0.07 lower (0.57 lower to 0.42 higher)	LOW	IMPORTANT
Family Functioning FU (follow-up 6 months; measured with: Level of Expressed Emotion (LEE); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	32	-	SMD 0.01 lower (0.5 lower to 0.49 higher)	LOW	IMPORTANT

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1 1 Gorin 2003: Dropout rate>20% (34% for whole sample), inadequate randomization method (used blocks by binge eating frequency), unclear allocation
2 concealment, participant and assessor blinding.
3 2 CI crosses either 0.5 or -0.5 (SMD).
4 3 <400 participants.

L.4 5 Does any psychological intervention produce benefits/harms in the parents or carers of 6 children or young people with an eating disorder compared with any other intervention or 7 controls?

L.4.1 8 Interventions for parents or carers of people with anorexia nervosa

9 **Table 104: Full GRADE profile for self-help or guided self-help and treatment as usual versus treatment as usual at 12-months after**
10 **referral for outpatient treatment for carers of young people with anorexia nervosa – patient and carer outcomes**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-Help or Guided Self-Help + TAU	TAU	Relative (95% CI)	Absolute	Quality	Importance
Carer General Psychopathology at 12 months (measured with: DASS-21; range of scores: 0-126; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	99	50	-	SMD 0.03 higher (0.31 lower to 0.37 higher)	LOW	CRITICAL
Patient General Psychopathology (measured with: DASS-21; range of scores: 0-126; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	99	50	-	SMD 0.09 lower (0.43 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-Help or Guided Self-Help + TAU	TAU	Relative (95% CI)	Absolute		
										0.25 higher)		

1 *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*
2 *ECHO with guidance, 49 carer-patient dyads received ECHO without guidance.*
3 *2 <400 participants.*

4 **Table 105: Full GRADE profile for guided self-help and treatment as usual versus treatment as usual at 12- and 24-months after**
5 **inpatient discharge for carers of adults with anorexia nervosa – carer outcomes**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	TAU	Relative (95% CI)	Absolute		
Carer Burden at 12 months (measured with: EDSIS; range of scores: 0-96; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	91	91	-	SMD 0.24 lower (0.54 lower to 0.05 higher)	ÅÅOO LOW	CRITICAL

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Carer Quality of Life at 12 months (measured with: WHO-Quol; range of scores: 4-20; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	91	91	-	SMD 0.32 higher (0.03 to 0.61 higher)	ÅÅOO LOW	CRITICAL
Carer Accommodation & Enabling at 12 months (measured with: AESED; range of scores: 0-132; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	91	91	-	SMD 0.19 lower (0.48 lower to 0.1 higher)	ÅÅOO LOW	CRITICAL
Carer Burden after 24 months (measured with: EDSIS; range of scores: 0-96; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	88	97	-	SMD 0.2 lower (0.49 lower to 0.09 higher)	ÅÅOO LOW	CRITICAL
Carer Quality of Life after 24 months (measured with: WHO-Quol; range of scores: 4-20; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	88	97	-	SMD 0.24 higher (0.05 lower to	ÅÅOO LOW	CRITICAL

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										0.53 higher)		
Carer Accommodation & Enabling after 24 months (measured with: AESED; range of scores: 0-132; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	88	97	-	SMD 0.23 lower (0.52 lower to 0.06 higher)	ÅÅOO LOW	CRITICAL
Carer General Psychopathology after 24 months (measured with: DASS-21; range of scores: 0-126; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	88	97	-	SMD 0.23 lower (0.52 lower to 0.06 higher)	ÅÅOO LOW	CRITICAL
Carer Time Spent Caring after 24 months (measured with: CSRI; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	88	97	-	SMD 0.2 lower (0.49 lower to 0.09 higher)	ÅÅOO LOW	IMPORTANT

1

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Table 106: Full GRADE profile for guided self-help and treatment as usual versus treatment as usual at 12- and 24-months after inpatient admission for carers of anorexia nervosa – patient outcomes

Table 107: Full GRADE profile for guided self-help and treatment as usual versus self-help and treatment as usual at 6- and 12-months after inpatient admission for carers of anorexia nervosa – carer outcomes

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	Self-Help+TAU	Relative (95% CI)	Absolute	Quality	Importance
Carer Accommodation & Enabling at 6 months (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	79	72	-	SMD 0.3 lower (0.63 lower to 0.02 higher)	LOW	CRITICAL
Carer Family Functioning at 6 months (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	79	72	-	SMD 0.2 lower (0.52 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	Self-Help+TAU	Relative (95% CI)	Absolute		
										to 0.12 higher)		
Carer General Psychopathology at 12 months (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	79	72	-	SMD 0.04 lower (0.36 lower to 0.28 higher)	LOW	CRITICAL
Carer Skills at 12 months (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	79	72	-	SMD 0.03 lower (0.35 lower to 0.29 higher)	LOW	CRITICAL
Time Spent Caregiving at 12 months (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	79	72	-	SMD 0.01 higher (0.31 lower to 0.33 higher)	LOW	IMPORTANT
Direct Spending at 12 months (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	Self-Help+TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	79	72	-	SMD 0 higher (0.32 lower to 0.32 higher)	LOW	IMPORTANT

1 1 Hodsoll 2016: Unclear, no details given of statistical significance for social demographic and clinical variables. Randomization method, allocation
2 concealment and participant blinding unclear. No investigator blinding. Dropout rate of TAU group>20%.
3 2 CI crosses either 0.5 or -0.5 (SMD).
4 3 <400 participants.

5 **Table 108: Full GRADE profile for guided self-help and treatment as usual versus self-help and treatment as usual at 12-months after**
6 **inpatient admission for carers of anorexia nervosa – patient outcomes**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	Self-Help+TAU	Relative (95% CI)	Absolute		
BMI at 12 months (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	49	-	SMD 0.45 lower (0.85 to 0.05 lower)	LOW	IMPORTANT
Gender Standardized Weight for Height Percentage at 12 months (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	Self-Help+TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	49	-	SMD 0.34 lower (0.73 lower to 0.06 higher)	LOW	IMPORTANT
SEED for AN at 12 months (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	49	-	SMD 0.19 higher (0.2 lower to 0.59 higher)	LOW	IMPORTANT
General Psychopathology at 12 months (measured with: DASS-21; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	49	-	SMD 0.13 lower (0.52 lower to 0.27 higher)	LOW	IMPORTANT
Clinical Impairment due to ED at 12 months (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	49	-	SMD 0.21 lower (0.6 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help+TAU	Self-Help+TAU	Relative (95% CI)	Absolute		
										to 0.19 higher)		
Strength & Difficulties Questionnaire - Peer Problems at 12 months (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	49	-	SMD 0.43 lower (0.83 to 0.03 lower)	LOW	IMPORTANT
Strength & Difficulties Questionnaire - Prosocial Behaviour at 12 months (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	50	49	-	SMD 0.05 higher (0.35 lower to 0.44 higher)	LOW	IMPORTANT

1 1 Hodsoll 2016: Unclear, no details given of statistical significance for social demographic and clinical variables. Randomization method, allocation
2 concealment and participant blinding unclear. No investigator blinding. Dropout rate of TAU group>20%.
3 2 CI crosses either 0.5 or -0.5 (SMD).
4 3 <400 participants.

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Table 109: Full GRADE profile for web-based guided self-help versus treatment as usual for carers of anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	TAU	Relative (95% CI)	Absolute	Quality	Importance
Carer Accommodation & Enabling (follow-up 3 months; measured with: AESED; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.34 lower (0.84 lower to 0.16 higher)	LOW	CRITICAL
Carer Family Functioning (follow-up 3 months; measured with: Level of Expressed Emotion; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.46 lower (0.96 lower to 0.05 higher)	LOW	CRITICAL
Carer Burden (follow-up 3 months; measured with: EDSIS; Experience of Caregiving Inventory (ECI) Negative; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.32 lower (0.67 lower to 0.04 higher)	LOW	CRITICAL
Carer Experience of Caregiving (ECI) Positive (follow-up 3 months; measured with: Experience of Caregiving Inventory (ECI); Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.06 higher (0.44 lower to 0.55 higher)	LOW	CRITICAL
Carer General Psychopathology (Distress) (follow-up 3 months; measured with: Depression Anxiety Stress Scales (DASS-21); Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.55 lower (1.05 to 0.05 lower)	LOW	CRITICAL

1 1 Grover 2011: Participant not blinded. Unclear whether baseline similar.
2 2 CI crosses either 0.5 or -0.5 (SMD).

3 **Table 110: Full GRADE profile for web-based guided self-help versus treatment as usual for carers of anorexia nervosa at end of**
4 **treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	TAU	Relative (95% CI)	Absolute		
Carer Accommodation & Enabling FU (follow-up 3 months; measured with: AESED; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.02 lower (0.52 lower to 0.47 higher)	LOW	CRITICAL
Carer Family Functioning FU (follow-up 3 months; measured with: Level of Expressed Emotion; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.18 lower (0.67 lower to 0.32 higher)	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	TAU	Relative (95% CI)	Absolute	Quality	Importance
Carer Burden FU (follow-up 3 months; measured with: EDSIS; Experience of Caregiving Inventory (ECI) Negative; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	33	30	-	SMD 0.15 lower (0.5 lower to 0.2 higher)	LOW	CRITICAL
Experience of Caregiving (ECI) Positive FU (follow-up 3 months; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	30	-	SMD 0.18 higher (0.32 lower to 0.67 higher)	LOW	CRITICAL
Carer General Psychopathology (Distress) FU (follow-up 3 months; measured with: Hospital Anxiety & Depression Scale; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	33	30	-	SMD 0.01 lower (0.5 lower to 0.49 higher)	LOW	CRITICAL

1 1 Grover 2011: Participant not blinded. Unclear whether baseline similar.
2 2 CI crosses either 0.5 or -0.5 (SMD).
3 3 <400 participants.

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Table 111: Full GRADE profile for web-based guided self-help versus web-based self-help for carers of anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	Web-based Self-Help	Relative (95% CI)	Absolute	Quality	Importance
Carer Family Functioning (follow-up 3 months; measured with: LEE; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.56 lower (1.33 lower to 0.21 higher)	LOW	CRITICAL
Carer Burden (follow-up 3 months; measured with: EDSIS; ECI negative; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.31 higher (0.23 lower to 0.85 higher)	LOW	CRITICAL
Carer Experience of Caregiving (ECI) Positive (follow-up 3 months; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.45 higher (0.32 lower to 1.21 higher)	LOW	CRITICAL
Carer Quality of Life (follow-up 3 months; measured with: GHQ-28; SF-36; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.15 lower (0.69	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	Web-based Self-Help	Relative (95% CI)	Absolute		
										lower to 0.39 higher)		
Carer General Psychopathology (Distress) (follow-up 3 months; measured with: DASS-21; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	14	-	SMD 0.48 lower (1.25 lower to 0.28 higher)	LOW	CRITICAL

1 1 Hoyle 2013: Unclear randomization method, allocation concealment, participant and assessor blinding.
2 2 CI crosses 0.5 or -0.5 (SMD).

3 **Table 112: Full GRADE profile for web-based guided self-help versus web-based self-help for carers of anorexia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	Web-based Self-Help	Relative (95% CI)	Absolute		
Carer Family Functioning FU (follow-up 3 months; measured with: LEE; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13	16	-	SMD 1.01 lower (1.8 to 0.23 lower)	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Web-based Guided Self-Help	Web-based Self-Help	Relative (95% CI)	Absolute	Quality	Importance
Carer Burden FU (follow-up 3 months; measured with: EDSIS, ECI Negative; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	13	16	-	SMD 0.46 higher (0.06 lower to 0.99 higher)	LOW	
Carer Experience of Caregiving (ECI) Positive FU (follow-up 3 months; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	13	16	-	SMD 0.18 higher (0.56 lower to 0.91 higher)	VERY LOW	
Carer Quality of Life FU (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	13	16	-	SMD 0.11 lower (0.63 lower to 0.4 higher)	LOW	
Carer General Psychopathology (Distress) FU (follow-up 3 months; measured with: DASS-21; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	13	16	-	SMD 0.35 lower (1.09 lower to 0.39 higher)	LOW	CRITICAL

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1 1 Hoyle 2013: Unclear randomization method, allocation concealment, participant and assessor blinding.
2 2 CI crosses 0.5 or -0.5 (SMD).
3 3 CI crosses both 0.5 and -0.5 (SMD).

L.4.24 Interventions for parents or carers of people with any eating disorder

5 **Table 113: Full GRADE profile for psychoeducation versus wait list control in carers of young people with any eating disorder at end**
6 **of treatment**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychoeducation	WLC	Relative (95% CI)	Absolute	Quality	Importance
Carer Self-Efficacy (follow-up 260 days; measured with: Parents Versus Anorexia (PVA); Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	18	13	-	SMD 1.74 higher (0.89 to 2.59 higher)	VERY LOW	CRITICAL
Carer Knowledge of ED (follow-up median 260 days; measured with: Knowledge of Eating Disorders Scale (KEDS); Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	17	11	-	SMD 0.75 higher (0.04 lower to 1.54 higher)	VERY LOW	CRITICAL

7 1 Spettigue 2015: Randomization method unclear, allocation concealment unclear, participant and assessor not blinded, investigator blinding unclear,
8 dropout rate for both arms>20%, available case analysis.
9 2 Study targeted carers of medically stable adolescents awaiting assessment by specialized eating disorder program. End of treatment data for wait list
10 control was after 1 month. At time of assessment, 4 of 36 adolescents were not diagnosed with an eating disorder. Mean time to assessment: 94 days,
11 range 27-287 days

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1 3 <400 participants.
2 4 CI crosses either 0.5 or -0.5 (SMD).

3 **Table 114: Full GRADE profile for psychoeducation versus wait list control in carers of young people with any eating disorder at**
4 **follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychoeducation	WLC	Relative (95% CI)	Absolute		
Carer Self-Efficacy FU (measured with: Parents Versus Anorexia (PVA); Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	18	13	-	SMD 0.89 higher (0.14 to 1.64 higher)	VERY LOW	CRITICAL
Carer Knowledge of ED FU (measured with: Knowledge of Eating Disorders Scale (KEDS); Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	17	11	-	SMD 0.99 higher (0.18 to 1.8 higher)	VERY LOW	CRITICAL
Carer Burden FU (measured with: Eating Disorder Symptom Impact Scale (EDSIS); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	21	15	-	SMD 0.57 higher (0.11 lower to 1.25 higher)	VERY LOW	CRITICAL

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1 1 Spettigue 2015: Randomization method unclear, allocation concealment unclear, participant and assessor not blinded, investigator blinding unclear,
2 dropout rate for both arms>20%, available case analysis.
3 2 Study targeted carers of medically stable adolescents awaiting assessment by specialized eating disorder program. End of treatment data for wait list
4 control was after 1 month. At time of assessment, 4 of 36 adolescents were not diagnosed with an eating disorder. Mean time to assessment: 94 days,
5 range 27-287 days
6 3 CI crosses either 0.5 or -0.5 (SMD).

7 **Table 115: Full GRADE profile for guided self-help versus self-help in carers of adults with any eating disorder**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help	Self-Help	Relative (95% CI)	Absolute	Quality	Importance
Carer Burden (follow-up 3 months; measured with: ECI Negative; EDSIS; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57	63	-	SMD 0.02 higher (0.24 lower to 0.27 higher)	LOW	CRITICAL
Carer Quality of Life (follow-up 3 months; measured with: General Health Questionnaire-12 (GHQ-12); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57	63	-	SMD 0.07 lower (0.43 lower to 0.28 higher)	LOW	CRITICAL
Family Functioning (follow-up 3 months; measured with: Family Questionnaire; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57	63	-	SMD 0.14 lower (0.5 lower to 0.22 higher)	LOW	CRITICAL
Carer Self-Efficacy (follow-up 3 months; measured with: Revised Scale for Caregiving Self-Efficacy (CSE); Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	57	63	-	SMD 0.15 higher (0.21 lower to 0.51 higher)	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided Self-Help	Self-Help	Relative (95% CI)	Absolute	Quality	Importance
Experience of Caregiving Inventory (ECI) Positive (follow-up 3 months; measured with: Experience of Caregiving Inventory (ECI); Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57	63	-	SMD 0.05 higher (0.3 lower to 0.41 higher)	LOW	CRITICAL
Carer Accommodation & Enabling (follow-up 3 months; measured with: AESED; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57	63	-	SMD 0.01 lower (0.37 lower to 0.35 higher)	LOW	CRITICAL
Carer General Psychopathology (Distress) (follow-up 3 months; measured with: Hospital & Anxiety Depression Scale (HADS); Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57	63	-	SMD 0.06 lower (0.42 lower to 0.3 higher)	LOW	CRITICAL

1 1 Goddard 2011: Unclear whether baseline characteristics of carers were similar. Also, dropout rate<20% and reasons not stated.
2 2 <400 participants.
3 3 CI crosses either 0.5 or -0.5 (SMD)

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L.5 Does any pharmacological intervention produce benefits/harms on specified outcomes in people with eating disorders?

L.5.1 Pharmacological intervention for people with anorexia nervosa

Table 116: Full GRADE profile for antidepressants versus placebo for adults with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute	Quality	Importance
BMI. Adults - SSRIs (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	26	26	-	SMD 0.72 higher (0.16 to 1.29 higher)	VERY LOW	CRITICAL
Change in % average body weight. Adults - SSRIs (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	reporting bias3	11	12	-	SMD 0.61 lower (1.45 lower to 0.23 higher)	VERY LOW	IMPORTANT
Depression. Adults (Better indicated by lower values)												
2	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	42	46	-	SMD 0.58 lower (1.01	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute		
										to 0.15 lower)		
Depression. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	reporting bias3	26	26	-	SMD 0.67 lower (1.23 to 0.11 lower)	VERY LOW	CRITICAL
Depression. Adults - TCA (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	reporting bias3	16	20	-	SMD 0.45 lower (1.12 lower to 0.22 higher)	VERY LOW	CRITICAL
EDI - Bulimia. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	reporting bias3	26	26	-	SMD 0.26 lower (0.81 lower to 0.28 higher)	VERY LOW	IMPORTANT
Achieved target weight. Adults - TCA												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious7	reporting bias3	17/23 (73.9%)	16/25 (64%)	RR 1.15 (0.7 to 1.42)	96 more per 1000 (from 192 fewer to 269 more)	VERY LOW	CRITICAL
Relapse (LSE because of deteriorating clinical state). Adults - SSRIs												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious8	reporting bias3	6/16 (37.5%)	16/19 (84.2%)	RR 0.45 (0.23 to 0.86)	463 fewer per 1000 (from 118 fewer to 648 fewer)	VERY LOW	IMPORTANT

[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%.

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1 [7] 95% CI crossed 1 MID (1.25)
2 [8] 95% CI crossed 1 MID (0.75)

3 **Table 117: Full GRADE profile for antidepressant versus another antidepressant for adults with AN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
No episodes of vomiting. Adults - SSRI vs. TCA												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	4/10 (40%)	0/13 (0%)	RR 0.61 (0.37 to 1.01)	-	VERY LOW	IMPORTANT
Bingeing. Adults - SSRI vs. TCA												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	reporting bias3	7/10 (70%)	7/13 (53.8%)	RR 1.3 (0.68 to 2.48)	162 more per 1000 (from 172 fewer to 797 more)	VERY LOW	IMPORTANT
Amenorrhea. Adults - SSRI vs. TCA												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	reporting bias3	7/10 (70%)	7/13 (53.8%)	RR 1.3 (0.68 to 2.48)	162 more per 1000 (from 172 fewer	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Antidepressant	Relative (95% CI)	Absolute		
										to 797 more)		

1 [1] It was unclear how random sequence was generated and if allocation concealment was conducted. The participants and investigators were blind but it was
2 unclear if the assessors were blind. High dropouts were reported >20%.
3 [2] 95% CI crossed 1 MID (0.75)
4 [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
5 findings are being published, there is selective outcome reporting and outliers are being excluded.
6 [4] 95% CI crossed 2 MIDs (0.75 and 1.25)

7 **Table 118: Full GRADE profile for antipsychotic versus placebo for young people or adults with AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antipsychotic	placebo	Relative (95% CI)	Absolute		
Weight - Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	27	30	-	SMD 0.15 lower (0.67 lower to 0.37 higher)	VERY LOW	CRITICAL
Depression - Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	14	12	-	SMD 0.54 higher	VER	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antipsychotic	placebo	Relative (95% CI)	Absolute	Quality	Importance
										(0.25 lower to 1.32 higher)	Y LOW	
No side effects Total												
3	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious6	reporting bias3	1/44 (2.3%)	2/50 (4%)	RR 1.02 (0.93 to 1.12)	1 more per 1000 (from 3 fewer to 5 more)	VERY LOW	IMPORTANT
No side-effects - Adolescents												
2	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious6	reporting bias3	1/28 (3.6%)	2/32 (6.3%)	RR 1.04 (0.91 to 1.18)	2 more per 1000 (from 6 fewer to 11 more)	VERY LOW	IMPORTANT
No side-effects - Adults												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious6	reporting bias3	0/16 (0%)	0/18 (0%)	Not estimable	-	VERY LOW	IMPORTANT
Remission - Adolescents_ITT												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	very serious10	reporting bias3	6/19 (31.6%)	10/22 (45.5%)	RR 0.69 (0.31 to 1.55)	141 fewer per	VER	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antipsychotic	placebo	Relative (95% CI)	Absolute	**Quality**	**Importance**
										1000 (from 314 fewer to 250 more)	Y LOW	

[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)

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1 **Table 119: Full GRADE profile for combined antipsychotic and psychotherapy versus placebo and therapy for adults with AN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Combined Antipsychotic + Pscyhotherapy	Placebo + Therapy	Relative (95% CI)	Absolute	Quality	Importance
BMI. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	15	15	-	SMD 0.18 higher (0.54 lower to 0.89 higher)	VERY LOW	CRITICAL
EDI - Total. Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	reporting bias3	15	15	-	SMD 0.47 higher (0.26 lower to 1.19 higher)	VERY LOW	IMPORTANT
EDI - Drive for thinness. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	15	15	-	SMD 0.36 higher (0.37 lower to 1.08 higher)	VERY LOW	IMPORTANT
EDI - Bulimia. Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Combined Antipsychotic + Pscyhotherapy**	**Placebo + Therapy**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	15	15	-	SMD 0.18 higher (0.54 lower to 0.9 higher)	VERY LOW	IMPORTANT
EDI - Body dissatisfaction.Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	15	15	-	SMD 0.43 higher (0.29 lower to 1.16 higher)	VERY LOW	IMPORTANT
Yale - eating disorder rating scale. Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	reporting bias3	15	15	-	SMD 0.53 lower (1.26 lower to 0.2 higher)	VERY LOW	IMPORTANT
No side-effects. Adults												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	reporting bias3	0/17 (0%)	0/18 (0%)	RR: 1.00 (0.90 to 1.11)	-	VERY LOW	IMPORTANT

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[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)
[6] For a dichotomous outcome there were fewer than 300 events.

Table 120: Full GRADE profile for combined antidepressant and psychotherapy versus psychotherapy for adults with AN

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Combined Antidepressant + Psychotherapy**	**Therapy**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Weight % Ideal BW (final)-SSRI Adult (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	15	16	-	SMD 0.14 lower (0.85 lower to 0.56 higher)	VERY LOW	CRITICAL
Weight % Ideal BW (change)-SSRI Adult (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	49	44	-	SMD 0.46 lower (0.87 to 0.04 lower)	VERY LOW	CRITICAL
Depression (change and final) SSRI Total (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Combined Antidepressant + Psychotherapy**	**Therapy**	**Relative (95% CI)**	**Absolute**		
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	64	60	-	SMD 0.32 higher (0.03 lower to 0.68 higher)	VERY LOW	CRITICAL
Quality of life SSRI Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	49	44	-	SMD 0.38 lower (0.79 lower to 0.03 higher)	VERY LOW	IMPORTANT
Remission SSRI Adults_ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious5	reporting bias3	7/49 (14.3%)	4/44 (9.1%)	RR 1.57 (0.49 to 5.01)	52 more per 1000 (from 46 fewer to 365 more)	VERY LOW	CRITICAL
Global Improvement (CGI) SSRI Adults (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Combined Antidepressant + Psychotherapy	Therapy	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious6	reporting bias3	15	16	-	SMD 0.20 lower (0.91 lower to 0.51 higher)	VERY LOW	IMPORTANT

[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] 95% CI Crossed 2 MIDs (0.75 and 1.25)
[6] 95% CI crossed 2 MID (-0.5 and 0.5)

Table 121: Full GRADE profile for other medication versus placebo for adults with AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Other medication (not antidepressants)	Placebo	Relative (95% CI)	Absolute		
Achieved target weight. Adults - Antihistamine												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	17/23 (73.9%)	16/25 (64%)	RR 1.15 (0.79	96 more per	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Other medication (not antidepressants)	Placebo	Relative (95% CI)	Absolute		
									to 1.69)	1000 (from 134 fewer to 442 more)	Y LOW	
Depression, Adults - Antihistamine (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	18	20	-	SMD 0.58 lower (1.23 lower to 0.07 higher)	VERY LOW	CRITICAL

1 [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
2 was blind. High dropouts were reported >20%,
3 [2] 95% CI crossed 1 MID (1.25)
4 [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
5 findings are being published, there is selective outcome reporting and outliers are being excluded.
6 [4] 95% CI crossed 1 MID (-0.5)

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1 **Table 122: Full GRADE profile for antipsychotics versus antidepressants for adults with AN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Antipsychotics	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
No bingeing												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	3/12 (25%)	4/23 (17.4%)	RR 0.87 (0.61 to 1.24)	23 fewer per 1000 (from 68 fewer to 42 more)	VERY LOW	IMPORTANT
No vomiting												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	3/12 (25%)	3/23 (13%)	RR 0.87 (0.6 to 1.25)	17 fewer per 1000 (from 52 fewer to 33 more)	VERY LOW	
Amenorrhea												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	reporting bias3	8/12 (66.7%)	14/23 (60.9%)	RR 1.08 (0.65 to 1.81)	49 more per 1000 (from 213 fewer	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN Antipsychotics	Antidepressant	Relative (95% CI)	Absolute		
										to 493 more)		

[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 123: Full GRADE profile for cannaboid agonist versus placebo for adults with AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Cannaboid agonist	placebo	Relative (95% CI)	Absolute		
Weight gain. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	24	24	-	SMD 1.6 higher (0.95 to 2.26 higher)	LOW	CRITICAL
Intensity of physical activity. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	24	24	-	SMD 0.18 higher (0.39	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Cannabinoid agonist	placebo	Relative (95% CI)	Absolute		
										lower to 0.74 higher)		
Change in total EDI-2. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	24	24	-	SMD 0.78 lower (1.36 to 0.19 lower)	LOW	IMPORTANT
Change in EDI-2 Body dissatisfaction. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	24	24	-	SMD 0.07 lower (0.64 lower to 0.5 higher)	LOW	IMPORTANT
Change EDI-2 Drive for thinness. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	24	24	-	SMD 1.15 higher (0.53 to 1.76 higher)	LOW	IMPORTANT
Change in EDI-2 Bulmia. Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	no serious	none	24	24	-	SMD 0.72 higher	MODERATE	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Cannabinoid agonist	placebo	Relative (95% CI)	Absolute		
					imprecision					(0.13 to 1.3 higher)		
No adverse events. Adults												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	no serious imprecision	none	0/11 (0%)	0/14 (0%)	Not estimable	-	MODERATE	CRITICAL

[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)

L.5.24 Pharmacological interventions for people with bulimia nervosa

Table 124: Full GRADE profile for antidepressant versus placebo in people with bulimia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute		
Binge frequency, Adults - SSRIs (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	20	22	-	SMD 0.13 lower (0.73 lower	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute	Quality	Importance
										to 0.48 higher)		
Purge frequency. Adults - TCAs (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	40	38	-	SMD 0.34 lower (0.79 lower to 0.11 higher)	VERY LOW	CRITICAL
Vomiting frequency. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	reporting bias3	20	22	-	SMD 0.20 lower (0.8 lower to 0.41 higher)	VERY LOW	CRITICAL
EDI Adults (Better indicated by lower values)												
2	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	60	63	-	SMD 1.19 higher (0.74 to 1.64 higher)	VERY LOW	IMPORTANT
EDI Adults - SSRI (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Antidepressant**	**placebo**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	22	24	-	SMD 0.29 lower (0.87 lower to 0.29 higher)	VERY LOW	IMPORTANT
EDI Adults - MAOI (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious2	reporting bias3	38	39	-	SMD 3.34 higher (2.64 to 4.04 higher)	VERY LOW	IMPORTANT
EDI - Drive for thinness. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	22	24	-	SMD 0.44 lower (1.02 lower to 0.15 higher)	VERY LOW	IMPORTANT
EDI- Body dissatisfaction. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	22	24	-	SMD 0.48 lower (1.07 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute	Quality	Importance
										to 0.1 higher)		
EDI- Bulimia. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	22	24	-	SMD 0.15 lower (0.73 lower to 0.43 higher)	VERY LOW	IMPORTANT
Depression TCA (Better indicated by lower values)												
2	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious2	reporting bias3	50	51	-	SMD 0.35 lower (0.74 lower to 0.04 higher)	VERY LOW	CRITICAL
Depression scores. Adults - SSRIs (Better indicated by lower values)												
2	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious2	reporting bias3	42	46	-	SMD 0.39 lower (0.81 to 0.03 lower)	VERY LOW	CRITICAL
Depression scores. Adults - MAOIs (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute		
2	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	61	66	-	SMD 0.06 lower (0.4 lower to 0.29 higher)	VERY LOW	CRITICAL
Depression change score - SSRI (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious2	reporting bias3	75	71	-	SMD 0.19 lower (0.52 lower to 0.13 higher)	VERY LOW	CRITICAL
Global clinical score. Adults (Better indicated by lower values)												
4	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious5	reporting bias3	157	155	-	SMD 0.33 lower (0.55 to 0.1 lower)	VERY LOW	IMPORTANT
Global clinical score. Adults - TCA (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	40	38	-	SMD 0.33 lower (0.77 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute	Quality	Importance
										to 0.12 higher)		
Global clinical score. Adults - SSRI (Better indicated by lower values)												
3	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious5	reporting bias3	117	117	-	SMD 0.32 lower (0.58 to 0.07 lower)	VERY LOW	IMPORTANT
Did not have adverse event. Adults												
11	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious2	reporting bias3	47/509 (9.2%)	22/451 (4.9%)	RR 0.95 (0.92 to 0.99)	2 fewer per 1000 (from 0 fewer to 4 fewer)	VERY LOW	IMPORTANT
Did not have adverse event. Adults - TCAs												
2	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious2	reporting bias3	7/95 (7.4%)	1/70 (1.4%)	RR 0.94 (0.87 to 1.01)	1 fewer per 1000 (from 2 fewer to 0 more)	VERY LOW	IMPORTANT
Did not have adverse event. Adults- SSRIs												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Antidepressant**	**placebo**	**Relative (95% CI)**	**Absolute**		
5	randomised trials	serious9, 13	no serious inconsistency	no serious indirectness	serious2	reporting bias3	25/322 (7.8%)	14/288 (4.9%)	RR 0.97 (0.93 to 1.01)	1 fewer per 1000 (from 3 fewer to 0 more)	VERY LOW	IMPORTANT
Did not have adverse event. Adults Adults - MAOIs												
2	observational studies	serious6	very serious14	no serious indirectness	serious15	reporting bias3	14/69 (20.3%)	6/70 (8.6%)	RR 0.87 (0.75 to 1)	11 fewer per 1000 (from 21 fewer to 0 more)	VERY LOW	IMPORTANT
Dropout due to adverse events. Adults - Other												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious15	reporting bias3	1/23 (4.3%)	1/23 (4.3%)	RR 1 (0.88 to 1.13)	0 fewer per 1000 (from 5 fewer to 6 more)	VERY LOW	IMPORTANT
Did not achieve remission Adults Other_ITT												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious15	reporting bias3	2/23 (8.7%)	0/23 (0%)	RR 0.91 (0.79 to 1.06)	-	VERY LOW	CRITICAL
Binge frequencey Adults TCA FU (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	21	17	-	SMD 0.39 lower (1.04 lower to 0.25 higher)	VERY LOW	CRITICAL
Laxative use Adults TCA FU (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	very serious16	reporting bias3	21	17	-	SMD 0.08 higher (0.56 lower to 0.72 higher)	VERY LOW	IMPORTANT
Vomit frequency Adults TCA FU (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	21	17	-	SMD 0.46 lower (1.1 lower to 0.19 higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	placebo	Relative (95% CI)	Absolute		
Depression Adults TCA FU (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	21	17	-	SMD 0.27 higher (0.37 lower to 0.91 higher)	VERY LOW	CRITICAL
EDI - Body dissatisfaction Adults TCA FU (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	21	17	-	SMD 0.24 lower (0.88 lower to 0.4 higher)	VERY LOW	IMPORTANT

[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

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[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 125: Full GRADE profile for antidepressants versus another antidepressant for people with bulimia nervosa

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Antidepressant**	**another Antidepressant**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Depression - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	14	14	-	SMD 0.22 lower (0.97 lower to 0.52 higher)	VERY LOW	CRITICAL
EDI - Drive for thinness - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	14	14	-	SMD 0.34 higher (0.4	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	another Antidepressant	Relative (95% CI)	Absolute		
										lower to 1.09 higher)		
EDI- Body dissatisfaction - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	14	14	-	SMD 0 higher (0.74 lower to 0.74 higher)	VERY LOW	IMPORTANT
EDI - Bulimia - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	14	14	-	SMD 0.04 lower (0.78 lower to 0.7 higher)	VERY LOW	IMPORTANT
Exercise - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	14	14	-	SMD 1.23 higher (0.41 to 2.05 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	another Antidepressant	Relative (95% CI)	Absolute		
Clinical Global Impression - Adverse effect - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	reporting bias3	14	14	-	SMD 0.27 lower (1.02 lower to 0.47 higher)	VERY LOW	IMPORTANT
Dropouts due to any reason - SSRI (Citalopram) vs. SSRI (Fluoxetine). Adults												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious6	reporting bias3	5/19 (26.3%)	4/18 (22.2%)	RR 1.18 (0.38 to 3.72)	40 more per 1000 (from 138 fewer to 604 more)	VERY LOW	IMPORTANT

[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)

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1 **Table 126: Full GRADE profile for antidepressant versus combined antidepressant and psychotherapy for people with BN**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
Laxative use. Adults - Self-help (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	20	24	-	SMD 0.04 lower (0.64 lower to 0.55 higher)	VERY LOW	IMPORTANT
Vomiting frequency. Adults (Better indicated by lower values)												
3	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	reporting bias3	48	54	-	SMD 0.19 higher (0.21 lower to 0.58 higher)	VERY LOW	CRITICAL
Vomiting frequency. Adults - Self-help (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	20	24	-	SMD 0.02 lower (0.62 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										0.57 higher)		
Vomiting frequency. Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	reporting bias3	28	30	-	SMD 0.35 higher (0.17 lower to 0.87 higher)	VERY LOW	CRITICAL
Binge frequency- Adults (Better indicated by lower values)												
5	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious5	reporting bias3	104	99	-	SMD 0.26 higher (0.02 lower to 0.547 higher)	VERY LOW	CRITICAL
Binge frequency. Adults - CBT (Better indicated by lower values)												
3	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious5	reporting bias3	56	53	-	SMD 0.63 higher (0.24	VERY	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										to 1.02 higher)	LOW	
Binge frequency. Adults - Self-help (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious5	reporting bias3	20	24	-	SMD 0.02 higher (0.58 lower to 0.61 higher)	VERY LOW	CRITICAL
Binge frequency. Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious11	reporting bias3	28	22	-	SMD 0.29 lower (0.85 lower to 0.27 higher)	VERY LOW	CRITICAL
Purge frequency Total Adults (Better indicated by lower values)												
4	randomised trials	serious7	no serious inconsistency	no serious	serious5	reporting bias3	84	75	-	SMD 0.22 higher	VERY	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
				indirectness						(0.1 lower to 0.54 higher)	LOW	
Purge frequency, Adults - CBT (Better indicated by lower values)												
3	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious5	reporting bias3	56	53	-	SMD 0.49 higher (0.1 to 0.87 higher)	VERY LOW	CRITICAL
Purge frequency, Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious11	none3	28	22	-	SMD 0.35 lower (0.92 lower to 0.21 higher)	LOW	CRITICAL
General psychiatric features - Total Adults (Better indicated by lower values)												
4	randomised trials	serious7	no serious inconsistency	no serious	serious12	reporting bias3	92	87	-	SMD 0.04 lower	VERY	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
				indirectness						(0.33 lower to 0.26 higher)	LOW	
General psychiatric symptoms, Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious13	no serious inconsistency	no serious indirectness	serious5	reporting bias3	44	41	-	SMD 0.1 higher (0.33 lower to 0.53 higher)	VERY LOW	IMPORTANT
General psychiatric symptoms, Adults - Self-help (Better indicated by lower values)												
1	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious11	reporting bias3	20	24	-	SMD 0.09 lower (0.69 lower to 0.5 higher)	VERY LOW	IMPORTANT
General psychiatric symptoms, Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	**Quality**	**Importance**
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious11	reporting bias3	28	22	-	SMD 0.22 lower (0.78 lower to 0.34 higher)	VERY LOW	IMPORTANT
Depression Total Adults (Better indicated by lower values)												
5	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious12	reporting bias3	112	107	-	SMD 0.22 higher (0.05 lower to 0.49 higher)	VERY LOW	CRITICAL
Depression. Adults - CBT (Better indicated by lower values)												
4	randomised trials	serious15	no serious inconsistency	no serious indirectness	serious5	reporting bias3	64	61	-	SMD 0.29 higher (0.06 lower to 0.65	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										higher)		
Depression. Adults - Self-help (Better indicated by lower values)												
1	randomised trials	serious14	no serious inconsistency	no serious indirectness	serious5	reporting bias3	20	24	-	SMD 0.02 lower (0.62 lower to 0.57 higher)	VERY LOW	CRITICAL
Depression. Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious11	reporting bias3	28	22	-	SMD 0.26 higher (0.3 lower to 0.83 higher)	VERY LOW	
EDE-Shape concern. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	12	12	-	SMD 0.26 higher (0.54 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										to 1.07 higher)		
EDE-Weight concern. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	very serious2	reporting bias3	12	12	-	SMD 0.19 higher (0.62 lower to 0.99 higher)	VERY LOW	IMPORTANT
EDE-Global score, Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious16	no serious inconsistency	no serious indirectness	serious5	reporting bias3	28	23	-	SMD 0.54 higher (0.03 lower to 1.1 higher)	VERY LOW	
EDI-Drive for thinness. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	reporting bias3	16	18	-	SMD 0.24 higher (0.44	VERY	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.92 higher)	LOW	
EDI-Bulimia. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	reporting bias3	16	18	-	SMD 0.6 higher (0.09 lower to 1.29 higher)	VERY LOW	IMPORTANT
EDI-Body dissatisfaction. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	reporting bias3	16	18	-	SMD 0.34 higher (0.34 lower to 1.02 higher)	VERY LOW	IMPORTANT
Dropout due to adverse events. Adults - CBT												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
2	randomised trials	serious15	no serious inconsistency	no serious indirectness	very serious18	reporting bias3	6/70 (8.6%)	8/70 (11.4%)	RR 0.8 (0.31 to 2.07)	23 fewer per 1000 (from 79 fewer to 122 more)	VERY LOW	IMPORTANT
Remission (100% binge free). Adults - Focal/ Supportive Psychotherapy ITT												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	very serious18	reporting bias3	7/28 (25%)	5/17 (29.4%)	RR 1.10 (0.4 to 3)	29 more per 1000 (from 176 fewer to 588 more)	VERY LOW	CRITICAL
Remission (100% binge free). Adults - CBT ITT												
3	randomised trials	serious19	no serious inconsistency	no serious indirectness	serious20	reporting bias3	11/74 (14.9%)	18/81 (22.2%)	RR 0.56 (0.3 to 1.06)	98 fewer per 1000 (from 156 fewer	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										to 13 more)		
Did not achieve Remission (100% binge free) FU Adults - CBT ITT												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious20	reporting bias3	1/23 (4.3%)	1/29 (3.4%)	RR 0.99 (0.89 to 1.11)	0 fewer per 1000 (from 4 fewer to 4 more)	VERY LOW	CRITICAL
Remission (100% purge free). Adults - CBT ITT												
3	randomised trials	serious19	no serious inconsistency	no serious indirectness	serious21	reporting bias3	8/74 (10.8%)	7/81 (8.6%)	RR 1.15 (0.44 to 3.06)	13 more per 1000 (from 48 fewer to 178 more)	VERY LOW	CRITICAL
Remission (100% purge free). Adults - Focal/ Supportive Psychotherapy ITT												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	very serious18	reporting bias3	5/28 (17.9%)	3/22 (13.6%)	RR 1.31 (0.35 to 4.89)	42 more per 1000 (from	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
										89 fewer to 530 more)		
Did not achieve Remission (100% purge free) FU Adults - CBT ITT (Copy)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious20	reporting bias3	3/23 (13%)	1/29 (3.4%)	RR 0.90 (0.76 to 1.07)	3 fewer per 1000 (from 8 fewer to 2 more)	VERY LOW	CRITICAL
Quality of life. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious5	reporting bias3	16	18	-	SMD 0.17 higher (0.5 lower to 0.85 higher)	VERY LOW	IMPORTANT
EDI Body dissatisfaction FU. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious24	no serious inconsistency	no serious	serious5	reporting bias3	21	32	-	SMD 0.11 higher	VERY	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
				indirectness						(0.44 lower to 0.67 higher)	LOW	
Vomit frequency FU. Adults - CBT (Better indicated by lower values)												
1	randomised trials	Serious24	no serious inconsistency	no serious indirectness	serious11	reporting bias3	21	32	-	SMD 0.09 lower (0.65 lower to 0.46 higher)	VERY LOW	CRITICAL
Depression FU. Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious23	no serious inconsistency	no serious indirectness	serious20	reporting bias3	41	51	-	SMD 0.07 higher (0.35 lower to 0.48 higher)	VERY LOW	CRITICAL
Laxative FU abuse - CBT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant	Combined Antidepressant + Psychotherapy (BN)	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 24	no serious inconsistency	no serious indirectness	serious5	reporting bias3	21	32	-	SMD 0.18 higher (0.38 lower to 0.73 higher)	VERY LOW	IMPORTANT
Binge frequency FU. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious24	no serious inconsistency	no serious indirectness	serious12	reporting bias3	21	32	-	SMD 0.00 higher (0.55 lower to 0.55 higher)	VERY LOW	CRITICAL

[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)

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[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 assessors were blind. High dropouts were reported >20%,
[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.
[10] Unclear how random sequence was generated and if allocation concealment was conducted. It is unclear if assessors were blind, High dropouts were reported.
[11] 95% CI crossed 1 MID (-0.5)
[12] For continuous variable, there were fewer than 400 participants.
[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.
[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.
[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.
[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.
[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.
[18] 95% CI crossed 2 MIDs (0.75 and 1.25)
[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.
[20] For a dichotomous outcome, there were fewer than 300 events.
[21] 95% CI crossed 1 MID (0.75)
[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%.
[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%.
[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%.

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1 **Table 127: Full GRADE profile for antidepressant and nutrition versus placebo and nutrition for people with bulimia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+Nutrition	Placebo+Nutrition	Relative (95% CI)	Absolute		
EDE- Weight concern FU. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	34	33	-	SMD 0.12 lower (0.6 lower to 0.36 higher)	VERY LOW	IMPORTANT
EDE- Weight . Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	34	33	-	SMD 0.94 lower (1.45 to 0.44 lower)	VERY LOW	IMPORTANT
EDE-Eating concern. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	34	33	-	SMD 0.04 lower (0.51 lower to 0.44 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+Nutrition	Placebo+Nutrition	Relative (95% CI)	Absolute	Quality	Importance
EDE-Eating concern FU. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	34	33	-	SMD 0.12 higher (0.36 lower to 0.6 higher)	VERY LOW	IMPORTANT
EDE-Shape concern. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	34	33	-	SMD 0.63 lower (1.13 to 0.14 lower)	VERY LOW	IMPORTANT
EDE-Shape concern FU. Adults - SSRI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	reporting bias3	34	33	-	SMD 0.26 higher (0.23 lower to 0.74 higher)	VERY LOW	IMPORTANT
Dropout due to any reason. Adults - SSRI												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+Nutrition	Placebo+Nutrition	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	reporting bias3	11/34 (32.4%)	7/33 (21.2%)	RR 1.53 (0.67 to 3.45)	112 more per 1000 (from 70 fewer to 520 more)	VERY LOW	IMPORTANT
Dropout due to adverse events. Adults - SSRI												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	reporting bias3	4/34 (11.8%)	0/33 (0%)	RR 0.88 (0.77 to 1.01)	-	VERY LOW	IMPORTANT

[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)

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1 **Table 128: Full GRADE profile for psychotherapy versus antidepressant for people with BN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute		
Laxative use. Adults - Self-help (Guided) (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	25	20	-	SMD 0.56 higher (0.04 lower to 1.16 higher)	VERY LOW	IMPORTANT
Vomiting. Adults (Better indicated by lower values)												
3	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	91	92	-	SMD 0.51 higher (0.21 to 0.8 higher)	VERY LOW	CRITICAL
Vomiting. Adults - Self-help (Guided) (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	25	20	-	SMD 0.82 higher (0.21 to 1.44 higher)	VERY LOW	CRITICAL
Vomiting. Adults - CBT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
2	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious2	reporting bias3	44	44	-	SMD 0.36 higher (0.06 lower to 0.78 higher)	VERY LOW	CRITICAL
Vomiting. Adults - Focal psychoeducation (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	22	28	-	SMD 0.49 higher (0.08 lower to 1.06 higher)	VERY LOW	CRITICAL
Binge frequency Total Adult (Better indicated by lower values)												
4	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious7	reporting bias3	91	92	-	SMD 0.09 higher (0.2 lower to 0.38 higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	**Quality**	**Importance**
Binge frequency. Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious7	reporting bias3	44	44	-	SMD 0.10 lower (0.52 lower to 0.32 higher)	VERY LOW	CRITICAL
Binge frequency. Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	22	28	-	SMD 0.19 higher (0.37 lower to 0.75 higher)	VERY LOW	CRITICAL
Binge frequency. Adults - Self-help (Guided) (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	25	20	-	SMD 0.37 higher (0.22 lower to 0.97	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
										higher)		
Binge frequency (follow up). Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious8	reporting bias3	61	45	-	SMD 0.13 lower (0.51 lower to 0.26 higher)	VERY LOW	CRITICAL
Purge frequency Total Adults (Better indicated by lower values)												
3	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious7	reporting bias3	66	72	-	SMD 0.28 higher (0.05 lower to 0.62 higher)	VERY LOW	CRITICAL
Purge frequency. Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious7	reporting bias3	44	44	-	SMD 0.17 higher (0.25 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
										0.59 higher)		
Purge frequency. Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	22	28	-	SMD 0.49 higher (0.08 lower to 1.06 higher)	VERY LOW	CRITICAL
Purge frequency (follow-up). Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious8	reporting bias3	14	12	-	SMD 0.36 lower (1.14 lower to 0.42 higher)	VERY LOW	CRITICAL
General psychiatric symptoms. Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious8	reporting bias3	44	44	-	SMD 0.11 lower (0.53 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
										to 0.31 higher)		
General psychiatric symptoms. Adults - Self-help (Guided) (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	25	20	-	SMD 0.48 higher (0.11 lower to 1.08 higher)	VERY LOW	IMPORTANT
General psychiatric symptoms. Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	22	28	-	SMD 0.22 higher (0.34 lower to 0.78 higher)	VERY LOW	IMPORTANT
EDI-Drive for thinness. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious8	reporting bias3	19	16	-	SMD 0.39 lower (1.06	VERY	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.28 higher)	LOW	
EDI-Weight concern. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious2	reporting bias3	14	12	-	SMD 0.15 lower (0.93 lower to 0.62 higher)	VERY LOW	IMPORTANT
EDI-Shape concern. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	very serious12	reporting bias3	14	12	-	SMD 0.25 lower (1.03 lower to 0.52 higher)	VERY LOW	IMPORTANT
Depression scores. Adults - CBT (Better indicated by lower values)												
4	randomised trials	serious4	no serious inconsistency	no serious	serious8	reporting bias3	79	62	-	SMD 0.14 lower	VERY	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
				indirectness						(0.48 lower to 0.2 higher)	LOW	
Depression scores. Adults - Self-help (guided) (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious8	reporting bias3	25	20	-	SMD 0.45 higher (0.14 lower to 1.05 higher)	VERY LOW	CRITICAL
Depression scores. Adults - Focal/ Supportive Psychotherapy (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	reporting bias3	22	28	-	SMD 0.2 higher (0.36 lower to 0.76 higher)	VERY LOW	CRITICAL
Depression scores (follow up). Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious13	no serious inconsistency	no serious	serious7	reporting bias3	46	30	-	SMD 0 higher	VERY	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute		
				indirectness						(47 lower to 0.47 higher)	LOW	
EDE-Global Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious8	reporting bias3	25	28	-	SMD 0.39 lower (0.94 lower to 0.15 higher)	VERY LOW	IMPORTANT
EDE-Bulimia. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious8	reporting bias3	19	16	-	SMD 0.51 lower (1.19 lower to 0.17 higher)	VERY LOW	IMPORTANT
EDE-Body dissatisfaction. Adults - CBT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious8	reporting bias3	19	16	-	SMD 0.44 lower (1.11 lower to 0.24 higher)	VERY LOW	IMPORTANT
Did not achieve remission (100% purge free). Adults - CBT ITT												
3	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious14	reporting bias3	18/71 (25.4%)	8/74 (10.8%)	RR 0.84 (0.71 to 0.98)	17 fewer per 1000 (from 2 fewer to 31 fewer)	VERY LOW	CRITICAL
Did not achieve remission (100% purge free). Adults - Focal/ Supportive Psychotherapy ITT												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious15	reporting bias3	2/22 (9.1%)	5/28 (17.9%)	RR 1.11 (0.89 to 1.38)	20 more per 1000 (from 20 fewer to 68 more)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
Did not achieve remission (100% purge free) FU Adults - CBT ITT												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious15	reporting bias3	2/24 (8.3%)	3/23 (13%)	RR 1.05 (0.86 to 1.29)	7 more per 1000 (from 18 fewer to 38 more)	VERY LOW	
Did not achieve remission (100% binge free). Adults - CBT ITT												
4	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious14	reporting bias3	34/105 (32.4%)	20/128 (15.6%)	RR 0.78 (0.67 to 0.92)	34 fewer per 1000 (from 12 fewer to 52 fewer)	VERY LOW	CRITICAL
Did not achieve remission (100% binge free). Adults - Focal/ Supportive Psychotherapy ITT												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	very serious16	reporting bias3	5/22 (22.7%)	7/28 (25%)	RR 1.03 (0.75 to 1.41)	7 more per 1000 (from 62 fewer	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	**Quality**	**Importance**
										to 102 more)		
Did not achieve remission (100% binge free) FU. Adults - CBT ITT												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious15	reporting bias3	4/24 (16.7%)	1/23 (4.3%)	RR 0.87 (0.71 to 1.06)	6 fewer per 1000 (from 13 fewer to 3 more)	VERY LOW	CRITICAL
No adverse events. Adults - CBT												
2	randomised trials	serious18	no serious inconsistency	no serious indirectness	serious19	reporting bias3	1/53 (1.9%)	6/70 (8.6%)	RR 1.09 (0.99 to 1.2)	8 more per 1000 (from 1 fewer to 17 more)	VERY LOW	IMPORTANT
Quality of life - CBT (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious7	reporting bias3	19	16	-	SMD 0.49 lower (1.17 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
										0.19 higher)		
Laxative FU abuse - CBT (Better indicated by lower values)												
1	randomised trials	serious20	no serious inconsistency	no serious indirectness	serious7	reporting bias3	24	21	-	SMD 0.41 lower (1 lower to 0.18 higher)	VERY LOW	IMPORTANT
Vomit frequency FU. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious20	no serious inconsistency	no serious indirectness	very serious12	reporting bias3	24	21	-	SMD 0.05 lower (0.64 lower to 0.54 higher)	VERY LOW	CRITICAL
EDI Body dissatisfaction FU. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious20	no serious inconsistency	no serious indirectness	serious8	reporting bias3	24	21	-	SMD 0.49 lower (1.09 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Antidepressant	Relative (95% CI)	Absolute		
										to 0.1 higher)		

[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 bind 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 drop outs 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 drop outs 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 drop outs 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%,

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[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 129: Full GRADE profile for psychotherapy versus combined antidepressant and psychotherapy for people with BN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Combined Psychotherapy+Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
Binges. Adults (Better indicated by lower values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	44	42	-	SMD 0.42 higher (0.01 lower to 0.85 higher)	VERY LOW	CRITICAL
Binges. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	very serious 5	reporting bias3	19	18	-	SMD 0.46 higher (0.19 lower to 1.12 higher)	VERY LOW	CRITICAL
Binges. Adults - Guided SH (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious 7	reporting bias3	25	24	-	SMD 0.39 higher (0.18 lower to 0.95 higher)	VERY LOW	CRITICAL
Vomiting. Total Adults (Better indicated by lower values)												
4	randomised trials	serious1	very serious8	no serious	serious 9	reporting bias3	105	99	-	SMD 0.74 higher (0.45	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Combined Psychotherapy+Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
				indirectness						to 1.04 higher)		
Vomiting. Adults - CBT (Better indicated by lower values)												
3	randomised trials	serious1	very serious8	no serious indirectness	serious 2	reporting bias3	58	53	-	SMD 0.98 higher (0.56 to 1.4 higher)	VERY LOW	CRITICAL
Vomiting. Adults - Guided SH (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	25	24	-	SMD 0.75 higher (0.16 to 1.33 higher)	VERY LOW	CRITICAL
Vomiting. Adults - Focal psychoeducation (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	22	22	-	SMD 0.25 higher (0.35 lower to 0.84 higher)	VERY LOW	CRITICAL
Objective purges. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	14	12	-	SMD 0.44 higher (0.35 lower to 1.22 higher)	VERY LOW	CRITICAL
Laxative use - Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	25	24	-	SMD 0.55 higher (0.02 lower to 1.12 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychotherapy	Combined Psychotherapy+Antidepressant	Relative (95% CI)	Absolute	Quality	Importance
EDE-Global score. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious2	reporting bias3	25	23	-	SMD 0.14 higher (0.42 lower to 0.71 higher)	VERY LOW	IMPORTANT
EDE - Shape concern. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	very serious5	reporting bias3	14	12	-	SMD 0 higher (0.77 lower to 0.77 higher)	VERY LOW	IMPORTANT
EDE-Body dissatisfaction, Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	very serious5	reporting bias3	19	18	-	SMD 0.04 lower (0.68 lower to 0.61 higher)	VERY LOW	IMPORTANT
EDE-Weight concern, Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious11	no serious inconsistency	no serious indirectness	very serious5	reporting bias3	14	12	-	SMD 0 higher (0.77 lower to 0.77 higher)	VERY LOW	IMPORTANT
EDI-Drive for thinness. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious9	reporting bias3	19	18	-	SMD 0.16 lower (0.8 lower to 0.49 higher)	VERY LOW	IMPORTANT
EDI-Bulimia. Adults - CBT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychotherapy**	**Combined Psychotherapy+Antidepressant**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	very serious 5	reporting bias3	19	18	-	SMD 0.01 higher (0.63 lower to 0.66 higher)	VERY LOW	IMPORTANT
Depression, Adults - CBT (Better indicated by lower values)												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	57	51	-	SMD 0.18 higher (0.2 lower to 0.56 higher)	VERY LOW	CRITICAL
Depression, Adults - Focal psychoeducation (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	22	22	-	SMD 0.37 higher (0.22 lower to 0.97 higher)	VERY LOW	CRITICAL
Remission. Adults - CBT_ITT												
3	randomised trials	serious1	serious13	no serious indirectness	very serious 14	reporting bias3	14/71 (19.7%)	15/81 (18.5%)	RR 1.14 (0.32 to 4.13)	26 more per 1000 (from 126 fewer to 580 more)	VERY LOW	CRITICAL
Remission. Adults - Focal/psychoeducation_ITT												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	very serious 14	reporting bias3	2/22 (9.1%)	3/22 (13.6%)	RR 0.67 (0.12 to 3.61)	45 fewer per 1000 (from 120 fewer to 356 more)	VERY LOW	CRITICAL
Quality of life - Adults - CBT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychotherapy**	**Combined Psychotherapy+Antidepressant**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious 9	reporting bias3	19	18	-	SMD 0.43 lower (1.08 lower to 0.22 higher)	VERY LOW	IMPORTANT
General symptoms - Guided SH (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	25	24	-	SMD 0.37 higher (0.2 lower to 0.93 higher)	VERY LOW	IMPORTANT
General symptoms - CBT (Better indicated by lower values)												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious 2	reporting bias3	25	23	-	SMD 0.18 higher (0.23 lower to 0.59 higher)	VERY LOW	
General symptoms - Focal psychoeducation (Better indicated by lower values)												
1	randomised trials	serious10	no serious inconsistency	no serious indirectness	very serious 5	reporting bias3	22	22	-	SMD 0 higher (0.59 lower to 0.59 higher)	VERY LOW	IMPORTANT
No side-effects. Adults - CBT												
2	randomised trials	serious15	no serious inconsistency	no serious indirectness	serious 16	reporting bias3	1/53 (1.9%)	8/70 (11.4%)	RR 1.12 (1.01 to 1.25)	14 more per 1000 (from 1 more to 29 more)	VERY LOW	IMPORTANT
Binge frequency FU. Adults - CBT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychotherapy**	**Combined Psychotherapy+Antidepressant**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious9	reporting bias3	24	32	-	SMD 0.05 lower (0.58 lower to 0.48 higher)	VERY LOW	CRITICAL
Laxative FU abuse - CBT (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious9	reporting bias3	46	41	-	SMD 0.06 lower (0.5 lower to 0.38 higher)	VERY LOW	IMPORTANT
VERY LOW												
VERY LOW	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious9	reporting bias3	24	32	-	SMD 0.13 lower (0.66 lower to 0.4 higher)	□□□□ VERY LOW	CRITICAL
Depression FU. Adults - CBT (Better indicated by lower values)												
2	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious2	reporting bias3	46	41	-	SMD 0.18 higher (0.25 lower to 0.62 higher)	VERY LOW	CRITICAL
EDI Body dissatisfaction FU. Adults - CBT (Better indicated by lower values)												
1	randomised trials	serious17	no serious inconsistency	no serious indirectness	serious9	reporting bias3	24	32	-	SMD 0.36 lower (0.89 lower to 0.18 higher)	VERY LOW	IMPORTANT
Did not achieve Remission-FU. Adults - CBT_ITT												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychotherapy**	**Combined Psychotherapy+Antidepressant**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious 19	reporting bias3	4/24 (16.7%)	1/29 (3.4%)	RR 0.86 (0.71 to 1.05)	5 fewer per 1000 (from 10 fewer to 2 more)	VERY LOW	CRITICAL

[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 drop outs 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 drop outs 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 drop outs 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 drop outs 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 drop outs 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 drop outs were reported >20%,
[13] Heterogeneity was detected 12>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 drop outs were reported >20%,

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[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.

Table 130: Full GRADE profile for anticonvulsants versus placebo for people with BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Anticonvulsant	placebo	Relative (95% CI)	Absolute		
Clinical Global Impressions-Severity of Illness Scale (CGI-S). Adults (Better indicated by lower values)												
1	randomised trials	Serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	31	33	-	SMD 0.47 lower (0.97 lower to 0.02 higher)	VERY LOW	IMPORTANT
Clinical Global Impressions-Improvement Scale (CGI-I). Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	31	33	-	SMD 0.68 lower (1.19 to 0.18 lower)	VERY LOW	CRITICAL
EDI - Drive for thinness. Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	31	33	-	SMD 0.86 lower (1.37 to 0.34 lower)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Anticonvulsant	placebo	Relative (95% CI)	Absolute		
EDI - Bulimia. Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	31	33	-	SMD 0.66 lower (1.17 to 0.16 lower)	VERY LOW	IMPORTANT
EDI - Body dissatisfaction. Adults (Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious2	reporting bias3	31	33	-	SMD 0.7 lower (1.21 to 0.19 lower)	VERY LOW	IMPORTANT
General health perceptions - SF-36. Adults (Better indicated by higher values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious1	reporting bias3	30	30	-	SMD 1.22 higher (0.67 to 1.78 higher)	VERY LOW	IMPORTANT
No side-effects. Adults												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious6	reporting bias3	1/34 (2.9%)	2/33 (6.1%)	RR 1.03 (0.93 to 1.15)	2 more per 1000 (from 4 fewer	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Anticonvulsant	placebo	Relative (95% CI)	Absolute		
										to 9 more)		

[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 131: Full GRADE profile for another medication versus placebo for people with BN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Other medication (not antidepressants) vs, placebo	Control	Relative (95% CI)	Absolute		
Ddid not dropout due to adverse events. Adults - Antiemetics												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	0/14 (0%)	0/12 (0%)	Not estimable	-	VERY LOW	IMPORTANT

[1] It was unclear if assessors were blind.
[2] For a dichotomous outcome there were fewer than 300 events.

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[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.

L.5.3 Pharmacological interventions for binge eating disorder

Table 132: Full GRADE profile for antidepressant versus placebo in adults with binge eating disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute	Quality	Importance
Remission (follow-up 12 months; assessed with: >=2 weeks assessment period (e.g. EDE OBE))												
4	randomised trials	serious1,2,3,4	no serious inconsistency	serious5	serious6	none	37/99 (37.4%)	27/100 (27%)	RR 1.39 (0.92 to 2.09)	105 more per 1000 (from 22 fewer to 294 more)	VERY LOW	CRITICAL
Binge Frequency (measured with: binge episodes/week or month, binge days/week; Better indicated by lower values)												
4	randomised trials	serious1,2,3,4	no serious inconsistency	serious5	serious7	none	96	100	-	SMD 0.18 lower (0.42 lower to 0.06 higher)	VERY LOW	CRITICAL
BMI/Weight (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
8	randomised trials	serious1,2,3,4,8,9,10,11	serious12	serious5	serious7	reporting bias13	193	186	-	SMD 0.15 lower (0.51 lower to 0.22 higher)	VERY LOW	IMPORTANT
Withdrawn due to Adverse Events												
5	randomised trials	serious2,3,8,9,10	no serious inconsistency	serious5	serious7	reporting bias13	12/129 (9.3%)	4/126 (3.2%)	RR 2.35 (0.91 to 6.08)	43 more per 1000 (from 3 fewer to 161 more)	VERY LOW	CRITICAL
EDE-Q Global (range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,4	no serious inconsistency	no serious indirectness	serious7	none	58	57	-	SMD 0.03 higher (0.34 lower to 0.39 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
EDE-Q Dietary Restraint (range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,4	serious12	no serious indirectness	very serious14	none	58	57	-	SMD 0.07 higher (0.51 lower to 0.66 higher)	VERY LOW	IMPORTANT
EDE-Q Eating Concerns (range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,4	no serious inconsistency	no serious indirectness	serious6	none	58	57	-	SMD 0.15 higher (0.22 lower to 0.52 higher)	LOW	IMPORTANT
EDE-Q Weight Concerns (range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,4	no serious inconsistency	no serious indirectness	serious7	none	58	57	-	SMD 0.1 higher (0.27 lower to 0.46	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
										higher)		
EDE-Q Shape Concerns (range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,4	no serious inconsistency	no serious indirectness	serious7	none	58	57	-	SMD 0.11 lower (0.47 lower to 0.26 higher)	LOW	IMPORTANT
Depression (measured with: HRSD, BDI, IDS-C; Better indicated by lower values)												
8	randomised trials	serious1,2,3,4,8,9,10,11	no serious inconsistency	serious5	serious7	reporting bias13	195	187	-	SMD 0.2 lower (0.4 lower to 0.01 higher)	VERY LOW	IMPORTANT
Clinical Global Impressions - Severity of Illness (range of scores: 1-7; Better indicated by lower values)												
6	randomised trials	serious2,3,8,9,10,11	no serious inconsistency	serious5	serious6	reporting bias13	137	130	-	SMD 0.71 lower (0.96 to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Placebo	Relative (95% CI)	Absolute		
										0.46 lower)		
Clinical Global Impressions - Severity of Illness for depressive disorders (range of scores: 1-7; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	serious5	serious6	none	18	20	-	SMD 0.51 lower (1.16 lower to 0.14 higher)	VERY LOW	IMPORTANT
Clinical Global Impressions - Improvement of Illness for depressive disorders (range of scores: 1-7; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	serious5	serious6	none	18	20	-	SMD 0.54 lower (1.19 lower to 0.11 higher)	VERY LOW	IMPORTANT

1 1 Grilo 2005/2012: Randomization method and allocation concealment unclear. Assessor blinding unclear. Intervention group dropout rate>20%.
2 2 Guerdjikova 2008: Randomization method unclear. Intervention group dropout rate>20%.
3 3 Guerdjikova 2012: Duloxetine group significantly older than placebo group. Randomization method unclear. Dropout rate for both groups>20%.
4 4 White 2013: Randomization method and allocation concealment unclear. Assessor blinding unclear.
5 5 Population for Guerdjikova 2012 were BED patients with comorbid depressive disorder.
6 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
7 7 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

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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: Randomization 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).

Table 133: Full GRADE profile for antidepressant-1 versus antidepressant-2 in adults with binge eating disorder at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1 v Antidepressant-2		Relative (95% CI)	Absolute	Quality	Importance
Binge Frequency (measured with: Mean binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	21	22	-	SMD 0.33 higher (0.27 lower to 0.94 higher)	LOW	CRITICAL
BMI (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	16	15	-	SMD 0.40 higher (1.11 lower to 0.31 higher)	LOW	IMPORTANT
#>5% Weight Loss												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1 v Antidepressant-2		Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	very serious4	none	8/17 (47.1%)	9/20 (45%)	RR 1.05 (0.52 to 2.1)	22 more per 1000 (from 216 fewer to 495 more)	VERY LOW	CRITICAL
Withdrawn due to Adverse Events (follow-up 12 months)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	none	2/21 (9.5%)	4/22 (18.2%)	RR 0.52 (0.11 to 2.56)	87 fewer per 1000 (from 162 fewer to 284 more)	VERY LOW	CRITICAL
# Binge Eating Scale score < 17												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	very serious4	none	7/17 (41.2%)	10/22 (45.5%)	RR 0.91 (0.44 to 1.88)	41 fewer per 1000 (from 255 fewer to 400 more)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1 v Antidepressant-2		Relative (95% CI)	Absolute		
Binge Eating Scale (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	15	16	-	SMD 0.32 higher (0.39 lower to 1.03 higher)	LOW	IMPORTANT
EDI-2 Drive for Thinness (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	15	16	-	SMD 0.26 lower (0.97 lower to 0.45 higher)	LOW	IMPORTANT
EDI-2 Bulimia (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	15	16	-	SMD 0.24 higher (0.46 lower to 0.95 higher)	LOW	IMPORTANT
EDI-2 Body Dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	very serious4	none	15	16	-	SMD 0.1 lower	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1 v Antidepressant-2		Relative (95% CI)	Absolute		
										(0.81 lower to 0.6 higher)	Y LOW	
Depression (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	15	16	-	SMD 0.24 lower (0.95 lower to 0.47 higher)	LOW	IMPORTANT
Clinical Global Impression - Severity of Illness (Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	15	16	-	SMD 0.32 higher (0.39 lower to 1.03 higher)	LOW	IMPORTANT

1 1 Ricca 2001: inadequate randomization method, treatment allocation unclear. No participant, investigator nor assessor blinding. Dropout rate of both
2 treatment groups>20%.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 Leombruni 2008: Randomization method and allocation concealment unclear. Investigator and assessor blinding unclear. Dropout rate both groups>20%,
5 reasons not stated.
6 4 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

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Table 134: Full GRADE profile for antidepressant-1 versus antidepressant-2 in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1	Antidepressant-2	Relative (95% CI)	Absolute		
Binge Frequency 12-mo FU (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	16	16	-	SMD 1.17 higher (0.41 to 1.93 higher)	LOW	IMPORTANT

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).

Table 135: Full GRADE profile for antidepressant versus any individual therapy in adults with binge eating disorder at end of treatment and follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Any individual therapy	Relative (95% CI)	Absolute		
Binge Frequency (follow-up 12 months; measured with: Mean binge episodes/month; Better indicated by lower values)												
2	randomised trials	serious1,2	serious3	serious4	serious5	none	63	40	-	SMD 2.57 higher (2.02	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Any individual therapy	Relative (95% CI)	Absolute		
										to 3.13 higher)		
% Weight Loss (Better indicated by higher values)												
1	randomised trials	serious2	no serious inconsistency	serious4	serious5	none	20	20	-	SMD 2.26 lower (3.07 to 1.45 lower)	VERY LOW	IMPORTANT
EDI-2 Bulimia (Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	serious4	serious5	none	20	20	-	SMD 2.52 higher (1.67 to 3.38 higher)	VERY LOW	IMPORTANT
Depression (measured with: MMPI-2 Depression; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	serious4	serious5	none	20	20	-	SMD 1.17 higher (0.5 to 1.85 higher)	VERY LOW	IMPORTANT
Family Functioning (measured with: MMPI-2 Family Problems; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	serious4	serious6	none	20	20	-	SMD 0.14 higher (0.48	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants	Any individual therapy	Relative (95% CI)	Absolute		
										lower to 0.76 higher)		
Binge Frequency FU (measured with: Mean binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	32	17	-	SMD 3.08 higher (2.19 to 3.97 higher)	LOW	CRITICAL

1 1 Ricca 2001: Randomization method inadequate (allocated to treatment groups enrolment day, allocation concealment unclear. No participant, investigator,
2 assessor blinding. Dropout rate for both arms>20%.
3 2 Molinari 2005: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear.
4 3 I2>=50%.
5 4 Molinari 2005: both Fluoxetine+CBT and CBT only groups also had Group Nutritional Counselling + Diet.
6 5 <400 participants.
7 6 CI crosses either 0.5 or -0.5 (SMD).

8 **Table 136: Full GRADE profile for appetite suppressant versus placebo in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Appetite Suppressants	Control	Relative (95% CI)	Absolute		
Remission (ITT) (assessed with: 100% reduction binge episodes in past 4 weeks)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Appetite Suppressants	Control	Relative (95% CI)	Absolute		
3	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	no serious imprecision	none	220/582 (37.8%)	62/450 (13.8%)	RR 2.6 (2.02 to 3.36)	220 more per 1000 (from 141 more to 325 more)	MODERATE	CRITICAL
BMI (change scores) (Better indicated by lower values)												
3	randomised trials	serious1,2	serious3	no serious indirectness	no serious imprecision	none	560	423	-	SMD 1.24 lower (1.51 to 0.98 lower)	LOW	IMPORTANT
Withdrawn due to Adverse Events												
3	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious4	none	26/569 (4.6%)	9/435 (2.1%)	RR 2.05 (1.01 to 4.18)	22 more per 1000 (from 0 more to 66 more)	LOW	CRITICAL
Binge Eating Scale (range of scores: 0-46; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Appetite Suppressants	Control	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	193	62	-	SMD 4.11 lower (4.59 to 3.63 lower)	LOW	IMPORTANT
Depression (measured with: MADRS; range of scores: 0-60; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	193	62	-	SMD 0.28 higher (0.01 lower to 0.57 higher)	LOW	IMPORTANT
General Physical Functioning (measured with: SF-12 Physical; range of scores: 0-100; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	193	62	-	SMD 0.27 higher (0.01 lower to 0.56 higher)	LOW	IMPORTANT
General Mental Functioning (measured with: SF-12 Mental; range of scores: 0-100; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious5	none	193	62	-	SMD 0.03 higher (0.26	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Appetite Suppressants	Control	Relative (95% CI)	Absolute		
										lower to 0.32 higher)		

1 1 McElroy 2015: Dropout rate for all arms>=20%.
2 2 McElroy and Hudson 2016 Study 1 and 2: unclear whether assessor blinded. McElroy and Hudson 2016 Study 2: dropout rate for both groups>=20%.
3 3 I2>50%.
4 4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
5 5 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

6

7 **Table 137: Full GRADE profile for antiepileptic (anticonvulsant) versus placebo in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptics	Placebo	Relative (95% CI)	Absolute		
Remission (ITT)												
2	randomised trials	serious1,2	serious3	no serious indirectness	very serious4	none	28/56 (50%)	31/55 (56.4%)	RR 0.88 (0.53 to 1.44)	68 fewer per 1000 (from 265 fewer	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptics	Placebo	Relative (95% CI)	Absolute		
										to 248 more)		
Binge Frequency (measured with: binge episodes/week or binge days/week; Better indicated by lower values)												
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious5	none	56	55	-	SMD 0.23 lower (0.49 lower to 0.03 higher)	LOW	CRITICAL
Withdrawn due to Adverse Events												
4	randomised trials	serious1,2,6,7	no serious inconsistency	no serious indirectness	serious5	none	46/285 (16.1%)	24/288 (8.3%)	RR 1.94 (1.22 to 3.08)	78 more per 1000 (from 18 more to 173 more)	LOW	CRITICAL
BMI (Better indicated by lower values)												
4	randomised trials	serious1,2,6,7	no serious inconsistency	no serious indirectness	serious5	none	281	284	-	SMD 0.45 lower (0.62 to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptics	Placebo	Relative (95% CI)	Absolute		
										0.29 lower)		
EDE-Q Global (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	26	25	-	SMD 0.44 lower (0.99 lower to 0.12 higher)	LOW	IMPORTANT
EDE-Q Restraint (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	26	25	-	SMD 0.12 lower (0.67 lower to 0.43 higher)	LOW	IMPORTANT
EDE-Q Weight Concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	26	25	-	SMD 0.48 lower (1.04 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptics	Placebo	Relative (95% CI)	Absolute		
										0.08 higher)		
EDE-Q Eating Concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	very serious4	none	26	25	-	SMD 0.03 lower (0.58 lower to 0.51 higher)	VERY LOW	IMPORTANT
EDE-Q Shape Concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious5	none	26	25	-	SMD 0.48 lower (1.04 lower to 0.08 higher)	LOW	IMPORTANT
Depression (measured with: HAM-D, MADRS, HDRS; Better indicated by lower values)												
4	randomised trials	serious1,2,6,7	serious3	no serious indirectness	no serious imprecision	none	281	284	-	SMD 0.05 higher (0.3 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptics	Placebo	Relative (95% CI)	Absolute		
										to 0.39 higher)		
Clinical Global Impressions - Severity of Illness (range of scores: 1-7; Better indicated by lower values)												
3	randomised trials	serious1,2,6	serious3	no serious indirectness	serious5	none	86	86	-	SMD 0.56 lower (0.9 to 0.23 lower)	VERY LOW	IMPORTANT
General functioning (measured with: Sheehan Disability Scale Total; range of scores: 0-10; Better indicated by lower values)												
2	randomised trials	serious2,7	no serious inconsistency	no serious indirectness	no serious imprecision	none	221	224	-	SMD 0.24 lower (0.43 to 0.05 lower)	MODERATE	IMPORTANT

1 1 McElroy 2006: Randomization method and allocation concealment unclear. Dropout rate for both groups>20%.
2 2 Guerdjikova 2009: Randomization method unclear. Dropout rate for both groups>20%.
3 3 I2>50%.
4 4 CI crosses both 0.5 and -0.5 (SMD).
5 5 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
6 6 McElroy and Arnold 2003: Randomization method and allocation concealment unclear. Dropout rate for both groups>20%.
7 7 McElroy and Hudson 2007: Randomization method and allocation concealment unclear. Dropout rate for both groups>20%.

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1

2 **Table 138: Full GRADE profile for substance abuse treatment agent versus placebo in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Substance Abuse Treatment Agents	Placebo	Relative (95% CI)	Absolute		
Remission												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	very serious3	none	15/52 (28.8%)	23/57 (40.4 %)	RR 0.82 (0.31 to 2.15)	73 fewer per 1000 (from 278 fewer to 464 more)	VERY LOW	CRITICAL
BMI (Better indicated by lower values)												
2	randomised trials	serious1, 2	very serious4	no serious indirectness	very serious3	none	41	45	-	SMD 0.49 lower (1.71 lower to 0.73 higher)	VERY LOW	IMPORTANT
Weight (Better indicated by lower values)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious5	none	41	45	-	SMD 0.05 lower (0.48 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Substance Abuse Treatment Agents	Placebo	Relative (95% CI)	Absolute		
										0.38 higher)		
Binge episode Frequency (measured with: Mean binge episodes/week (raw and change scores); Better indicated by lower values)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious6	none	41	45	-	SMD 0.15 lower (0.58 lower to 0.28 higher)	LOW	CRITICAL
Binge Day Frequency (measured with: binge days/week (raw and change scores); Better indicated by lower values)												
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious5	none	41	45	-	SMD 0.07 higher (0.36 lower to 0.5 higher)	LOW	CRITICAL
Withdrawn due to Adverse Event												
2	randomised trials	serious1, 2	very serious4	no serious indirectness	very serious3	none	14/51 (27.5%)	1/57 (1.8%)	RR 6.99 (0.4 to 123.52)	105 more per 1000 (from 11 fewer to 1000 more)	VERY LOW	CRITICAL
Clinical Global Impressions - Severity of Illness (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Substance Abuse Treatment Agents	Placebo	Relative (95% CI)	Absolute		
2	randomised trials	serious1, 2	no serious inconsistency	no serious indirectness	serious6	none	41	45	-	SMD 0.17 higher (0.26 lower to 0.61 higher)	LOW	IMPORTANT
Depression (measured with: MADRS; range of scores: 0-60; Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	very serious3	none	15	9	-	SMD 0.08 lower (0.9 lower to 0.75 higher)	VERY LOW	IMPORTANT
Depression - change scores (measured with: BDI; range of scores: 0-63; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	26	36	-	SMD 0.43 higher (0.08 lower to 0.95 higher)	LOW	IMPORTANT
General Physical Functioning (measured with: SF-12 Physical; range of scores: 0-100; Better indicated by higher values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	very serious3	none	15	9	-	SMD 0.25 higher (0.58 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Substance Abuse Treatment Agents	Placebo	Relative (95% CI)	Absolute		
										1.08 higher)		
General Mental Functioning (measured with: SF-12 Mental; range of scores: 0-100; Better indicated by higher values)												
1	randomised trials	serious2	no serious inconsistency	no serious indirectness	serious6	none	15	9	-	SMD 0.39 higher (0.45 lower to 1.22 higher)	LOW	IMPORTANT

1 1 McElroy 2013: Unclear randomization method and treatment allocation. Intervention group dropout rate>=50%.
2 2 McElroy 2011: Unclear randomization method. Dropout rate for both groups>20%.
3 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
4 4 I2>80%.
5 5 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
6 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

7

8 **Table 139: Full GRADE profile for atomoxetine versus placebo in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Atomoxetine	Placebo	Relative (95% CI)	Absolute		
Remission (assessed with: 100% decrease frequency binge episodes from baseline)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Atomoxetine	Placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	14/20 (70%)	6/19 (31.6%)	RR 2.33 (1.13 to 4.83)	420 more per 1000 (from 41 more to 1000 more)	LOW	CRITICAL
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	20	-	SMD 0.74 lower (1.38 to 0.1 lower)	LOW	IMPORTANT
Weight loss (kg) (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	20	-	SMD 0.77 higher (0.12 to 1.41 higher)	LOW	IMPORTANT
Binge Frequency (measured with: Binge episodes/week or binge days/week; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	20	-	SMD 0.72 lower (1.17 to 0.27 lower)	LOW	CRITICAL
Withdrawn due to Adverse Events												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Atomoxetine	Placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	3/20 (15%)	1/20 (5%)	RR 3 (0.34 to 26.45)	100 more per 1000 (from 33 fewer to 1000 more)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	20	20	-	SMD 0.05 higher (0.57 lower to 0.67 higher)	VERY LOW	IMPORTANT
Clinical Global Impressions - Severity of Illness (range of scores: 1-7; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	20	20	-	SMD 1.1 lower (1.77 to 0.44 lower)	LOW	IMPORTANT

1 1 McElroy 2007: Randomization method and allocation concealment unclear. Dropout rate for both arms>20%.
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 CI crosses both 0.5 and -0.5.

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1 **Table 140: Full GRADE profile for armodafinil versus placebo in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Armodafinil v Placebo	Control	Relative (95% CI)	Absolute		
Remission												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	7/27 (25.9%)	6/28 (21.4 %)	RR 1.21 (0.47 to 3.14)	45 more per 1000 (from 114 fewer to 459 more)	VERY LOW	CRITICAL
BMI - Change scores (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	27	28	-	SMD 0.67 lower (1.22 to 0.13 lower)	LOW	IMPORTANT
Withdrawn due to adverse events												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	2/30 (6.7%)	2/30 (6.7%)	RR 1 (0.15 to 6.64)	0 fewer per 1000 (from 57 fewer to 376 more)	LOW	CRITICAL
Binge Frequency - Change scores (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Armodafinil v Placebo	Control	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	27	28	-	SMD 0.46 lower (0.84 to 0.09 lower)	LOW	CRITICAL
Clinical Global Impressions Severity - Change scores (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	27	28	-	SMD 0.49 lower (1.03 lower to 0.04 higher)	LOW	IMPORTANT
Depression - Change scores (measured with: Inventory of Depressive Symptomology; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	27	28	-	SMD 0.01 higher (0.52 lower to 0.54 higher)	VERY LOW	IMPORTANT

1 1 McElroy & Guerdjikova 2015: Dropout rate of both groups >=47%.
2 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or 0.5 and -0.5 (SMD).
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or 0.5 or -0.5 (SMD).
4 4 <300 events.

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Table 141: Full GRADE profile for antidepressant and CBT-ED versus CBT-ED at end of treatment in adults with binge eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	CBT	Relative (95% CI)	Absolute		
Binge Frequency (follow-up 12 months; Better indicated by lower values)												
2	randomised trials	serious1,2	serious3	serious4	serious5	none	65	40	-	SMD 0.14 higher (0.6 lower to 0.89 higher)	VERY LOW	CRITICAL
% Weight Loss (Better indicated by higher values)												
1	randomised trials	serious2	no serious inconsistency	serious4	serious6	none	20	20	-	SMD 0.2 lower (0.82 lower to 0.43 higher)	VERY LOW	IMPORTANT
EDI-2 Bulimia (Better indicated by lower values)												
1	randomised trials	serious2	no serious inconsistency	serious4	serious7	none	20	20	-	SMD 1.25 higher (0.57 to 1.94 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	CBT	Relative (95% CI)	Absolute		
Not withdrawn due to Adverse Events (follow-up 12 months)												
2	randomised trials	serious1,2	no serious inconsistency	serious4	serious7	none	57/65 (87.7%)	40/40 (100%)	RR 0.92 (0.84 to 1.02)	80 fewer per 1000 (from 160 fewer to 20 more)	VERY LOW	CRITICAL
Binge Eating Scale (follow-up 12 months; range of scores: 0-46; Better indicated by lower values)												
1	randomised trials	serious8	no serious inconsistency	no serious indirectness	serious6	none	20	10	-	SMD 0.42 lower (1.19 lower to 0.35 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: MMPI-2 Depression; Better indicated by lower values)												
2	randomised trials	serious2,8	serious3	serious4	serious6	none	40	30	-	SMD 0.18 higher (0.31 lower to 0.68 higher)	VERY LOW	IMPORTANT
Family Functioning (follow-up 12 months; measured with: MMPI-2 family problems; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	CBT	Relative (95% CI)	Absolute		
1	randomised trials	serious2	no serious inconsistency	serious4	serious6	none	20	20	-	SMD 0.28 higher (0.34 lower to 0.91 higher)	VERY LOW	IMPORTANT

1 1 Ricca 2001: Inadequate randomization method. Allocation concealment unclear. No participant, investigator and assessor blinding. Dropout rate of four of
2 five groups>20%.
3 2 Molinari 2005: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear.
4 3 I2>50%.
5 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
6 had Group Nutritional Counselling + Diet.
7 5 CI crosses both 0.5 and -0.5 (SMD).
8 6 CI crosses either 0.5 or -0.5 (SMD).
9 7 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
10 8 Cristina 2014: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear. No details provided
11 regarding dropouts.

12

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Table 142: Full GRADE profile for antidepressant and CBT-ED versus CBT-ED at follow up in adults with binge eating disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	CBT	Relative (95% CI)	Absolute	Quality	Importance
Binge Frequency FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	34	16	-	SMD 4.42 lower (5.53 to 3.3 lower)	LOW	CRITICAL

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).

Table 143: Full GRADE profile for antidepressant and CBT-ED versus placebo and CBT-ED in adults with binge eating disorder at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute	Quality	Importance
Remission (>=2 weeks) (follow-up 12 months; assessed with: EDE-Q No OBE/28 days)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	15/26 (57.7%)	15/28 (53.6%)	RR 1.08 (0.67 to 1.73)	43 more per 1000 (from 177 fewer	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
										to 391 more)		
BMI (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.1 higher (0.43 lower to 0.63 higher)	LOW	IMPORTANT
Binge Frequency (follow-up 12 months; measured with: Mean binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.33 higher (0.21 lower to 0.87 higher)	LOW	CRITICAL
EDE-Q Global (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.08 higher (0.46 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
										0.61 higher)		
EDE-Q Dietary Restraint (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	26	28	-	SMD 0 higher (0.53 lower to 0.53 higher)	VERY LOW	IMPORTANT
EDE-Q Eating Concerns (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.19 lower (0.73 lower to 0.34 higher)	LOW	IMPORTANT
EDE-Q Weight Concerns (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.16 lower (0.69 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
										to 0.38 higher)		
EDE-Q Shape Concerns (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.06 lower (0.6 lower to 0.47 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	26	28	-	SMD 0.38 higher (0.16 lower to 0.92 higher)	LOW	IMPORTANT

1 1 Grilo 2005/2012: randomization method and allocation concealment unclear. Assessor blinding unclear. Dropout rate of three of four groups>20%.
2 2 CI crosses both 0.75 and 1.25 (Risk Rato), or both 0.5 and -0.5 (SMD).
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 144: Full GRADE profile for antidepressant and CBT-ED versus placebo and CBT-ED in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
Remission FU (assessed with: EDE-Q No OBE/28 days)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	7/26 (26.9%)	10/28 (35.7%)	RR 0.75 (0.34 to 1.69)	89 fewer per 1000 (from 236 fewer to 246 more)	VERY LOW	CRITICAL
BMI FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	22	-	SMD 0.43 higher (0.19 lower to 1.05 higher)	LOW	IMPORTANT
Binge Frequency FU (measured with: Mean binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	19	22	-	SMD 0 higher (0.61 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
										0.62 higher)		
EDE-Q Global FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	22	-	SMD 0.29 lower (0.91 lower to 0.33 higher)	LOW	IMPORTANT
EDE-Q Dietary Restraint FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	22	-	SMD 0.36 lower (0.98 lower to 0.26 higher)	LOW	IMPORTANT
EDE-Q Eating Concerns FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	19	22	-	SMD 0.04 lower (0.65 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
										to 0.58 higher)		
EDE-Q Weight Concerns FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	22	-	SMD 0.32 lower (0.94 lower to 0.3 higher)	LOW	IMPORTANT
EDE-Q Shape Concerns FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	19	22	-	SMD 0.45 lower (1.07 lower to 0.17 higher)	LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	19	22	-	SMD 0.04 lower (0.65 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT	Placebo+CBT	Relative (95% CI)	Absolute		
										to 0.58 higher)		

1 1 Grilo 2005/2012: randomization method and allocation concealment unclear. Assessor blinding unclear. Dropout rate of three of four groups>20%.
2 2 CI crosses both 0.75 and 1.25 (Risk Rato), or both 0.5 and -0.5 (SMD).
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4 **Table 145: Full GRADE profile for antidepresssant-1 and CBT-ED versus antidepressant-2 and CBT-ED in adults with binge eating**
5 **disorder at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1+CBT	Antidepressant-2+CBT	Relative (95% CI)	Absolute		
Binge Frequency (follow-up 12 months; measured with: Binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	22	23	-	SMD 0.5 lower (1.09 lower to 0.1 higher)	LOW	CRITICAL
Withdrawn due to Adverse Events (follow-up 12 months)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1+CBT	Antidepressant-2+CBT	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	3/22 (13.6%)	3/23 (13%)	RR 1.05 (0.24 to 4.64)	7 more per 1000 (from 99 fewer to 475 more)	VERY LOW	CRITICAL
Binge Eating Scale (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	very serious3	none	10	10	-	SMD 0.25 higher (0.63 lower to 1.13 higher)	VERY LOW	IMPORTANT

1 1 Ricca 2001: Randomization method inadequate. Allocation concealment unclear. No participant, investigator and assessor blinding. Dropout rate for
2 groups all>20%.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
5 4 Cristina 2014: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear. No details provided
6 regarding dropouts.

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Table 146: Full GRADE profile for antidepresssant-1 and CBT-ED versus antidepressant-2 and CBT-ED in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant-1+any CBT	Antidepressant-2+any CBT	Relative (95% CI)	Absolute		
Binge Frequency FU (measured with: Binge episodes/month ; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	16	18	-	SMD 0.34 lower (1.01 lower to 0.34 higher)	LOW	CRITICAL

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).

Table 147: Full GRADE profile for antiepileptic and group CBT-ED versus placebo and group CBT-ED in adults with binge eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptic+gCBT-ED	Placebo+gCBT-ED	Relative (95% CI)	Absolute		
BMI(Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious	serious2	none	30	26	-	SMD 0.41 lower (0.94	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptic+gCBT-ED	Placebo+gCBT-ED	Relative (95% CI)	Absolute		
				indirectness						lower to 0.12 higher)		
# patients achieving Weight Loss>10%												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	11/30 (36.7%)	3/26 (11.5%)	RR 3.18 (0.99 to 10.17)	252 more per 1000 (from 1 fewer to 1000 more)	LOW	IMPORTANT
Not withdrawn due to Adverse Events												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	36/37 (97.3%)	36/36 (100%)	RR 0.97 (0.9 to 1.05)	30 fewer per 1000 (from 100 fewer to 50 more)	LOW	CRITICAL
Binge Eating Scale (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiepileptic+gCBT-ED	Placebo+gCBT-ED	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	30	26	-	SMD 0.17 lower (0.69 lower to 0.36 higher)	LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	30	26	-	SMD 0.24 higher (0.29 lower to 0.77 higher)	LOW	CRITICAL

1 1 Claudino 2007: topiramate group significantly older and report more depression than placebo group. Dropout rate for placebo group>20%.
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 <300 events (dichotomous outcome).

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Table 148: Full GRADE profile for antidepressant, antiepileptic, group behavioural weight loss therapy and group CBT versus antidepressant, group behavioural weight loss therapy and group CBT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+Antiepileptic+gBWLT+gCBT+	Antidepressant+gBWLT+gCBT	Relative (95% CI)	Absolute	Quality	Importance
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	10	10	-	SMD 0.41 higher (0.48 lower to 1.29 higher)	LOW	CRITICAL

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 d 1700kcal Group BWLT+Sertraline+CBT group.

2 CI crosses either 0.5 or -0.5.

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Table 149: Antiobesity agent and guided self-help CBT-ED versus placebo and guided self-help CBT-ED in adults with binge eating disorder at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED	Control	Relative (95% CI)	Absolute		
Remission (ITT)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	16/25 (64%)	9/25 (36%)	RR 1.78 (0.98 to 3.24)	281 more per 1000 (from 7 fewer to 806 more)	LOW	CRITICAL
Binge frequency (measured with: EDE OBE in past 28 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.07 lower (0.63 lower to 0.48 higher)	LOW	CRITICAL
Weight loss>=5% (ITT)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	9/25 (36%)	2/25 (8%)	RR 4.5 (1.08 to 18.77)	280 more per 1000 (from 6 more	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED	Control	Relative (95% CI)	Absolute		
										to 1000 more)		
Weight loss (kg) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.62 higher (0.05 to 1.19 higher)	LOW	CRITICAL
Mean percentage weight loss (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.58 higher (0.01 to 1.15 higher)	LOW	CRITICAL
EDE Global (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.34 lower (0.9 lower to 0.22 higher)	LOW	IMPORTANT
EDE Dietary restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.05 higher (0.5 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED	Control	Relative (95% CI)	Absolute		
										to 0.61 higher)		
EDE Eating concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.1 lower (0.65 lower to 0.46 higher)	LOW	IMPORTANT
EDE Weight concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.21 lower (0.77 lower to 0.34 higher)	LOW	IMPORTANT
EDE Shape concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.39 lower (0.95 lower to 0.17 higher)	LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.54 lower (1.11	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED	Control	Relative (95% CI)	Absolute		
										lower to 0.02 higher)		

1 *1* Grilo, Masheb & Salent 2005: high risk of bias (unclear allocation concealment, dropout rate of both groups >=20%).
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

3

4 **Table 150: Antiobesity agent and guided self-help CBT-ED versus placebo and guided self-help CBT-ED in adults with binge eating**
5 **disorder at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED at 3-mo FU	Control	Relative (95% CI)	Absolute		
Remission (ITT)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	13/25 (52%)	13/25 (52%)	RR 1 (0.59 to 1.7)	0 fewer per 1000 (from 213 fewer to 364 more)	VERY LOW	CRITICAL
Binge frequency (measured with: EDE OBE in past 28 days; Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED at 3-mo FU	Control	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.1 higher (0.46 lower to 0.65 higher)	LOW	CRITICAL
Weight loss>=5% (ITT)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	8/25 (32%)	2/25 (8%)	RR 4 (0.94 to 17)	240 more per 1000 (from 5 fewer to 1000 more)	LOW	CRITICAL
Weight loss (kg) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.5 higher (0.07 lower to 1.06 higher)	LOW	CRITICAL
Mean percentage weight loss (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.48 higher (0.09	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED at 3-mo FU	Control	Relative (95% CI)	Absolute		
										lower to 1.04 higher)		
EDE Global (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.09 lower (0.65 lower to 0.46 higher)	LOW	IMPORTANT
EDE Dietary restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.15 lower (0.71 lower to 0.4 higher)	LOW	IMPORTANT
EDE Eating concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.07 lower (0.63 lower to 0.48 higher)	LOW	IMPORTANT
EDE Weight concern (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+gSH CBT-ED v Placebo+gSH CBT-ED at 3-mo FU	Control	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.08 higher (0.47 lower to 0.64 higher)	LOW	IMPORTANT
EDE Shape concern (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.07 lower (0.62 lower to 0.49 higher)	LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.47 lower (1.03 lower to 0.09 higher)	LOW	IMPORTANT

1 1 Grilo, Masheb & Salant 2005: high risk of bias (unclear allocation concealment, dropout rate of both groups >=20%).
2 2 CI crosses both 0.75 and 1.25 (Risk Ratio).
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4

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L.6 Does any nutritional intervention produce benefits/harms on specified outcomes in people with eating disorders?

L.6.1 Anorexia nervosa

Table 151: Full GRADE profile for nutritional counselling versus another intervention for AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN. Nutritional counselling	Other	Relative (95% CI)	Absolute		
Did not achieve remission_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	1/15 (6.7%)	8/18 (44.4 %)	RR 1.68 (1.09 to 2.59)	302 more per 1000 (from 40 more to 707 more)	LOW	CRITICAL
Relapse												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	0/15 (0%)	4/18 (22.2 %)	RR 2.40 (0.9 to 6.43)	311 more per 1000 (from 22 fewer to 1000 more)	LOW	IMPORTANT
Weight FU (Better indicated by lower values)												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	serious5	none	15	15	-	SMD 0.11 higher (0.61	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN. Nutritional counselling	Other	Relative (95% CI)	Absolute		
										lower to 0.82 higher)		
Menstruation absent FU												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	very serious6	none	10/15 (66.7%)	8/15 (53.3 %)	RR 1.25 (0.69 to 2.26)	133 more per 1000 (from 165 fewer to 672 more)	VERY LOW	IMPORTANT
Menstruation regular FU												
1	randomised trials	serious 4	no serious inconsistency	no serious indirectness	very serious6	none	3/15 (20%)	3/15 (20%)	RR 1 (0.24 to 4.18)	0 fewer per 1000 (from 152 fewer to 636 more)	VERY LOW	IMPORTANT
Did not achieve remission_ITT FU												
1	randomised trials	serious 4	no serious inconsistency	serious7	serious3	none	0/15 (0%)	4/15 (26.7 %)	RR 1.35 (0.98 to 1.85)	93 more per 1000 (from 5 fewer to 227 more)	VERY LOW	CRITICAL

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[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 drop outs 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 drop outs 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.

Table 152: Full GRADE profile for zinc versus placebo for adults with AN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	AN. Zinc	placebo	Relative (95% CI)	Absolute	Quality	Importance
BMI gain/day (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	16	19	-	SMD 0.6 higher (0.08 lower to 1.29 higher)	VERY LOW	CRITICAL
Did not have side-effects												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	0/16 (0%)	0/19 (0%)	RR 1 (0.9 to 1.11)	-	LOW	CRITICAL
% body fat gain/day (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	16	19	-	SMD 0.67 higher (0.02 lower to 1.36 higher)	LOW	CRITICAL

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[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)

L.6.27 Bulimia nervosa

Table 153: Full GRADE profile for nutritional counselling versus any other intervention in adults with bulimia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	Other	Relative (95% CI)	Absolute	Quality	Importance
Meal Frequency (measured with: meals/week; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	27	73	-	SMD 0.34 higher (0.11 lower to 0.78 higher)	LOW	IMPORTANT
Calories/day (kcal) (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	22	26	-	SMD 0.21 higher (0.36 lower to 0.78 higher)	LOW	IMPORTANT
EDI Bulimia (follow-up 12 months; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	Other	Relative (95% CI)	Absolute		
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	22	26	-	SMD 0.21 lower (0.78 lower to 0.36 higher)	LOW	IMPORTANT
EDI Body Dissatisfaction (follow-up 12 months; Better indicated by lower values)												
2	randomised trials	serious3, 4	no serious inconsistency	no serious indirectness	serious2	none	39	40	-	SMD 0.54 higher (0.09 to 0.99 higher)	LOW	IMPORTANT
EDI Drive for Thinness (follow-up 12 weeks; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	22	26	-	SMD 0.19 higher (0.38 lower to 0.76 higher)	LOW	IMPORTANT
Depression - raw scores (follow-up 12 months; measured with: Beck Depression Inventory; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	22	26	-	SMD 0.22 lower (0.79 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	Other	Relative (95% CI)	Absolute		
										0.35 higher)		
Depression - Change scores (measured with: Hamilton Depression Rating Scale; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	27	73	-	SMD 0.4 lower (0.85 lower to 0.04 higher)	LOW	IMPORTANT

1 1 Hsu 2001: Allocation concealment unclear. No participant nor investigator blinding. Dropout rate of Nutritional therapy group=46%; dropout rate of
2 Cognitive therapy group 39%. Difference between Nutritional+Cognitive Therapy group, Nutritional Therapy group and Cognitive Therapy group>20%.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 Laessle 1991: No details provided regarding randomization method nor allocation concealment. Participant, investigator and assessor blinding unclear.
5 4 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group
6 dropout rate=20%.

7 **Table 154: Full GRADE profile for nutritional counselling versus any other intervention in adults with bulimia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	Other	Relative (95% CI)	Absolute		
Recovered from Bulimia Nervosa FU (follow-up 18 months)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	0/17 (0%)	13/26 (50%)	RR 0.1 (0.02	450 fewer per	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	Other	Relative (95% CI)	Absolute		
									to 0.71)	1000 (from 145 fewer to 490 fewer)		
Satisfying EDNOS criteria FU (follow-up 18 months)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	4/17 (23.5%)	11/26 (42.3%)	RR 0.53 (0.2 to 1.36)	199 fewer per 1000 (from 338 fewer to 152 more)	VERY LOW	CRITICAL
Calories/day (kcal) FU (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	very serious3	none	18	24	-	SMD 0.1 higher (0.51 lower to 0.71 higher)	VERY LOW	IMPORTANT
EDI Bulimia FU (follow-up 18 months; Better indicated by lower values)												
2	randomised trials	serious1, 4	very serious5	no serious indirectness	very serious3	none	35	38	-	SMD 1.28 higher (2.15	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	Other	Relative (95% CI)	Absolute		
										lower to 4.72 higher)		
EDI Body Dissatisfaction FU (follow-up 18 months; Better indicated by lower values)												
2	randomised trials	serious1, 4	no serious inconsistency	no serious indirectness	serious6	none	35	38	-	SMD 0.25 higher (0.22 lower to 0.71 higher)	LOW	IMPORTANT
EDI Drive for Thinness FU (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious6	none	18	24	-	SMD 0.16 lower (0.77 lower to 0.46 higher)	LOW	IMPORTANT
Depression FU (follow-up 12 months; measured with: Beck Depression Inventory; range of scores: 0-63; Better indicated by lower values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious6	none	18	24	-	SMD 0.35 lower (0.96 lower to 0.27 higher)	LOW	IMPORTANT

1 1 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group
2 dropout rate=20%.

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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).

Table 155: Full GRADE profile for nutritional counselling versus wait list control in adults with bulimia nervosa at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Counselling	WLC	Relative (95% CI)	Absolute	Quality	Importance
Does not satisfy EDNOS criteria FU (follow-up 18 months)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13/17 (76.5%)	15/15 (100 %)	RR 0.77 (0.58 to 1.03)	230 fewer per 1000 (from 420 fewer to 30 more)	LOW	CRITICAL

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).

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Table 156: Full GRADE profile for nutritional therapy versus any other intervention in adults with bulimia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nutritional Therapy	Other	Relative (95% CI)	Absolute		
Meal Frequency (measured with: meals/week; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	23	50	-	SMD 0.021 higher (0.47 lower to 0.52 higher)	LOW	IMPORTANT
Depression - change scores (measured with: Hamilton Depression Rating Scale; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	23	50	-	SMD 0.17 lower (0.66 lower to 0.33 higher)	LOW	IMPORTANT

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).

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Table 157: Full GRADE profile for healthy weight program versus wait list control in adults with bulimia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Healthy Weight Program	WLC	Relative (95% CI)	Absolute	Quality	Importance
Remission (follow-up 3 months)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	7/43 (16.3%)	1/42 (2.4 %)	RR 6.84 (0.88 to 53.2)	139 more per 1000 (from 3 fewer to 1000 more)	VERY LOW	CRITICAL
Binge Frequency (follow-up 3 months; measured with: binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	43	42	-	SMD 0.95 lower (1.4 to 0.5 lower)	VERY LOW	CRITICAL

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).

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1 **Table 158: Full GRADE profile for healthy weight program versus wait list control in adults with bulimia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Healthy Weight Program	WLC	Relative (95% CI)	Absolute		
Remission FU (follow-up 3 months)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	15/43 (34.9%)	4/42 (9.5 %)	RR 3.66 (1.32 to 10.13)	253 more per 1000 (from 30 more to 870 more)	VERY LOW	CRITICAL
Binge Frequency FU (follow-up 3 weeks; measured with: binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	43	42	-	SMD 0.86 lower (1.3 to 0.41 lower)	VERY LOW	CRITICAL
General functioning FU (follow-up 3 months; measured with: Social Adjustment Scale (adapted); Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	43	42	-	SMD 0.31 lower (0.74 lower to 0.12 higher)	VERY LOW	IMPORTANT
Resource use FU (follow-up 3 months; measured with: Health Survey Utilization Scale ; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	43	42	-	SMD 0.16 lower (0.58 lower to 0.27 higher)	VERY LOW	IMPORTANT

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1 1 Burton 2006: No details of randomization method nor allocation concealment provided. No participant blinding, unclear investigator blinding. Dropout rate
2 of 3 of 4 groups>25%. Reasons for dropout not stated.
3 2 Sample is participants with Full- and Sub-Threshold Bulimia Nervosa. Participants classified as Full Threshold BN if they have (i) >=8 binge eating
4 episodes or compensatory behaviour episodes in month prior to study and (ii) overvalue weight and shape. Participants classified as Sub Threshold BN if
5 they are not classified as Full Threshold (minimum of 4 binge eating and 4 compensatory episodes in past month).
6 3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
7 4 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

L.6.38 Binge eating disorder

9 **Table 159: Full GRADE profile for online nutritional counselling versus treatment as usual in adults with binge eating disorder at end**
10 **of treatment**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Online Nutritional Counselling	TAU	Relative (95% CI)	Absolute	Quality	Importance
Weight (change scores) (follow-up 3 months; measured with: lbs; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.72 lower (1.25 to 0.19 lower)	VERY LOW	IMPORTANT
EDE Global (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.4 lower (0.92 lower to 0.11 higher)	VERY LOW	IMPORTANT
Depression (follow-up 3 months; measured with: BDI; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Online Nutritional Counselling	TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.34 lower (0.86 lower to 0.17 higher)	VERY LOW	IMPORTANT
General functioning (follow-up 3 months; measured with: Treatment Self-Regulation Questionnaire - Autonomous Motivation; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.23 higher (0.28 lower to 0.74 higher)	VERY LOW	IMPORTANT

1 1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE
2 Global scores significantly different at baseline.
3 2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).
4 3 CI crosses either 0.5 or -0.5 (SMD).

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Table 160: Full GRADE profile for online nutritional counselling versus treatment as usual in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Online Nutritional Counselling	TAU	Relative (95% CI)	Absolute		
Weight (change scores) FU (measured with: lbs; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.74 lower (1.27 to 0.21 lower)	VERY LOW	IMPORTANT
EDE Global FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.24 lower (0.76 lower to 0.27 higher)	VERY LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	no serious risk of bias1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.35 lower (0.86 lower to 0.17 higher)	VERY LOW	IMPORTANT
General functioning (measured with: Treatment Self-Regulation Questionnaire - Autonomous Motivation FU; Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Online Nutritional Counselling	TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	29	30	-	SMD 0.11 lower (0.62 lower to 0.4 higher)	VERY LOW	IMPORTANT

1 1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE
2 Global scores significantly different at baseline.
3 2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).
4 3 CI crosses either 0.5 or -0.5 (SMD).

5 **Table 161: Full GRADE profile for group nutritional counselling versus wait list control in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Nutritional Counselling	WLC	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	62	58	-	SMD 0.22 higher (0.14 lower to 0.57 higher)	VERY LOW	IMPORTANT
Binge Eating Scale (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Nutritional Counselling	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	62	58	-	SMD 0.83 lower (1.2 to 0.46 lower)	VERY LOW	IMPORTANT

1 1 Goodrick 1998: randomization method and allocation concealment unclear. No participant nor assessor blinding. Investigator blinding unclear. Reasons for
2 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
3 assessments.
4 2 Goodrick 1998: Women only. Participants were selected on basis of 14-41 kg overweight based on 1983 Metropolitan Life Insurance Company
5 Height/Weight tables and having Binge Eating Scale score>21.
6 3 CI crosses either 0.5 or -0.5 (SMD).

7 **Table 162: Full GRADE profile for group behavioural weight loss therapy versus wait list control in adults with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	WLC	Relative (95% CI)	Absolute		
BMI (Better indicated by lower values)												
2	randomised trials	serious1, 2	no serious inconsistency	very serious3,4	serious5	none	111	94	-	SMD 0.20 higher (0.07 lower to 0.48 higher)	VERY LOW	IMPORTANT
Binge Eating Scale (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	WLC	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	65	58	-	SMD 1.07 lower (1.45 to 0.69 lower)	VERY LOW	IMPORTANT

1 1 Goodrick 1998: randomization method and allocation concealment unclear. No participant nor assessor blinding. Investigator blinding unclear. Reasons for
2 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
3 assessments.
4 2 Reeves 2001: randomization method and allocation concealment unclear. No participant blinding. Assessor and investigator blinding unclear. Dropout rate
5 of intervention group>20%.
6 3 Goodrick 1998: Women only. Participants were selected on basis of 14-41 kg overweight based on 1983 Metropolitan Life Insurance Company
7 Height/Weight tables and having Binge Eating Scale score>21.
8 4 Reeves 2001: Women only. Participants were selected on basis of weight>=31 lbs or <90 lbs overweight based on 1983 Metropolitan Height/Weight
9 tables, and Binge Eating Scale score>20.
10 5 <400 participants.

11 **Table 163: Full GRADE profile for behavioural weight loss therapy versus any other intervention in adults with binge eating disorder**
12 **at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
Remission (follow-up 2 years)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	52/64 (81.3 %)	119/141 (84.4%)	RR 0.96 (0.84	34 fewer per 1000	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
									to 1.11)	(from 135 fewer to 93 more)		
Rapid Response (assessed with: >=70% reduction binge eating by 4th week treatment)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	47/64 (73.4 %)	98/141 (69.5%)	RR 1.05 (0.88 to 1.27)	35 more per 1000 (from 83 fewer to 188 more)	LOW	IMPORTANT
Binge Frequency (follow-up 2 years; measured with: EDE, past 28 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	64	141	-	SMD 0.07 higher (0.22 lower to 0.37 higher)	LOW	CRITICAL
BMI (follow-up 2 years; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	64	141	-	SMD 0.12 lower (0.41 lower to 0.18 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
EDE Global (follow-up 2 years; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	64	141	-	SMD 0.36 higher (0.06 to 0.66 higher)	LOW	IMPORTANT
# 5% Reduction in Weight												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	41/64 (64.1 %)	30/141 (21.3%)	RR 3 (2.08 to 4.33)	426 more per 1000 (from 230 more to 709 more)	LOW	IMPORTANT

1 1 Wilson 2010/Hilbert 2015: adequate randomisation, unclear allocation concealment. No participant blinding, unclear investigator and assessor blinding.
2 Dropout rates of Diet and CBT group >20%.
3 2 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 164: Full GRADE profile for behavioural weight loss therapy versus any other intervention in adults with binge eating disorder at 1- year follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
Binge Frequency 12-mo FU (follow-up 1 years; measured with: EDE Binges/past 28 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	64	141	-	SMD 0.24 higher (0.06 lower to 0.54 higher)	LOW	CRITICAL
BMI 12-mo FU (follow-up 1 years; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	64	141	-	SMD 0.04 higher (0.26 lower to 0.33 higher)	LOW	IMPORTANT
EDE Global 12-mo FU (follow-up 1 years; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	64	141	-	SMD 0.41 higher (0.11 to 0.71 higher)	LOW	IMPORTANT
# 5% Reduction in Weight 12-mo FU (follow-up 1 years)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	27/64 (42.2 %)	47/141 (33.3%)	RR 1.26 (0.87 to 1.82)	87 more per 1000 (from 43 fewer to 273 more)	LOW	IMPORTANT

1 1 Wilson 2010/Hilbert 2015: adequate randomisation, unclear allocation concealment. No participant blinding, unclear investigator and assessor blinding.
2 Dropout rates of Diet and CBT group >20%.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

5 **Table 165: Full GRADE profile for behavioural weight loss therapy versus any other intervention in adults with binge eating disorder**
6 **at 2 -year follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
Binge Frequency 24-mo FU (measured with: EDE Binges/past 28 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	64	141	-	SMD 0.23 higher (0.07 lower to 0.52 higher)	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT	Any other intervention	Relative (95% CI)	Absolute		
BMI 24-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	64	141	-	SMD 0.07 higher (0.22 lower to 0.37 higher)	LOW	IMPORTANT
EDE Global 24-mo FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	64	141	-	SMD 0.27 higher (0.03 lower to 0.57 higher)	LOW	IMPORTANT
# 5% Reduction in Weight 24-mo FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	27/64 (42.2 %)	44/141 (31.2%)	RR 1.35 (0.92 to 1.96)	109 more per 1000 (from 25 fewer to 300 more)	LOW	IMPORTANT

1 1 Wilson 2010/Hilbert 2015: adequate randomisation, unclear allocation concealment. No participant blinding, unclear investigator and assessor blinding.
2 Dropout rates of Diet and CBT group >20%.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

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Table 166: Full GRADE profile for guided self-help behavioural weight loss versus any other intervention in adults with binge eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GSH BWL	Any other intervention	Relative (95% CI)	Absolute		
Remission												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	9/38 (23.7 %)	26/52 (50%)	RR 0.52 (0.27 to 1.01)	240 fewer per 1000 (from 365 fewer to 5 more)	LOW	CRITICAL
Rapid Response (assessed with: >=65% reduction in binge eating by week 4 of treatment)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18/38 (47.4 %)	23/37 (62.2%)	RR 0.76 (0.5 to 1.16)	149 fewer per 1000 (from 311 fewer to 99 more)	LOW	IMPORTANT
BMI or Weight (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	52	-	SMD 0.06 higher (0.37 lower to 0.49 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GSH BWL	Any other intervention	Relative (95% CI)	Absolute		
Binge Frequency (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	38	52	-	SMD 0.29 higher (0.14 lower to 0.72 higher)	LOW	CRITICAL
EDE-Q Dietary Restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	38	52	-	SMD 0.28 higher (0.15 lower to 0.71 higher)	LOW	IMPORTANT
EDE-Q Eating Concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	38	52	-	SMD 0.26 higher (0.17 lower to 0.69 higher)	LOW	IMPORTANT
EDE-Q Weight Concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	38	52	-	SMD 0.03 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GSH BWL	Any other intervention	Relative (95% CI)	Absolute		
										(0.4 lower to 0.46 higher)		
EDE-Q Shape Concerns (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	38	52	-	SMD 0.05 higher (0.38 lower to 0.48 higher)	LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	38	52	-	SMD 0.18 higher (0.25 lower to 0.61 higher)	LOW	CRITICAL

1 1 Grilo 2005/Masheb 2007: No participant nor investigator blinding. Dropout rate for Guided Self-Help Behavioural Weight Loss Therapy >40%. Difference
2 between other groups >20%.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 <400 participants.

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Table 167: Full GRADE profile for group behavioural weight loss therapy versus any other intervention in adults with binge eating disorder at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
Remission (follow-up 1 years; assessed with: No OBEs/28 days (EDE);)												
3	randomised trials	serious1,2,3	serious4	serious	very serious5	none	52/102 (51%)	45/105 (42.9%)	RR 0.99 (0.74 to 1.33)	4 fewer per 1000 (from 111 fewer to 141 more)	VERY LOW	CRITICAL
Remission - subgroup analysis of severity of illness <18 binges/month (follow-up 1 years; assessed with: No OBEs/28 days (EDE))												
2	randomised trials	serious1,2	serious4	no serious indirectness	serious6	none	38/81 (46.9 %)	38/89 (42.7%)	RR 1.11 (0.79 to 1.54)	47 more per 1000 (from 90 fewer to 231 more)	VERY LOW	CRITICAL
Remission - subgroup analysis of severity of illness >18 binges/month (follow-up 1 years; assessed with: No OBEs/28 days (EDE))												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious6	none	7/16 (43.8 %)	14/21 (66.7%)	RR 0.66 (0.35 to 1.24)	227 fewer per 1000 (from 433 fewer	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
										to 160 more)		
No longer meets all DSM-IV BED criteria (follow-up 6 months)												
1	randomised trials	serious3	no serious inconsistency	serious	serious6	none	19/21 (90.5 %)	12/16 (75%)	RR 1.21 (0.88 to 1.65)	158 more per 1000 (from 90 fewer to 487 more)	VERY LOW	IMPORTANT
Binge Frequency (follow-up 1 years; measured with: Binge days or binge episodes in past 28 days; Better indicated by lower values)												
3	randomised trials	serious1,2,3	no serious inconsistency	serious	serious6	none	84	91	-	SMD 0.42 higher (0.12 to 0.72 higher)	VERY LOW	CRITICAL
BMI or Weight (follow-up 1 years; Better indicated by lower values)												
3	randomised trials	serious1,2,3	no serious inconsistency	serious	serious6	none	97	110	-	SMD 0.54 lower (0.82 to 0.26 lower)	VERY LOW	CRITICAL
Weight Loss (lbs) (follow-up 1 years; Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	45	45	-	SMD 0.53 higher (0.11 to 0.96 higher)	LOW	IMPORTANT
EDE Global (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious6	none	45	45	-	SMD 0.12 higher (0.3 lower to 0.53 higher)	LOW	IMPORTANT
EDE Restraint (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
3	randomised trials	serious1,2,3	no serious inconsistency	serious	serious7	none	84	91	-	SMD 0.17 higher (0.12 lower to 0.47 higher)	VERY LOW	IMPORTANT
EDE Shape Concern (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
3	randomised trials	serious1,2,3	serious4	no serious indirectness	serious6	none	84	91	-	SMD 0.22 higher (0.27 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
										to 0.71 higher)		
EDE Shape Concern - subgroup analysis of severity of illness <18 binges/month (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious7	none	68	70	-	SMD 0.01 higher (0.33 lower to 0.34 higher)	LOW	IMPORTANT
EDE Shape Concern - subgroup analysis of severity of illness >18 binges/month (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious6	none	16	21	-	SMD 0.83 higher (0.15 to 1.51 higher)	LOW	IMPORTANT
EDE Weight Concern (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
3	randomised trials	serious1,2,3	serious4	serious	serious6	none	84	91	-	SMD 0.16 higher (0.44 lower to 0.77 higher)	VERY LOW	IMPORTANT
EDE Weight Concern - subgroup analysis of severity of illness <18 binges/month (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Group BWLT**	**Any other intervention**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
2	randomised trials	serious1,2	no serious inconsistency	no serious indirectness	serious7	none	68	70	-	SMD 0.1 lower (0.43 lower to 0.23 higher)	LOW	IMPORTANT
EDE Weight Concern - subgroup analysis of severity of illness >18 binges/month (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious6	none	16	21	-	SMD 0.9 higher (0.21 to 1.58 higher)	LOW	IMPORTANT
EDE Eating Concern (follow-up 1 years; range of scores: 0-6; Better indicated by lower values)												
3	randomised trials	serious1,2,3	no serious inconsistency	serious	serious6	none	84	91	-	SMD 0.22 higher (0.07 lower to 0.52 higher)	VERY LOW	IMPORTANT
Depression (follow-up 1 years; measured with: BDI; range of scores: 0-63; Better indicated by lower values)												
3	randomised trials	serious1,2,3	no serious inconsistency	serious	serious7	none	87	97	-	SMD 0.12 higher (0.17 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
										to 0.41 higher)		

1 1 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Group BWLT and
2 Group CBT dropout rates both >20%. Dropout reasons not stated.
3 2 Munsch 2007: randomization method used permuted block design. Allocation concealment unclear. No participant, investigator nor assessor blinding.
4 Dropout rates of both Group BWLT and Group CBT groups >20%. Dropout reasons not stated.
5 3 I2>50%.
6 4 CI crosses both 0.75 and 1.25 (Risk Ratio).
7 5 Nauta 2000/2001: randomization method and allocation concealment unclear. No investigator blinding, assessor blinding unclear.
8 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
9 7 <400 participants.

10

11 **Table 168: Full GRADE profile for group behavioural weight loss therapy versus any other intervention in adults with binge eating**
12 **disorder at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
Remission FU (follow-up 1 years)												
2	randomised trials	serious1,2	no serious inconsistency	serious3	very serious4	none	25/46 (54.3 %)	38/62 (61.3%)	RR 0.92 (0.66 to 1.27)	49 fewer per 1000 (from	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
										208 fewer to 165 more)		
Binge Frequency FU (follow-up 1 years; measured with: Binge days or episodes in past 28 days; Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious6	none	78	88	-	SMD 0.34 higher (0.03 to 0.65 higher)	VERY LOW	CRITICAL
BMI or Weight FU (follow-up 1 years; Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious7	none	91	107	-	SMD 0.1 lower (0.38 lower to 0.19 higher)	VERY LOW	IMPORTANT
Weight Loss (lbs) FU (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious6	none	45	45	-	SMD 0.11 higher (0.3 lower to 0.53 higher)	LOW	IMPORTANT
EDE Global FU (follow-up 1 years; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious6	none	45	45	-	SMD 0.12 higher (0.29 lower to 0.54 higher)	LOW	IMPORTANT
EDE Restraint FU (Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious7	none	73	79	-	SMD 0.09 higher (0.23 lower to 0.41 higher)	VERY LOW	IMPORTANT
EDE Shape Concern FU (Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious7	none	73	79	-	SMD 0.03 lower (0.35 lower to 0.3 higher)	VERY LOW	IMPORTANT
EDE Weight Concern FU (Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious7	none	73	79	-	SMD 0.1 higher (0.23 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Any other intervention	Relative (95% CI)	Absolute		
										to 0.42 higher)		
EDE Eating Concern FU (Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious7	none	73	79	-	SMD 0.08 lower (0.4 lower to 0.24 higher)	VERY LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
3	randomised trials	serious1,2,5	no serious inconsistency	serious3	serious7	none	76	85	-	SMD 0.1 higher (0.21 lower to 0.42 higher)	VERY LOW	IMPORTANT

1 1 Munsch 2007: randomization method used permuted block design. Allocation concealment unclear. No participant, investigator nor assessor blinding.
2 Dropout rates of both Group BWLT and Group CBT groups >20%. Dropout reasons not stated.
3 2 Nauta 2000/2001: randomization method and allocation concealment unclear. No investigator blinding, assessor blinding unclear.
4 3 Nauta 2000: Women only.
5 4 CI crosses both 0.75 and 1.25 (Risk Ratio).
6 5 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Group BWLT and
7 Group CBT dropout rates both >20%. Dropout reasons not stated.
8 6 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
9 7 <400 participants.

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Table 169: Full GRADE profile for group behavioural weight loss therapy versus group nutritional counselling in adults with binge eating disorder at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Group Nutritional Counselling	Relative (95% CI)	Absolute		
BMI (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	65	62	-	SMD 0.1 lower (0.45 lower to 0.25 higher)	VERY LOW	IMPORTANT
Binge Eating Scale (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	65	62	-	SMD 0.24 lower (0.59 lower to 0.11 higher)	VERY LOW	IMPORTANT

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).

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Table 170: Full GRADE profile for group behavioural weight loss therapy versus group nutritional counselling in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group BWLT	Group Nutritional Counselling	Relative (95% CI)	Absolute		
BMI FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	65	62	-	SMD 0.1 higher (0.25 lower to 0.44 higher)	VERY LOW	IMPORTANT
Binge Eating Scale FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	65	62	-	SMD 0.07 lower (0.41 lower to 0.28 higher)	VERY LOW	IMPORTANT

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.

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Table 171: Full GRADE profile for behavioural weight loss therapy and online motivational interviewing versus treatment as usual in adults at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	TAU	Relative (95% CI)	Absolute		
% Weight Change (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	seriousᵌ	none	30	30	-	SMD 0.45 lower (0.96 lower to 0.06 higher)	VERY LOW	IMPORTANT
EDE Global (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	seriousᵌ	none	30	30	-	SMD 0.23 higher (0.28 lower to 0.74 higher)	VERY LOW	IMPORTANT
Depression (follow-up 3 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	seriousᵌ	none	30	30	-	SMD 0.1 lower (0.61 lower to 0.41 higher)	VERY LOW	IMPORTANT
General functioning (follow-up 3 months; measured with: Treatment Self-Regulation Questionnaire - Autonomous Motivation; Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	30	30	-	SMD 0.34 higher (0.17 lower to 0.85 higher)	VERY LOW	IMPORTANT

1 1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE
2 Global scores significantly different at baseline.
3 2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).
4 3 CI crosses either 0.5 or -0.5 (SMD).

5 **Table 172: Full GRADE profile for behavioural weight loss therapy and online motivational interviewing versus treatment as usual in**
6 **adults with binge eating disorder at follow up with binge eating disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational interviewing	TAU	Relative (95% CI)	Absolute		
% Weight Change FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	30	30	-	SMD 0.37 lower (0.88 lower to 0.14 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational interviewing	TAU	Relative (95% CI)	Absolute		
EDE Global FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	30	30	-	SMD 0.21 higher (0.3 lower to 0.72 higher)	VERY LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	30	30	-	SMD 0.06 lower (0.57 lower to 0.44 higher)	VERY LOW	IMPORTANT
General functioning FU (measured with: Treatment Self-Regulation Questionnaire - Autonomous Motivation FU ; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	very serious2	serious3	none	30	30	-	SMD 0.1 lower (0.61 lower to 0.4 higher)	VERY LOW	IMPORTANT

1 1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE
2 Global scores significantly different at baseline.
3 2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).
4 3 CI crosses either 0.5 or -0.5 (SMD).

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Table 173: Full GRADE profile for behavioural weight loss therapy and online motivational interviewing versus online nutritional counselling at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	Online Nutritional Counselling	Relative (95% CI)	Absolute	Quality	Importance
% Weight Change (follow-up 3 weeks; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.25 higher (0.26 lower to 0.76 higher)	VERY LOW	IMPORTANT
EDE Global (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.74 higher (0.21 lower to 1.27 higher)	VERY LOW	IMPORTANT
Depression (follow-up 3 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.24 higher (0.27 lower to 0.75 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	Online Nutritional Counselling	Relative (95% CI)	Absolute	Quality	Importance
General functioning (follow-up 3 months; measured with: Treatment Self-Regulation Questionnaire - Autonomous Motivation; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.14 higher (0.37 lower to 0.65 higher)	VERY LOW	IMPORTANT

1 1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE
2 Global scores significantly different at baseline.
3 2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).
4 3 CI crosses either 0.5 or -0.5 (SMD).

5 **Table 174: Full GRADE profile for behavioural weight loss therapy and online motivational interviewing versus online nutritional**
6 **counselling at follow up**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	Online Nutritonal Counselling	Relative (95% CI)	Absolute	Quality	Importance
% Weight Change FU (follow-up 3 months; Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	Online Nutritonal Counselling	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.35 higher (0.17 lower to 0.86 higher)	VERY LOW	IMPORTANT
EDE Global FU (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.46 higher (0.06 lower to 0.97 higher)	VERY LOW	IMPORTANT
Depression FU (follow-up 3 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	very serious2	serious3	none	30	29	-	SMD 0.31 higher (0.2 lower to 0.82 higher)	VERY LOW	IMPORTANT
General functioning (follow-up 3 months; measured with: Treatment Self-Regulation Questionnaire - Autonomous Motivation FU; Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWLT + Online Motivational Interviewing	Online Nutritonal Counselling	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	very serious2	very serious4	none	30	29	-	SMD 0 higher (0.51 lower to 0.51 higher)	VERY LOW	IMPORTANT

1 1 Barnes 2014: Randomization method unclear (stratified by BED diagnosis), allocation concealment unclear. No participant nor investigator blinding. EDE
2 Global scores significantly different at baseline.
3 2 Sample is adults BMI>25 and <55, overweight and obese eaters with (n=23) and without BED (n=66).
4 3 CI crosses either 0.5 or -0.5 (SMD).
5 4 CI crosses both 0.5 and -0.5 (SMD).

6 **Table 175: Full GRADE profile for low energy density diet and CBT-ED versus general nutritional counselling and CBT-ED in adults**
7 **with binge eating disorder at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	LE Density Diet+CBT-ED	General Nutritonal Counselling+CBT-ED	Relative (95% CI)	Absolute		
Remission (follow-up 6 months)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	13/25 (52%)	11/25 (44%)	RR 1.18 (0.66 to 2.11)	79 more per 1000 (from	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	LE Density Diet+CBT-ED	General Nutritonal Counselling+CBT-ED	Relative (95% CI)	Absolute		
										150 fewer to 488 more)		
BMI (Change scores) (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.36 higher (0.19 lower to 0.92 higher)	LOW	IMPORTANT
# >=5% weight loss (follow-up 6 months)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	8/25 (32%)	5/25 (20%)	RR 1.6 (0.61 to 4.22)	120 more per 1000 (from 78 fewer to 644 more)	VERY LOW	IMPORTANT
Mean % Weight Loss (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.3 higher (0.26 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	LE Density Diet+CBT-ED	General Nutritonal Counselling+CBT-ED	Relative (95% CI)	Absolute		
										to 0.86 higher)		
EDE Global (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.2 lower (0.75 lower to 0.36 higher)	LOW	IMPORTANT
EDE Weight Concern (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.39 lower (0.95 lower to 0.17 higher)	LOW	IMPORTANT
EDE Shape Concern (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	25	25	-	SMD 0 higher (0.55 lower to 0.55 higher)	VERY LOW	IMPORTANT
EDE Eating Concern (follow-up 6 months; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	LE Density Diet+CBT-ED	General Nutritonal Counselling+CBT-ED	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.2 higher (0.36 lower to 0.75 higher)	LOW	IMPORTANT
Depression (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	25	25	-	SMD 0.1 higher (0.46 lower to 0.65 higher)	LOW	IMPORTANT

1 1 Masheb 2011: Allocation concealment unclear. No participant blinding, investigator blinding unclear. Intervention group dropout rate=20%. No details of
2 dropouts provided.
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 176: Full GRADE profile for low energy density diet and CBT-ED versus general nutritional counselling and CBT-ED in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	LE Density Diet+CBT-ED	General Nutritional Counselling + CBT-ED	Relative (95% CI)	Absolute	Quality	Importance
BMI (change scores) FU (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.26 higher (0.3 lower to 0.81 higher)	LOW	IMPORTANT
Mean % Weight Loss FU (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.2 higher (0.36 lower to 0.76 higher)	LOW	IMPORTANT
Binge Frequency FU (measured with: EDE; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	25	25	-	SMD 0.54 higher (0.02 lower to 1.11 higher)	LOW	CRITICAL
# patients achieving >=5% weight loss FU (follow-up 6 months)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	LE Density Diet+CBT-ED	General Nutritional Counselling + CBT-ED	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	7/25 (28%)	6/25 (24%)	RR 1.17 (0.46 to 2.98)	41 more per 1000 (from 130 fewer to 475 more)	VERY LOW	IMPORTANT

1 1 Masheb 2011: Allocation concealment unclear. No participant blinding, investigator blinding unclear. Intervention group dropout rate=20%. No details of
2 dropouts provided.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

5 **Table 177: Full GRADE profile for group CBT-ED then group behavioural weight loss therapy versus group CBT-ED in adults with**
6 **binge eating disorder at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute		
Remission (follow-up 12 months)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	17/35 (48.6%)	20/45 (44.4%)	RR 1.09 (0.68 to 1.75)	40 more per 1000 (from 142 fewer to 333 more)	VERY LOW	CRITICAL
Binge Frequency (follow-up 12 months; measured with: binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.18 higher (0.26 lower to 0.62 higher)	LOW	CRITICAL
BMI (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.07 higher (0.37 lower to 0.51 higher)	LOW	IMPORTANT
Weight Loss (follow-up 12 weeks; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.44 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute		
										(0.01 lower to 0.88 higher)		
EDE Global (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.11 lower (0.55 lower to 0.33 higher)	LOW	IMPORTANT
EDE Restraint (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.11 higher (0.34 lower to 0.55 higher)	LOW	IMPORTANT
EDE Eating Concern (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.32 lower (0.77 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute	Quality	Importance
										0.12 higher)		
EDE Shape Concern (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.15 lower (0.59 lower to 0.3 higher)	LOW	IMPORTANT
EDE Weight Concern (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0.17 lower (0.61 lower to 0.27 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	35	45	-	SMD 0.04 lower (0.49 lower to 0.4 higher)	LOW	IMPORTANT

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1 1 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Group BWLT+Group
2 CBT and Group CBT groups dropout rates both >20%. Dropout reasons not stated
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio).
4 3 CI crosses either 0.5 or -0.5 (SMD).
5 4 <400 participants.

6 **Table 178: Full GRADE profile for group CBT-ED then group behavioural weight loss therapy versus group CBT-ED in adults with**
7 **binge eating disorder at follow up**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute	Quality	Importance
Binge Frequency FU (measured with: binge episodes/month; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.19 higher (0.25 lower to 0.64 higher)	LOW	CRITICAL
BMI FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.07 higher (0.37 lower to 0.51 higher)	LOW	IMPORTANT
Weight Loss FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.14 higher (0.3 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute		
										to 0.59 higher)		
EDE Global FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.12 lower (0.56 lower to 0.32 higher)	LOW	IMPORTANT
EDE Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.09 lower (0.53 lower to 0.36 higher)	LOW	IMPORTANT
EDE Eating Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	35	45	-	SMD 0 higher (0.44 lower to 0.44 higher)	LOW	IMPORTANT
EDE Shape Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.23 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT-ED then Group BWLT	Group CBT-ED	Relative (95% CI)	Absolute	Quality	Importance
										(0.67 lower to 0.22 higher)		
EDE Weight Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.09 lower (0.54 lower to 0.35 higher)	LOW	IMPORTANT
Depression FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	35	45	-	SMD 0.07 higher (0.37 lower to 0.51 higher)	LOW	IMPORTANT

1 1 Grilo 2011: unclear allocation concealment. Participant blinding until start of treatment. Unclear investigator and assessor blinding. Group BWLT +Group
2 CBT and Group CBT groups dropout rates both >20%. Dropout reasons not stated
3 2 CI crosses either 0.5 or -0.5 (SMD).
4 3 <400 participants.

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Table 179: Full GRADE profile for antidepressant and group behavioural weight control therapy versus placebo and group behavioural weight control therapy in adults with binge eating disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+GBWLT	Placebo+GBWLT	Relative (95% CI)	Absolute	Quality	Importance
Weight (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	31	-	SMD 0.03 higher (0.46 lower to 0.53 higher)	LOW	IMPORTANT
Binge Frequency (measured with: EDE OBE; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious	none	32	31	-	SMD 0.16 lower (0.66 lower to 0.33 higher)	LOW	CRITICAL
Binge Eating Scale (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	31	-	SMD 0.13 lower (0.62 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+GBWLT	Placebo+GBWLT	Relative (95% CI)	Absolute		
										to 0.37 higher)		
General Psychopathology (measured with: Brief symptom inventory; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	31	-	SMD 0.07 lower (0.56 lower to 0.43 higher)	LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	31	-	SMD 0.38 lower (0.88 lower to 0.12 higher)	LOW	IMPORTANT

1 1 Devlin 2005: Randomization method and allocation concealment unclear. Dropout rates of all groups>20%. Dropout by groups not provided. Not clear if
2 baseline measures for groups are similar.
3 2 CI crosses either 0.5 or -0.5 (SMD).

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Table 180: Full GRADE profile for antidepressant, CBT-ED and group behavioural weight control therapy versus placebo, CBT-ED and group behavioural weight control therapy in adults with binge eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT-ED+GBWCT	Placebo+CBT-ED+GWCT	Relative (95% CI)	Absolute		
Weight (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	28	25	-	SMD 0.08 lower (0.62 lower to 0.46 higher)	LOW	IMPORTANT
Binge Frequency (measured with: EDE OBE; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	28	25	-	SMD 0.24 lower (0.78 lower to 0.3 higher)	LOW	CRITICAL
Binge Eating Scale (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	28	25	-	SMD 0.06 lower (0.6 lower to 0.48	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressant+CBT-ED+GBWCT	Placebo+CBT-ED+GWCT	Relative (95% CI)	Absolute		
										higher)		
General Psychopathology (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	28	25	-	SMD 0.19 lower (0.73 lower to 0.35 higher)	LOW	IMPORTANT
Depression - Fluoxetine+Group Behavioural Weight Control+CBT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	28	25	-	SMD 0.24 lower (0.78 lower to 0.3 higher)	LOW	IMPORTANT

1 1 Devlin 2005: Randomization method and allocation concealment unclear. Dropout rates of all groups>20%. Dropout by groups not provided. Not clear if
2 baseline measures for groups are similar.
3 2 CI crosses either 0.5 or -0.5 (SMD).

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Table 181: Full GRADE profile for CBT-ED then antidepressant and group behavioural weight loss therapy versus CBT-ED then group behavioural weight loss therapy in adults with binge eating disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-ED then Antidepressant+GBWLT	CBT-ED then GBWLT	Relative (95% CI)	Absolute	Quality	Importance
Weight (follow-up 3 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	36	36	-	SMD 0.28 higher (0.18 lower to 0.74 higher)	VERY LOW	IMPORTANT
Depression (follow-up 3 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	reporting bias3	36	36	-	SMD 0.14 lower (0.6 lower to 0.32 higher)	VERY LOW	IMPORTANT

1 Agras 1994: Randomization method and allocation concealment unclear. No participant blinding, investigator and assessor blinding unclear. Dropout rate of CBT+Behavioural Weight Loss Therapy+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.

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1

2 **Table 182: Antiobesity agent and diet versus placebo and diet in adults with binge eating disorder at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+Diet	Placebo+Diet	Relative (95% CI)	Absolute		
Weight loss (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	39	34	-	SMD 0.9 higher (0.47 to 1.33 higher)	LOW	
No longer meets BED DSM-IV criteria												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	30/39 (76.9%)	24/34 (70.6%)	RR 1.09 (0.83 to 1.44)	64 more per 1000 (from 120 fewer to 311 more)	LOW	IMPORTANT
EDI Total (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	44	45	-	SMD 0.3 lower (0.72 lower to 0.12	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+Diet	Placebo+Diet	Relative (95% CI)	Absolute		
										higher)		
General psychopathology (measured with: HADS; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	44	45	-	SMD 0.42 lower (0.84 lower to 0 higher)	LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	44	45	-	SMD 0.40 lower (0.82 lower to 0.02 higher)	LOW	IMPORTANT
No longer meets Generalized Anxiety disorder DSM-IV criteria												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	29/39 (74.4%)	21/34 (61.8%)	RR 1.2 (0.87 to 1.66)	124 more per 1000 (from 80 fewer	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+Diet	Placebo+Diet	Relative (95% CI)	Absolute		
										to 408 more)		
No longer meets Major depressive disorder DSM-IV criteria												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	38/39 (97.4%)	30/34 (88.2%)	RR 1.1 (0.97 to 1.26)	88 more per 1000 (from 26 fewer to 229 more)	LOW	IMPORTANT
Quality of Life (measured with: Nottingham Health Profile; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	44	45	-	SMD 0.2 lower (0.62 lower to 0.21 higher)	LOW	IMPORTANT

1 *1* Golay 2005: high risk of bias (unclear whether baseline similar, unclear randomisation method and allocation concealment; placebo+diet arm dropout
2 rate>20%).
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 183: Antiobesity agent and behavioural weight loss therapy versus placebo and behavioural weight loss therapy in adults with binge eating disorder at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+BWLT	Placebo+BWLT	Relative (95% CI)	Absolute		
Remission (ITT) (assessed with: No OBEs in past 28 days)												
1	randomised trials	serious1	no serious inconsistency	serious1	very serious2	none	12/20 (60%)	14/20 (70%)	RR 0.86 (0.54 to 1.36)	98 fewer per 1000 (from 322 fewer to 252 more)	VERY LOW	CRITICAL
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	19	19	-	SMD 0.31 higher (0.33 lower to 0.95 higher)	VERY LOW	CRITICAL
EDE Global (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	19	19	-	SMD 0.49 lower (1.13 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+BWLT	Placebo+BWLT	Relative (95% CI)	Absolute	Quality	Importance
										0.16 higher)		
EDE Dietary restraint (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	19	19	-	SMD 0.28 lower (0.92 lower to 0.36 higher)	VERY LOW	IMPORTANT
EDE Eating concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	very serious2	none	19	19	-	SMD 0 higher (0.64 lower to 0.64 higher)	VERY LOW	IMPORTANT
EDE Shape concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	19	19	-	SMD 0.27 lower (0.91 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+BWLT	Placebo+BWLT	Relative (95% CI)	Absolute		
										to 0.37 higher)		
EDE Weight concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	19	19	-	SMD 0.51 lower (1.15 lower to 0.14 higher)	VERY LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	19	19	-	SMD 0.51 lower (1.16 lower to 0.13 higher)	VERY LOW	IMPORTANT

1 1 Grilo 2013: high risk of bias (unclear randomisation method and allocation concealment, dropout rate of both groups >=20%). Participants limited to
2 Latino/Latina patients.
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 184: Antiobesity agent and behavioural weight loss therapy versus placebo and behavioural weight loss therapy in adults with binge eating disorder at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+BWLT	Placebo+BWLT	Relative (95% CI)	Absolute	Quality	Importance
Remission (ITT)												
1	randomised trials	serious1	no serious inconsistency	serious1	very serious2	none	10/20 (50%)	10/20 (50%)	RR 1 (0.54 to 1.86)	0 fewer per 1000 (from 230 fewer to 430 more)	VERY LOW	CRITICAL
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	18	19	-	SMD 0.16 higher (0.49 lower to 0.81 higher)	VERY LOW	CRITICAL
EDE Global (range of scores: 0-6; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+BWLT	Placebo+BWLT	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	18	19	-	SMD 0.43 lower (1.08 lower to 0.22 higher)	VERY LOW	IMPORTANT
EDE Dietary restraint (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	very serious2	none	18	19	-	SMD 0.08 lower (0.73 lower to 0.56 higher)	VERY LOW	IMPORTANT
EDE Eating concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	18	19	-	SMD 0.54 lower (1.2 lower to 0.12 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antiobesity+BWLT	Placebo+BWLT	Relative (95% CI)	Absolute		
EDE Shape concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	18	19	-	SMD 0.32 lower (0.97 lower to 0.32 higher)	VERY LOW	IMPORTANT
EDE Weight concern (range of scores: 0-6; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	18	19	-	SMD 0.29 lower (0.94 lower to 0.36 higher)	VERY LOW	IMPORTANT
Depression (measured with: BDI; range of scores: 0-63; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious1	serious3	none	18	19	-	SMD 0.94 lower (1.62 to 0.25 lower)	VERY LOW	IMPORTANT

1

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1 1 Grilo 2013: high risk of bias (unclear randomisation method and allocation concealment, dropout rate of both groups >=20%). Participants limited to
2 Latino/Latina patients.
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

5

L.76 Do physical interventions, such as transcranial magnetic stimulation or physiotherapy, 7 produce benefits/harms in people with eating disorders?

L.7.18 Physical interventions for people with anorexia nervosa

9 **Table 185: Full GRADE profile for repetitive transcranial magnetic stimulation versus 'sham' repetitive transcranial magnetic**
10 **stimulation in adults with anorexia nervosa at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RTMS	Control	Relative (95% CI)	Absolute		
VAS Core AN symptoms (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.57 lower (1.14 lower to 0.01 higher)	MODERATE	IMPORTANT
VAS Restrict (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.2 lower (0.77 lower to	MODERATE	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RTMS	Control	Relative (95% CI)	Absolute		
		of bias								0.36 higher)		
VAS Feeling Full (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.45 lower (1.02 lower to 0.12 higher)	MODERATE	IMPORTANT
VAS Feeling Fat (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.71 lower (1.29 to 0.13 lower)	MODERATE	IMPORTANT
VAS Mood (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.17 higher (0.4 lower to 0.73 higher)	MODERATE	IMPORTANT
VAS Hunger (follow-up 1 days; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RTMS	Control	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.24 lower (0.81 lower to 0.33 higher)	MODERATE	
VAS Urge to Eat (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.16 lower (0.73 lower to 0.4 higher)	MODERATE	IMPORTANT
VAS Urge to Binge Eat (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.3 lower (0.87 lower to 0.27 higher)	MODERATE	IMPORTANT
VAS Urge to be Sick/Purge (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.53 lower (1.11 lower to	MODERATE	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RTMS	Control	Relative (95% CI)	Absolute		
										0.04 higher)		

1 *1 CI crosses either 0.5 or -0.5 (SMD).*

2 **Table 186: Full GRADE profile for repetitive transcranial magnetic stimulation versus 'sham' repetitive transcranial magnetic**
3 **stimulation in adults with anorexia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RTMS	Control	Relative (95% CI)	Absolute		
VAS Restrict 24-hr FU (Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.53 lower (1.1 lower to 0.05 higher)	MODERATE	IMPORTANT
VAS Feeling Full 24-hr FU (Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.65 lower (1.23 to 0.06 lower)	MODERATE	

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RTMS	Control	Relative (95% CI)	Absolute		
VAS Feeling Fat 24-hr FU (Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious1	none	21	28	-	SMD 0.71 lower (1.29 to 0.13 lower)	MODERATE	IMPORTANT

1 1 CI crosses either 0.5 or -0.5 (SMD).

2 **Table 187: Full GRADE profile for bright light treatment and CBT versus any other intervention in young people with anorexia**
3 **nervosa-restricting**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Light Therapy+CBT	CBT only	Relative (95% CI)	Absolute		
Depression (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	12	12	-	SMD 1.14 lower (2.01 to 0.27 lower)	VERY LOW	IMPORTANT
Remission of Depression (HAM-D<=8)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Light Therapy+CBT	CBT only	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	very serious2	serious4	none	3/12 (25%)	11/12 (91.7 %)	RR 0.27 (0.1 to 0.74)	669 fewer per 1000 (from 238 fewer to 825 fewer)	VERY LOW	IMPORTANT

1 1 Janas-Kozik 2011: Unclear randomization method and allocation concealment. No participant, investigator, nor assessor blinding.
2 2 Sample was participants diagnosed with Anorexia Nervosa-Restricting type with concomitant depressive symptoms.
3 3 CI crosses -0.5.
4 4 <300 events.

5 **Table 188: Full GRADE profile for warming therapy and refeeding versus refeeding in adults with anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Warming+Refeeding	Refeeding only	Relative (95% CI)	Absolute		
BMI - change scores (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2, 3	none	10	11	-	SMD 0.02 higher (0.84 lower	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Warming+Refeeding	Refeeding only	Relative (95% CI)	Absolute		
										to 0.87 higher)		

1 1 Birmingham 2004: Unclear randomization method, unclear allocation concealment. No participant, investigator, nor assessor blinding. Dropout rate of
2 control group>20%, reasons not stated.
3 2 CI crosses both 0.5 and -0.5 (SMD)
4 3 CI crosses 0.5.

5 **Table 189: Full GRADE profile for video feedback and treatment as usual versus treatment as usual in young people with anorexia**
6 **nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Video Feedback + TAU	TAU	Relative (95% CI)	Absolute		
BMI (change scores) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious3	none	16	16	-	SMD 0.16 higher (0.53 lower to 0.86 higher)	VERY LOW	CRITICAL

7 1 Touyz 1994: Randomization method and allocation concealment unclear. Participant, investigator and assessor blinding unclear. Significant difference at
8 baseline in EDI Body Dissatisfaction score.
9 2 Participants were diagnosed according to DSM-III-R.
10 3 CI crosses both 0.5 and -0.5.

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Table 190: Full GRADE profile for acupuncture and treatment as usual versus acupressure, massage and treatment as usual in adults with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute	Quality	Importance
BMI - change scores (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.07 lower (0.94 lower to 0.81 higher)	VERY LOW	CRITICAL
EDI-3 Bulimia - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	10	10	-	SMD 0.45 higher (0.44 lower to 1.34 higher)	LOW	IMPORTANT
EDI-3 Drive for Thinness - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.26 higher (0.62 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute	Quality	Importance
										1.14 higher)		
EDI-3 Body Dissatisfaction - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.14 higher (0.73 lower to 1.02 higher)	VERY LOW	IMPORTANT
EDE-Q Global - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	10	10	-	SMD 0.47 higher (0.42 lower to 1.36 higher)	LOW	IMPORTANT
EDE-Q Restraint - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	10	10	-	SMD 0.67 higher (0.24 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute		
										to 1.58 higher)		
EDE-Q Eating Concerns - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	10	10	-	SMD 0.44 higher (0.45 lower to 1.33 higher)	LOW	IMPORTANT
EDE-Q Weight Concerns - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.07 lower (0.94 lower to 0.81 higher)	VERY LOW	IMPORTANT
EDE-Q Shape Concerns - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	10	10	-	SMD 1.38 lower (2.38	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute		
										to 0.38 lower)		
General Psychopathology - DASS Total - change scores (measured with: Depression, Anxiety, and Stress Scale (DASS); Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.03 higher (0.84 lower to 0.91 higher)	VERY LOW	IMPORTANT
Depression - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.03 higher (0.85 lower to 0.91 higher)	VERY LOW	IMPORTANT
Stress - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.14 higher (0.73	VERY	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute	Quality	Importance
										lower to 1.02 higher)	LOW	
Quality of Life - EDQoL - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.05 higher (0.83 lower to 0.92 higher)	VERY LOW	IMPORTANT
EDQoL Psychological - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.11 lower (0.99 lower to 0.76 higher)	VERY LOW	IMPORTANT
EDQoL Physical/Cognitive - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious	very serious2	none	10	10	-	SMD 0 higher	VERY	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute		
				indirectness						(0.88 lower to 0.88 higher)	LOW	
EDQoL Financial - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.34 higher (0.54 lower to 1.23 higher)	VERY LOW	IMPORTANT
EDQoL Work/School - change scores (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	10	10	-	SMD 0.12 lower (1 lower to 0.75 higher)	VERY LOW	IMPORTANT
Withdrawn due to Adverse Events												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + TAU	Acupressure+Massage + TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	3/13 (23.1%)	3/13 (23.1%)	RR 1 (0.25 to 4.07)	0 fewer per 1000 (from 173 fewer to 708 more)	VERY LOW	IMPORTANT

1 1 Smith 2014: No participant blinding. Dropout rate of both groups>20%.
2 2 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
3 3 CI crosses either 0.5 or -0.5 (SMD).

4 **Table 191: Full GRADE profile for resistance training and treatment as usual versus treatment as usual in young people with**
5 **anorexia nervosa-restricting at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Resistance Training + TAU	TAU	Relative (95% CI)	Absolute		
BMI (follow-up 3 weeks; Better indicated by higher values)												
2	randomised trials	serious1, 2	no serious inconsistency	serious3	serious4	none	33	31	-	SMD 0.21 lower (0.70 lower to 0.29 higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Resistance Training + TAU	TAU	Relative (95% CI)	Absolute		
Quality of Life (follow-up 3 weeks; measured with: SF-36 Mental, SF-36 Physical; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious4	none	11	11	-	SMD 0.39 higher (0.2 lower to 0.99 higher)	VERY LOW	CRITICAL

1 1 del Valle 2010: Unclear randomization method and allocation concealment. No participant blinding, unclear investigator and assessor blinding.
2 2 del Valle 2014: Unclear whether baseline similar. Randomization method and allocation concealment unclear. No participant blinding, unclear investigator
3 and assessor blinding.
4 3 Sample consisted of participants diagnosed with Anorexia Nervosa-Restricting type. Participants in both groups also received psychotherapy 3 days a
5 week and were on diet.
6 4 CI crosses either 0.5 or -0.5 (SMD).

7 **Table 192: Full GRADE profile for resistance training and treatment as usual versus treatment as usual in young people with**
8 **anorexia nervosa-restricting at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Resistance Training + TAU	TAU	Relative (95% CI)	Absolute		
BMI FU (follow-up 4 weeks; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	18	18	-	SMD 0.53 lower (1.19 lower to 0.14 higher)	VERY LOW	CRITICAL

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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 week and were on diet.
3 CI crosses either 0.5 or -0.5 (SMD).

Table 193: Full GRADE profile for chiropractic therapy versus any other intervention in young people with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Chiropractic therapy	Other intervention	Relative (95% CI)	Absolute	Quality	Importance
Efficacy rate (assessed with: (Recovered+Significant Improvement)/Total N)												
5	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	171/178 (96.1%)	149/193 (77.2%)	RR 1.24 (1.14 to 1.35)	185 more per 1000 (from 108 more to 270 more)	LOW	IMPORTANT

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).

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L.7.21 Physical interventions for bulimia nervosa

Table 194: Full GRADE profile for repetitive transcranial magnetic stimulation versus placebo in adults with bulimia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Real) rTMS	(Sham) rTMS	Relative (95% CI)	Absolute		
Food Craving Questionnaire-State (raw scores) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	17	20	-	SMD 0.33 lower (0.98 lower to 0.32 higher)	VERY LOW	IMPORTANT
Food Craving Questionnaire-State (change scores) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	17	20	-	SMD 0.41 lower (1.06 lower to 0.25 higher)	VERY LOW	IMPORTANT
Not Withdrawn due to Adverse Events (follow-up 1 days)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	17/18 (94.4 %)	20/20 (100%)	RR 0.94 (0.81 to 1.09)	60 fewer per 1000 (from 190 fewer to 90 more)	VERY LOW	IMPORTANT
Urge To Eat (Visual Analogue Scale) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	17	20	-	SMD 0.44 lower (1.09 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Real) rTMS	(Sham) rTMS	Relative (95% CI)	Absolute	Quality	Importance
										0.22 higher)		
Mood (Visual Analogue Scale) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious	none	17	20	-	SMD 0.38 higher (0.27 lower to 1.03 higher)	VERY LOW	IMPORTANT
Tension (Visual Analogue Scale) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	very serious5	none	17	20	-	SMD 0.04 higher (0.6 lower to 0.69 higher)	VERY LOW	IMPORTANT
Hunger (Visual Analogue Scale) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	17	20	-	SMD 0.58 lower (1.25 lower to 0.08 higher)	VERY LOW	IMPORTANT
Urge To Binge Eat (Visual Analogue Scale) (follow-up 1 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	very serious5	none	17	20	-	SMD 0.03 lower (0.68 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Real) rTMS	(Sham) rTMS	Relative (95% CI)	Absolute	Quality	Importance
										0.61 higher)		
# patients NOT binged in 24 hours after treatment (follow-up 1 days)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	16/16 (100%)	14/18 (77.8 %)	RR 1.27 (0.98 to 1.66)	210 more per 1000 (from 16 fewer to 513 more)	VERY LOW	IMPORTANT

1 1 van den Eynde 2010: unclear randomization method and allocation concealment. No investigator blinding. Blinding only partially successful with 15/18
2 participants in real rTMS group correctly guessed treatment group; 11/20 participants in sham rTMS incorrectly guessed treatment group.
3 2 Sample consists of 20 BN participants and 17 EDNOS participants. EDNOS subgroup includes participants diagnosed with Binge Eating Disorder.
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
5 4 <300 events.
6 5 CI crosses both 0.5 and -0.5 (SMD).

7 **Table 195: Full GRADE profile for aerobic exercise versus any other intervention in adults with bulimia nervosa at follow up**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise	Other	Relative (95% CI)	Absolute	Quality	Importance
Recovery from Bulimia Nervosa FU (follow-up 18 months)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	Very serious2	none	8/12 (66.7%)	5/31 (16.1 %)	RR 5.04 (0.3 to 83.76)	652 more per 1000 (from 113 fewer to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise	Other	Relative (95% CI)	Absolute		
										1000 more)		
Satisfied EDNOS criteria FU (follow-up 18 months)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	1/12 (8.3%)	6/31 (19.4 %)	RR 0.57 (0.11 to 3.06)	83 fewer per 1000 (from 172 fewer to 399 more)	VERY LOW	CRITICAL
EDI Drive for Thinness FU (follow-up 18 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	14	-	SMD 1.36 higher (0.47 to 2.25 higher)	LOW	IMPORTANT

1 1 Sundgot-Borgen 2002: Unclear randomization and allocation concealment. No participant blinding, unclear investigator blinding. Physical exercise group
2 dropout rate=20%.
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio).
4 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 196: Full GRADE profile for aerobic exercise versus wait list control in adults with bulimia nervosa at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise	WLC	Relative (95% CI)	Absolute	Quality	Importance
Not recovered from Bulimia Nervosa FU (follow-up 18 months)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	12/12 (100%)	15/15 (100 %)	RR 0.36 (0.17 to 0.76)	640 fewer per 1000 (from 240 fewer to 830 fewer)	LOW	CRITICAL
Does not satisfy EDNOS criteria FU (follow-up 18 months)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	11/12 (91.7%)	15/15 (100 %)	RR 0.91 (0.74 to 1.13)	90 fewer per 1000 (from 260 fewer to 130 more)	LOW	CRITICAL

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).

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1 **Table 197: Full GRADE profile for relaxation training versus any other intervention in adults with bulimia nervosa at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation training	other intervention for adult BN	Relative (95% CI)	Absolute		
Binge frequency (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	39	72	-	SMD 0.09 higher (0.3 lower to 0.48 higher)	VERY LOW	CRITICAL
Vomiting frequency (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious	serious4	none	39	72	-	SMD 0.33 higher (0.07 lower to 0.72 higher)	VERY LOW	IMPORTANT
Laxative use frequency (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.37 higher (0.03 lower to 0.76 higher)	VERY LOW	IMPORTANT
Purge frequency (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.42 higher (0.03	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation training	other intervention for adult BN	Relative (95% CI)	Absolute		
										to 0.82 higher)		
No binge or purge episodes/2 weeks (follow-up 12 months)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious5	none	18/39 (46.2%)	39/72 (54.2%)	RR 0.85 (0.57 to 1.27)	81 fewer per 1000 (from 233 fewer to 146 more)	VERY LOW	IMPORTANT
EDI Drive for Thinness (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	39	72	-	SMD 0.09 higher (0.3 lower to 0.48 higher)	VERY LOW	IMPORTANT
EDI Bulimia (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.55 higher (0.15 to 0.94 higher)	VERY LOW	IMPORTANT
EDI Body dissatisfaction (follow-up 12 weeks; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	39	72	-	SMD 0.1 higher	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation training	other intervention for adult BN	Relative (95% CI)	Absolute		
										(0.29 lower to 0.49 higher)	Y LOW	
Depression (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	seriou s6	seriou s2	seriou s4	none	39	72	-	SMD 0.61 higher (0.21 to 1.01 higher)	VER Y LOW	IMPORTANT
Global Functioning (follow-up 12 weeks; measured with: GAFS; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	seriou s2	seriou s4	none	39	72	-	SMD 0.3 lower (0.69 lower to 0.09 higher)	VER Y LOW	IMPORTANT

1 1 Bulik 1998: unclear randomisation method and allocation concealment. Unclear participant and investigator blinding. Seventeen participants discontinued
2 treatment during prior CBT-ED, whilst 2 were withdrawn by investigators. Five participants discontinued treatment prior to randomization.
3 2 All participants received 8 sessions of CBT-ED over 8 week period prior to randomisation to intervention groups.
4 3 <400 participants.
5 4 CI crosses either 0.5 or -0.5 (SMD).
6 5 CI crosses both 0.75 and 1.25 (Risk Ratio).
7 6 I2>50%.

8

9

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2 **Table 198: Full GRADE profile for relaxation training versus any other intervention in adults with bulimia nervosa at follow up**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation training	other intervention for adult BN 12-mo FU	Relative (95% CI)	Absolute	Quality	Importance
Binge frequency (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	39	72	-	SMD 0.08 lower (0.47 lower to 0.31 higher)	VERY LOW	CRITICAL
Vomiting frequency (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.16 higher (0.23 lower to 0.56 higher)	VERY LOW	IMPORTANT
Laxative use frequency (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.4 higher (0.01 to 0.79 higher)	VERY LOW	IMPORTANT
Purge frequency (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation training	other intervention for adult BN 12-mo FU	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.27 higher (0.13 lower to 0.66 higher)	VERY LOW	IMPORTANT
No binge or purge episodes/2 weeks												
1	randomised trials	serious1	serious5	serious2	serious4	none	17/39 (43.6%)	40/72 (55.6%)	RR 0.78 (0.52 to 1.19)	122 fewer per 1000 (from 267 fewer to 106 more)	VERY LOWW	IMPORTANT
EDI Drive for Thinness (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	39	72	-	SMD 0.05 higher (0.34 lower to 0.44 higher)	VERY LOW	IMPORTANT
EDI Bulimia (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	39	72	-	SMD 0.05 higher (0.34	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation training	other intervention for adult BN 12-mo FU	Relative (95% CI)	Absolute		
										lower to 0.44 higher)		
EDI Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.17 higher (0.22 lower to 0.56 higher)	VERY LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.47 higher (0.08 to 0.87 higher)	VERY LOW	IMPORTANT
Global Functioning (Measured with: GAFS; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	39	72	-	SMD 0.44 lower (0.84 to 0.05 lower)	VERY LOW	IMPORTANT

1 1 Bulik 1998: unclear randomisation method and allocation concealment. Unclear participant and investigator blinding. Seventeen participants discontinued
2 treatment during prior CBT-ED, whilst 2 were withdrawn by investigators. Five participants discontinued treatment prior to randomization.
3 2 All participants received 8 sessions of CBT-ED over 8 week period prior to randomisation to intervention groups.
4 3 <400 participants.
5 4 CI crosses either 0.75 or 1.25 (SMD), or either 0.5 or -0.5 (SMD).

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1 5 I2>50%.

2

L.7.33 Physical interventions for binge eating disorder

4 **Table 199: Full GRADE profile for yoga versus wait list control in adults with binge eating disorder at end of treatment**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	WLC	Relative (95% CI)	Absolute	Quality	Importance
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	25	25	-	SMD 0.3 higher (0.26 lower to 0.86 higher)	VERY LOW	IMPORTANT
Binge Eating Scale (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	25	25	-	SMD 1.77 lower (2.43 to 1.11 lower)	VERY LOW	IMPORTANT

5 1 McIver 2009: Allocation concealment unclear. No participant, investigator nor assessor blinding. Dropout rate for both groups>20%.
6 2 Sample was participants with BMI>25 and Binge Eating Scale score>20.
7 3 CI crosses either 0.5 or -0.5 (SMD)
8 4 <400 participants.

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1 **Table 200: Full GRADE profile for aerobic exercise and group CBT-ED versus group CBT-ED at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise+Group CBT	Group CBT	Relative (95% CI)	Absolute		
BMI (changes scores) (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	17	-	SMD 0.93 lower (1.61 to 0.24 lower)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	17	-	SMD 0.51 lower (1.17 lower to 0.15 higher)	LOW	IMPORTANT

2 1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Dropout
3 rate of aerobic exercise+CBT group and CBT only group both >20%.
4 2 CI crosses either 0.5 or -0.5 (SMD).

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1 **Table 201: Full GRADE profile for aerobic exercise and group CBT-ED versus group CBT-ED at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise+Group CBT	Group CBT	Relative (95% CI)	Absolute		
BMI (changes scores) FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	17	-	SMD 0.91 lower (1.6 to 0.23 lower)	LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	17	-	SMD 0.26 lower (0.91 lower to 0.39 higher)	LOW	IMPORTANT

2 1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Dropout
3 rate of aerobic exercise +CBT group and CBT only group both >20%.
4 2 CI crosses either 0.5 or -0.5 (SMD).

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1 **Table 202: Full GRADE profile for aerobic exercise and group CBT-ED versus group CBT-ED and maintenance at end of treatment**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise+Group CBT	Group CBT+Maintenance	Relative (95% CI)	Absolute	Quality	Importance
BMI (Change scores) (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	23	-	SMD 0.28 lower (0.88 lower to 0.33 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	23	-	SMD 0.34 lower (0.94 lower to 0.27 higher)	LOW	IMPORTANT

2 1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Dropout
3 rate of aerobic exercise +CBT group>20%.
4 2 CI crosses either 0.5 or -0.5 (SMD).

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Table 203: Full GRADE profile for aerobic exercise and group CBT-ED versus group CBT-ED and maintenance at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise+Group CBT	Group CBT+Maintenance	Relative (95% CI)	Absolute	Quality	Importance
BMI (Change scores) FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	20	23	-	SMD 0.18 lower (0.78 lower to 0.42 higher)	LOW	CRITICAL
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	20	17	-	SMD 0.02 lower (0.58 lower to 0.62 higher)	VERY LOW	IMPORTANT

1 Pendleton 2002: randomization method and allocation concealment unclear. No participant blinding, unclear investigator and assessor blinding. Dropout rate of aerobic exercise+CBT group>20%.

2 CI crosses either 0.5 or -0.5 (SMD).

3 CI crosses both 0.5 and -0.5 (SMD).

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Table 204: Full GRADE profile for aerobic exercise, group CBT-ED and maintenance versus group CBT-ED and maintenance at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise+Group CBT+Maintenance	Group CBT+Maintenance	Relative (95% CI)	Absolute	Quality	Importance
BMI (change scores) (follow-up 12 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	24	23	-	SMD 0.53 lower (1.11 lower to 0.05 higher)	LOW	IMPORTANT
Depression (follow-up 12 months; measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	24	23	-	SMD 0.55 lower (1.14 lower to 0.03 higher)	LOW	IMPORTANT

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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Table 205: Full GRADE profile for aerobic exercise, group CBT-ED and maintenance versus group CBT-ED and maintenance at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise+Group CBT+Maintenance	Group CBT+Maintenance	Relative (95% CI)	Absolute	Quality	Importance
BMI (change scores) FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	24	23	-	SMD 0.57 lower (1.15 lower to 0.02 higher)	LOW	IMPORTANT
Depression FU (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	24	23	-	SMD 0.42 lower (1 lower to 0.16 higher)	LOW	IMPORTANT

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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L.7.41 Physical interventions for people with any eating disorder

Table 206: Full GRADE profile for yoga and treatment as usual versus treatment as usual in young people with any eating disorder at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga+TAU	TAU	Relative (95% CI)	Absolute	Quality	Importance
BMI or Weight (follow-up 3 weeks; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.22 higher (0.32 lower to 0.76 higher)	LOW	CRITICAL
EDE Global (follow-up 3 weeks; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.05 higher (0.49 lower to 0.59 higher)	LOW	IMPORTANT
EDE Restraint (follow-up 3 weeks; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.22 lower (0.76 lower to 0.32 higher)	LOW	IMPORTANT
EDE Weight Concern (follow-up 3 weeks; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.14 higher	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga+TAU	TAU	Relative (95% CI)	Absolute		
										(0.4 lower to 0.68 higher)		
EDE Shape Concern (follow-up 3 days; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.14 higher (0.4 lower to 0.68 higher)	LOW	IMPORTANT
EDE Eating Concern (follow-up 3 weeks; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.09 higher (0.45 lower to 0.62 higher)	LOW	IMPORTANT
Depression (follow-up 3 weeks; measured with: BDI-2; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	26	27	-	SMD 0 higher (0.54 lower to 0.54 higher)	VERY LOW	IMPORTANT

1 1 Carei 2010: Unclear randomization method (stratified, permuted block scheme after baseline measures). No participant blinding; unclear investigator and
2 assessor blinding. Sample consisted of 29 AN, 9 BN, and 15 EDNOS.
3 2 CI crosses either 0.5 or -0.5 (SMD).
4 3 CI crosses both 0.5 and 0.5 (SMD).

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Table 207: Full GRADE profile for yoga and treatment as usual versus treatment as usual in young people with eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga + TAU	TAU	Relative (95% CI)	Absolute		
BMI or Weight FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.21 higher (0.33 lower to 0.75 higher)	LOW	IMPORTANT
EDE Global FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.38 lower (0.92 lower to 0.17 higher)	LOW	IMPORTANT
EDE Restraint FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.65 lower (1.2 to 0.09 lower)	LOW	IMPORTANT
EDE Weight Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.09 lower (0.63 lower to 0.45 higher)	LOW	IMPORTANT
EDE Shape Concern FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.36 lower (0.9 lower to 0.19 higher)	LOW	IMPORTANT
EDE Eating Concern FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga + TAU	TAU	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.28 lower (0.82 lower to 0.27 higher)	LOW	IMPORTANT
Depression FU (measured with: BDI-2; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26	27	-	SMD 0.09 lower (0.63 lower to 0.45 higher)	LOW	IMPORTANT

1 1 Carei 2010: Unclear randomization method (stratified, permuted block scheme after baseline measures). No participant blinding; unclear investigator and
2 assessor blinding. Sample consisted of 29 AN, 9 BN, and 15 EDNOS.
3 2 CI crosses either 0.5 or -0.5 (SMD).

4

5

6 **Table 208: Full GRADE profile for body image therapy and maintenance treatment as usual versus maintenance treatment as usual**
7 **in adults with any eating disorder at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body image therapy+MTAU	MTAU for adult ED	Relative (95% CI)	Absolute		
EDE weight concerns (follow-up 6 months; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body image therapy+MTAU	MTAU for adult ED	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	24	21	-	SMD 0.11 lower (0.7 lower to 0.47 higher)	VERY LOW	IMPORTANT
EDE shape concerns (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	24	21	-	SMD 0.24 higher (0.35 lower to 0.82 higher)	VERY LOW	IMPORTANT

1 1 Trottier 2015: Randomization method not specified, unclear allocation concealment; no participant nor investigator blinding, unclear assessor blinding.
2 Dropout both groups>20%.
3 2 Participants received interventions after intensive day hospital treatment involving group cognitive behavioural program.
4 3 CI crosses either 0.5 or -0.5 (SMD).

5

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Table 209: Full GRADE profile for body image therapy and maintenance treatment as usual versus maintenance treatment as usual in adults with any eating disorder at follow up

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body image therapy+MTAU	MTAU for adult ED 6-mo FU	Relative (95% CI)	Absolute		
EDE weight concerns (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	24	21	-	SMD 0.2 higher (0.39 lower to 0.79 higher)	VERY LOW	IMPORTANT
EDE shape concerns (follow-up 6 months; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious4	none	24	21	-	SMD 0.03 lower (0.61 lower to 0.56 higher)	VERY LOW	IMPORTANT

1 Trottier 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).
4 CI crosses both 0.5 and -0.5 (SMD).

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Table 210: Full GRADE profile for acceptance-based mirror exposure therapy and treatment as usual versus non-directive body image therapy and treatment as usual in adults with any eating disorder at end of treatment

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body Image Therapy -1	Body Image Therapy -2	Relative (95% CI)	Absolute		
EDE-Q Restraint (follow-up 1 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	17	16	-	SMD 0.11 lower (0.35 lower to 0.13 higher)	VERY LOW	IMPORTANT
EDE-Q Eating Concern (follow-up 1 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	17	16	-	SMD 0.33 lower (0.57 to 0.09 lower)	VERY LOW	IMPORTANT
EDE-Q Shape Concern (follow-up 1 months; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	17	16	-	SMD 0.68 lower (0.94 to 0.43 lower)	VERY LOW	IMPORTANT
EDE-Q Weight Concern (follow-up 1 months; Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body Image Therapy -1	Body Image Therapy -2	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	17	16	-	SMD 0.73 lower (0.99 to 0.48 lower)	VERY LOW	IMPORTANT

1 1 Hildebrandt 2012: Unclear randomization and allocation concealment. No assessor blinding. Control group dropout rate>20%.
2 2 Inclusion criteria included participation in concurrent psychotherapy. Eighteen of the 31 participants were receiving either CBT or Family Therapy.
3 3 <400 participants.
4 4 CI crosses either 0.5 or -0.5 (SMD).

5 **Table 211: Full GRADE profile for psychomotor therapy and supportive contact versus supportive contact in adults with any eating**
6 **disorder**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychomotor Therapy + Support	Support	Relative (95% CI)	Absolute		
Self-Expression & Control Scale - Anger In (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious1	serious2	none	17	12	-	SMD 0.49 lower (1.24 lower to 0.26 higher)	VERY LOW	IMPORTANT
Self-Expression & Control Scale - Anger Out (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychomotor Therapy + Support	Support	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious1	serious2	none	17	12	-	SMD 0.28 lower (1.02 lower to 0.47 higher)	VERY LOW	IMPORTANT

1 *1* Boerhout 2016: unclear randomisation method; no participant nor investigator blinding. Dropout rate of both groups >20%. Supportive contact included
2 consultation with hospital staff once every one or two weeks, prescription of medication, psychoeducation, and diet management. Sample consisted of 9 AN,
3 16 BN and 4 BED participants.
4 2 CI crosses either 0.5 or -0.5.

L.8 5 What interventions are effective at managing or reducing short and long-term physical 6 complications of eating disorders?

L.8.1 7 Low bone mineral density

8 **Table 212: Full GRADE profile for DHEA versus HRT for young people with AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	DHEA vs.HRT	Control	Relative (95% CI)	Absolute		
Change in Total Hip BMD - Adolescents (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	31	30	-	SMD 0.11 lower	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	DHEA vs.HRT	Control	Relative (95% CI)	Absolute		
										(0.61 lower to 0.39 higher)		
Change in LS BMD - Adolescents (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	31	30	-	SMD 0.49 lower (1 lower to 0.02 higher)	LOW	CRITICAL
Did not drop out due to side effects												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	0/31 (0%)	0/30 (0%)	Not estimable	-	LOW	CRITICAL
Change in Weight - Adolescents (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	31	30	-	SMD 0.13 higher (0.38 lower to 0.63 higher)	LOW	CRITICAL
Regular menses - Adolescents												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious6	none	18/31 (58.1 %)	24/30 (80%)	RR 0.73 (0.51 to 1.03)	216 fewer per 1000 (from 392 fewer to 24 more)	LOW	CRITICAL

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[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% drop out rate.
[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 (0.5).
[6] 95% CI crossed 1 MID (0.75)

Table 213: Full GRADE profile for DHEA and combined oral contraceptive pill versus placebo for adults with AN

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	DHEA+COC	placebo	Relative (95% CI)	Absolute	Quality	Importance
Change in Femoral Shaft BMD - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	40	33	-	SMD 12.86 higher (10.66 to 15.05 higher)	LOW	CRITICAL
Change in Femoral Neck BMD - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	34	-	SMD 14.38 higher (11.99 to 16.77 higher)	LOW	CRITICAL
Change in Femoral Shaft Bone Strength Index - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	40	33	-	SMD 18.99 higher (15.79 to 22.19 higher)	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	DHEA+COC	placebo	Relative (95% CI)	Absolute		
Change in FN Bone Strength Index - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	42	34	-	SMD 0.95 lower (1.43 to 0.47 lower)	LOW	CRITICAL
Change in Weight - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	31	29	-	SMD 0.99 higher (0.45 to 1.53 higher)	LOW	CRITICAL
Change in BMI (% median for age) - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	31	29	-	SMD 0.96 higher (0.42 to 1.5 higher)	LOW	CRITICAL
Amenorrheic - Adults												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	31/31 (100%)	29/29 (100%)	RR 1 (0.94 to 1.07)	0 fewer per 1000 (from 60 fewer to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	DHEA+COC	placebo	Relative (95% CI)	Absolute		
										70 more)		
Did not drop outdue to side-effects												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	0/31 (0%)	0/29 (0%)	Not estimable	-	LOW	CRITICAL

[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.

Table 214: Full GRADE profile for PTH versus placebo for adults with AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**PTH**	**placebo**	**Relative (95% CI)**	**Absolute**		
% Change in Weight - Adults (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	10	11	-	SMD 2.45 lower (3.63 to 1.26 lower)	VERY LOW	CRITICAL
Change in Lateral Spine BMD - Adults (Better indicated by higher values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PTH	placebo	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	10	11	-	SMD 5.09 higher (3.18 to 7 higher)	VERY LOW	CRITICAL
Change in Total Hip BMD - Adults (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious4	none	10	11	-	SMD 0.19 lower (1.05 lower to 0.67 higher)	VERY LOW	CRITICAL
Change in FN BMD - Adults (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	10	11	-	SMD 0.86 lower (1.77 lower to 0.04 higher)	VERY LOW	CRITICAL
Change in AP Spine BMD - Adults (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	10	11	-	SMD 4.61 higher (2.84 to 6.38 higher)	VERY LOW	CRITICAL
Did not drop out out due to side effects												
1	randomised trials	serious1	no serious inconsistency	serious2	serious6	none	0/10 (0%)	0/11 (0%)	Not estimable	-	VERY LOW	CRITICAL

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[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 drop outs 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).
[6] For a dichotomous outcome, there were fewer than 300 events.

Table 215: Full GRADE profile for IGF-I versus another therapy in adults with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute	**Quality**	**Importance**
Change in Total Hip BMD - IGF-I vs. placebo (Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	serious[2]	serious[3]	none	16	15	-	SMD 0.37 higher (0.36 lower to 1.11 higher)	VERY LOW	CRITICAL
Change in Total Hip BMD - IGF + OCP vs. placebo (Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	serious[2]	serious[3]	none	16	15	-	SMD 0.49 higher (0.23 lower to 1.2 higher)	VERY LOW	CRITICAL
Change in Total Hip BMD - IGF vs. OCP (Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	serious[2]	serious[3]	none	16	15	-	SMD 1.08 higher (0.29 to	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										1.86 higher)	Y LOW	
Change in Total Hip BMD - IGF-I + OCP vs. OCP (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	16	15	-	SMD 1.18 higher (0.41 to 1.95 higher)	VERY LOW	CRITICAL
Change in Total Hip BMD - IGF-I + OCP vs. IGF-I (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	16	16	-	SMD 0.10 higher (0.62 lower to 0.82 higher)	VERY LOW	CRITICAL
Change Total Body BMD - IGF-I vs. placebo (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious5	none	14	15	-	SMD 0.10 higher (0.63 lower to 0.83 higher)	VERY LOW	CRITICAL
Change Total Body BMD - IGF + OCP vs. placebo (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious	none	16	15	-	SMD 1.27 higher	VER	

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										(0.49 to 2.05 higher)	LOW	
Change Total Body BMD - IGF vs. OCP (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	14	15	-	SMD 1.33 higher (0.51 to 2.15 higher)	VERY LOW	CRITICAL
Change Total Body BMD - IGF-I + OCP vs. OCP (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	16	15	-	SMD 2.55 higher (1.58 to 3.53 higher)	VERY LOW	CRITICAL
Change Total Body BMD - IGF-I + OCP vs. IGF-I (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	16	14	-	SMD 1.17 higher (0.38 to 1.95 higher)	VERY LOW	CRITICAL
Change in Radial BMD - IGF-I vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	14	15	-	SMD 0.25 higher (0.48	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										lower to 0.98 higher)		
Change in Radial BMD - OCP vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	15	15	-	SMD 0.62 higher (0.12 lower to 1.35 higher)	VERY LOW	CRITICAL
Change in Radial BMD - IGF + OCP vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	16	15	-	SMD 1.34 higher (0.55 to 2.13 higher)	VERY LOW	CRITICAL
Change in Radial BMD - IGF vs. OCP (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious6	none	14	15	-	SMD 0.29 lower (1.02 lower to 0.44 higher)	VERY LOW	CRITICAL
Change in Radial BMD - IGF-I + OCP vs. IGF-I (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	16	14	-	SMD 0.88	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										higher (0.12 to 1.63 higher)	VERY LOW	
Change in AP Spine BMD - IGF-I vs. placebo (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious4	none	14	15	-	SMD 1.17 higher (0.37 to 1.96 higher)	VERY LOW	CRITICAL
Change in AP Spine BMD - IGF + OCP vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	16	15	-	SMD 2.34 higher (1.4 to 3.28 higher)	VERY LOW	CRITICAL
Change in AP Spine BMD - IGF vs. OCP (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	14	15	-	SMD 0.58 higher (0.16 lower to 1.33 higher)	VERY LOW	CRITICAL
Change in AP Spine BMD - IGF-I + OCP vs. OCP (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	16	15	-	SMD 1.75	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										higher (0.91 to 2.6 higher)	Y LOW	
Change in AP Spine BMD - IGF-I + OCP vs. IGF-I (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	16	14	-	SMD 1.17 higher (0.38 to 1.95 higher)	VERY LOW	CRITICAL
Change in Lean Mass - IGF-I vs. placebo (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	14	15	-	SMD 1.59 higher (0.74 to 2.44 higher)	VERY LOW	CRITICAL
Change in Lean Mass - IGF + OCP vs. placebo (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious5	none	16	15	-	SMD 2.34 higher (1.4 to 3.28 higher)	VERY LOW	CRITICAL
Change in Radial BMD - IGF-I + OCP vs. OCP (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	16	15	-	SMD 0.58 higher	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										(0.14 lower to 1.31 higher)	Y LOW	
Change in Lean Mass - IGF vs. OCP (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious5	none	14	15	-	SMD 1.46 higher (0.63 to 2.29 higher)	VERY LOW	CRITICAL
Change in Lean Mass - IGF-I + OCP vs. OCP (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious5	none	16	15	-	SMD 2.12 higher (1.22 to 3.03 higher)	VERY LOW	CRITICAL
Change in Lean Mass - IGF-I + OCP vs. IGF-I (Better indicated by higher values)												
2	randomised trials	serious 1	no serious inconsistency	serious2	serious3	none	30	29	-	SMD 0.60 higher (0.08 to 1.13 higher)	VERY LOW	CRITICAL
Change in Weight - IGF-I vs.placebo (Better indicated by higher values)												
2	randomised trials	serious 1	no serious inconsistency	serious7	serious3	none	30	29	-	SMD 0.54 higher	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
										(0.02 to 1.07 higher)	VERY LOW	
Change in Weight - IGF-I +Estrogen vs. placebo (Better indicated by higher values)												
2	randomised trials	serious1	very serious8	serious7	serious5	none	30	29	-	SMD 0.14 lower (0.72 lower to 0.44 higher)	VERY LOW	CRITICAL
Change in Weight - IGF-I + Estrogen vs. Estrogen (Better indicated by higher values)												
2	randomised trials	serious1	serious8	serious7	serious5	none	30	30	-	SMD 0.53 lower (1.07 lower to 0.01 higher)	VERY LOW	
Change in Weight - IGF-I + Estrogen vs. IGF-I (Better indicated by higher values)												
2	randomised trials	serious1	no serious inconsistency8	serious7	serious5	none	30	30	-	SMD 0.48 lower (1.06 lower to 0.09 higher)	VERY LOW	CRITICAL
Change in Weight - IGF-I vs. Estrogen (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
2	randomised trials	serious1	no serious inconsistency8	serious7	serious3	none	30	30	-	SMD 0.35 higher (0.18 lower to 0.89 higher)	VERY LOW	CRITICAL
Change in BMI - IGF-I vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious7	serious3	none	15	14	-	SMD 0.76 higher (0 to 1.52 higher)	VERY LOW	CRITICAL
Change in BMI - IGF-I +Estrogen vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious7	serious5	none	15	14	-	SMD 1.46 lower (2.29 to 0.63 lower)	VERY LOW	CRITICAL
Change in BMI - IGF-I + Estrogen vs. Estrogen (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious7	serious6	none	15	15	-	SMD 0.97 lower (1.74 to 0.21 lower)	VERY LOW	CRITICAL
Change in BMI - IGF-I + Estrogen vs. IGF-I (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious7	serious5	none	15	15	-	SMD 1.91 lower (2.79 to 1.02 lower)	VERY LOW	CRITICAL
Change in BMI - IGF-I vs. Estrogen (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious7	serious3	none	15	15	-	SMD 1.14 higher (0.36 to 1.93 higher)	VERY LOW	CRITICAL
Did not drop out due to side-effects - OCP vs. placebo												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious9	none	0/15 (0%)	0/15 (0%)	RR 1.00 (0.88 to 1.13)	-	VERY LOW	CRITICAL
Did not drop out due to side-effects - IGF-I + OCP vs IGF-I												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious9	none	0/16 (0%)	0/14 (0%)	RR 1.00 (0.88 to 1.13)	-	VERY LOW	CRITICAL
Did not drop outdue to side-effects - IGF-I vs. OCP												
1	randomised trials	serious 1	no serious inconsistency	serious7	serious9	none	1/15 (6.7 %)	0/15 (0%)	RR 0.94 (0.78 to 1.12)	-	VERY LOW	CRITICAL
Did not drop out due to side-effects. Combined vs. placebo												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IGF	Control	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious7	serious9	none	0/16 (0%)	0/15 (0%)	RR 1.00 (0.89 to 1.13)	-	VERY LOW	
Did not drop out due to side-efffects. IGF-I + OCP vs. OCP												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious9	none	0/16 (0%)	0/15 (0%)	RR 1.00 (0.88 to 1.13)	-	VERY LOW	

[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.

Table 216: Full GRADE profile for estrogen versus placebo in young people or adults with AN

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Estrogen	Placebo	Relative (95% CI)	Absolute		
Change LS BMD - Adolescents (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Estrogen	Placebo	Relative (95% CI)	Absolute		
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	108	114	-	SMD 1.05 higher (0.74 to 1.36 higher)	LOW	CRITICAL
Change LS BMD - Adults (Better indicated by higher values)												
2	randomised trials	serious3	no serious inconsistency	no serious indirectness	serious2	none	34	40	-	SMD 1.05 higher (0.74 to 1.36 higher)	LOW	CRITICAL
Change in FN BMD - Adolescents (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious	none	53	59	-	SMD 0.22 lower (0.15 lower to 0.6 higher)	LOW	CRITICAL
Change Total Hip BMD - Adolescents (Better indicated by higher values)												
2	randomised trials	serious1	very serious4	no serious indirectness	serious2	none	108	114	-	SMD 0.61 higher (0.33 to 0.88 higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Estrogen	Placebo	Relative (95% CI)	Absolute		
Change Total Hip BMD - Adults (Better indicated by higher values)												
1	randomised trials	serious5	serious6	no serious indirectness	serious2	none	15	15	-	SMD 1.02 lower (1.79 to 0.25 lower)	VERY LOW	CRITICAL
Change in Weight - Adolescents (Better indicated by higher values)												
2	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	108	114	-	SMD 0.34 higher (0.07 to 0.6 higher)	LOW	CRITICAL
Change in Weight - Adults (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious2	none	15	14	-	SMD 0.39 lower (1.13 lower to 0.35 higher)	LOW	CRITICAL
Change in BMI - Adolescents (Better indicated by higher values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious2	none	55	55	-	SMD 0.27 higher (0.11 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Estrogen	Placebo	Relative (95% CI)	Absolute		
										0.64 higher)		
Change in BMI - Adults (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious8	none	70	69	-	SMD 0.11 higher (0.22 lower to 0.45 higher)	LOW	CRITICAL
Change in Lean mass - Adolescents (Better indicated by higher values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious2	none	55	55	-	SMD 0.17 higher (0.2 lower to 0.55 higher)	LOW	CRITICAL
Change in Lean Mass - Adults (Better indicated by lower values)												
1	randomised trials	serious5	no serious inconsistency	no serious indirectness	serious8	none	70	70	-	SMD 0.13 higher (0.2 lower to 0.47 higher)	LOW	CRITICAL
Change in Fat Mass - Adolescents (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Estrogen	Placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious2	none	55	55	-	SMD 0.17 higher (0.2 lower to 0.55 higher)	LOW	CRITICAL
Change in Total Body BMD - Adults (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious10	none	15	15	-	SMD 1.23 lower (2.02 to 0.44 lower)	LOW	CRITICAL
Did not achieve normal menses Adolescents												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious11	none	0/55 (0%)	5/55 (9.1%)	RR 1.0 (1 to 1.2)	0 fewer per 1000 (from 0 more to 18 more)	LOW	CRITICAL
Did not achieve remission - Adults												
1	randomised trials	serious12	no serious inconsistency	no serious indirectness	serious11	none	2/19 (10.5%)	6/25 (24%)	RR 1.10 (0.9 to 1.54)	24 more per 1000 (from 24 fewer to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Estrogen	Placebo	Relative (95% CI)	Absolute		
										130 more)		
Did not drop out due to side-effects- Adolescent												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious11	none	3/61 (4.9%)	1/62 (1.6%)	RR 0.97 (0.91 to 1.03)	0 fewer per 1000 (from 1 fewer to 0 more)	LOW	IMPORTANT

[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 drop outs 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 drop outs 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 drop outs 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 drop outs 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 drop outs 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 drop outs were reported in both studies >20%

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1 **Table 217: Full GRADE profile for bisphosphonates versus placebo for adults and young people with AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bisphosphonate	Control	Relative (95% CI)	Absolute		
Tibia SOS - Etidronate vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	14	12	-	SMD 0.33 higher (0.45 lower to 1.1 higher)	LOW	CRITICAL
Tibia SOS - Etidronate vs. Calcium Vit D (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	14	15	-	SMD 0.47 lower (1.21 lower to 0.27 higher)	LOW	CRITICAL
Tibia Z Score - Etidronate vs. placebo (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	14	12	-	SMD 0.64 higher (0.15 lower to 1.43 higher)	LOW	CRITICAL
Tibia Z Score - Etidronate vs. Calcium Vit D (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious	none	14	15	-	SMD 0.24 lower		CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bisphosphonate	Control	Relative (95% CI)	Absolute		
										(0.97 lower to 0.49 higher)		
Difference in Lateral spine BMD (Better indicated by higher values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	none	20	19	-	SMD 1.35 higher (2.05 to 0.64 lower)	LOW	CRITICAL
Difference in hip BMD (Better indicated by higher values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	none	20	18	-	SMD 1.42 higher (2.13 to 0.71 lower)	LOW	CRITICAL
PA Spine BMD Z score (Better indicated by higher values)												
1	randomised trials	serious4	no serious inconsistency	no serious indirectness	serious5	none	20	18	-	SMD 1.26 higher (0.56 lower to 1.96 higher)	LOW	CRITICAL
LS BMD Z score change - Adolescents (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bisphosphonate	Control	Relative (95% CI)	Absolute		
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious7	none	14	15	-	SMD 0.05 lower (0.78 lower to 0.68 higher)	LOW	CRITICAL
FN BMD Z score change - - Adolescents (Better indicated by lower values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	very serious7	none	14	15	-	SMD 0.39 higher (0.34 lower to 1.13 higher)	VERY LOW	CRITICAL
Trochanter BMD Change - Adolescents (Better indicated by higher values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious5	none	14	15	-	SMD 4.60 higher (3.13 to 6.07 higher)	LOW	IMPORTANT
Wards Triangle Change BMD - Adolescents (Better indicated by higher values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	14	15	-	SMD 0.54 higher (0.2 lower to 1.28 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bisphosphonate	Control	Relative (95% CI)	Absolute		
Total Hip BMD Change - Adolescents (Better indicated by higher values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious2	none	14	15	-	SMD 0.24 higher (0.49 lower to 0.97 higher)	LOW	CRITICAL
Did not drop out due to SE - Bisphosphonates vs. placeo												
3	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious8	none	0/48 (0%)	1/47 (2.1 %)	RR 1.02 (0.94 to 1.1)	0 more per 1000 (from 1 fewer to 2 more)	LOW	CRITICAL
Did not drop out due to SE - Bisphosphonates vs. Ca Vit D												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious8	none	0/14 (0%)	0/15 (0%)	Not estimable	-	LOW	CRITICAL

[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 drop outs 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.

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[7] 95% CI crossed 2 MIDs (-0.5 and 0.5)
[8] For a dichotomous outcome, there were fewer than 300 events.

L.8.23 Treating low body weight and malnourished people with anorexia nervosa

Table 218: Full GRADE profile for parenteral and enteral nutrition versus enteral nutrition in young people with anorexia nervosa at end of treatment

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Parenteral+Enteral Refeeding	Enteral Refeeding	Relative (95% CI)	Absolute	Quality	Importance
BMI or Weight (follow-up mean 33.3 months; Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	104	94	-	SMD 0.28 lower (0.56 lower to 0 higher)	VERY LOW	CRITICAL
% Ideal Body Weight - Adolescent (follow-up mean 33.3 months; Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	104	94	-	SMD 0.37 lower (0.65 to 0.09 lower)	VERY LOW	CRITICAL
Weight Gain (g/week) - Adolescent (follow-up mean 33.3 months; Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	104	94	-	SMD 16.27 higher (14.63 to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Parenteral+Enteral Refeeding	Enteral Refeeding	Relative (95% CI)	Absolute		
										17.91 higher)		
Length of Treatment (days) - Adolescent (follow-up mean 33.3 months; Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	104	94	-	SMD 8.66 higher (7.75 to 9.56 higher)	VERY LOW	CRITICAL
Maximum Energy Intake (kcal/day) - Adolescent (follow-up mean 33.3 months; Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	104	94	-	SMD 3.06 higher (2.64 to 3.47 higher)	VERY LOW	CRITICAL
Abdominal Pain - Adolescent (follow-up mean 33.3 months)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	8/104 (7.7%)	18/94 (19.1%)	RR 0.4 (0.18 to 0.88)	115 fewer per 1000 (from 23 fewer to 157 fewer)	VERY LOW	CRITICAL
Bloating - Adolescent (follow-up mean 33.3 months)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Parenteral+Enteral Refeeding	Enteral Refeeding	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	7/104 (6.7%)	14/94 (14.9%)	RR 0.45 (0.19 to 1.07)	82 fewer per 1000 (from 121 fewer to 10 more)	VERY LOW	CRITICAL
Constipation - Adolescent (follow-up mean 33.3 months)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	none	8/104 (7.7%)	10/94 (10.6%)	RR 0.72 (0.3 to 1.76)	30 fewer per 1000 (from 74 fewer to 81 more)	VERY LOW	CRITICAL

1 1 Diamanti 2008: high selection bias(significantly higher psychiatric comorbidity, weight loss at diagnosis, and resting energy expenditure in parenteral
2 group; significantly lower % Ideal Body Weight, Weight at diagnosis and BMI in parenteral group).
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 <300 events or <400 participants.
5 4 CI crosses both 0.75 and 1.25 (Risk Ratio).

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Table 219: Full GRADE profile for parenteral and enteral nutrition versus enteral nutrition at follow up for adolescent anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Parenteral and Enteral Refeeding	Enteral Refeeding	Relative (95% CI)	Absolute	Quality	Importance
Recovered after nutritional rehabilitation - Adolescent												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	38/62 (61.3%)	43/67 (64.2%)	RR 0.95 (0.73 to 1.25)	32 fewer per 1000 (from 173 fewer to 160 more)	VERY LOW	CRITICAL
Rehospitalized - Adolescent												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	very serious3	none	14/62 (22.6%)	17/67 (25.4%)	RR 0.89 (0.48 to 1.65)	28 fewer per 1000 (from 132 fewer to 165 more)	VERY LOW	CRITICAL
Length of 2nd rehospitalization - Adolescent (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	62	67	-	SMD 0.62 higher (0.27 to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Parenteral and Enteral Refeeding	Enteral Refeeding	Relative (95% CI)	Absolute	Quality	Importance
										0.98 higher)		

1 1 Diamanti 2008: high selection bias(significantly higher psychiatric comorbidity, weight loss at diagnosis, and resting energy expenditure in parenteral
2 group; significantly lower % Ideal Body Weight, Weight at diagnosis and BMI in parenteral group).
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 CI crosses both 0.75 and 1.25 (Risk Ratio).

5 **Table 220: Full GRADE profile for percutaneous gastric tube feeding and meals versus meals with or without nasogastric tube**
6 **feeding for underweight adults with anorexia nervosa**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Percutaneous Gastric	Nasogastric Feeding/No Tube	Relative (95% CI)	Absolute	Quality	Importance
Weight Gain (kg) at discharge - Adult (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	57	11	-	SMD 0.17 higher (0.47 lower to 0.82 higher)	VERY LOW	CRITICAL
Length of Treatment (days) - Adult (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Percutaneous Gastric	Nasogastric Feeding/No Tube	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	57	11	-	SMD 0.87 higher (0.21 to 1.54 higher)	VERY LOW	CRITICAL

1 1 Born 2015: high selection bias (method of allocation to groups related to potential confounding factors), high performance bias (participants received
2 varioius forms of therapies).
3 2 CI crosses 0.5 or -0.5.

4 **Table 221: Full GRADE profile for nasogastric tube and oral refeeding diet versus oral refeeding diet for malnourished young people**
5 **with anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute		
BMI - Adolescent (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	52	48	-	SMD 0.48 higher (0.08 to 0.88 higher)	VERY LOW	CRITICAL
BMI change at discharge - Adolescent (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	52	48	-	SMD 1 higher (0.58 to 1.42 higher)	VERY LOW	CRITICAL
Weight (kg) - Adolescent (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	52	48	-	SMD 0.27 higher (0.13 lower to 0.66 higher)	VERY LOW	CRITICAL
Weight Gain at discharge - Adolescent (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	52	48	-	SMD 0.95 higher (0.54 to 1.36 higher)	VERY LOW	CRITICAL
Length of Stay (days) - Adolescent (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	52	48	-	SMD 0.02 higher (0.38 lower	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute		
										to 0.41 higher)		
Maximum Caloric Intake (kcal/day) - Adolescents (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	52	48	-	SMD 1.27 higher (0.84 to 1.7 higher)	VERY LOW	IMPORTANT

1 1 Robb 2002: high selection bias (significantly higher number of hospitalizations in nocturnal NG + oral refeeding group); high performance bias (participants
2 received various therapies during course of treatment).
3 2 CI crosses 0.5 or -0.5.
4 3 <300 events or <400 participants.

5 **Table 222: Full GRADE profile for nasogastric and oral refeeding diet versus oral refeeding diet for malnourished adults with**
6 **anorexia nervosa at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding for adult AN	Relative (95% CI)	Absolute		
BMI>18.5 (follow-up 1 years)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding for adult AN	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	16/41 (39%)	3/40 (7.5%)	RR 5.2 (1.64 to 16.49)	315 more per 1000 (from 48 more to 1000 more)	LOW	CRITICAL
Weight (kg) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	41	40	-	SMD 0.63 higher (0.18 to 1.08 higher)	LOW	CRITICAL
Weight (kg) - AN-R (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	27	-	SMD 1.13 higher (0.56 to 1.7 higher)	LOW	CRITICAL
Weight (kg) - AN-BP (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	12	13	-	SMD 1.15 higher (0.29	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding for adult AN	Relative (95% CI)	Absolute		
										to 2.01 higher)		
Weight Gain (g/day) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	41	40	-	SMD 4.04 higher (3.27 to 4.82 higher)	LOW	CRITICAL
Relapse-Free Period (weeks) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	41	40	-	SMD 0.94 higher (0.48 to 1.41 higher)	LOW	CRITICAL
Change in Extracellular fluids (kg) (follow-up 1 years; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	41	40	-	SMD 5.03 lower (5.94 to 4.13 lower)	LOW	CRITICAL
Creatinine urinary output (mg/day) (follow-up 1 years; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	41	40	-	SMD 0.67 higher (0.22	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding for adult AN	Relative (95% CI)	Absolute		
										to 1.12 higher)		
Fat Free Mass (kg) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	41	40	-	SMD 1.04 higher (0.57 to 1.5 higher)	LOW	CRITICAL
Fat Free Mass Gain (g/day) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	41	40	-	SMD 3.06 higher (2.41 to 3.71 higher)	LOW	CRITICAL
Fat Mass Gain (g/day) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	41	40	-	SMD 0.55 higher (0.1 to 0.99 higher)	LOW	CRITICAL
Added Sugar (sucrose) (g/day) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	41	40	-	SMD 0.45 lower (0.89	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding for adult AN	Relative (95% CI)	Absolute		
										to 0.01 lower)		
Added Fat (g/day) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	41	40	-	SMD 0.24 higher (0.2 lower to 0.68 higher)	LOW	CRITICAL
Energy Intake (kcal/day) - AN-R (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	29	27	-	SMD 0.46 higher (0.08 lower to 0.99 higher)	LOW	CRITICAL
Energy Intake (kcal/day) - AN-BP (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	12	13	-	SMD 0.93 lower (1.77 to 0.1 lower)	LOW	CRITICAL

1 1 Rigaud 2007: no details of randomization method provided; unclear whether participant, investigator or assessor blinded.
2 2 <300 events or <400 participants.
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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Table 223: Full GRADE profile for nasogastric and oral refeeding diet versus oral refeeding diet for malnourished adults with anorexia nervosa at follow up

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute	Quality	Importance
Weight (kg) - AN-R 12-mo FU (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	29	27	-	SMD 0.99 higher (0.43 to 1.55 higher)	LOW	CRITICAL
Weight (kg) AN-BP 12-mo FU (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	12	13	-	SMD 1.2 higher (0.33 to 2.06 higher)	LOW	CRITICAL
# Relapsed 12-mo FU (follow-up 1 years)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	18/41 (43.9%)	21/40 (52.5%)	RR 0.84 (0.53 to 1.32)	84 fewer per 1000 (from 247 fewer to 168 more)	VERY LOW	CRITICAL
Energy Intake - AN-R 12-mo FU (kcal/day) (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	29	27	-	SMD 0 higher (0.52 lower to 0.53 higher)	VERY LOW	CRITICAL
Energy Intake AN-BP 12-mo FU (kcal/day) (follow-up 1 years; Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	12	13	-	SMD 0.28 lower (1.07 lower to 0.51 higher)	VERY LOW	CRITICAL
# BMI>18.5 + adequate energy intake 12-mo FU (follow-up 1 years)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	15/41 (36.6%)	11/40 (27.5%)	RR 1.33 (0.7 to 2.53)	91 more per 1000 (from 83 fewer to 421 more)	VERY LOW	CRITICAL
EDI Total 12-mo FU (follow-up 1 years; Better indicated by lower values)												
1	randomised trials	very serious1	no serious inconsistency	no serious indirectness	serious2	none	41	40	-	SMD 0.15 lower (0.59	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute		
										lower to 0.28 higher)		
Resumed menses 12-mo FU (follow-up 1 years)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	15/15 (100%)	10/11 (90.9%)	RR 1.11 (0.88 to 1.4)	100 more per 1000 (from 109 fewer to 364 more)	LOW	CRITICAL
# taking antidepressants 12-mo FU (follow-up 1 years)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	6/41 (14.6%)	5/40 (12.5%)	RR 1.17 (0.39 to 3.53)	21 more per 1000 (from 76 fewer to 316 more)	VERY LOW	CRITICAL
# taking antixiolytics 12-mo FU												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious3	none	7/41 (17.1%)	9/40 (22.5%)	RR 0.76 (0.31 to 1.84)	54 fewer per 1000 (from	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) Nasogastric+Oral	Oral Refeeding	Relative (95% CI)	Absolute		
										155 fewer to 189 more)		

1 1 Rigaud 2007: no details of randomization method provided; unclear whether participant, investigator or assessor blinded.
2 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
3 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).

4 **Table 224: Full GRADE profile for high-calorie refeeding diet versus low-calorie refeeding diet for malnourished young people with**
5 **anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
QT-corrected Interval at 4 days - QT-c (ms) (measured with: QT-c, QT-change; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious	serious2	none	18	18	-	SMD 0.01 higher (0.64 lower to 0.67 higher)	VERY LOW	CRITICAL
QT-corrected Interval at 4 days - Change scores (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.24 higher (0.42 lower to 0.89 higher)	VERY LOW	CRITICAL
Heart Rate at 4 days - Heart Rate (bpm) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.58 higher (0.09 lower to 1.25 higher)	VERY LOW	CRITICAL
Heart Rate at 4 days - Change (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	very serious4	none	18	18	-	SMD 0 higher (0.65 lower to 0.65 higher)	VERY LOW	CRITICAL
Weight (kg) at 4 days - Weight (kg) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.21 lower (0.86 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
										0.45 higher)		
Weight (kg) at 4 days - Change (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.64 higher (0.03 lower to 1.31 higher)	VERY LOW	IMPORTANT
BMI at 4 days - BMI (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.37 higher (0.29 lower to 1.03 higher)	VERY LOW	IMPORTANT
BMI at 4 days - Change (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.44 higher (0.22 lower to 1.11 higher)	VERY LOW	IMPORTANT
mBMI (%) at 4 days - mBMI (%) (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.47 higher (0.2 lower to 1.13 higher)	VERY LOW	IMPORTANT
mBMI (%) at 4 days - Change (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.56 higher (0.11 lower to 1.23 higher)	VERY LOW	IMPORTANT
Serum Phosphate Concentration at 4 days - Nadir (mmol/L) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	very serious4	none	18	18	-	SMD 0.06 higher (0.6 lower to 0.71 higher)	VERY LOW	CRITICAL
Serum Phosphate Concentration at 4 days - Change (mmol/L) (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.17 lower (0.82 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute	Quality	Importance
										0.49 higher)		
Energy Intake at 4 days - Kcal/day (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	18	18	-	SMD 2.16 higher (1.32 to 3 higher)	VERY LOW	IMPORTANT
Energy Intake at 4 days - Kcal/g (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	18	18	-	SMD 1.78 higher (0.99 to 2.56 higher)	VERY LOW	IMPORTANT
Weight (kg) at 10 days - Weight (kg) (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.18 lower (0.84 lower to 0.47 higher)	VERY LOW	IMPORTANT
Weight (kg) at 10 days - Change (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.49 higher (0.17	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
										lower to 1.16 higher)		
BMI at 10 days - BMI (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.32 higher (0.34 lower to 0.98 higher)	VERY LOW	IMPORTANT
BMI at 10 days - Change (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.55 higher (0.11 lower to 1.22 higher)	VERY LOW	IMPORTANT
mBMI (%) at 10 days (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.5 higher (0.17 lower to 1.16 higher)	VERY LOW	IMPORTANT
mBMI (%) at 10 days - Change (Better indicated by higher values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.64 higher (0.04 lower to 1.31 higher)	VERY LOW	IMPORTANT
Energy Intake at 10 days - Kcal/day (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.95 higher (0.25 to 1.64 higher)	VERY LOW	IMPORTANT
Energy Intake at 10 days - Kcal/g (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.91 higher (0.22 to 1.6 higher)	VERY LOW	IMPORTANT
Glucose (mmol/L) at 10 days (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.39 higher (0.27 lower to 1.05 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
Insulin (miu mol/L) at 10 days (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.34 higher (0.32 lower to 1 higher)	VERY LOW	IMPORTANT
HOMA at 10 days (measured with: Homeostatic Model Assessment Insulin Resistance; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.62 higher (0.05 lower to 1.29 higher)	VERY LOW	IMPORTANT
White Blood Cell Count (x 10 9/L) (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious2	none	18	18	-	SMD 0.42 higher (0.24 lower to 1.08 higher)	VERY LOW	IMPORTANT
No adverse Events within first 4 days of treatment												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	18/18 (100%)	17/18 (94.4 %)	RR 1.06 (0.91	57 more per 1000 (from 85 fewer to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(RCT) High-Calorie Diet	Low-Calorie Diet	Relative (95% CI)	Absolute		
									to 1.23)	217 more)		
No Oral Phosphate Supplementation due to low PO												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	17/18 (94.4%)	17/18 (94.4%)	RR 1 (0.85 to 1.17)	0 fewer per 1000 (from 142 fewer to 161 more)	VERY LOW	CRITICAL
Hypophosphatemia within first 2 days												
1	randomised trials	serious 1	no serious inconsistency	serious3	very serious4	none	5/18 (27.8%)	2/18 (11.1%)	RR 2.5 (0.56 to 11.25)	167 more per 1000 (from 49 fewer to 1000 more)	VERY LOW	CRITICAL

1 1 O'Connor 2016: no info regarding allocation concealment; no participant nor investigator blinding. Two participants in each group required nasogastric tube
2 feeding due to failing to achieve >=80% expected energy intake within 48 hours of admission.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or 0.5 or -0.5 (SMD).
4 3 Sample was participants diagnosed with anorexia nervosa or atypical anorexia nervosa.
5 4 CI crosses both 0.75 and 1.25 (Risk Ratio) or 0,5 and -0.5 (SMD).
6 5 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

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Table 225: Full GRADE profile for normal-sodium nasogastric and oral refeeding diet versus low-sodium diet for adult anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Nasogastric+Oral Refeeding for adult AN: Normal Sodium	Low Sodium diet	Relative (95% CI)	Absolute	Quality	Importance
Weight (kg) (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious2	none	42	176	-	SMD 0.25 higher (0.09 lower to 0.59 higher)	VERY LOW	CRITICAL
BMI (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious3	none	42	176	-	SMD 0.13 lower (0.47 lower to 0.21 higher)	VERY LOW	CRITICAL
Fat Free Mass (kg; skinfold) (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious2	none	42	176	-	SMD 0.41 higher (0.07 to 0.75 higher)	VERY LOW	CRITICAL
Active Fat Free Mass (kg) (Better indicated by higher values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Nasogastric+Oral Refeeding for adult AN: Normal Sodium	Low Sodium diet	Relative (95% CI)	Absolute	Quality	Importance
1	observational studies	serious1	no serious inconsistency	very serious1	serious2	none	42	176	-	SMD 0.32 lower (0.66 lower to 0.02 higher)	VERY LOW	CRITICAL
Fat Mass (kg; skinfold and BIA) - Fat Mass skinfold (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious2	none	42	176	-	SMD 0.36 lower (0.7 to 0.03 lower)	VERY LOW	
Fat Mass (kg; skinfold and BIA) - Fat Mass BIA (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious3	none	42	176	-	SMD 0.16 lower (0.5 lower to 0.18 higher)	VERY LOW	CRITICAL
Energy Input (kcal/day) (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious2	none	42	176	-	SMD 0.19 higher (0.14 lower	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Nasogastric+Oral Refeeding for adult AN: Normal Sodium	Low Sodium diet	Relative (95% CI)	Absolute	Quality	Importance
										to 0.53 higher)		
Energy input tube feeding (kcal/day) (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	serious1	serious2	none	42	176	-	SMD 0.52 lower (0.86 to 0.18 lower)	VERY LOW	CRITICAL
Edema of legs												
1	observational studies	serious1	no serious inconsistency	serious1	serious3	none	9/42 (21.4%)	11/176 (6.3%)	RR 3.43 (1.52 to 7.74)	152 more per 1000 (from 32 more to 421 more)	VERY LOW	CRITICAL

1 *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.*
2 *Sample was 98% women, duration of illness not reported.*
3 *2 CI crosses 0.5 or -0.5.*
4 *3 <300 events or <400 participants.*

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Table 226: Full GRADE profile for oral potassium supplementation versus no supplementation for cardiac dysfunction in female adult anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	(Obs) Oral Potassium Supplementation	Control	Relative (95% CI)	Absolute	Quality	Importance
QT Dispersion (ms) (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	14	14	-	SMD 1.47 lower (2.32 to 0.62 lower)	VERY LOW	CRITICAL
Corrected QT Dispersion (ms) (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	14	14	-	SMD 1.03 lower (1.83 to 0.23 lower)	VERY LOW	CRITICAL
Serum potassium (mmol l-1) (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	14	14	-	SMD 0.82 higher (0.04 to 1.59 higher)	VERY LOW	CRITICAL
Urinary potassium excretion (mmol 24h-1) (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	14	14	-	SMD 1.79 higher (0.9 to 2.69 higher)	VERY LOW	CRITICAL

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1 1 Franzoni 2002: high selection bias (unclear method of allocation to groups). Demographic and baseline details of treated and untreated group not
2 provided.
3 2 CI crosses 0.5 or -0.5.
4 3 <400 participants.

L.9 5 Does any intervention for an eating disorder need to be modified in the presence of 6 common long-term health conditions?

L.9.1 7 RCTs for people with an eating disorder and diabetes

8 **Table 227: Full GRADE profile for group psychoeducation and treatment as usual versus treatment as usual for carers and people**
9 **with type I diabetes and disturbed eating attitudes.**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute	Quality	Importance
EDE Objective Binge Episodes - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.13 lower (0.56 lower to 0.31 higher)	LOW	IMPORTANT
EDE Restraint - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.33 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute	Quality	Importance
										(0.77 lower to 0.1 higher)		
EDE Eating Concerns - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.32 lower (0.75 lower to 0.12 higher)	LOW	IMPORTANT
EDE Shape Concerns - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.07 lower (0.5 lower to 0.36 higher)	LOW	IMPORTANT
EDE Weight Concerns - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.15 lower (0.58 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute	Quality	Importance
										to 0.28 higher)		
EDI Drive for Thinness - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	49	32	-	SMD 0.28 lower (0.73 lower to 0.17 higher)	LOW	IMPORTANT
EDI Bulimia - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	49	32	-	SMD 0.35 lower (0.8 lower to 0.1 higher)	LOW	IMPORTANT
EDI Body Dissatisfaction - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	49	32	-	SMD 0.38 lower (0.83 lower to 0.07 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute		
Insulin Omission Days - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	50	35	-	SMD 0.17 higher (0.26 lower to 0.6 higher)	LOW	CRITICAL
HbA1c Level (%) - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	49	33	-	SMD 0 higher (0.44 lower to 0.44 higher)	LOW	CRITICAL
EDE Objective Binge Episodes FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.34 lower (0.78 lower to 0.09 higher)	LOW	IMPORTANT
EDE Restraint FU - Group Psychoeducation-ED (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	50	35	-	SMD 0 higher (0.43 lower to 0.43 higher)	LOW	IMPORTANT
EDE Overeating FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.22 lower (0.66 lower to 0.21 higher)	LOW	IMPORTANT
EDE Eating Concerns FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.25 lower (0.69 lower to 0.18 higher)	LOW	IMPORTANT
EDE Shape Concerns FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.07 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute	Quality	Importance
										(0.5 lower to 0.36 higher)		
EDE Weight Concerns FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	50	35	-	SMD 0.08 lower (0.51 lower to 0.36 higher)	LOW	IMPORTANT
EDI Drive for Thinness FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	49	32	-	SMD 0.03 lower (0.48 lower to 0.41 higher)	LOW	IMPORTANT
EDI Bulimia FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	49	32	-	SMD 0.34 lower (0.79 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Psychoeducation	TAU for Disturbed eating + Diabetes TI - Adolescents	Relative (95% CI)	Absolute	Quality	Importance
										to 0.11 higher)		
EDI Body Dissatisfaction FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	49	32	-	SMD 0.13 lower (0.58 lower to 0.31 higher)	LOW	IMPORTANT
Insulin Omission Days FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	50	35	-	SMD 0.04 higher (0.4 lower to 0.47 higher)	LOW	CRITICAL
HbA1c Level (%) FU - Group Psychoeducation-ED (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	49	33	-	SMD 0 higher (0.44 lower to 0.44 higher)	LOW	CRITICAL

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[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.

Table 228: Full GRADE profile for group CBT-ED versus control therapy in people with type II diabetes and binge eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Group CBT-ED	Other for BED + Diabetes T2 - Adults	Relative (95% CI)	Absolute		
Remission - Group CBT-ED v Group NPT												
1	randomised trials	serious1	no serious inconsistency	serious2	serious3	none	8/17 (47.1%)	5/17 (29.4%)	RR 1.6 (0.66 to 3.91)	176 more per 1000 (from 100 fewer to 856 more)	VERY LOW	CRITICAL
BMI - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	17	17	-	SMD 0.63 higher (0.06 lower to 1.32 higher)	VERY LOW	CRITICAL
Binge Frequency - Group CBT-ED v Group NPT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Group CBT-ED	Other for BED + Diabetes T2 - Adults	Relative (95% CI)	Absolute		
1	randomised trials	serious1	no serious inconsistency	serious2	serious5	none	17	17	-	SMD 0.32 lower (1 lower to 0.36 higher)	VERY LOW	CRITICAL
EDI Bulimia - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious6	none	17	17	-	SMD 0.03 lower (0.71 lower to 0.64 higher)	VERY LOW	IMPORTANT
EDI Drive for Thinness - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious6	none	17	17	-	SMD 0.17 lower (0.84 lower to 0.5 higher)	VERY LOW	IMPORTANT
EDI Body Dissatisfaction - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious6	none	17	17	-	SMD 0.06 higher (0.61	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Group CBT-ED	Other for BED + Diabetes T2 - Adults	Relative (95% CI)	Absolute		
										lower to 0.73 higher)		
Quality of Life - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious6	none	17	17	-	SMD 0 higher (0.67 lower to 0.67 higher)	VERY LOW	CRITICAL
Remission FU - Group CBT-ED v Group NPT												
1	randomised trials	serious1	no serious inconsistency	serious2	serious7	none	10/17 (58.8 %)	3/17 (17.6%)	RR 3.33 (1.11 to 10.03)	411 more per 1000 (from 19 more to 1000 more)	VERY LOW	CRITICAL
BMI FU - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	serious4	none	17	17	-	SMD 0.64 higher (0.06 lower to 1.33 higher)	VERY LOW	CRITICAL
Binge Frequency FU - Group CBT-ED v Group NPT (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Group CBT-ED	Other for BED + Diabetes T2 - Adults	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious2	serious5	none	17	17	-	SMD 0.52 lower (1.2 lower to 0.17 higher)	VERY LOW	CRITICAL
EDI Bulimia FU - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious6	none	17	17	-	SMD 0.03 lower (0.7 lower to 0.65 higher)	VERY LOW	IMPORTANT
EDI Drive for Thinness FU - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious6	none	17	17	-	SMD 0.16 higher (0.52 lower to 0.83 higher)	VERY LOW	IMPORTANT
EDI Body Dissatisfaction FU - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious6	none	17	17	-	SMD 0.04 higher	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	RCT: Group CBT-ED	Other for BED + Diabetes T2 - Adults	Relative (95% CI)	Absolute		
										(0.63 lower to 0.71 higher)	Y LOW	
Quality of Life FU - Group CBT-ED v Group NPT (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious2	very serious6	none	17	17	-	SMD 0.17 lower (0.84 lower to 0.51 higher)	VERY LOW	CRITICAL

1 [1] Inadequate randomisation was performed and it was unclear if allocation concealment was carried out. Neither the participant or investigator was blind, nor
2 was it clear if the assessor was blind. It was unclear how many participants completed the intervention..
3 [2] Population included disturbed eating attitudes and behaviour based on EDI scale results.
4 [3] 95% CI crossed 2 MIDs (0.75 and 1.25)
5 [4] 95% CI crossed 1 MID (0.5)
6 [5] 95% CI crossed 1 MID (-0.5)
7 [6] 95% CI crossed 2 MIDs (-0.5 and 0.5)
8 [7] 95% CI crossed 1 MID (0.75)

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L.9.21 Observational studies for diabetes

Table 229: Full GRADE profile for response to therapy in those with type I diabetes and an eating disorder versus an eating disorder alone

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED+Diabetes TI	Any ED only	Relative (95% CI)	Absolute		
Dropouts												
1	observational studies	serious1	no serious inconsistency	serious2	serious3	none	5/20 (25%)	10/20 (50%)	RR 1.45 (0.9 to 2.34)	225 more per 1000 (from 50 fewer to 670 more)	VERY LOW	IMPORTANT
Dropouts - Anorexia Nervosa												
1	observational studies	serious1	no serious inconsistency	serious2	serious8	none	0/2 (0%)	0/2 (0%)	Not estimable	-	VERY LOW	IMPORTANT
Dropouts - Bulimia Nervosa												
1	observational studies	serious1	no serious inconsistency	serious2	serious4	none	0/5 (0%)	40%	RR 1.57 (0.77 to 3.22)	228 more per 1000 (from 92 fewer to 888 more)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED+Diabetes TI	Any ED only	Relative (95% CI)	Absolute		
Dropouts - EDNOS												
1	observational studies	serious1	no serious inconsistency	serious2	very serious5	none	4/11 (36.4%)	7/11 (63.6 %)	RR 1.75 (0.71 to 4.31)	477 more per 1000 (from 185 fewer to 1000 more)	VERY LOW	IMPORTANT
Dropouts - Binge Eating Disorder												
1	observational studies	serious1	no serious inconsistency	serious2	very serious5	none	1/2 (50%)	1/2 (50%)	RR 1 (0.14 to 7.1)	0 fewer per 1000 (from 430 fewer to 1000 more)	VERY LOW	IMPORTANT
Full or Partial Remission												
2	observational studies	serious6	no serious inconsistency	serious2	serious7	none	16/52 (30.8%)	385/821 (46.9 %)	RR 0.52 (0.33 to 0.81)	225 fewer per 1000 (from 89 fewer	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED+Diabetes TI	Any ED only	Relative (95% CI)	Absolute		
										to 314 fewer)		
Full or Partial Remission - Anorexia Nervosa												
2	observational studies	serious6	no serious inconsistency	serious2	very serious5	none	2/7 (28.6%)	125/269 (46.5%)	RR 0.44 (0.13 to 1.48)	260 fewer per 1000 (from 404 fewer to 223 more)	VERY LOW	CRITICAL
Full or Partial Remission - Bulimia Nervosa												
2	observational studies	serious6	no serious inconsistency	serious2	serious7	none	6/21 (28.6%)	73%	RR 0.47 (0.23 to 0.97)	387 fewer per 1000 (from 22 fewer to 562 fewer)	VERY LOW	CRITICAL
Full or Partial Remission - EDNOS												
2	observational studies	serious6	no serious inconsistency	serious2	serious7	none	7/22 (31.8%)	131/278 (47.1%)	RR 0.58 (0.29 to 1.15)	198 fewer per 1000 (from 335 fewer	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED+Diabetes TI	Any ED only	Relative (95% CI)	Absolute		
										to 71 more)		
Full or Partial Remission - Binge Eating Disorder												
1	observational studies	serious6	no serious inconsistency	serious2	very serious5	none	1/2 (50%)	1/2 (50%)	RR 1 (0.14 to 7.1)	0 fewer per 1000 (from 430 fewer to 1000 more)	VERY LOW	CRITICAL

[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

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Table 230: Inpatient integrated care for diabetes and inpatient care versus inpatient care for people with bulimia nervosa and type I diabetes

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IP therapy v No IP Therapy for BN+Diabetes 1	Control	Relative (95% CI)	Absolute		
Did not achieve remission (no diagnosis of BN)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness 2	serious3	none	8/9 (88.9%)	1/9 (11.1 %)	RR 0.13 (0.02 to 0.8)	97 fewer per 1000 (from 22 fewer to 109 fewer)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness 2	serious4	none	8	9	-	SMD 1.42 lower (2.52 to 0.32 lower)	VERY LOW	IMPORTANT
General Psychopathology (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness 2	serious5	none	8	9	-	SMD 1.25 lower (2.31 to 0.18 lower)	VERY LOW	IMPORTANT
No inappropriate compensatory behaviours to prevent weight gain past 3 monthsN												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IP therapy v No IP Therapy for BN+Diabetes 1	Control	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness 2	serious3	none	1/9 (11.1%)	7/9 (77.8 %)	RR 4 (1.15 to 13.88)	1000 more per 1000 (from 117 more to 1000 more)	VERY LOW	CRITICAL
Insulin Omission												
1	observational studies	serious1	no serious inconsistency	no serious indirectness 2	serious3	none	1/9 (11.1%)	5/9 (55.6 %)	RR 2 (0.93 to 4.3)	556 more per 1000 (from 39 fewer to 1000 more)	VERY LOW	CRITICAL
Calorific Value of Binge Epsiodes (Kcal) (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious4	none	9	9	-	SMD 1.52 lower (2.6 to 0.44 lower)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IP therapy v No IP Therapy for BN+Diabetes 1	Control	Relative (95% CI)	Absolute		
EDI Total (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious4	none	8	9	-	SMD 1.16 lower (2.21 to 0.11 lower)	VERY LOW	IMPORTANT

[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 mo for IP group and 24 mo 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.

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L.9.31 Bulimia nervosa and history of substance abuse

Table 231: Full GRADE profile for group CBT in adults with bulimia nervosa and history of substance abuse versus adults with bulimia nervosa and no history of substance abuse

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT for BN with history of substance abuse	Group CBT for BN without history of substance abuse	Relative (95% CI)	Absolute	Quality	Importance
Remission FU (follow-up mean 3.5 years)												
1	observational studies	serious 1	no serious inconsistency	very serious1	very serious2	none	15/22 (68.2%)	44/65 (67.7%)	RR 1.01 (0.72 to 1.4)	7 more per 1000 (from 190 fewer to 271 more)	VERY LOW	CRITICAL
Treatment Failures FU (follow-up mean 3.5 years)												
1	observational studies	serious 1	no serious inconsistency	very serious1	very serious2	none	6/22 (27.3%)	16/65 (24.6%)	RR 1.11 (0.5 to 2.48)	27 more per 1000 (from 123 fewer to 364 more)	VERY LOW	CRITICAL
Hospitalised for substance abuse FU (follow-up mean 3.5 years)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group CBT for BN with history of substance abuse	Group CBT for BN without history of substance abuse	Relative (95% CI)	Absolute		
1	observational studies	serious 1	no serious inconsistency	very serious1	very serious2	none	1/22 (4.5%)	3/65 (4.6%)	RR 0.98 (0.11 to 8.99)	1 fewer per 1000 (from 41 fewer to 369 more)	VERY LOW	CRITICAL

1 1 Mitchell 1990: Sample is those with and without history of substance abuse; current substance abuse comorbidity not included; selection bias (history of
2 substance abuse group significantly older); performance bias (no info about intervention etc.); attrition bias (insufficient info about intervention); high
3 detection bias.
4 2 CI crosses both 0.75 and 1.25.

L.9.45 Binge eating disorder and major depressive disorder

6 **Table 232: Diabetes prevention programme in people with binge eating disorder and major depressive disorder versus people with**
7 **binge eating disorder alone at end of treatment**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Weight Loss Program	Control	Relative (95% CI)	Absolute		
Achieved Weight Loss Goal>=7%												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Weight Loss Program	Control	Relative (95% CI)	Absolute		
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	4/22 (18.2%)	3/17 (17.6 %)	RR 1.03 (0.27 to 4)	5 more per 1000 (from 129 fewer to 529 more)	VERY LOW	CRITICAL

1 1 Pagoto 2007: retrospective chart review, no control intervention and unclear length of treatment, high selection bias.
2 2 CI crosses both 0.75 and 1.25.

L.9.53 Any eating disorder and alcohol misuse

4 **Table 233: CBT-Enhanced for people with eating disorders and high alcohol use versus people with eating disorder and low alcohol**
5 **use at end of treatment and follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-E for BN+EDNOS and High Alcohol Use	CBT-E for BN+EDNOS and Low Alcohol Use	Relative (95% CI)	Absolute		
EDE >1 SD above community norm (follow-up 60 weeks)												
1	observational studies	serious1	no serious inconsistency	very serious1	very serious2	none	13/35 (37.1%)	27/84 (32.1%)	RR 1.16 (0.68	51 more per 1000 (from	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-E for BN+EDNOS and High Alcohol Use	CBT-E for BN+EDNOS and Low Alcohol Use	Relative (95% CI)	Absolute	Quality	Importance
									to 1.97)	103 fewer to 312 more)		
Excessive Drinking (follow-up 60 weeks)												
1	observational studies	serious1	no serious inconsistency	very serious1	serious3	none	17/35 (48.6%)	10/84 (11.9%)	RR 4.08 (2.08 to 8.01)	367 more per 1000 (from 129 more to 835 more)	VERY LOW	CRITICAL
EDE Global 60-week FU (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	very serious1	serious4	none	29	75	-	SMD 0.23 lower (0.66 lower to 0.2 higher)	VERY LOW	CRITICAL

1 1 Karacic 2011: attrition bias (dropout for low alcohol group >20 %); sample did not have current alcohol use disorder comorbidity; group allocated on basis
2 of self-reported alcohol use. Sample consisted of 67 BN, 10 BED and 72 EDNOS. Participants with anorexia nervosa were excluded.
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio) or 0.5 and -0.5 (SMD).
4 3 <300 events.
5 4 CI crosses 0.5 or -0.5 (SMD).

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L.10 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?

L.10.1 RCTs for coordinating care for people with anorexia nervosa

Table 234: Full GRADE profile for inpatient care versus another setting people with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute	Quality	Importance
BMI Adults - Inpatient vs. Day Clinic (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	21	22	-	SMD 0.04 higher (0.56 lower to 0.64 higher)	VERY LOW	CRITICAL
Bingeing - Adults - Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	21	22	-	SMD 0.45 lower (1.05 lower to 0.16 higher)	LOW	CRITICAL
Vomiting- Adults - Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	21	22	-	SMD 0.39 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
										(0.99 lower to 0.21 higher)		
EDI-2 Bulimia - Adults- Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 0.12 higher (0.48 lower to 0.72 higher)	LOW	IMPORTANT
Change in Global MR - In-patient vs. Outpatient Individual + FT_Adults (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.14 lower (0.70 lower to 0.43 higher)	VERY LOW	IMPORTANT
Change in Global MR - In-patient vs. Outpatient Group Adults (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.06 higher (0.50 lower to 0.63 higher)	VERY LOW	IMPORTANT
Change in Global MR - In-patient vs. WLC Adults (Better indicated by higher values)												

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient vs.Other (AN)**	**Control**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.03 higher (0.54 lower to 0.60 higher)	VERY LOW	IMPORTANT
Change in MR: Menstruation - In-patient vs. Outpatient Individual + FT (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	30	20	-	SMD 0.02 lower (0.59 lower to 0.55 higher)	LOW	IMPORTANT
Change in MR: Menstruation - In-patient vs. Outpatient Group (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.16 lower (0.72 lower to 0.41 higher)	VERY LOW	IMPORTANT
Change in MR: Menstruation - In-patient vs. WLC (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	30	20	-	SMD 0.02 higher (0.55 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
										0.58 higher)		
Change in MR: Nutrition - In-patient vs. Outpatient Individual + FT (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.06 lower (0.63 lower to 0.51 higher)	VERY LOW	IMPORTANT
Change in MR: Nutrition - In-patient vs. Outpatient Group (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	30	20	-	SMD 0.2 lower (0.77 lower to 0.36 higher)	LOW	IMPORTANT
Change in MR: Nutrition - In-patient vs. WLC (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	30	20	-	SMD 0.33 higher (0.24 lower to 0.90 higher)	LOW	IMPORTANT
Change in MR: Mental State - In-patient vs. Outpatient Individual + FT (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	30	20	-	SMD 0.29 lower	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
										(0.86 lower to 0.28 higher)		
Change MR: Mental State - In-patient vs. Outpatient Group (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.07 higher (0.50 lower to 0.64 higher)	VERY LOW	IMPORTANT
Change MR: Mental State - In-patient vs. WLC (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.12 lower (0.69 lower to 0.45 higher)	VERY LOW	IMPORTANT
Change in MR: Sexual adjustment - In-patient vs. Outpatient Individual + FT (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.11 higher (0.46 lower to 0.67 higher)	VERY LOW	IMPORTANT
Change in MR: Sexual adjustment - In-patient vs. Outpatient Group (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient vs.Other (AN)**	**Control**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.07 lower (0.64 lower to 0.49 higher)	VERY LOW	IMPORTANT
Change in MR: Sexual adjustment - In-patient vs. WLC (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious2	none	30	20	-	SMD 0.05 lower (0.62 lower to 0.51 higher)	VERY LOW	IMPORTANT
Change in MR: Social economic adjustment - In-patient vs. Outpatient Individual + FT (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	30	20	-	SMD 0.31 lower (0.88 lower to 0.26 higher)	LOW	IMPORTANT
Change in MR: Social economic adjustment - In-patient vs. Outpatient Group (Better indicated by higher values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	30	20	-	SMD 0 higher (0.57 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient vs.Other (AN)**	**Control**	**Relative (95% CI)**	**Absolute**		
										0.57 higher)		
Change in MR: Social economic adjustment - In-patient vs. WLC (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	10	20	-	SMD 0.13 higher (0.43 lower to 0.70 higher)	VERY LOW	IMPORTANT
Global Severity Index -_Adults - Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 0.41 higher (0.19 lower to 1.02 higher)	LOW	IMPORTANT
Remission - _Adults - Inpatient vs. Day Clinic_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	7/27 (25.9%)	4/28 (14.3 %)	RR 1.81 (0.6 to 5.5)	116 more per 1000 (from 57 fewer to 643 more)	LOW	CRITICAL
BMI- _Adults FU - Inpatient vs. Specialist Outpatient (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient vs.Other (AN)**	**Control**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious3	none	26	50	-	SMD 0.00 higher (0.47 lower to 0.47 higher)	LOW	CRITICAL
BMI- Adults FU - Inpatient vs. General Outpatient (Better indicated by higher values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious3	none	26	48	-	SMD 0.25 lower (0.73 lower to 0.23 higher)	LOW	CRITICAL
BMI Young People FU - Inpatient vs. Day patient (Better indicated by higher values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious8	none	75	86	-	SMD 0.09 lower (0.4 lower to 0.22 higher)	LOW	CRITICAL
Bingeing - _Adults FU - Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 0.36 higher (0.24 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
										0.97 higher)		
Vomiting - _Adults FU - Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious3	none	21	23	-	SMD 0.31 lower (0.91 lower to 0.28 higher)	LOW	IMPORTANT
Menstruation regular -Young People FU												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	very serious5	none	12/75 (16%)	16/81 (19.8 %)	RR 0.81 (0.41 to 1.6)	38 fewer per 1000 (from 117 fewer to 119 more)	VERY LOW	IMPORTANT
EDI Total - _Adults FU - Inpatient vs. Specialist Outpatient (Better indicated by lower values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious3	none	43	42	-	SMD 0.28 lower (0.7 lower to 0.15 higher)	LOW	IMPORTANT
EDI Total - _Adults FU - Inpatient vs. General Outpatient (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient vs.Other (AN)**	**Control**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious3	none	43	40	-	SMD 0.46 lower (0.9 to 0.02 lower)	LOW	IMPORTANT
EDI Total Young People FU - Inpatient vs. Day Patient (Better indicated by lower values)												
1	randomised trials	serious7	no serious inconsistency	no serious indirectness	serious8	none	69	74	-	SMD 0.11 higher (0.22 lower to 0.43 higher)	LOW	IMPORTANT
EDI-2 Bulimia -Young People FU - Inpatient vs. Day Clinic (Better indicated by lower values)												
1	randomised trials	serious9	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 0.58 higher (0.03 lower to 1.19 higher)	LOW	IMPORTANT
MR: Total Outcome - FU - Inpatient vs. Specialist Outpatient (Better indicated by higher values)												
1	randomised trials	serious6	no serious inconsistency	no serious indirectness	serious8	none	52	51	-	SMD 0.04 lower (0.43 lower to	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
										0.35 higher)		
MR: Total Outcome - FU - Inpatient vs. General Outpatient (Better indicated by higher values)												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious8	none	52	52	-	SMD 0 higher (0.38 lower to 0.38 higher)	LOW	IMPORTANT
Global severity index Young People FU - Inpatient vs. Day Patient (Better indicated by lower values)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious8	none	68	73	-	SMD 0.20 higher (0.13 lower to 0.53 higher)	LOW	IMPORTANT
Global severity index - Adults FU - Inpatient vs. Day Patient (Copy) (Better indicated by lower values)												
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious8	none	21	22	-	SMD 0.21 higher (0.39 lower to 0.81 higher)	LOW	IMPORTANT
Readmissions/Relapse for ED - Young People FU - Inpatient vs. Day patient												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious10	none	19/75 (25.3%)	13/86 (15.1 %)	RR 1.68 (0.89	103 more per 1000	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
									to 3.16)	(from 17 fewer to 327 more)		
Remission - Young People FU - Inpatient vs. Day patient_ITT (Copy)												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	serious11	none	53/87 (60.9%)	57/85 (67.1 %)	RR 0.91 (0.73 to 1.14)	60 fewer per 1000 (from 181 fewer to 94 more)	LOW	CRITICAL
Serious adverse events - Young People FU												
1	randomised trials	serious 7	no serious inconsistency	no serious indirectness	very serious5	none	8/75 (10.7%)	7/86 (8.1%)	RR 1.31 (0.5 to 3.44)	25 more per 1000 (from 41 fewer to 199 more)	VERY LOW	CRITICAL
Remission _Adults FU - Inpatient vs. Specialist Outpatient_ITT												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	serious10	none	19/57 (33.3%)	13/55 (23.6 %)	RR 1.41 (0.77 to 2.57)	97 more per 1000 (from 54 fewer to 371 more)	LOW	CRITICAL
Remission - Adults FU - Inpatient vs.General Outpatient_ITT												
1	randomised trials	serious 6	no serious inconsistency	no serious indirectness	very serious5	none	19/57 (33.3%)	20/55 (36.4 %)	RR 0.92 (0.55	29 fewer per 1000 (from	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient vs.Other (AN)	Control	Relative (95% CI)	Absolute		
									to 1.52)	164 fewer to 189 more)		
Remission - Adults FU - Inpatient vs. Day patient_ITT												
1	randomised trials	serious 9	no serious inconsistency	no serious indirectness	serious11	none	3/27 (11.1%)	6/28 (21.4 %)	RR 0.52 (0.14 to 1.87)	103 fewer per 1000 (from 184 fewer to 186 more)	LOW	CRITICAL

[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.

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1 [11] For a dichotomous outcome, there are fewer than 300 events.
2 [12] 95% CI crossed 1 MID (1.25)

3 **Table 235: Full GRADE profile for specialist outpatient versus general outpatient for people with AN at follow-up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Specialist outpatient	General outpatient (AN)	Relative (95% CI)	Absolute		
BMI FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	50	48	-	SMD 0.29 lower (0.69 lower to 0.11 higher)	LOW	CRITICAL
EDI Total FU (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	42	40	-	SMD 0.17 lower (0.6 lower to 0.26 higher)	LOW	IMPORTANT
MR: Total Outcome FU (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	51	52	-	SMD 0.04 higher (0.35 lower to 0.43 higher)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Specialist outpatient	General outpatient (AN)	Relative (95% CI)	Absolute		
Subsequent admission to hospital FU												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious4	none	17/55 (30.9%)	15/55 (27.3%)	RR 1.13 (0.63 to 2.03)	35 more per 1000 (from 101 fewer to 281 more)	VERY LOW	IMPORTANT
Remission FU_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious5	none	13/55 (23.6%)	20/55 (36.4%)	RR 0.65 (0.36 to 1.17)	127 fewer per 1000 (from 233 fewer to 62 more)	LOW	CRITCIAL

[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 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] 95% CI crossed 2 MIDs (0.75 and 1.25)
[5] 95% CI crossed 1 MID (0.75)

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L.10.21 RCTs for coordinating care for people with bulimia nervosa

Table 236: Full GRADE profile inpatient group versus outpatient care for people with bulimia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient Group	Outpatient (BN)	Relative (95% CI)	Absolute	Quality	Importance
Binges FU (Better indicated by lower values)												
1	randomised trials	very serious 1	no serious inconsistency	no serious indirectness	serious2	none	32	39	-	SMD 0.06 lower (0.53 lower to 0.41 higher)	VERY LOW	CRITICAL
Self-induced vomiting FU (Better indicated by lower values)												
1	randomised trials	very serious 1	no serious inconsistency	no serious indirectness	serious2	none	32	39	-	SMD 0.11 lower (0.57 lower to 0.36 higher)	VERY LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	randomised trials	very serious 1	no serious inconsistency	no serious indirectness	serious3	none	32	39	-	SMD 0.14 higher (0.33 lower to 0.61 higher)	VERY LOW	IMPORTANT
Bulimic severity score FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient Group**	**Outpatient (BN)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious 1	no serious inconsistency	no serious indirectness	serious2	none	28	39	-	SMD 0.07 lower (0.55 lower to 0.42 higher)	VERY LOW	CRITICAL
Remission FU_ITT												
1	randomised trials	very serious 1	no serious inconsistency	no serious indirectness	very serious4	none	11/32 (34.4%)	17/39 (43.6%)	RR 0.79 (0.43 to 1.43)	92 fewer per 1000 (from 248 fewer to 187 more)	VERY LOW	

[1] The study was only partially randomised, only 52% were assigned randomly. The investigators felt that some patients need to be allocated due to their clinical condition. It was unclear if either the participants, investigators and assessors were blind. High drop outs 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)

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L.10.31 RCTs for coordinating care for people with any eating disorder

Table 237: Full GRADE profile for modified day treatment versus traditional outpatient care for any disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Modified day treatment	Traditional outpatient (ANY ED)	Relative (95% CI)	Absolute	Quality	Importance
BMI (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	21	22	-	SMD 0.57 higher (0.12 to 1.02 higher)	LOW	CRITICAL
Bingeing episodes (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	21	22	-	SMD 0.93 lower (1.57 to 0.3 lower)	LOW	CRITICAL
Purging episodes (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	21	22	-	SMD 1.21 lower (1.87 to 0.56 lower)	LOW	CRITICAL
Depression (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Modified day treatment	Traditional outpatient (ANY ED)	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	21	22	-	SMD 0.83 lower (1.45 to 0.2 lower)	LOW	IMPORTANT
EDI-2 Total score (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 1.42 lower (2.09 to 0.74 lower)	LOW	IMPORTANT
EDI-2 Drive for thinness (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 1.88 lower (2.61 to 1.15 lower)	LOW	IMPORTANT
EDI-2 Bulimia (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 1.52 lower (2.21 to 0.83 lower)	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Modified day treatment	Traditional outpatient (ANY ED)	Relative (95% CI)	Absolute		
EDI-2 Body dissatisfaction (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious4	none	21	22	-	SMD 1.2 lower (1.86 to 0.55 lower)	LOW	IMPORTANT

1 [1] It was unclear if allocation concealment was performed. It was also unclear if either the participants, investigators and assessors were blind.
2 [2] 95% CI crossed 1 MID (0.5)
3 [3] 95% CI crossed 1 MID (-0.5)
4 [4] For a continuous outcome, there were fewer than 400 participants.

5 **Table 238: Full GRADE profile for inpatient weight stabilisation (short) versus weight restoration (longer) for young people with**
6 **AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient weight stabilisation (short)**	**weight restoration (longer) (AN)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Remission Adolescents_ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	10/41 (24.4%)	9/41 (22%)	RR 1.11 (0.5 to 2.45)	24 more per 1000	LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient weight stabilisation (short)	weight restoration (longer) (AN)	Relative (95% CI)	Absolute	Quality	Importance
										(from 110 fewer to 318 more)		
Change EDE Global score Adolescents FU (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious3	none	36	33	-	SMD 0.12 lower (0.59 lower to 0.36 higher)	LOW	IMPORTANT
Hospital readmission Adoelscents FU												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	none	14/40 (35%)	14/38 (36.8%)	RR 0.95 (0.53 to 1.72)	18 fewer per 1000 (from 173 fewer to 265 more)	VERY LOW	IMPORTANT
Remission Adolescents FU_ITT												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	very serious4	none	12/41 (29.3%)	13/41 (31.7%)	RR 0.92 (0.48	25 fewer per 1000	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient weight stabilisation (short)	weight restoration (longer) (AN)	Relative (95% CI)	Absolute		
									to 1.78)	(from 165 fewer to 247 more)		

[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)

L.10.46 Observational studies for coordinating care for people with anorexia nervosa

Table 239: Full GRADE profile for inpatient care versus day patient care for adults with anorexia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient	Day patient - Adult - AN	Relative (95% CI)	Absolute		
Binge eating												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	37/137 (27%)	10/15 (66.7 %)	RR 0.41 (0.26	393 fewer per 1000	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient	Day patient - Adult - AN	Relative (95% CI)	Absolute	Quality	Importance
									to 0.64)	(from 240 fewer to 493 fewer)		
Laxative use												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	12/137 (8.8%)	2/15 (13.3 %)	RR 0.66 (0.16 to 2.66)	45 fewer per 1000 (from 112 fewer to 221 more)	VERY LOW	IMPORTANT
Self induced vomiting												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	26/137 (19%)	5/15 (33.3 %)	RR 0.57 (0.26 to 1.26)	143 fewer per 1000 (from 247 fewer to 87 more)	VERY LOW	IMPORTANT
Excessive Exercise												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	41/137 (29.9%)	7/15 (46.7 %)	RR 0.64 (0.35	168 fewer per	VER	IMPORTANT

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient**	**Day patient - Adult - AN**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
									to 1.17)	1000 (from 303 fewer to 79 more)	Y LOW	
EDE- Total (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	137	15	-	SMD 0.25 lower (0.79 lower to 0.28 higher)	VERY LOW	IMPORTANT
BMI (Better indicated by higher values)												
2	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	149	30	-	SMD 0.55 lower (0.99 to 0.1 lower)	VERY LOW	CRITICAL
Quality of life (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	137	15	-	SMD 0.08 lower (0.62 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient**	**Day patient - Adult - AN**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										0.45 higher)		
BMI FU (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	12	15	-	SMD 0.35 lower (1.11 lower to 0.42 higher)	VERY LOW	CRITICAL
Readmission FU												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	4/12 (33.3%)	2/12 (16.7%)	RR 2 (0.45 to 8.94)	167 more per 1000 (from 92 fewer to 1000 more)	VERY LOW	CRITICAL

[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

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1 **Table 240: Full GRADE profile for inpatient care versus outpatient care for people with anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient	Outpatient (ambulatory care) AN	Relative (95% CI)	Absolute		
BMI FU (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	46	97	-	SMD 0.13 lower (0.48 lower to 0.22 higher)	VERY LOW	CRITICAL
Hospitalisation in last 6 months FU												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	19/46 (41.3%)	15/97 (15.5%)	RR 2.67 (1.5 to 4.77)	258 more per 1000 (from 77 more to 583 more)	VERY LOW	IMPORTANT
Remission _ITT_FU												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	7/46 (15.2%)	18/97 (18.6%)	RR 0.82 (0.37 to 1.82)	33 fewer per 1000 (from 117 fewer to 152 more)	VERY LOW	CRITICAL

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[1] Patient in hospital had a lower BMI vs. 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

Table 241: Full GRADE profile for partial hospitalisation and support versus partial hospitalisation for people with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partial Hospitalisation + Support	PH AN	Relative (95% CI)	Absolute	Quality	Importance
Difference in Weight Gain (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 1.02 higher (0.13 to 1.91 higher)	VERY LOW	CRITICAL
Difference in BMI (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.4 higher (0.26 lower to 1.06 higher)	VERY LOW	CRITICAL
Difference in Purging (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.57 higher (0.38 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partial Hospitalisation + Support	PH AN	Relative (95% CI)	Absolute		
										1.52 higher)		
Difference in EDI-2 Total Risk (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.92 higher (0.12 to 1.72 higher)	VERY LOW	IMPORTANT
Difference in EDI-2 Drive for thinness (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.68 higher (0.12 lower to 1.48 higher)	VERY LOW	CRITICAL
Difference in EDI-2 Body dissatisfaction (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.51 higher (0.31 lower to 1.33 higher)	VERY LOW	IMPORTANT
Difference in EDI-2 Bulimia (Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partial Hospitalisation + Support	PH AN	Relative (95% CI)	Absolute		
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 1.31 higher (0.51 to 2.11 higher)	VERY LOW	IMPORTANT
Difference EDEQ: Restraint (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.39 higher (0.38 lower to 1.16 higher)	VERY LOW	IMPORTANT
Difference EDEQ: Eating concern (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.33 higher (0.44 lower to 1.1 higher)	VERY LOW	IMPORTANT
Difference EDEQ: Shape concern (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.33 higher (0.47 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partial Hospitalisation + Support	PH AN	Relative (95% CI)	Absolute		
										1.13 higher)		
Difference EDEQ: Weight concern (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16	19	-	SMD 0.83 higher (0.03 to 1.63 higher)	VERY LOW	IMPORTANT

[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.

Table 242: Full GRADE profile for family therapy versus inpatient care for people with anorexia nervosa

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family therapy	Inpatient AN	Relative (95% CI)	Absolute		
Readmission												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	16/52 (30.8 %)	65/119 (54.6%)	RR 0.56 (0.36 to 0.87)	240 fewer per 1000 (from 71 fewer to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family therapy	Inpatient AN	Relative (95% CI)	Absolute	Quality	Importance
										350 fewer)		
Readmission > 3 times												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	4/36 (11.1 %)	10/54 (18.5%)	RR 0.6 (0.2 to 1.77)	74 fewer per 1000 (from 148 fewer to 143 more)	VERY LOW	CRITICAL

[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.

Table 243: Full GRADE profile for inpatient care versus a variation of other care (day, hospital, and outpatient) for people with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient	Variation (Day, Hospital, OutP) - AN	Relative (95% CI)	Absolute	Quality	Importance
Body Weight (ABW) (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	15	14	-	SMD 0.75 lower	VER	

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient	Variation (Day, Hospital, OutP) - AN	Relative (95% CI)	Absolute		
										(1.51 lower to 0.01 higher)	Y LOW	

1 [1] Patients were matched for clinical and demographic data. They only followed one group for 3 years. Neither participants nor investigators were blinded.
2 [2] For a continuous outcome, there were fewer than 400 participants.

3 **Table 244: Full GRADE profile for specialist eating disorder ward versus general ward for people with anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Eating disorder unit**	**General ward**	**Relative (95% CI)**	**Absolute**		
BMI (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	65	45	-	SMD 1.29 higher (0.87 to 1.72 higher)	VERY LOW	CRITICAL
Length of time in hospital (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	65	45	-	SMD 0.02 higher (0.37	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eating disorder unit	General ward	Relative (95% CI)	Absolute		
										lower to 0.4 higher)		
Morgan Russell Score (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	65	45	-	SMD 0.68 higher (0.28 to 1.07 higher)	VERY LOW	CRITICAL
General health (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	65	45	-	SMD 0.19 higher (0.19 lower to 0.57 higher)	VERY LOW	CRITICAL
Children's global asessment (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious4	none	65	45	-	SMD 0.15 lower (0.54 lower to 0.23 higher)	VERY LOW	CRITICAL

1 [1] The groups were not matched at baseline for general health. Those in the eating disorder unit were more severely ill. Change scores could not be
2 calculated to account for differences, nor were any adjustments made for confounders. Means and SD of the baseline characteristics were not provided.

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1 There was very little description on the differences between the two wards.
2 [2] Few than 400 participants were available for this outcome.
3 [3] 95% CI crossed 1 MID (0.5)
4 [4] 95% CI crossed 1 MID (-0.5)

5 **Table 245: Full GRADE profile for meal supervision versus no meal supervision for people with anorexia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meal Supervision	Not	Relative (95% CI)	Absolute		
Length of Hospital Stay (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	13	38	-	SMD 0.51 higher (0.13 lower to 1.15 higher)	VERY LOW	IMPORTANT
Weight gain (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	12	35	-	SMD 0.33 higher (0.33 lower to 0.99 higher)	VERY LOW	CRITICAL
Bradycardia (HR (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	12	38	-	SMD 0.62 lower (1.28 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meal Supervision	Not	Relative (95% CI)	Absolute		
										0.04 higher)		

1 [1] Patients with supervision had higher maximum and average weights compared with patients without supervision However, no adjustments were made.
2 Only those whose meal was supervised had a 3 year follow-up.
3 [2] For a continuous outcome, there were fewer than 400 participants.

L.10.54 Observational studies for coordinating care for people with bulimia nervosa

5 **Table 246: Full GRADE profile of day patient versus inpatient care for people with bulimia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Day patient	Inpatient BN	Relative (95% CI)	Absolute		
EDI - Drive for thinness (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	18	-	SMD 0.22 lower (0.87 lower to 0.44 higher)	VERY LOW	IMPORTANT
EDI - Body dissatisfaction (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Day patient	Inpatient BN	Relative (95% CI)	Absolute		
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	15	-	SMD 0.32 higher (0.37 lower to 1.01 higher)	VERY LOW	IMPORTANT
EDI - Bulimia (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	15	-	SMD 0.13 higher (0.56 lower to 0.82 higher)	VERY LOW	IMPORTANT
SCL -90R Global Severity Index (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	17	17	-	SMD 0.26 lower (0.94 lower to 0.42 higher)	VERY LOW	CRITICAL
Depression (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious	none	17	17	-	SMD 0.27 lower (0.94 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Day patient	Inpatient BN	Relative (95% CI)	Absolute		
										0.41 higher)		
Remission_ITT												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious3	none	5/18 (27.8 %)	6/18 (33.3%)	RR 0.83 (0.31 to 2.24)	57 fewer per 1000 (from 230 fewer to 413 more)	VERY LOW	CRITICAL
EDI - Bulimia FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	18	-	SMD 0.41 lower (1.07 lower to 0.25 higher)	VERY LOW	IMPORTANT
EDI - Drive for thinness FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	18	-	SMD 0.49 lower (1.15 lower to 0.18 higher)	VERY LOW	IMPORTANT
SCL -90R Global Severity Index FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Day patient	Inpatient BN	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	18	-	SMD 0.35 lower (1.01 lower to 0.3 higher)	□□□□ LOW	CRITICAL
Depression FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious	none	18	18	-	SMD 0.35 lower (1.01 lower to 0.3 higher)	VERY LOW	IMPORTANT
Bingeing FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	18	-	SMD 0.23 lower (0.88 lower to 0.43 higher)	VERY LOW	CRITICAL
Vomiting Severity FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	18	18	-	SMD 0.21 higher (0.45 lower to	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Day patient	Inpatient BN	Relative (95% CI)	Absolute		
										0.86 higher)		
Remission FU_ITT												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	serious3	none	10/18 (55.6 %)	2/18 (11.1%)	RR 5 (1.27 to 19.68)	444 more per 1000 (from 30 more to 1000 more)	□□□□ LOW	CRITICAL

1 [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
2 more severely ill. Differences were also detected for depression, and interpersonal sensitivity. The authors did not adjust for these differences. Neither the
3 participants nor investigators were blind to treatment. There was an unclear duration of follow-up.
4 [2] For a continuous outcome, there are fewer than 400 participants.
5 [3] For a dichotomous outcome, there are fewer than 300 events.

L.10.66 Observational studies for coordination of care for people with an eating disorder

7 **Table 247: Full GRADE profile for 5 days versus 4 days of inpatient care for people with either BN or AN**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days	4 days_AN_BN	Relative (95% CI)	Absolute		
Bingeing (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days	4 days_AN_BN	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	254	115	-	SMD 0.37 lower (0.59 to 0.14 lower)	VERY LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	248	111	-	SMD 0.21 lower (0.43 lower to 0.02 higher)	VERY LOW	CRITICAL
BMI (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	89	64	-	SMD 0.37 lower (0.69 to 0.04 lower)	VERY LOW	CRITICAL
EDI - Drive for thinness (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	350	111	-	SMD 0.64 lower (0.85 to 0.42 lower)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days	4 days_AN_BN	Relative (95% CI)	Absolute		
EDI - Bulimia (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	350	111	-	SMD 0.49 lower (0.71 to 0.28 lower)	VERY LOW	IMPORTANT
EDI - Body dissatisfaction (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	350	111	-	SMD 0.55 lower (0.77 to 0.33 lower)	VERY LOW	IMPORTANT
Depression (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	301	107	-	SMD 0.73 lower (0.95 to 0.5 lower)	VERY LOW	IMPORTANT
Remission_ITT												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious4	none	156/468 (33.3%)	29/288 (10.1%)	RR 3.31 (2.29 to 4.78)	233 more per 1000 (from 130	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days	4 days_AN_BN	Relative (95% CI)	Absolute		
										more to 381 more)		

[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.

Table 248: Full GRADE profile for inpatient CAMHS versus outpatient CAMHS for any eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient CAMHS	Outpatient CAMHS ANY ED	Relative (95% CI)	Absolute		
BMI FU (Better indicated by higher values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	24	-	SMD 0.17 lower (0.69 lower to 0.36 higher)	VERY LOW	CRITICAL
EDI Bulimia FU (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Inpatient CAMHS**	**Outpatient CAMHS ANY ED**	**Relative (95% CI)**	**Absolute**		
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	24	-	SMD 0.4 higher (0.14 lower to 0.93 higher)	VERY LOW	IMPORTANT
EDI Body dissatisfaction FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	24	-	SMD 0.05 lower (0.57 lower to 0.48 higher)	VERY LOW	IMPORTANT
EDI Drive for thinness FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	24	-	SMD 0.19 lower (0.71 lower to 0.34 higher)	VERY LOW	IMPORTANT
SCL-90 Global Severity Index FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	24	-	SMD 0.22 lower (0.75 lower	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Inpatient CAMHS	Outpatient CAMHS ANY ED	Relative (95% CI)	Absolute		
										to 0.31 higher)		
Rosenberg Self Esteem FU (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	33	24	-	SMD 3.1 higher (2.31 to 3.89 higher)	VERY LOW	IMPORTANT

[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. CAHMS 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.

Table 249: Full GRADE profile for guided self-help versus day patient care for people with BN or ENDOS

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided SH	Day Patient BN or EDNOS	Relative (95% CI)	Absolute		
EDE-Q Total (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	32	34	-	SMD 0.15 higher	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Guided SH	Day Patient BN or EDNOS	Relative (95% CI)	Absolute		
										(0.34 lower to 0.63 higher)	VERY LOW	
Objective binge eating (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	34	-	SMD 0.43 higher (0.06 lower to 0.92 higher)	VERY LOW	CRITICAL
Vomiting (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	31	34	-	SMD 0.24 higher (0.25 lower to 0.73 higher)	VERY LOW	CRITICAL
Excessive Exercise (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	32	34	-	SMD 0.22 lower (0.71 lower to 0.26 higher)	VERY LOW	IMPORTANT

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[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.

Table 250: Full GRADE profile for extensive programme versus a limited program for any eating disorder

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extensive Program	Limited Program ANY ED	Relative (95% CI)	Absolute	Quality	Importance
Remission												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	11/56 (19.6%)	36/67 (53.7%)	RR 0.39 (0.21 to 0.73)	328 fewer per 1000 (from 145 fewer to 424 fewer)	VERY LOW	CRITICAL
Remission - AN												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	7/38 (18.4%)	10/22 (45.5%)	RR 0.41 (0.18 to 0.91)	268 fewer per 1000 (from 41 fewer to 373 fewer)	VERY LOW	CRITICAL
Remission - BN												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	4/18 (22.2%)	26/45 (57.8%)	RR 0.38 (0.16	358 fewer per 1000	VER	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extensive Program	Limited Program ANY ED	Relative (95% CI)	Absolute		
									to 0.95)	(from 29 fewer to 485 fewer)	Y LOW	
Remission FU												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	21/56 (37.5%)	51/67 (76.1%)	RR 0.5 (0.35 to 0.72)	381 fewer per 1000 (from 213 fewer to 495 fewer)	VERY LOW	CRITICAL
Remission FU - AN												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13/38 (34.2%)	18/22 (81.8%)	RR 0.42 (0.26 to 0.68)	475 fewer per 1000 (from 262 fewer to 605 fewer)	VERY LOW	CRITICAL
Remission FU - BN												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	8/18 (44.4%)	33/45 (73.3%)	RR 0.61 (0.35	286 fewer per 1000	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extensive Program	Limited Program ANY ED	Relative (95% CI)	Absolute		
									to 1.05)	(from 477 fewer to 37 more)		

[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.

Table 251: Full GRADE profile for history of inpatient care versus no history of inpatient care for any eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	History of Inpatient	No history ANY ED	Relative (95% CI)	Absolute		
EDI- Drive for thinness (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	160	62	-	SMD 0.02 higher (0.28 lower to 0.31 higher)	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	History of Inpatient	No history ANY ED	Relative (95% CI)	Absolute		
EDI- Bulimia (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	160	62	-	SMD 0.07 higher (0.22 lower to 0.36 higher)	VERY LOW	IMPORTANT
EDI-Body dissatisfaction (Better indicated by lower values)												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	160	62	-	SMD 0.18 lower (0.48 lower to 0.11 higher)	VERY LOW	IMPORTANT

[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.

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1 **Table 252: Full GRADE profile for specialist versus non-specialist assessment and treatment for any eating disorder**

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Specialist	non-specialist assessment and treatment (ANY ED)	Relative (95% CI)	Absolute	**Quality**	**Importance**
Admitted to inpatient treatment - Sp to Sp vs. NonSp to Non Sp												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	8/53 (15.1%)	3/16 (18.8%)	RR 0.81 (0.24 to 2.68)	36 fewer per 1000 (from 142 fewer to 315 more)	VERY LOW	IMPORTANT
Admitted to inpatient treatment - Sp to Sp vs. NonSp to Sp												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	8/53 (15.1%)	6/15 (40%)	RR 0.38 (0.15 to 0.92)	248 fewer per 1000 (from 32 fewer to 340 fewer)	VERY LOW	IMPORTANT
Admitted to inpatient treatment - Non Sp to Non Sp vs. Non Sp to Sp												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	3/16 (18.8%)	6/15 (40%)	RR 0.47 (0.14 to 1.55)	212 fewer per 1000 (from	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Specialist	non-specialist assessment and treatment (ANY ED)	Relative (95% CI)	Absolute		
										344 fewer to 220 more)		
Continuity of care - Sp to Sp vs. NonSp to Sp												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	44/53 (83%)	12/16 (75%)	RR 1.11 (0.81 to 1.51)	83 more per 1000 (from 142 fewer to 382 more)	VERY LOW	IMPORTANT
Continuity of care - Sp to Sp vs. NonSp to NonSp												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	44/53 (83%)	6/15 (40%)	RR 2.08 (1.1 to 3.9)	432 more per 1000 (from 40 more to 1000 more)	VERY LOW	IMPORTANT
Continuity of care - Non Sp to Sp vs. Non Sp to Sp												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Specialist	non-specialist assessment and treatment (ANY ED)	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	12/16 (75%)	6/15 (40%)	RR 1.88 (0.95 to 3.71)	352 more per 1000 (from 20 fewer to 1000 more)	VERY LOW	IMPORTANT

[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.

Table 253: Full GRADE profile for prior opt-in programme versus post opt-in in people with any eating disorder

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Prior opt-in	Post opt-in ANY ED	Relative (95% CI)	Absolute		
% attended their first appointment												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Prior opt-in	Post opt-in ANY ED	Relative (95% CI)	Absolute		
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	57/70 (81.4 %)	42/68 (61.8 %)	RR 1.1 (1.02 to 1.18)	62 more per 1000 (from 12 more to 111 more)	VERY LOW	IMPORTANT
Overall attrition rates												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	13/70 (18.6 %)	7/68 (10.3 %)	RR 1.80 (0.77 to 4.25)	82 more per 1000 (from 24 fewer to 335 more)	VERY LOW	IMPORTANT
Did not attend												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	11/70 (15.7 %)	3/68 (4.4%)	RR 3.2 (1.04 to 8.18)	97 more per 1000 (from 2 more to 317 more)	VERY LOW	IMPORTANT
No cancellations												
1	observational studies	serious 1	no serious inconsistency	no serious indirectness	serious2	none	2/70 (2.9%)	0/68 (0%)	RR 0.97 (0.93 to 1.02)	-	VERY LOW	IMPORTANT

[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.

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L.11 Do different ways of coordinating care produce benefits/harms for people with eating disorders?

L.11.1 Stepped care for people with eating disorders

Table 254: Full GRADE profile for family-based treatment then intensive parental coaching versus family-based treatment only in young people with anorexia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	FBT->IPC	FBT	Relative (95% CI)	Absolute	Quality	Importance
Recovered from AN (>=95% EBW)												
1	randomised trials	serious 1	no serious inconsistency	serious2	very serious3	none	7/12 (58.3 %)	12/23 (52.2 %)	RR 1.12 (0.6 to 2.07)	63 more per 1000 (from 209 fewer to 558 more)	VERY LOW	CRITICAL
BMI (Better indicated by higher values)												
1	randomised trials	serious 2	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.28 higher (0.42 lower to 0.98 higher)	VERY LOW	CRITICAL
% Expected Body Weight (Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.22 higher (0.48 lower to 0.92 higher)	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	FBT->IPC	FBT	Relative (95% CI)	Absolute		
EDE Global (Better indicated by lower values)												
1	randomised trials	serious 2	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.92 higher (0.18 to 1.65 higher)	VERY LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.59 higher (0.12 lower to 1.3 higher)	VERY LOW	IMPORTANT
Yale-Brown-Cornell Eating Disorder Scale (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.71 higher (0.01 lower to 1.43 higher)	VERY LOW	IMPORTANT
Service user experience (measured with: Helping Relationship Questionnaire; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.86 lower (1.59 to 0.13 lower)	VERY LOW	IMPORTANT
Number of Sessions attended (Better indicated by lower values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	FBT->IPC	FBT	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.92 higher (0.18 to 1.65 higher)	VERY LOW	IMPORTANT
Suitability of therapy - child (measured with: Therapy Suitability and Patient Expectancy; Better indicated by higher values)												
1	randomised trials	serious 2	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.38 lower (1.09 lower to 0.32 higher)	VERY LOW	IMPORTANT
Child's expectations about therapy (measured with: Therapy Suitability and Patient Expectancy; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.45 lower (1.16 lower to 0.26 higher)	VERY LOW	IMPORTANT
Suitability of therapy - Mother (measured with: Therapy Suitability and Patient Expectancy; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.64 higher (0.08 lower to 1.35 higher)	VERY LOW	IMPORTANT
Mother's expectations about therapy (measured with: Therapy Suitability and Patient Expectancy; Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	FBT->IPC	FBT	Relative (95% CI)	Absolute		
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.54 higher (0.17 lower to 1.25 higher)	VERY LOW	IMPORTANT
Suitability of therapy - Father (measured with: Therapy Suitability and Patient Expectancy; Better indicated by higher values)												
1	randomised trials	serious 2	no serious inconsistency	serious1	very serious3	none	12	23	-	SMD 0 higher (0.7 lower to 0.7 higher)	VERY LOW	IMPORTANT
Father's expectations about therapy (measured with: Therapy Suitability and Patient Expectancy; Better indicated by higher values)												
1	randomised trials	serious 1	no serious inconsistency	serious2	serious4	none	12	23	-	SMD 0.27 lower (0.97 lower to 0.43 higher)	VERY LOW	IMPORTANT

1 1 Lock & Le Grange 2015: High risk of selection and performance bias.
2 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
3 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.
4 3 CI crosses both 0.75 and 1.25 (Risk Ratio), or both 0.5 and -0.5 (SMD).
5 4 CI crosses either 0.75 or 1.25 (Risk ratio), or either 0.5 or -0.5 (SMD).

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1 **Table 255: Full GRADE profile for guided self-help CBT-ED then antidepressant then CBT-ED versus CBT-ED then antidepressant in**
2 **adults with bulimia nervosa**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GSH CBT->AD->CBT-BN	CBT-BN->AD	Relative (95% CI)	Absolute		
Remission												
1	randomised trials	serious1	serious2	serious3	very serious4	none	43/146 (29.5%)	46/147 (31.3%)	RR 0.94 (0.67 to 1.33)	19 fewer per 1000 (from 103 fewer to 103 more)	VERY LOW	CRITICAL
EDE Global (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.06 lower (0.29 lower to 0.17 higher)	VERY LOW	IMPORTANT
EDE Restraint (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.06 lower (0.29 lower to 0.17 higher)	VERY LOW	IMPORTANT
EDE Shape Concerns (Better indicated by lower values)												

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Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GSH CBT->AD->CBT-BN	CBT-BN->AD	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.12 lower (0.35 lower to 0.1 higher)	VERY LOW	IMPORTANT
EDE Weight Concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.07 lower (0.3 lower to 0.16 higher)	VERY LOW	IMPORTANT
EDE Eating Concerns (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0 higher (0.23 lower to 0.23 higher)	VERY LOW	IMPORTANT
Yale-Brown-Cornell ED Scale - Preoccupation (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.09 lower (0.32 lower to	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	GSH CBT->AD->CBT-BN	CBT-BN->AD	Relative (95% CI)	Absolute		
										0.14 higher)		
Yale-Brown-Cornell ED Scale - Ritual (Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.08 lower (0.31 lower to 0.14 higher)	VERY LOW	IMPORTANT
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.11 lower (0.34 lower to 0.12 higher)	VERY LOW	IMPORTANT
Quality of Life (measured with: Quality of Well Being Scale; Better indicated by lower values)												
1	randomised trials	serious 1	no serious inconsistency	serious3	serious5	none	146	147	-	SMD 0.02 higher (0.21 lower to 0.25 higher)	VERY LOW	IMPORTANT

1 1 Mitchell 2011/Crow 2013: Unclear allocation concealment. No participant nor investigator blinding. Dropout rates of both groups>20%, no details provided
2 for reasons.

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2 I2>50%.
3 Randomization was to different treatments. No randomisation to next level of stepped care.
4 CI crosses both 0.75 and 1.25 (Risk Ratio).
5 <400 participants.

Table 256: Full GRADE profile for self-help manual for bulimia nervosa then CBT-ED versus CBT-ED in adults with bulimia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-Help Manual for BN -> CBT-ED	CBT-ED	Relative (95% CI)	Absolute	Quality	Importance
Remission (follow-up 18 months; assessed with: Abstinence from bingeing, purging or other weight control behaviour in past month (or if not available: BITE Symptom score<=11 and BITE Severity score=0))												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	14/46 (30.4%)	12/40 (30%)	RR 1.01 (0.53 to 1.93)	3 more per 1000 (from 141 fewer to 279 more)	VERY LOW	CRITICAL
Remission 18-mo FU (assessed with: Abstinence from bingeing, purging or other weight control behaviour in past month (or if not available: BITE Symptom score<=11 and BITE Severity score=0))												
1	randomised trials	serious 1	no serious inconsistency	no serious indirectness	very serious2	none	12/30 (40%)	14/34 (41.2%)	RR 0.97 (0.54 to 1.76)	12 fewer per 1000 (from 189 fewer to 313 more)	VERY LOW	CRITICAL

1 Treasure 1996: inadequate randomization method and allocation concealment; No participant blinding, unclear investigator and assessor blinding; dropout rate of CBT-ED group>20%.
2 CI crosses both 0.75 and 1.25.

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Table 257: Full GRADE profile for group psychoeducation then CBT-ED versus group psychoeducation then wait list control in adults with bulimia nervosa

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Psychoeducation->CBT-ED	Group Psychoeducation->WLC	Relative (95% CI)	Absolute	Quality	Importance
Not in Remission												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	21/37 (56.8%)	16/19 (84.2%)	RR 0.67 (0.48 to 0.95)	278 fewer per 1000 (from 42 fewer to 438 fewer)	LOW	CRITICAL
Not in Remission from Bingeing												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	18/37 (48.6%)	15/19 (78.9%)	RR 0.62 (0.41 to 0.92)	300 fewer per 1000 (from 63 fewer to 466 fewer)	LOW	CRITICAL
Not in Remission from Purging												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	10/37 (27%)	15/19 (78.9%)	RR 0.58 (0.38 to 0.89)	332 fewer per 1000 (from 87	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Psychoeducation->CBT-ED	Group Psychoeducation->WLC	Relative (95% CI)	Absolute		
										fewer to 489 fewer)		
Binge Frequency (measured with: EDE 28 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	19	-	SMD 0.54 lower (1.11 lower to 0.02 higher)	LOW	CRITICAL
Purge Frequency (measured with: EDE 28 days; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	19	-	SMD 0.7 lower (1.27 to 0.13 lower)	LOW	CRITICAL
EDE Global (Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	19	-	SMD 0.08 lower (0.63 lower to 0.48	LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Psychoeducation->CBT-ED	Group Psychoeducation->WLC	Relative (95% CI)	Absolute		
										higher)		
Depression (measured with: BDI; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	19	-	SMD 0.17 lower (0.72 lower to 0.39 higher)	LOW	IMPORTANT
General Psychopathology (measured with: Brief Symptom Inventory; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	19	-	SMD 0.21 lower (0.76 lower to 0.35 higher)	LOW	IMPORTANT
General Functioning (measured with: SAS; Better indicated by lower values)												
1	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious2	none	37	19	-	SMD 0.3 lower (0.86 lower to	LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group Psychoeducation->CBT-ED	Group Psychoeducation->WLC	Relative (95% CI)	Absolute		
										0.25 higher)		

1 1 Davis 1999: unclear randomization method and allocation concealment. No participant blinding, unclear investigator and assessor blinding. Unclear
2 whether baseline characteristics similar.
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio).

L.12 4 What factors/indicators should be considered when assessing whether a person with an 5 eating disorder should be admitted for compulsory treatment (including any form of 6 restrictive interventions usually implemented in refeeding.

L.12.1 7 Compulsory versus voluntary treatment

8 **Table 258: Full GRADE profile for compulsory treatment versus voluntary treatment in young people with any eating disorder at**
9 **discharge**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory treatment	Voluntary treatment	Relative (95% CI)	Absolute		
BMI at discharge - young people (follow-up 12 months; Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	15	32	-	SMD 0.69 higher (0.06	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory treatment	Voluntary treatment	Relative (95% CI)	Absolute		
										to 1.32 higher)		
Morgan-Russell Outcome (change scores) - young people (follow-up 12 months; Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	15	32	-	SMD 0.53 higher (0.09 lower to 1.16 higher)	VERY LOW	IMPORTANT
Regular Menstruation - young people (follow-up 12 months)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	10/15 (66.7%)	5/32 (15.6%)	RR 4.27 (1.77 to 10.3)	511 more per 1000 (from 120 more to 1000 more)	VERY LOW	IMPORTANT
Disengaged from Family Therapy - young people (follow-up 12 months)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	very serious4	none	4/16 (25%)	15/34 (44.1%)	RR 0.57 (0.22 to 1.44)	190 fewer per 1000 (from 344 fewer	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory treatment	Voluntary treatment	Relative (95% CI)	Absolute		
										to 194 more)		
Required Nasogastric Feeding - young people (follow-up 12 months)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	11/16 (68.8%)	4/34 (11.8%)	RR 5.84 (2.2 to 15.54)	569 more per 1000 (from 141 more to 1000 more)	VERY LOW	IMPORTANT
Prematurely Discharged - young people (follow-up 12 months)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	very serious4	none	2/16 (12.5%)	12/34 (35.3%)	RR 0.35 (0.09 to 1.4)	229 fewer per 1000 (from 321 fewer to 141 more)	VERY LOW	IMPORTANT
General Functioning - young people (follow-up 12 months; Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	15	32	-	SMD 0.91 lower (1.36	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory treatment	Voluntary treatment	Relative (95% CI)	Absolute		
										to 0.45 lower)		
Depression - young people (follow-up 12 months; Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	15	32	-	SMD 0.77 lower (1.41 to 0.14 lower)	VERY LOW	IMPORTANT

1 1 Ayton 2009: high selection bias (group allocation likely to affect outcome, no attempt to balance design, baseline not comparable); high performance bias
2 (compulsory group treated significantly longer than voluntary group, sig more in compulsory group required nasogastric feeding).
3 2 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).
4 3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
5 4 CI crosses both 0.75 and 1.25 (Risk Ratio).

6 **Table 259: Full GRADE profile for compulsory treatment versus voluntary treatment in young people with any eating disorder at**
7 **follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
>90% Weight for Height 12-mo after discharge - young people												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	very serious2	none	6/12 (50%)	11/29 (37.9%)	RR 1.32 (0.63	121 more per 1000	VER	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
									to 2.74)	(from 140 fewer to 660 more)	Y LOW	
Intermediate Outcome 12-mo after discharge - young people (assessed with: Clinically underweight and either receiving ongoing OP treatment or prematurely disengaged with services)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	very serious2	none	4/12 (33.3%)	6/29 (20.7%)	RR 1.61 (0.55 to 4.7)	126 more per 1000 (from 93 fewer to 766 more)	VERY LOW	IMPORTANT
Patients alive 12-mo after discharge - young people												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	12/12 (100%)	27/29 (93.1%)	RR 1.05 (0.9 to 1.22)	47 more per 1000 (from 93 fewer to 205 more)	VERY LOW	CRITICAL
Readmitted to Hospital 12-mo after discharge - young people												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	very serious2	none	0/12 (0%)	2/29 (6.9%)	RR 0.46 (0.02 to 8.96)	37 fewer per 1000 (from 68 fewer to 549 more)	VERY LOW	IMPORTANT

1 1 Ayton 2009: high selection bias (group allocation likely to affect outcome, no attempt to balance design, baseline not comparable); high performance bias
2 (compulsory group treated significantly longer than voluntary group, sig more in compulsory group required nasogastric feeding).
3 2 CI crosses both 0.75 and 1.25 (Risk Ratio).
4 3 <300 events (dichotomous outcome) or <400 participants (continuous outcome).

5 **Table 260: Full GRADE profile for compulsory treatment versus voluntary treatment in adults with any eating disorder at discharge**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED: Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
BMI at discharge - adults (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	66	331	-	SMD 0.05 lower (0.32 lower	VERY LOW	CRITICAL

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED: Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
										to 0.21 higher)		
Weight Gain (lbs) - adults (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	66	331	-	SMD 0.33 higher (0.07 to 0.6 higher)	VERY LOW	CRITICAL
Rate of Weight Gain (lbs/week) - adults (Better indicated by higher values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	66	331	-	SMD 0.18 higher (0.09 lower to 0.44 higher)	VERY LOW	CRITICAL
# achieving >85% ABW or BMI>18 - adults												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious2	none	52/66 (78.8%)	267/331 (80.7%)	RR 0.98 (0.85 to 1.12)	16 fewer per 1000 (from 121 fewer to 97 more)	VERY LOW	CRITICAL
# AN patients achieving >85% ABW - adults												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any ED: Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	21/28 (75%)	109/150 (72.7%)	RR 1.03 (0.82 to 1.31)	22 more per 1000 (from 131 fewer to 225 more)	VERY LOW	CRITICAL
Length of Hospital Stay (days) - adults (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious3	none	66	331	-	SMD 0.45 higher (0.19 to 0.72 higher)	VERY LOW	IMPORTANT

1 1 Watson 2000: low selection bias (group allocation likely to affect outcome); high performance bias (no participant nor investigator blinding).
2 2 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
3 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

4 **Table 261: Full GRADE profile for compulsory treatment versus voluntary treatment in adults with anorexia nervosa at discharge**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
BMI at discharge (follow-up 5.7 years; Better indicated by higher values)												

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
3	observational studies	serious1,2,3	no serious inconsistency	no serious indirectness	serious4	none	122	224	-	SMD 0.04 higher (0.19 lower to 0.27 higher)	VERY LOW	CRITICAL
Weight Gain (Better indicated by lower values)												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious5	none	26	70	-	SMD 0.23 higher (0.22 lower to 0.68 higher)	VERY LOW	CRITICAL
Duration of hospital stay (Better indicated by lower values)												
2	observational studies	serious2,3	no serious inconsistency	no serious indirectness	serious5	none	96	154	-	SMD 0.46 higher (0.18 to 0.73 higher)	VERY LOW	IMPORTANT
Refeeding Syndrome												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious5	none	10/26 (38.5%)	12/70 (17.1%)	RR 2.24 (1.1 to 4.56)	213 more per 1000 (from 17	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
										more to 610 more)		
Locked Ward												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious4	none	11/26 (42.3%)	1/70 (1.4%)	RR 29.62 (4.02 to 218.18)	409 more per 1000 (from 43 more to 1000 more)	VERY LOW	IMPORTANT
Required Tube Feeding												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious4	none	12/26 (46.2%)	11/70 (15.7%)	RR 2.94 (1.48 to 5.82)	305 more per 1000 (from 75 more to 757 more)	VERY LOW	IMPORTANT
Achieved Target Weight												
1	observational studies	serious3	no serious inconsistency	no serious indirectness	very serious5	none	4/15 (26.7%)	30/73 (41.1%)	RR 0.65 (0.27	144 fewer per 1000	VERY LOW	IMPORTANT

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Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
									to 1.57)	(from 300 fewer to 234 more)		
Required >1 Specialist Medical Consultation												
1	observational studies	serious3	no serious inconsistency	no serious indirectness	serious5	none	14/15 (93.3%)	53/73 (72.6%)	RR 1.29 (1.06 to 1.56)	211 more per 1000 (from 44 more to 407 more)	VERY LOW	IMPORTANT

1 1 Carney 2006: high selection bias (group allocation likely to affect study outcome, no attempt made to balance design, groups not comparable at baseline);
2 high performance bias (Voluntary group not likely to be on locked ward nor subject to tube feeding).
3 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
4 baseline).
5 3 Griffiths 1997: high selection bias (group allocation likely to affect study outcome, no attempt made to balance design, socioeconomic status of compulsory
6 group significantly higher than voluntary group); low performance bias (compulsory group had significantly longer treatment).
7 4 <300 events (dichotomous outcome) or <400 participants (continuous outcome).
8 5 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

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1 **Table 262: Full GRADE profile for compulsory treatment versus voluntary treatment in adults with anorexia nervosa at follow up**

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compulsory Treatment	Voluntary Treatment	Relative (95% CI)	Absolute		
Patient Deaths FU												
2	observational studies	serious1,2	no serious inconsistency	no serious indirectness	serious3	none	11/94 (11.7%)	2/151 (1.3%)	RR 5.66 (1.49 to 21.54)	62 more per 1000 (from 6 more to 272 more)	VERY LOW	CRITICAL
Patient Deaths 20-yr FU												
1	observational studies	serious1	no serious inconsistency	no serious indirectness	serious4	none	17/79 (21.5%)	10/78 (12.8%)	RR 1.68 (0.82 to 3.43)	87 more per 1000 (from 23 fewer to 312 more)	VERY LOW	CRITICAL

2
3 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
4 baseline).
5 2 Griffiths 1997: high selection bias (group allocation likely to affect study outcome, no attempt made to balance design, socioeconomic status of compulsory
6 group significantly higher than voluntary group); low performance bias (compulsory group had significantly longer treatment).
7 3 CI crosses either 0.75 or 1.25 (Risk Ratio), or either 0.5 or -0.5 (SMD).

8

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