NKR23 - PICO1 - Bulimia Nervosa: CBT-BN versus non-symptom focused psychotherapy

Characteristics of studies

Characteristics of included studies

Agras 2000

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: 28.3 (7.0) ● *BN/BN-like (% of sample (N))*: 100 (110) ● *Sex (female % of sample (N))*: 100 (110) ● *BMI (SD)*: 22.7 (4.2) IPT/SPT/notCBT ● *Age (SD)*: 27.9 (7.5) ● *BN/BN-like (% of sample (N))*: 100 (110) ● *Sex (female % of sample (N))*: 100 (110) ● *BMI (SD)*: 23.2 (5.2) **Included criteria:** DSM-III-R criteria for bulimia nervosa **Excluded criteria:** Exclusion factors for the study included associatedsevere physical or psychiatric conditions that would interferewith treatment (eg, psychosis), current anorexianervosa, current psychotherapeutic treatment of any type,all psychotropic medication, and pregnancy. participants who had received an adequate trial of CBT orIPT for bulimia nervosa were also excluded.
Interventions	**Intervention Characteristics** CBT ● *Frequency*: 19 individual sessions conducted over a periodof 20 weeks. Each session was 50 minutes in length andoccurred twice weekly for the first 2 weeks, weekly for thenext12weeks,andthenat2-weekintervals forthelast6weeks ● *Content*: Cognitive-behavioral therapy has 3overlapping phases. In the first phase, the main goal is toeducate the patient about bulimia nervosa and the processesthat maintain the disorder. Patients are helped to increasethe regularity of their eating, and to resist the urgeto binge eat and to purge. Use is made of detailed recordsof food intake, binge eating, purging, and related eventsand cognitions, and these records form the basis for eachtherapy session. In the second phase, beginning at aboutthe ninth session, procedures to reduce dietary restraint continue(eg, broadening food choices). In addition, cognitiveprocedures supplemented by behavioral experimentsare used to identify and correct dysfunctional cognitions,and avoidance behaviors related to eating, weight, and shapeconcerns. The third stage is composed of the last 3 therapysessions and is primarily concerned with the maintenanceof change after the end of treatment. Relapse preventionstrategies are used to prepare for possible future setbacks. IPT/SPT/notCBT ● *Frequency*: 19 individual sessions conducted over a periodof 20 weeks. Each session was 50 minutes in length andoccurred twice weekly for the first 2 weeks, weekly for thenext12weeks,andthenat2-weekintervals forthelast6weeks ● *Content*: IPT: the treatment has3phases.Thefirst phase (comprising the first 4 sessions) is devoted to a detailedanalysis of the interpersonal context within which theeating disorder developed and was maintained. This leads toa formulation of the current interpersonal problem area or areas,which then form the focus of the second stage of therapyaimed at helping the patient make interpersonal changes inthe specific area or areas identified. The last 3 sessions are devoted to a review of the patient's progress, and an explorationof ways to handle future interpersonal difficulties. At nostage in the treatment is attention paid to eating habits or attitudestoward weight and shape, nor does the treatment containany of the specific behavioral or cognitive procedures thatcharacterizeCBT.Noself-monitoring isusedin this treatment.
Outcomes	*Continuous*: ● Binges/month ● Binges/month ● Purges/month ● EDE Global ● EDE restraint ● EDE weight concern ● EDE shape concern ● EDE eating concern ● Vomiting/month ● EDI drive for thinness ● EDI bulimia ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Recovered from ED ● Recovered from ED

Identification	**Sponsorship source:** This research was supported in part by grant R10MH49877 from the National Institute of Mental Health,Bethesda, Md (Drs Agras and Walsh), and by a WellcomePrincipal Fellowship grant 046386 from the Wellcome Trust,Cambridge, England (Dr Fairburn). **Country:** USA and UK **Setting:** 2 behandlingssteder, universitetsklinikker **Comments:** **Authors name:** W. Stewart Agras **Institution:** Department of Psychiatry and Behavioral Sciences, Stanford University, Stanford, Calif **Email:** sagras@leland.stanford.edu **Address:** Departmentof Psychiatry and Behavioral Sciences, StanfordUniversity School of Medicine, 401 Quarry Rd, Stanford,CA 94305
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** *Tine Pedersen* EDE: median(interquartile range) **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

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

Bossert 1989

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: ● *BN/BN-like (% of sample (N))*: 87.5 (7) ● *Sex (female % of sample (N))*: 100 (8) ● *BMI (SD)*: IPT/SPT/notCBT ● *Age (SD)*: ● *BN/BN-like (% of sample (N))*: 67 (4) ● *Sex (female % of sample (N))*: 100 (6) ● *BMI (SD)*: **Included criteria:** Female patients meeting DSM-III criteria for bulimia **Excluded criteria:**
Interventions	**Intervention Characteristics** CBT ● *Frequency*: 3 x 40 min. session/uge 90,9 (44,8) dage ● *Content*: Five components and phases: self-monitoring, training of alternative behavior, contract system, self-administered response-prevention, breaks from hospital treatment. IPT/SPT/notCBT ● *Frequency*: 3 x 40 min. session/uge101,6 (39,9) dage ● *Content*: No specific self-control techniques. Based on supportive therapeutic relationship, introspection, and self-disclosure.
Outcomes	*Continuous*: ● Purges/month ● EDE restraint ● EDE shape concern ● EDE Global ● Binges/month ● EDE eating concern ● EDE weight concern

	● EDI bulimia ● Vomiting/month ● EDI drive for thinness ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Recovered from ED ● Recovered from ED
Identification	**Sponsorship source:** not stated **Country:** Germany **Setting:** Inpatient treatment **Comments:** **Authors name:** Sabine Bossert **Institution:** Max Planck Institute of Psychiatry **Email:** **Address:** Max Planck Institute of Psychiatry, Kraepelinstrasse 10, D-8000 München 40 (FRG)
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** **Dichotomous outcomes:** **Adverse outcomes:** *Loa Clausen* 4 pat med AN historie viste tendens til skrift fra opkast til faste under CBT

Risk of bias table

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

Fairburn 1986

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: no info ● *BN/BN-like (% of sample (N))*: 100 (12) ● *Sex (female % of sample (N))*: 100 (12) ● *BMI (SD)*: no info IPT/SPT/notCBT ● *Age (SD)*: no info ● *BN/BN-like (% of sample (N))*: 100 (12) ● *Sex (female % of sample (N))*: 100 (12) ● *BMI (SD)*: no info **Included criteria:** Female, age above 17, strict definition of BN according to Russell, weight minimum 80% of populated mean weight **Excluded criteria:** Major psychiatric disorder other than depression, anxiety, obsessional state, dependence on drugs or alcohol, need for hospitalization, treatment from another source, not being available for full course of study (12 months).
Interventions	**Intervention Characteristics** CBT ● *Frequency*: twice weekly for first month, weekly for following 2 months, every 14 days for final 6 weeks (19 sessions over 18 weeks). ● *Content*: Used Fairburn's manual for CBT for bulimia. IPT/SPT/notCBT ● *Frequency*: twice weekly for first month, weekly for following 2 months, every 14 days for final 6 weeks (19 sessions over 18 weeks).

	● *Content*: Short term focal psychotherapy. BN is a maladaptive solution for underlying problems. Explores the origins of the eating problem, examinates maintaining factors, emphasis upon termination as a "loss".
Outcomes	*Continuous*: ● Purges/month ● EDE restraint ● EDE shape concern ● EDE Global ● Binges/month ● EDE eating concern ● EDE weight concern ● EDI bulimia ● Vomiting/month ● EDI drive for thinness ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Recovered from ED ● Recovered from ED
Identification	**Sponsorship source:** Grant from the Medical Research Council **Country:** England **Setting:** outpatient **Comments:** **Authors name:** Christopher G. Fairburn **Institution:** University of Oxford, Department of Psychiatry **Email:** **Address:** University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, England
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** *Loa Clausen* No SD *Tine Pedersen* Binges and vomiting reported as the median. **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

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

Fairburn 1991

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: no info ● *BN/BN-like (% of sample (N))*: 100 (25) ● *Sex (female % of sample (N))*: 100 (25) ● *BMI (SD)*: no info IPT/SPT/notCBT ● *Age (SD)*: no info ● *BN/BN-like (% of sample (N))*: 100 (25) ● *Sex (female % of sample (N))*: 100 (25) ● *BMI (SD)*: no info **Included criteria:** 17 or older, DSM-III-R criteria for BN, BMI greater than 17.

	Excluded criteria:
Interventions	**Intervention Characteristics** CBT ● *Frequency*: 19 sessions over 18 weeks. 40-50 minutes in length. Twice weekly for first month, weekly for following two months, fortnight during final 6 weeks. ● *Content*: CBT Fairburn/Oxford model IPT/SPT/notCBT ● *Frequency*: 19 sessions over 18 weeks. 40-50 minutes in length. Twice weekly for first month, weekly for following two months, fortnight during final 6 weeks. ● *Content*: IPT: focus on patient's current circumstances and relationships.
Outcomes	*Continuous*: ● Binges/month ● Vomiting/month ● EDE restraint ● EDE weight concern ● EDE shape concern ● EDE eating concern ● Funktionsevne ● Livskvalitet ● Purges/month ● EDE restraint ● EDE shape concern ● EDE Global ● Binges/month ● EDE eating concern ● EDE weight concern ● EDI bulimia ● Vomiting/month ● EDI drive for thinness ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Recovered from ED ● Dropout ● Recovered from ED
Identification	**Sponsorship source:** Wellcome Trust London **Country:** England **Setting:** outpatient **Comments:** **Authors name:** Christopher G. Fairburn **Institution:** University department of Psychiatry, Oxford **Email:** **Address:** Warneford Hospital, Oxford, england
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** *Loa Clausen* CBT og IPT data brugt. Adfærdsterapi (BT) ikke inkluderet i dataextration **Pretreatment:** **Continuous outcomes:** **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

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

Fairburn 1995

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: ● *BN/BN-like (% of sample (N))*: ● *Sex (female % of sample (N))*: ● *BMI (SD)*: IPT/SPT/notCBT ● *Age (SD)*: ● *BN/BN-like (% of sample (N))*: ● *Sex (female % of sample (N))*: ● *BMI (SD)*: **Included criteria:** **Excluded criteria:**
Interventions	**Intervention Characteristics** CBT ● *Frequency*: Long term follow up of Fairburn 1986 + 1991 ● *Content*: IPT/SPT/notCBT ● *Frequency*: Long term follow up of Fairburn 1986 + 1991 ● *Content*:
Outcomes	*Continuous*: ● Purges/month ● EDE restraint ● EDE shape concern ● EDE Global ● Binges/month ● EDE eating concern ● EDE weight concern ● EDI bulimia ● Vomiting/month ● EDI drive for thinness ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Recovered from ED ● Recovered from ED
Identification	**Sponsorship source:** UK Medical Research CouncilMedical Research CouncilWellcome Trust **Country:** England **Setting:** outpatient **Comments:** **Authors name:** Christopher G. Fairburn **Institution:** University of Oxford, Department of Psychiatry **Email:** **Address:** University of Oxford, Department of Psychiatry, Warnefard Hospital, Oxford OX3 7JX, England
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

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

Incomplete outcome data (attrition bias)	Low risk	
Selective reporting (reporting bias)	Low risk	
Other bias	High risk	

Garner 1993

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: 23.7 (4.4) ● *BN/BN-like (% of sample (N))*: 100 (30) ● *Sex (female % of sample (N))*: 100 (30) ● *BMI (SD)*: 95.3 % (9.8) IPT/SPT/notCBT ● *Age (SD)*: 24.6 (4.0) ● *BN/BN-like (% of sample (N))*: 100 (30) ● *Sex (female % of sample (N))*: 100 (30) ● *BMI (SD)*: 94.9 % (7.9) **Included criteria:** DSM-III-R criteria for BN, not required two objective binges per week, two episodes vomiting per week, minimum duration 1 yr, body weight between 85%-120%, age 18-35, no other current BN treatment **Excluded criteria:**
Interventions	**Intervention Characteristics** CBT ● *Frequency*: 19 sessions, 45-60 minutes, over 18 weeks in accordance with the model by Fairburn. ● *Content*: Manual described by Fairburn. Self-monitoring forms. IPT/SPT/notCBT ● *Frequency*: 19 sessions, 45-60 minutes, over 18 weeks in accordance with the model by Fairburn. ● *Content*: Manual as described by Lubersky. Nondirective and no advice.
Outcomes	*Continuous*: ● Purges/month ● EDE restraint ● EDE shape concern ● EDE Global ● Binges/month ● EDE eating concern ● EDE weight concern ● EDI bulimia ● Vomiting/month ● EDI drive for thinness ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Recovered from ED ● Recovered from ED
Identification	**Sponsorship source:** Health and Welfare CanadaNATO Grants for Collaborative ResearchOntario Mental Health Foundation **Country:** Canada **Setting:** tertiary care program **Comments:** **Authors name:** David M Garner **Institution:** Department of Psychiatry, Michigan state University College of Human Medicine **Email:** no info **Address:** Michigan State University College of Human MedicineEast LansingMI 48824
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

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

Poulsen 2014

Methods	**Study design:** Randomized controlled trial **Study grouping:** **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** CBT ● *Age (SD)*: 25.7 (5.4) ● *BN/BN-like (% of sample (N))*: 100 (36) ● *Sex (% female of sample (N))*: 97.2 (35) ● *BMI (SD)*: 22.94 (2.49) IPT/SPT/notCBT ● *Age (SD)*: 25.8 (4.3) ● *BN/BN-like (% of sample (N))*: 100 (34) ● *Sex (% female of sample (N))*: 100 (34) ● *BMI (SD)*: 22.24 (2.11) **Included criteria:** The inclusion criteria were age at least 18 years, being availablefor the duration of the longer of the two treatments, and meetingDSM-IV criteria for bulimia nervosa.Individuals already receiving psychopharmacologicaltreatment as well as individuals meeting ICD210 criteria formoderate or severe depression but who were otherwise consideredeligible for the trial were referred to a consulting psychiatrist.When a stable dose of medication had been reached, theassessment procedure was continued. Patients in psychopharmacologicaltreatments were monitored regularly by the consultingpsychiatrist. **Excluded criteria:** The exclusion criteria weresevere physical and psychiatric conditions that would interferewith treatment (e.g., psychosis), pregnancy, current psychotherapeutictreatment, and difficulty speaking or understandingDanish. Patients were withdrawn from the trial if theirphysical health became a cause for concern.
Interventions	**Intervention Characteristics** CBT ● *Frequency*: The treatment comprises 20 50-minutesessions that are preceded by one 90-minute preparatory sessionand followed by one review session 20 weeks after treatment. Thesessions are twice-weekly for the first 4 weeks, weekly for the next10 weeks, and every 2 weeks over the final 6 weeks. ● *Content*: The “enhanced” version of the original CBT for bulimianervosa is characterized by increased focus on engagement,greater emphasis on the modification of concerns about shapeand weight, and the development of skills to deal with setbacks. We used the focused form of the treatment,which concentrates exclusively on modifying the patient’s eatingdisorder psychopathology. IPT/SPT/notCBT ● *Frequency*: 50 min sessioner over 2 år mean number of sessions 72.3 (10.6), 42-86 (n=24) ● *Content*: The treatment is based on the assumptionthat bulimic symptoms are rooted in a need to ward off innerfeeling states and desires (5) and in difficulties acknowledgingand regulating such inner states (20). Accordingly, the therapyaims to increase the capacity to reflect on and tolerate affectiveexperience and to facilitate insight into the mechanisms hidingunconscious and disavowed aspects of the patient (8). It ischaracterized by a nondirective approach where the patient isinvited to talk as freely as possible, a focus on the therapeuticrelationship, and involvement of the patient in a mutual reflectionon the function of and the circumstances triggering thesymptoms of the disorder (21). The bulimic symptoms are notnecessarily discussed in every session, but the therapist assists the patient in understanding possible connections between theway that he or she eats and his or her affective state. The treatmentconsists of three phases: an initial phase focusing on establishingthe therapeutic frame and alliance and addressing the bulimicsymptoms, the work phase where additional attention is directedtoward the transference relationship, and the termination phase.
Outcomes	*Continuous*: ● Binges/month ● Purging/month ● EDE global ● EDE restraint ● EDE eating concern ● EDE shape concern ● EDE weight concern ● Binges/month ● Purging/month ● Vomiting/month

	● EDE Global ● EDE restraint ● EDE weight concern ● EDE shape concern ● EDE eating concern ● EDI drive for thinness ● EDI bulimia ● EDI body dissatisfaction ● Funktionsevne ● Livskvalitet *Dichotomous*: ● Dropout ● Remission of ED
Identification	**Sponsorship source:** Supported in part by grant 9901684/25-01-0011 from the DanishCouncil for Independent Research/Humanities, grant 41470 from theEgmont Foundation and grant 07018005 from the Ivan NielsenFoundation. C.G.F. is supported by a Principal Research Fellowshipfrom the Wellcome Trust (046386). **Country:** Denmark **Setting:** university outpatient clinic **Comments:** **Authors name:** Stig Poulsen **Institution:** Department of Psychology, University of Copenhagen, Denmark **Email:** stig.poulsen@psy.ku.dk **Address:**
Notes	**Identification:** **Participants:** **Study design:** **Baseline characteristics:** **Intervention characteristics:** **Pretreatment:** **Continuous outcomes:** *Tine Pedersen* Poulsen 2014 angiver estimated marginal means frem for mean. *Loa Clausen* EMM i stedet for mean **Dichotomous outcomes:** **Adverse outcomes:**

Risk of bias table

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

Footnotes

Characteristics of excluded studies

=Lacey 1983

Reason for exclusion	Wrong study design

Agras 1989

Reason for exclusion	Wrong comparator

Bachar 1999

Reason for exclusion	Wrong intervention

Bergh 2002

Reason for exclusion	Wrong comparator

Burton 2006

Reason for exclusion	Wrong comparator

Carter 2003

Reason for exclusion	Wrong comparator

Cooper 1995

Reason for exclusion	Wrong comparator

Cooper 1996

Reason for exclusion	Wrong intervention

Esplen 1998

Reason for exclusion	Wrong intervention

Fairburn 1981

Reason for exclusion	Wrong study design

Fairburn 1993

Reason for exclusion	Wrong outcomes

Fairburn 1993a

Reason for exclusion	Wrong study design

Fairburn 2009

Reason for exclusion	Wrong comparator

Freeman 1985

Reason for exclusion	Wrong comparator

Freeman 1988

Reason for exclusion	Wrong comparator

Ghaderi 2006

Reason for exclusion	Wrong comparator

Griffiths 1993

Reason for exclusion	Wrong intervention

Griffiths 1994

Reason for exclusion	Wrong intervention

Griffiths 1996

Reason for exclusion	Wrong intervention

Hay 2013

Reason for exclusion	Wrong study design

Hsu 2001

Reason for exclusion	Wrong intervention

Jones 1993

Reason for exclusion	Wrong study design

Kirkley 1985

Reason for exclusion	Wrong intervention

Laessle 1987

Reason for exclusion	Wrong intervention

Laessle 1991

Reason for exclusion	Wrong intervention

Ordman 1985

Reason for exclusion	Wrong comparator

Ruwaard 2013

Reason for exclusion	dublet

Ruwaard 2013a

Reason for exclusion	Wrong intervention

Safer 2001

Reason for exclusion	Wrong intervention

Schmidt 2008

Reason for exclusion	Wrong intervention

Shelley Ummenhofer 2007

Reason for exclusion	Wrong intervention

Sundgot Borgen 2002

Reason for exclusion	Wrong comparator

Touyz 2013

Reason for exclusion	dublet

Treasure 1994

Reason for exclusion	Wrong comparator

Treasure 1996

Reason for exclusion	Wrong comparator

Treasure 1997

Reason for exclusion	Wrong intervention

Treasure 1999

Reason for exclusion	Wrong comparator

Turnbull 1997

Reason for exclusion	Wrong comparator

Wagner 2013

Reason for exclusion	Wrong intervention

Wilfley 1993

Reason for exclusion	Wrong intervention

Wilson 1986

Reason for exclusion	Wrong comparator

Wilson 1991

Reason for exclusion	Wrong comparator

Wonderlich 2014

Reason for exclusion	Wrong comparator

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

References to studies

Included studies

Agras 2000

Agras,W. S.; Walsh,T.; Fairburn,C. G.; Wilson,G. T.; Kraemer,H. C.. A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. Archives of General Psychiatry 2000;57(5):459-466. [DOI:]

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Fairburn 1995

Fairburn,C. G.; Norman,P. A.; Welch,S. L.; O'Connor,M. E.; Doll,H. A.; Peveler,R. C.. A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. Archives of General Psychiatry 1995;52(4):304-312. [DOI:]

Garner 1993

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Poulsen 2014

Poulsen,S.; Lunn,S.; Daniel,S. I.; Folke,S.; Mathiesen,B. B.; Katznelson,H.; Fairburn,C. G.. A randomized controlled trial of psychoanalytic psychotherapy or cognitive-behavioral therapy for bulimia nervosa.. American Journal of Psychiatry 2014;171(1):109-116. [DOI:]

Excluded studies

=Lacey 1983

Lacey JH. Bulimia nervosa, binge eating, and psychogenic vomiting: A controlled treatment study and long term outcome. British medical journal (Clinical research ed.) 1983;286(6378):1609-1613. [DOI:]

Agras 1989

Agras,W. S.; Schneider,J. A.; Arnow,B.; Raeburn,S. D.; Telch,C. F.. Cognitive-behavioral and response-prevention treatments for bulimia nervosa. Journal of consulting and clinical psychology 1989;57(2):215-221. [DOI:]

Bachar 1999

Bachar,E.; Latzer,Y.; Kreitler,S.; Berry,E. M.. Empirical comparison of two psychological therapies. Self psychology and cognitive orientation in the treatment of anorexia and bulimia. The Journal of psychotherapy practice and research 1999;8(2):115-128. [DOI:]

Bergh 2002

Bergh,C.; Brodin,U.; Lindberg,G.; Sodersten,P.. Randomized controlled trial of a treatment for anorexia and bulimia nervosa. Proceedings of the National Academy of Sciences of the United States of America 2002;99(14):9486-9491. [DOI: 10.1073/pnas.142284799 [doi]]

Burton 2006

Burton, E.; Stice, E.. Evaluation of a healthy-weight treatment program for bulimia nervosa: A preliminary randomized trial. Behaviour Research and Therapy 2006;44(12):1727-1738. [DOI: S0005-7967(05)00275-5 [pii]]

Carter 2003

Carter,J. C.; Olmsted,M. P.; Kaplan,A. S.; McCabe,R. E.; Mills,J. S.; Aime,A.. Self-help for bulimia nervosa: a randomized controlled trial. The American Journal of Psychiatry 2003;160(5):973-978. [DOI:]

Cooper 1995

Cooper,P. J.; Steere,J.. A comparison of two psychological treatments for bulimia nervosa: implications for models of maintenance. Behaviour research and therapy 1995;33(8):875-885. [DOI: 000579679500033T [pii]]

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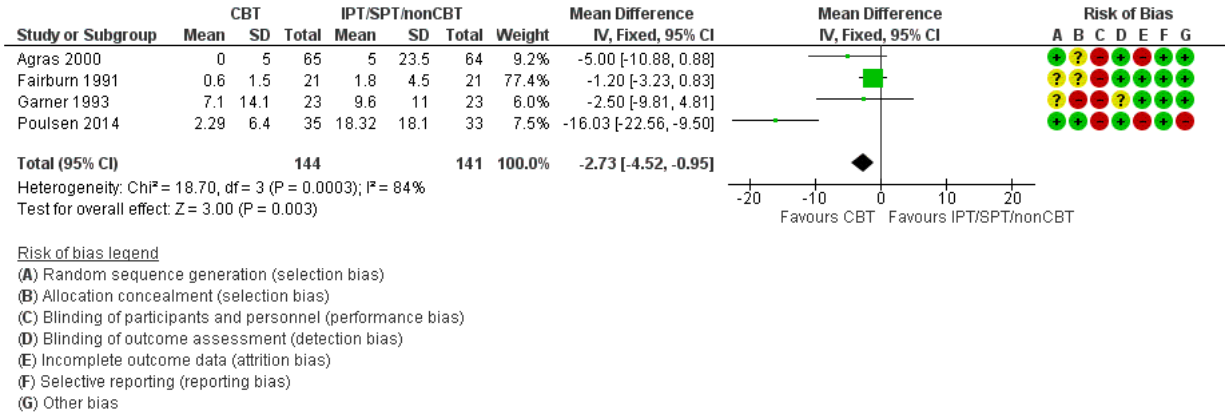
Data and analyses

1 CBT vs IPT/SPT/nonCBT

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 ED behaviour, Binges/month, end of treatment	4	285	Mean Difference (IV, Fixed, 95% CI)	-2.73 [-4.52, -0.95]
1.2 ED behaviour, Purges/vomiting per month, end of treatment	4	289	Mean Difference (IV, Fixed, 95% CI)	-9.85 [-13.78, -5.91]
1.3 Remission, Recovery from ED symptoms, longest FU	4	378	Risk Ratio (IV, Fixed, 95% CI)	1.53 [1.12, 2.11]
1.4 Psychological ED symptoms, EDE Global, end of treatment	2	197	Mean Difference (IV, Fixed, 95% CI)	-0.57 [-0.85, -0.29]
1.5 Psychological ED symptoms, EDE restraint, end of treatment	4	289	Mean Difference (IV, Fixed, 95% CI)	-0.89 [-1.22, -0.55]
1.6 Psychological ED symptoms, EDE eating concern, end of treatment	2	197	Mean Difference (IV, Fixed, 95% CI)	-0.52 [-0.80, -0.23]
1.7 Psychological ED symptoms, EDE shape concern, end of treatment	4	289	Mean Difference (IV, Fixed, 95% CI)	-0.41 [-0.71, -0.11]
1.8 Psychological ED symptoms, EDE weight concern, end of treatment	4	289	Mean Difference (IV, Fixed, 95% CI)	-0.54 [-0.83, -0.25]
1.9 Psychological ED symptoms, EDI drive for thinness, end of treatment	1	49	Mean Difference (IV, Fixed, 95% CI)	-3.50 [-7.17, 0.17]
1.10 Psychological ED symptoms, EDI bulimia, end of treatment	1	49	Mean Difference (IV, Fixed, 95% CI)	-2.60 [-4.96, -0.24]
1.11 Psychological ED symptoms, EDI body dissatisfaction, end of treatment	1	49	Mean Difference (IV, Fixed, 95% CI)	-2.00 [-6.63, 2.63]
1.12 Dropout, end of treatment	6	438	Risk Ratio (IV, Fixed, 95% CI)	1.10 [0.77, 1.56]
1.13 Somatic complications, end of treatment	0	0	Odds Ratio (M-H, Fixed, 95% CI)	Not estimable
1.14 Quality of life, longest FU	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable
1.15 Level of Functioning, longest FU	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable

Figures

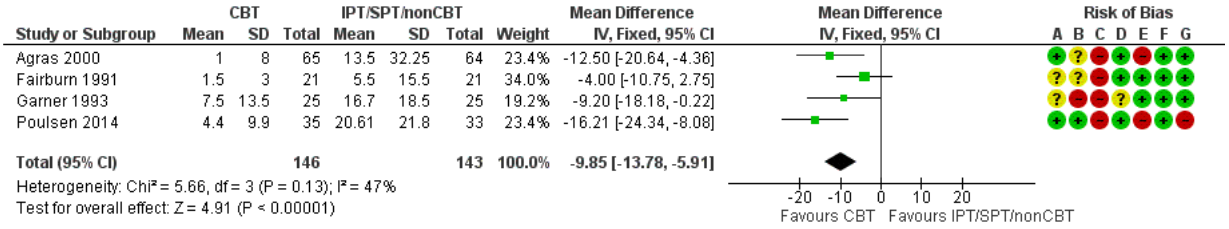
Figure 1 (Analysis 1.1)



Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.1 ED behaviour, Binges/month, end of treatment.

Figure 2 (Analysis 1.2)



Risk of bias legend
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(D) Blinding of outcome assessment (detection bias)
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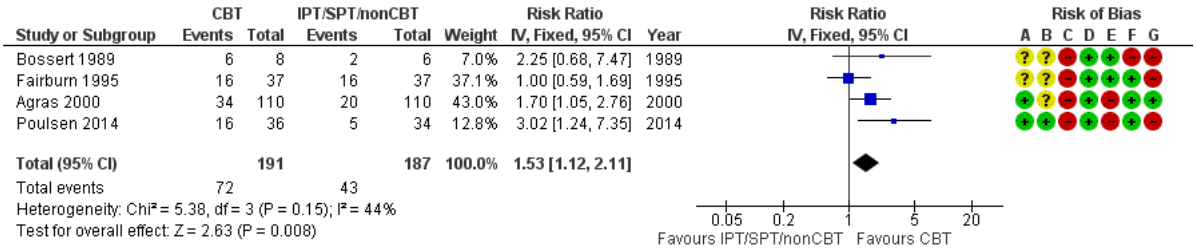
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.2 ED behaviour, Purges/vomiting per month, end of treatment.

Figure 3 (Analysis 1.3)



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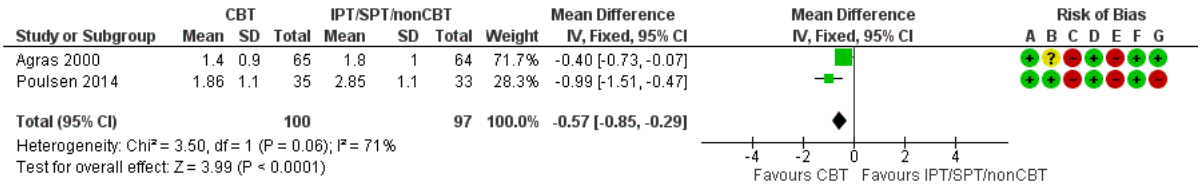
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.3 Remission, Recovery from ED symptoms, longest FU.

Figure 4 (Analysis 1.4)



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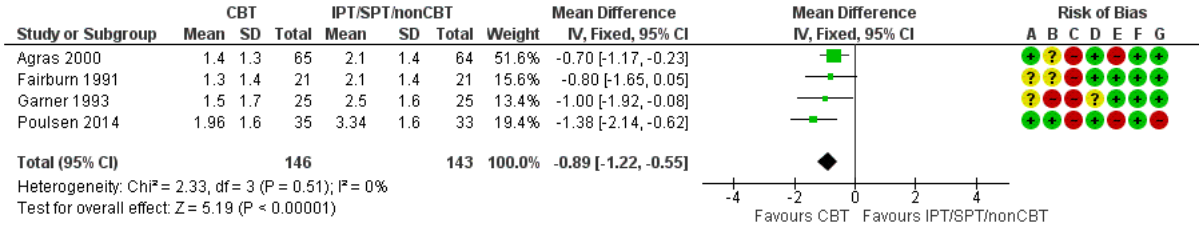
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.4 Psychological ED symptoms, EDE Global, end of treatment.

Figure 5 (Analysis 1.5)



Risk of bias legend
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(B) Allocation concealment (selection bias)
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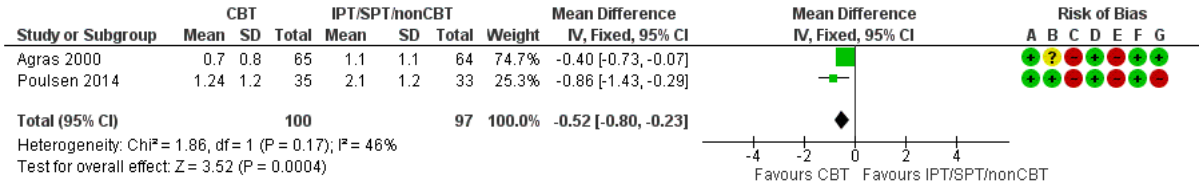
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.5 Psychological ED symptoms, EDE restraint, end of treatment.

Figure 6 (Analysis 1.6)



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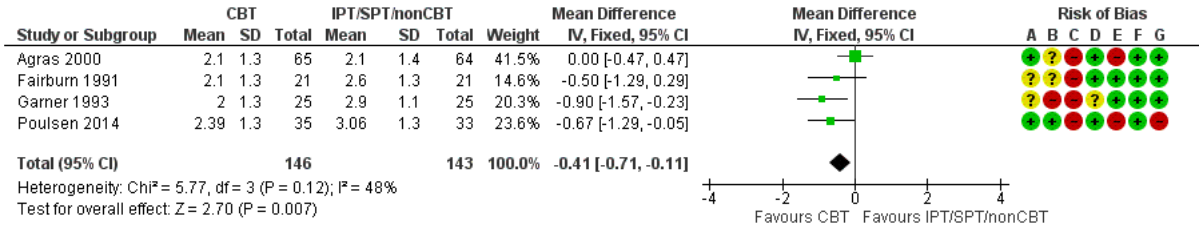
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.6 Psychological ED symptoms, EDE eating concern, end of treatment.

Figure 7 (Analysis 1.7)



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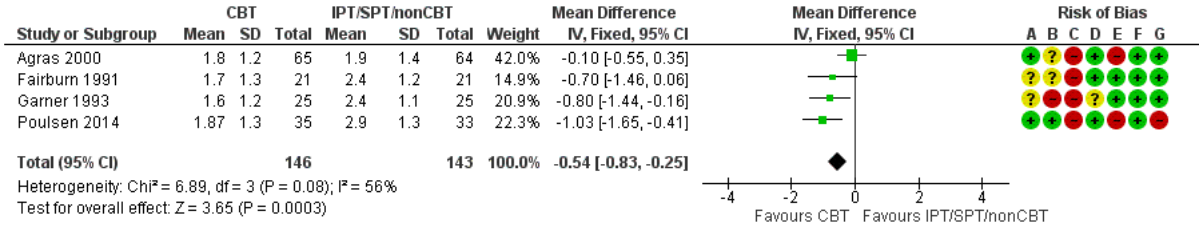
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.7 Psychological ED symptoms, EDE shape concern, end of treatment.

Figure 8 (Analysis 1.8)



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(D) Blinding of outcome assessment (detection bias)
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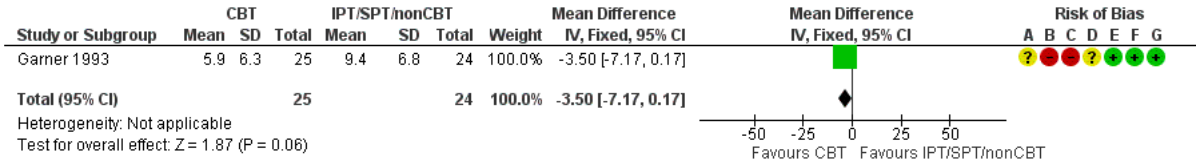
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.8 Psychological ED symptoms, EDE weight concern, end of treatment.

Figure 9 (Analysis 1.9)



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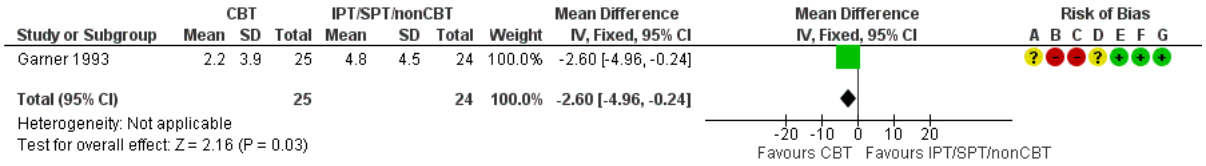
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.9 Psychological ED symptoms, EDI drive for thinness, end of treatment.

Figure 10 (Analysis 1.10)



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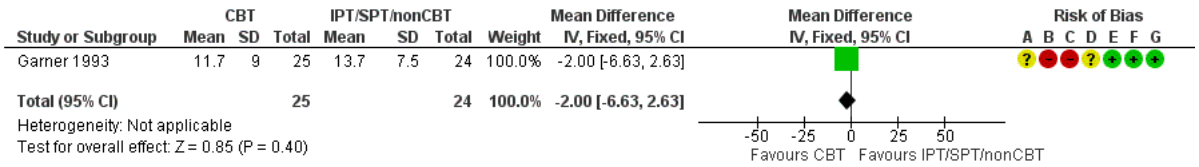
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.10 Psychological ED symptoms, EDI bulimia, end of treatment.

Figure 11 (Analysis 1.11)



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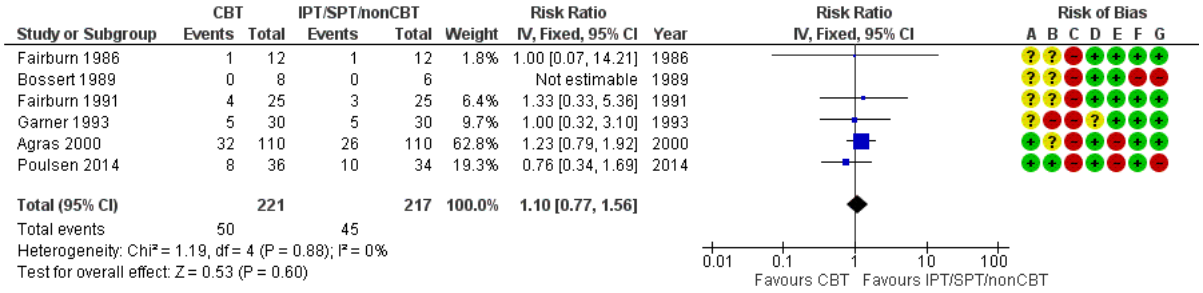
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.11 Psychological ED symptoms, EDI body dissatisfaction, end of treatment.

Figure 12 (Analysis 1.12)



Risk of bias legend
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(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 CBT vs IPT/SPT/nonCBT, outcome: 1.12 Dropout, end of treatment.