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Brazilian Psychiatric Association Guidelines for the Treatment of Eating Disorders

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Brazilian Psychiatric Association guidelines for the treatment of eating disorders

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ABSTRACT

Eating disorders (ED), such as anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), are serious psychiatric conditions that significantly impact psychological and medical health. This paper aims to summarize the recommendations of the Brazilian Association of Psychiatry – [Associação Brasileira de Psiquiatria (ABP)] for the treatment of EDs, based on the latest available evidence. Systematic reviews focused on the multidisciplinary treatment of ED were conducted. Findings were evaluated based on evidence strength, and recommendations using the evidence-based methodology of the Oxford Centre for Evidence-Based Medicine, finalized by an expert panel consensus. A summary of the recommendations and their corresponding levels of evidence was produced. Overall, the management of AN should use the least restrictive setting, combining monitored nutritional rehabilitation with psychotherapy. Pharmacotherapy plays a limited role in selected cases. BN is typically managed in an outpatient setting, focusing on structured nutritional care and CBT-based treatment, with pharmacotherapy adjunctive, preferably fluoxetine. BED is treated in an outpatient setting with structured care and CBT, with lisdexamfetamine as the preferred pharmacotherapy when needed. These guidelines represent a significant advancement in managing eating disorders in Brazil, providing a structured framework for clinical care while also supporting the development of future public mental health policies.

Keywords: Feeding and eating disorders, practical guideline, anorexia nervosa, bulimia nervosa, binge eating disorder

INTRODUCTION

Eating disorders (EDs) are characterized by persistent impairment of eating behavior that results in altered food consumption or absorption, affecting physical and psychosocial health (1). They often include body image disturbances and low self-esteem(2). EDs can begin early in life, and their initial symptoms may go unnoticed until complications(2) lead individuals to seek treatment, contributing to chronicity and potentially resulting in serious health consequences, including death(3)(4). Although the DSM-5-TR (5) and ICD-11(6) include a broader range of conditions under the category of Feeding and Eating Disorders—including anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), avoidant/restrictive food intake disorder, pica, and rumination disorder—the present guidelines focus specifically on AN, BN, and BED, which are among the most extensively studied disorders and have the most robust evidence base for treatment.

The management of EDs should involve a collaborative approach encompassing a diverse team of professionals, such as psychiatrists, psychologists, dietitians, and various other healthcare workers (1). This teamwork is vital throughout the stages of assessment, treatment planning, and follow-up care (7). Providing effective support for ED patients demands specialized training for healthcare providers and a comprehensive care system that addresses all severity levels—from primary care for less severe cases to specialized clinics and inpatient treatment for more critical situations. Furthermore, the development of targeted health policies is essential to ensure the effective delivery of care services (7).

Epidemiological studies indicate that EDs in Brazil show a prevalence and impact comparable to global data(8)(9). However, care for ED patients is inadequate, lacking public policies and systematic treatment (10). Few specialized units exist, mainly in universities and large cities, offering standardized treatments based on international protocols.(11). The status of ED care across different regions in Brazil remains unclear.

This situation highlights the need for systematic care in the country. Treatment guidelines are crucial for managing EDs. Although international guidelines exist (12–14) local guidelines are necessary to address specific questions relevant to our health care system. This project aims to summarize the Brazilian Association of Psychiatry's (ABP) recommendations for multidisciplinary ED treatment, covering treatment settings, nutritional, psychological, and pharmacological areas, based on

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the latest evidence and considering the specificities of the health care environment of our country.

METHODS

The Brazilian Association of Psychiatry – [*Associação Brasileira de Psiquiatria* (ABP)] EDs Committee appointed a Guideline Development Group (GDG) to specifically develop a comprehensive clinical guideline for the management of EDs. This group was composed of a comprehensive multiprofessional team of 11 Brazilian experts in the area (psychiatrists, psychologists and dietitians). The criteria for participation in the GDG were to have relevant ED expertise (in clinical, research, or methodological area), experience with systematic reviews and metanalysis methodology, and the ability to work effectively in group settings. The *Appraisal of Guidelines, Research and Evaluation* - AGREE II (15) and the *Methodological Guidelines: Clinical Guideline Development* from the National Committee for Health Technology Incorporation – CONITEC, Ministry of Health, Brazil(16) were used to inform guideline development and reporting.

This guideline targets adults and adolescents with EDs such as AN, BN, and BED, as defined by DSM-5-TR (5) or ICD-11(6). The present guideline focuses on AN, BN, and BED as mentioned before. ARFID, pica, and rumination disorder have distinct clinical features and treatment approaches and would require a separate, specific review beyond the scope of the current guideline. The following areas will be covered: treatment settings, nutritional, psychotherapeutic, pharmacological interventions. It focuses on treatment settings, nutritional, psychotherapeutic, and pharmacological interventions, primarily for health care professionals in Brazil's Unified Health System (SUS). Notably, it excludes children, pregnant women, and the elderly.

The GDG identified clinical gaps and formulated research questions in a PICO Patient/Population, Intervention, Comparison, Outcome) format. These research questions were then used to establish search terms for the literature search by each clinical area (Supplementary material 1). Key questions included:

a) What is the optimal treatment setting for the treatment of adults and adolescents with an ED “Y”?
b) Is the nutritional intervention “X” efficacious (effective, safe, acceptable) for the treatment of adults and adolescents with an ED “Y”?

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c) Is the psychological intervention “X” efficacious (effective, safe, acceptable) for the treatment of adults and adolescents with an ED “Y”?
d) Is the pharmacological agent “X” efficacious (effective, safe, acceptable) for the treatment of adults and adolescents with an ED “Y”?

Literature reviews

The GDG was divided into sub-groups of at least 2 experts to conduct systematic reviews on treatment areas: settings, nutrition, psychology, pharmacology, and adolescent interventions. The reviews followed PRISMA guidelines (17) and were conducted across several databases (PubMed/Medline, Web of Science, PsycINFO, Cochrane Database, Scopus, Scielo) up to June 30, 2025, without language restrictions. Inclusion criteria focused primarily on systematic reviews with or without metanalysis of ED treatment, randomized controlled trials, and non-controlled trials. Narrative reviews were excluded. The electronic search was supplemented by manual searches of reference lists to find additional relevant publications (Supplementary material 2).

Data Collection

Two reviewers in each subgroup independently screened and selected the studies based on title and abstract. Following consensus on the primary selection, both authors independently reviewed the full text of the selected studies to determine the suitability for inclusion, based on the established selection criteria. Disagreements between the two reviewers were resolved by discussion with each other and a third reviewer until consensus was reached. Study selection was finalized based on a strict adherence to the Oxford Centre for Evidence-Based Medicine (CEBM) appraisal tools(18). To be included, papers were required to satisfactorily address all appraisal questions within the respective CEBM appraisal worksheet for Systematic Reviews and RCTs, ensuring high-quality evidence.

Data Extraction

One researcher extracted data from each study using a standardized extraction form designed for the purpose of the present review. Data extracted included sociodemographic and clinical characteristics of trials’ participants, the type and characteristics of intervention, trial duration; and the following outcomes:

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“response”; “remission”, “tolerability”, “acceptability”. Each sub-group was responsible for compiling the data into an Excel spreadsheet.

Data Synthesis

The evidence synthesis was performed using a hierarchical approach in accordance with international guideline development standards (World Health Organization, 2014(19)). This guideline was based primarily on high-quality systematic reviews and meta-analyses. In areas where synthesized evidence was unavailable or lacked sufficient data, we supplemented our findings with data from randomized controlled trials (RCTs).Non-controlled clinical studies were included only in the absence of evidence from randomized trials or when evidence was insufficient to inform guideline recommendations.

Grading the Evidence

Evidence was categorized according to Oxford Centre for Evidence-Based Medicine (OCEBM) 2011 Levels of Evidence(20). The recommendations were compiled by assessing the level of evidence and assigning a grade to each recommendation as follows: Level 1: Systematic reviews (with homogeneity) of randomized controlled trials (RCTs) or \(n\)-of-1 trials; Level 2: Individual randomized trials or observational studies with moderate to large effect sizes; Level 3: Non-randomized, prospective, or well-designed case-control and cohort studies; Level 4: Case series and poor-quality case-control or cohort studies; Level 5: Mechanism-based reasoning, such as expert opinion based on basic science, physiology, or bench research.

Consensus on the recommendations

Hence, to reach consensus on the recommendations, the GDG held five virtual expert consensus meetings (ECMs) for specific treatment areas. The meetings were conducted using a modified Nominal Group Technique(21), which aims to have experts discuss and agree on what the interventions should be and why. At each meeting, the results of the literature review and grading of the evidence according to the Oxford Levels of Evidence were initially presented. Recommendations were then made by the GDG based on the level, quality, consistency and clinical relevance of the available evidence, the potential benefits and harms of the interventions, as well

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as the applicability and feasibility of the interventions in the Brazilian healthcare system. The GDG also considered the methodological quality and consistency of the studies and their clinical relevance when the evidence was contradictory. If evidence was weak or insufficient to support a firm evidence-based recommendation, the GDG relied on expert consensus based on indirect evidence and clinical practice. Recommendations were endorsed when a strong consensus (more than 75%) of all participants was reached.

RESULTS

Anorexia Nervosa

Treatment Settings

The definition of the optimal treatment setting (level of care) for AN patients should prioritize weight restoration, nutritional rehabilitation, clinical stabilization and improvement of associated psychopathology as initial parameters, seeking the least restrictive, but effective, therapeutic environment that ensures the patient's clinical safety. Systematic reviews and meta-analyses comparing different settings of care, such as full-time inpatient versus outpatient treatment, have found no clear or significant differences in weight gain outcomes or the proportion of patients achieving weight restoration by the end of treatment(22). Similarly, improvements in specific ED psychopathology and general psychopathology (including depressive symptoms) did not differ between care levels [Level of Evidence (LOE)=1]. There is very low-quality evidence suggesting that outpatient treatment may have higher completion rates (acceptability) compared to inpatient care(22). Furthermore, comparisons between inpatient and partial hospitalization for adolescents also showed no significant differences in weight gain or overall recovery(22). In summary, current evidence does not support the superiority of full-time inpatient care over less restrictive settings, such as outpatient treatment or partial hospitalization, for most efficacy outcomes (LOE=1). Therefore, the decision regarding the level of care must always be individualized, based on clinical severity, life-threatening risk, and social support. However, priority should be given to the least restrictive setting possible that ensures both safety and therapeutic effectiveness.

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Nutritional

The primary objective of nutritional therapy in AN is weight restoration, which reduces mortality and improves ED psychopathology and psychiatric conditions (LOE 1)(12)(23). Research indicates that higher initial caloric intakes in refeeding protocols lead to faster weight gain under strict medical supervision, thereby minimizing refeeding syndrome risks (LOE 1) (24). For severely malnourished patients, inpatient care is recommended, starting at 1,200-1,600 kcal/day and increasing to 2,000-3,000 kcal/day, targeting 0.5-1 kg weight gain weekly in outpatient settings and 1-1.5 kg in inpatient care(24). While oral feeding remains the preferred method, enteral nutrition may be necessary for individuals exhibiting significant food refusal or facing high nutritional risk(25). This approach aids in weight gain, recovery of lean body mass, and reduction of purging behaviors (LOE 2)(26)(25). Regardless of the feeding method, it is crucial to monitor and correct electrolyte levels (specifically phosphorus, potassium, magnesium, and calcium) (LOE 1) (12)(23).

Nutritional interventions must extend beyond mere caloric intake to confront dysfunctional beliefs regarding food and weight. Dietitians play a key role in providing education, emotional support, and gradual exposure to feared foods, which aids treatment adherence (LOE 2) (27)(28). As patients approach weight restoration, the focus of treatment should shift towards normalizing hunger and satiety signals, diminishing cognitive restraint, and facilitating reintegration into social situations involving food. Optimal outcomes arise when nutritional therapy complements effective psychotherapies, such as cognitive-behavioral therapy for EDs (CBT-ED) and family-based treatment (FBT), fostering improvements in mood, anxiety, (LOE 1) (12) and supporting long-term recovery (LOE 2) (28).

Psychological

The primary goals of psychotherapy for AN are to restore weight and improve ED symptoms, psychological well-being, minimizing dropout rates(12)(13). While psychological treatments generally provide symptom relief and clinical improvement, no single method has consistently proven superior to others (7).

Regarding body mass index (BMI), active therapeutic interventions — such as cognitive-behavioral therapy for EDs (CBT-ED), cognitive-behavioral therapy (CBT), behavioral therapy (BT), family intervention (FAM-i), family-based therapy (FBT), interpersonal psychotherapy (IPT), and acceptance and commitment therapy (ACT)

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— show no significant advantage over treatment as usual (TAU[1]), with a small effect size (SMD = 0.23) (23)(29)(30)(31)(32). Enhanced CBT (CBT-E), specialist supportive clinical management (SSCM), the Maudsley model of AN treatment for adults (MANTRA), and focal psychodynamic therapy (FPT)have been shown to improve BMI, however, they are not significantly more effective than other methods(29).

FBT in its individual format (FBT-i) shows a notable advantage for eating symptom remission compared to TAU (risk ratio 3.50)(23). However, no significant efficacy differences were found among CBT-E, MANTRA, and SSCM (LOE 1)(29). Other approaches, including BT, BT-BWL, and ACT, did not outperform standard treatment regarding overall and ED-specific psychopathology(23)(30)(31). In terms of overall psychopathology and improvements specific to ED psychopathology, BT, BT-BWL, CBT-ED, FAM-i, FBT, IPT, SSCM, psychodynamic supportive therapy (PSD), and ACT did not outperform TAU according to the evidence available (LOE 1)(23)(30)(31). Comparisons among CBT-ED, MANTRA, and SSCM revealed no distinctive advantages; each approach resulted in clinically meaningful enhancements in ED psychopathology with moderate to large effect sizes reported (LOE 1) (29). Finally, regarding dropout rates, both CBT and CBT-E exhibited lower dropout frequencies when compared to PSD and TAU respectively (OR = 0.54) (LOE 1)(32).

Although there is no comparative evidence establishing superiority among these approaches, it is recommended that psychological interventions be manualized yet personalized and administered by clinicians proficient in managing EDs; as such, they are generally considered first-line options.

Pharmacological

Drug treatments in AN aimed at improving weight gain and reducing the core preoccupations and behaviors of the disorder, as well as comorbid mood or obsessive-compulsive symptoms, either in the acute phase or as a form of relapse prevention after weight restoration. Several classes of drugs have been evaluated in

[1] TAU was usually described as a diverse set of interventions available in the services. It was usually composed of a range of different psychological interventions combined with nutritional counselling and, supported by functioning counseling and pharmacotherapy as needed.

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AN, but the overall quality of the studies is low, and findings have not been replicated (33).

Systematic reviews and meta-analyses in AN do not support the use of antidepressants (tricyclics, SSRIs) neither to treat ED-specific psychopathology, nor to obtain weight gain in the acute or maintenance phases (34)(35) (LOE=1). In recent decades, research on second generation antipsychotics has increased due to their effects on a broad range of symptoms present in AN (anxiety, depressive, obsessive-compulsive, and psychotic-like symptoms, as well as being underweight). Initial systematic reviews and metanalyses of antipsychotic drugs for AN did not show efficacy of these drugs (34,36) (LOE=1). However, most recent and largest trial (N=152) that tested olanzapine in AN found a small effect on weight gain (Attia et al., 2019). Subsequent metanalyses that included this trial provided evidence of small to medium effect sizes for olanzapine's impact on weight gain (e.g., greater rate of weight gain or end-of-treatment BMI), but not for eating or general psychopathology(35,37) **(**LOE=1). The most common adverse effects were drowsiness and sedation with antipsychotics, though overall tolerability was good(37).

While olanzapine is not approved for the treatment of AN, it may be considered as an adjunct to psychological therapy in cases of insufficient weight recovery (for example due to cognitive rigidity or psychotic-like symptoms). Close monitoring of glucose and lipid metabolism is recommended if olanzapine is prescribed. Notably, the acceptability of drug treatment is limited due to the specific core psychopathology of AN (fear of weight gain) (35) (LOE=1) (Supplementary material 3).

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Bulimia Nervosa

Treatment Settings

For BN, the choice of treatment setting focuses on reducing binge-eating episodes and compensatory behaviors in an environment appropriate to the severity of the case. The evidence comparing different levels of care for these conditions is scarce (22). A systematic review that included one study comparing specialist inpatient care with partial hospitalization for BN found no clear differences between modalities(22). Specifically, there were no significant discrepancies in the frequency or abstinence from binge-eating episodes, in general psychopathology, or in the

acceptability (completion rates) of the treatment between the groups. The evidence, although based on a limited number of studies, does not demonstrate the superiority of inpatient treatment over partial hospitalization for patients with BN (LOE=1)(22).

The indication for a more intensive level of care should be based on clinical severity, the presence of decompensated psychiatric or medical comorbidities, or failure in previous outpatient treatments, rather than the assumed inherent superiority of inpatient care.

Nutrition

The primary goal of nutritional treatment in BN is to disrupt the cycle of restriction, binge eating, and purging, thereby reducing binge eating episodes and compensatory behaviors such as vomiting, laxative abuse, and fasting. Evidence from systematic reviews and randomized controlled trials indicates that nutritional interventions are most effective when integrated into multidisciplinary care, particularly alongside CBT-ED and psychiatric management (LOE 1) (27)(28)(38). Nutritional management begins with a comprehensive dietary assessment addressing eating history, binge-purge frequency, nutritional deficiencies, and medical complications. Based on this, a structured meal plan typically consisting of three meals and two to three snacks at regular intervals is recommended to prevent extreme hunger, reduce binge urges, and support treatment adherence (LOE 2) (28),(27).

Beyond meal planning, nutritional therapy emphasizes education on hunger and satiety physiology, the risks of restriction, and the value of dietary variety. Gradual, supported exposure to feared foods has been proven effective in reducing binge and purge episodes (LOE 2) (27)(28), while promoting dietary flexibility counters the “all-or-nothing” mentality that perpetuates the disorder (LOE 1) (27), (28). Monitoring and correcting electrolyte disturbances, particularly hypokalemia and hypomagnesemia, are essential due to cardiovascular risks, with dietitians supporting medical management through food-based strategies (LOE 1) (27). Post-meal supervision and emotion-regulation techniques further reduce purging behaviors. Overall, structured nutritional interventions improve dietary adequacy (LOE 2) (27), (28), reduce binge–purge behaviors (LOE 2) (27), and enhance mood and anxiety symptoms (LOE 2) (27)(28). Weight stabilization occurs as a natural outcome rather than a primary treatment goal (LOE 1) (27)(28).

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Psychological

Psychological interventions for BN should aim to reduce binge–purge behaviors, improve eating-disorder–specific and general psychopathology, and prevent relapse (39). For individuals with mild to moderate BN, guided cognitive-behavioral self-help (CBT-gsh) is recommended as a first line, stepped-care intervention. CBT-gsh results in binge–purge abstinence in approximately one-third of patients (OR = 3.81 for guided; OR = 3.49 for unguided), although sustained abstinence following treatment is attained by a minority (14.7%) (LOE 1) (39,40). If response to CBT-gsh is inadequate, or if CBT-gsh is not appropriate, treatment should be escalated to individual, clinician-delivered cognitive-behavioral therapy for EDs (CBT-ED). CBT-ED demonstrates the highest remission rates (OR = 3.89) and yields abstinence in 33.1% of patients (LOE 1) (39,40). For individuals with severe or extreme BN, CBT-ED should be offered as the primary treatment (LOE 1) (39,40). Alternative psychotherapeutic interventions demonstrate variable efficacy, with abstinence rates of 39.7% for behavioral therapy, 36.3% for multidisciplinary treatment, 28.0% for family-based therapy, 27.5% for dialectical behavior therapy, 20.2% for interpersonal therapy, and 23.5% for psychodynamic psychotherapy over five months (LOE 1) (7)(29). Over longer follow-up periods, psychodynamic psychotherapy may achieve outcomes comparable to CBT-E, with remission rates of approximately 50% at two years (LOE 1)(29)(39).

With respect to eating-disorder psychopathology, the largest effects were observed for individual CBT-ED (SMD = 1.01) and general individual psychotherapy (structured, non–eating disorder–specific therapies that address broader psychological processes and serve as an alternative when CBT-ED is unsuitable or unavailable) (SMD = 1.22) compared to waitlist or no treatment; however, CBT-ED demonstrated smaller effects when compared to other active treatments or treatment as usual (g = 0.27) (LOE 1)(23). Guided and unguided self-help CBT, group CBT, and interpersonal therapy showed inconsistent or non-significant effects (LOE 1) (23). Concerning general psychopathology, individual CBT-ED (SMD = 0.80) and general individual psychotherapy (SMD = 0.58) were superior to waitlist or no treatment, but not to active comparators (LOE 1)(23). General individual psychotherapy demonstrated the highest treatment retention (RR = 1.82), while dropout rates for CBT-ED, CBT self-help, group CBT, and interpersonal therapy were comparable to control conditions (LOE 1) (23)(40).

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Clinicians should offer guided CBT-based self-help as first-line treatment for BN and escalate to individual CBT-ED in cases of non-response or severe illness (LOE 1).

Pharmacological

Pharmacological treatment of BN aims to reduce binge-eating and compensatory behaviors while improving associated psychopathology. The most extensively studied agents include antidepressants (SSRIs, SNRIs, TCAs, MAOIs), topiramate, and ondansetron (35)(41).

Fluoxetine is the most extensively studied medication and the only agent specifically approved for BN by regulatory agencies (FDA, ANVISA). At a dose of 60 mg/day, fluoxetine is associated with higher binge-eating remission rates and lower dropout rates compared with placebo, with small-to-moderate effect sizes (LOE=1) (35,41–43). Fluoxetine also demonstrates a small benefit for depressive symptoms (LOE=1) and is generally well tolerated; common adverse effects (e.g., insomnia, nausea, asthenia, tremor) are typically mild and self-limiting (LOE=2)(44). Other SSRIs (e.g., sertraline, fluvoxamine) show potential to reduce binge eating (LOE=3) but lack sufficient evidence for a formal recommendation (LOE=1) (35,42). TCAs and MAOIs demonstrate efficacy (LOE=1) but are limited by poorer tolerability and higher adverse-effect burden, including increased cardiovascular risk (35,41,42).

Topiramate shows high efficacy in reducing binge-eating and purging behaviors (LOE=1) and is associated with weight loss, which is not a primary treatment goal in BN (41,42). Adverse effects include cognitive symptoms, fatigue, flu-like symptoms, and paresthesia; however, dropout rates are not increased, and no serious adverse events have been reported(43). Nevertheless, clinical use requires careful risk–benefit assessment.

Ondansetron has demonstrated reduction in binge-purge frequency in a randomized trial without effects on weight (LOE=3), but evidence remains limited and experimental (45). Other medications, including trazodone, mirtazapine, naltrexone, spironolactone, and lithium, have not demonstrated efficacy and are not recommended (LOE=1) (35,42). Notably, bupropion is contraindicated in BN due to increased seizure risk (LOE=2) (46).

Fluoxetine (60 mg/day) is recommended as the first-line pharmacological treatment for BN based on efficacy and safety. Topiramate may be considered in

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selected cases (e.g., high BMI or inadequate SSRI response). Ondansetron should be reserved for exceptional, refractory cases (LOE=3) (Supplementary material 3).

Binge Eating Disorder

Treatment Settings

For BED, the primary goal of treatment is to achieve abstinence from binge-eating episodes and to address associated psychopathology, such as weight and shape concerns and depressive symptoms. There is currently no evidence from comparative trials to support the superiority of one treatment setting over another for this condition (LOE=1)(22). The decision to intensify the level of care should be individualized, based on factors such as the clinical severity of the binge-eating episodes, the presence of severe medical or psychiatric comorbidities that require a more structured environment, or a failure to respond to less intensive outpatient treatments (LOE=3)(22). Notably, hospitalization for individuals with BED is uncommon and is reserved for those with high severity psychiatric/somatic comorbidities.

Nutritional

Nutritional treatment of BED aims to reduce binge episodes, improve eating-disorder (ED) psychopathology and the relationship with food, and address associated metabolic conditions, including overweight and obesity. Weight loss should not be the initial treatment goal, in accordance with international guidelines (LOE 1) (5).

Systematic reviews and meta-analyses indicate that nutritional interventions are most effective when integrated with evidence-based psychotherapy, particularly CBT-ED, resulting in greater reductions in binge frequency and severity, improved ED psychopathology, and, when appropriate, sustainable long-term weight changes (LOE 1) (23,47). Nutritional management should begin with a comprehensive assessment of eating patterns, binge triggers, and nutritional deficiencies, followed by a structured meal plan consisting of three meals and two to three snacks at regular intervals to reduce fasting and binge vulnerability (LOE 1)(47). Interventions should focus on improving the recognition of hunger and satiety cues, reducing cognitive restraint, and managing emotional and environmental triggers. Strategies such as food monitoring, mindful eating, and gradual exposure to trigger foods are

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effective in improving eating control and supporting remission (LOE 1) (12,48). Weight management should be considered only after binge eating has stabilized, using gradual, non-restrictive approaches in individuals with overweight or obesity; early, severe caloric restriction should be avoided due to an increased risk of relapse. Micronutrient supplementation is recommended only when deficiencies are documented (LOE 1) (12).

When delivered within a multidisciplinary treatment framework including psychotherapy, medical monitoring, and pharmacotherapy when indicated, nutritional interventions consistently reduce binge frequency, improve ED psychopathology, and may support sustainable weight outcomes (LOE 1) (12,23,48).

Psychological

The primary goal of psychological treatment for BED is to reduce or eliminate binge eating while improving associated psychological symptoms and long-term functioning (49). For moderate-to-severe BED, clinician-delivered cognitive-behavioral therapy (CBT) is recommended as the first-line treatment, achieving binge-eating remission in 48–53% of patients, with effects maintained for up to 24 months (LOE 1) (50–52). When access or adherence is limited, CBT-gsh may be offered as a stepped-care alternative, with remission rates of 42–46% (LOE 1) (50–52).

If CBT is unavailable or ineffective, interpersonal therapy (IPT) or dialectical behavior therapy (DBT) may be considered, demonstrating remission rates between 33% and 63%, in contrast behavioral weight loss (BWL) interventions show smaller and less durable effects (23–41%) (LOE 1) (31,50,53). Given the frequent co-occurrence of BED and obesity, behavioral lifestyle and weight-management strategies, including nutritional counseling and physical activity, should complement psychotherapy (LOE 1) (54).

Clinician-delivered CBT produces large improvements in eating-disorder psychopathology (g = 0.91; SMD = 0.83) and moderate improvements in general psychopathology (d = 0.44; g = 0.65), achieving remission of dysfunctional cognitions in 37–67% of individuals with obesity (LOE 1) (23,51–53). Third-wave interventions (ACT, mindfulness-based interventions, metacognitive therapy, compassion-focused therapy) yield moderate effects on binge frequency (g = 0.40–0.84) and may be particularly beneficial for patients with emotional dysregulation, rumination, or self-

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criticism, however long-term data remain limited (LOE 1) (53). Combined CBT and BWL produces only transient weight loss (5–7 kg, not sustained beyond 12 months) (LOE 1) (52,53,55). Treatments are generally well tolerated, with dropout rates of 19% for psychotherapies and 24% for self-help formats (LOE 1) (23,51,52).

Clinicians should offer CBT as the first-line treatment for BED, utilize guided self-help CBT when access is limited, and consider third-wave or interpersonal approaches for patients with significant emotional dysregulation, while integrating lifestyle interventions and relapse-prevention strategies (LOE 1).

Pharmacological

Pharmacological treatment of BED should address the core domains of the disorder: reduction or remission of binge eating, improvement of eating-disorder–specific and general psychopathology, and body weight outcomes in individuals with an elevated BMI. Pharmacotherapy should be used as part of a multimodal treatment approach alongside psychotherapy and behavioral interventions. Drug classes evaluated in BED include antidepressants, anticonvulsants, anti-obesity agents, central nervous system stimulants, and anti-addiction agents (56).

Lisdexamfetamine is the only medication approved by the FDA and ANVISA for BED. Pooled analyses of three randomized controlled trials show that lisdexamfetamine significantly reduces binge-eating frequency and increases remission rates, with medium effect sizes (LOE 1). It also improves BED-related psychopathology but has no significant effect on depressive symptoms. Lisdexamfetamine produces small but significant weight loss and is generally well tolerated; common adverse effects include insomnia, dry mouth, anxiety, headache, constipation, and diarrhea (35).

Several medications are used off label. Topiramate reduces binge-eating frequency, ED-specific and general psychopathology, and body weight in placebo-controlled and CBT-adjunctive trials (LOE=1) (35,57–59), but is associated with cognitive and sensory adverse effects. Sibutramine reduces binge-eating frequency, ED-related psychopathology, and weight, but not remission rates (LOE=1) ((35,60–62); despite cardiovascular concerns and its withdrawal in many countries, it remains available in Brazil. However, prescribing sibutramine in the county necessitates a B2 Prescription Notification along with an Informed Consent that must be signed by both the physician and the patient. Additionally, the physician must consider various

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contraindications for its use, including a history of cardiovascular disease, uncontrolled hypertension, individuals over 65 years old, as well as children and adolescents. SSRIs (e.g., fluoxetine, sertraline) reduce binge frequency and depressive symptoms but do not produce clinically meaningful weight loss(63). Naltrexone–bupropion does not reduce binge-eating frequency or improve remission (LOE=1) (9,10), although it improves weight and ED-related psychopathology and is well tolerated.

Given the growing attention to glucagon-like peptide-1 receptor agonists (GLP-1 RAs) in obesity and eating disorders, we considered it important to address this emerging topic in these guidelines despite the limitations of the current evidence. Preliminary studies suggest that GLP-1 RAs, including liraglutide, semaglutide, and dulaglutide, may reduce binge-eating symptoms and promote weight loss in individuals with binge-eating disorder (BED), particularly those with comorbid obesity or metabolic conditions(64). However, the evidence remains limited by small samples, heterogeneous designs, short follow-up periods, and inconsistent assessment of eating-disorder and psychiatric outcomes. Therefore, GLP-1 RAs should not yet be considered established first-line treatments for BED. Their use in selected patients with BED and significant obesity or metabolic comorbidities may be considered as part of a comprehensive, multidisciplinary treatment plan, with careful screening and monitoring for eating-disorder symptoms. Larger, well-designed randomized controlled trials are needed to establish their efficacy, safety, and appropriate role in the treatment of BED(65).”

Lisdexamfetamine should be considered the first-line pharmacological treatment for BED when medication is indicated (LOE=1). Topiramate may be considered as an off-label option in selected patients, particularly those with elevated BMI or inadequate response to first-line therapy (LOE=1). Other agents should be used cautiously and on an individual basis, always in combination with evidence-based psychotherapy (LOE=1) (Supplementary Material 3).

DISCUSSION

This clinical practice guideline offers actionable recommendations for treating EDs, including AN, BN, and BED. These recommendations are grounded in high-quality evidence from systematic reviews and randomized controlled trials, alongside consensus from Brazilian experts in the field. The document adheres to both

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international and national health guidelines for recommendation development, such as AGREE II(15) and the CONITEC(16) Manuals, while also considering its relevance within the Brazilian Unified Health System (SUS)(66).

Implementation

Overall, EDs (EDs) are often neglected in healthcare, public policy, and research despite their high mortality and morbidity rates(67). There are significant gaps in treatment, with many areas lacking specialized teams and facilities, forcing patients to rely on suboptimal care. The centralization of services in urban areas creates additional barriers to accessing intensive therapy. Primary care physicians and mental health practitioners express low confidence in managing EDs, compounded by a shortage of trained specialists in evidence-based therapies(68).

It is essential to recognize the specific barriers within the Brazilian mental healthcare environment. The Brazilian mental healthcare framework consists of a community-focused network that ensures universal access to mental health services (69). Despite notable progress, significant deficiencies persist in terms of coverage, funding, and quality of care(70). One such deficiency is the lack of support for individuals with EDs. Currently, there are no dedicated services within the existing mental health model to address these needs(10). Consequently, for these recommendations to be effectively implemented it is imperative that the country's mental health care system incorporates comprehensive services for EDs that provide nationwide coverage across primary, secondary, and tertiary levels. Furthermore, the insufficient training available for psychiatrists (71) and other healthcare providers regarding the management of EDs in Brazil remains a significant challenge that must be addressed.

The publication of this guideline serves as a catalytic factor. It represents a crucial advancement toward establishing a standardized treatment approach for patients, addressing the notable disparities in treatment methods across Brazil(11)(10). Furthermore, it provides a valuable resource for training psychiatrists and other healthcare professionals in the management of EDs. Ultimately, this guideline could also inform the development of public policies tailored to meet the specific needs of individuals facing these disorders.

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Dissemination strategies include the following actions

a) Inform members of the Brazilian Association of Psychiatry about the guideline's publication;

b) Provide links to both English and Portuguese versions on the association's website;

c) Present the guideline at scientific events, such as national such as international conferences, clinical meetings, study days, and forums;

d) Incorporate fictionalized case studies to enrich the guideline's clinical context;

e) Partner with other professional organizations to support its promotion;

f) Release updates as peer-reviewed structured guidance statements when new relevant data regarding the clinical management of EDs arise.

Limitations

This guideline does not cover every relevant topic related to the management of EDs, such as prevention, screening, assessment. Additionally, we acknowledge that other categories and presentations of EDs, including avoidant restrictive feeding and eating disorders (ARFID), pica and rumination disorder, were not addressed in this document. These areas were determined to be outside the current scope due to time constraints. Consequently, we propose that they be considered for inclusion in future updates. In the interim, we recommend referring to existing guidelines for recommendations regarding these topics(13)(72). Finally, although the GDG was structured to consider the diverse needs and perspectives of individuals affected by eating disorders, some populations—including individuals with severe and enduring eating disorders, LGBTQIA+ individuals, and athletes—were not specifically represented in the development process. These groups may present distinct clinical characteristics, risk factors, treatment needs, and barriers to accessing appropriate care. However, the available evidence remains limited and heterogeneous, with relatively few studies specifically designed to evaluate treatment approaches and outcomes in these populations, making it difficult to formulate specific evidence-based recommendations. Future research should prioritize these underrepresented groups to strengthen the evidence base and support the development of more tailored and inclusive clinical recommendations.

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Gaps in knowledge

During the preparation of this guideline, several gaps in knowledge emerged regarding the multidisciplinary treatment of EDs as previously described in the literature (73,74). A major challenge lies in the significant variability across healthcare systems internationally, which affects access to care, treatment settings, hospital capacity, and the and the availability of specialized teams. This heterogeneity complicates comparisons of research findings on treatment effectiveness. Evidence supporting nutritional treatments is limited by a lack of standardized protocols, paucity of high-quality trials, a predominant focus on short-term outcomes, and insufficient research specifically addressing BN and BED. Additionally, the integration of nutritional and psychological care remains underexplored, with many interventions focusing on weight restoration without adequately addressing underlying disordered eating behaviors.

Psychological treatment research is comparatively more advanced for BN and BED than for AN but still faces significant limitations. These include small sample sizes, brief follow-up periods, limited participant diversity, and underrepresentation of males, adolescents, and ethnic minorities. Studies often rely heavily on self-report measures, overlook comorbid conditions, and inconsistently document therapist training. Evidence for pharmacological treatment is particularly limited for AN, with few effective medications available; existing studies tend to have small samples, lack placebo controls, and concentrate on short-term symptoms rather than long-term recovery. Overall, there is a clear need for rigorous, long-term, and comprehensive research that addresses these gaps and promotes the integration of nutritional, psychological, and pharmacological interventions tailored to the diverse needs of individuals with EDs.

External review

Relevant stakeholders, identified by the steering committee, provided insights in February/March 2026 regarding the clarity and clinical applicability of the recommendations (see Acknowledgments Section). The working group reviewed and assessed this feedback, integrating appropriate suggestions into the guidelines where necessary.

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Sponsorship and Editorial Independence

The development of these guidelines was sponsored by the Brazilian Association of Psychiatry, and it did not receive any external funding or commercial support. The group maintained full editorial independence, ensuring that the final recommendations were not influenced by the sponsoring organization.

Other guidelines

Several guidelines on the management of EDs have been published in recent years(13)(12)(75). Overall, our recommendations are consistent with these existing documents. A notable distinction is that our guideline includes recommendations specifically aligned with the healthcare practices for EDs in our country. Additionally, the evidence and frameworks from these international guidelines informed the expert meetings, ensuring that our recommendations were harmonized with global standards.

Although international guidelines for eating disorders are available, national guidelines may improve the applicability of evidence-based recommendations to specific healthcare contexts. This guideline was based on an independent, updated literature review and expert consensus. Its consistency with international recommendations reflects convergence of the available evidence, while considering the Brazilian healthcare context and barriers to implementation.

Table 1. Summary of Recommendations for the Treatment of Anorexia Nervosa

Treatment domain	Recommendation	LOE	Refs
Level of care	Treatment should be provided in the least restrictive setting that ensures medical and psychological safety, with outpatient or day programs prioritized whenever clinically appropriate. The level of care should be individualized according to medical instability, suicide risk, severity of malnutrition, and available social support.	1	(18)
First-line interventions	**Psychotherapy:** Structured, individualized psychotherapy delivered by eating-disorder specialists should be considered a first-line treatment. CBT-E, MANTRA, SSCM, and FPT have comparable efficacy for improving BMI and eating-disorder psychopathology. Family-based therapy is recommended for improving remission of eating symptoms.	1	(7,10-11, 19,25)

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Treatment domain	Recommendation	LOE	Refs
	Nutritional rehabilitation: Higher-calorie refeeding under appropriate medical supervision is recommended, including in severe malnutrition. Refeeding may start at 1200–1600 kcal/day and advance to 2000–3000 kcal/day, aiming for a weight gain of 0.5–1 kg/week in outpatient settings and 1–1.5 kg/week in inpatient settings. Electrolytes should be routinely monitored and corrected during refeeding.	1	(10,19-24)
Second-line or adjunctive interventions	Oral feeding should be preferred whenever possible. Enteral nutrition may be used when oral intake is insufficient or nutritional risk is high. Dietitian-led nutritional therapy should address food fears and maladaptive beliefs and should be integrated with psychological treatment, including CBT-ED or FBT, when appropriate.	1-2	(19-24, 28)
Pharmacological treatment	Pharmacological treatment should **not** be used as monotherapy for anorexia nervosa. Antidepressants are not recommended for weight restoration or improvement of core eating-disorder psychopathology. Olanzapine may be considered as an adjunctive treatment in selected severe cases because of its small effect on weight gain, with appropriate metabolic monitoring.	1	(29-31,33)

Note: LOE = Oxford 2011 Levels of Evidence; CBT-E= Enhanced Cognitive Behavior Therapy; CBT-ED= Cognitive Behavior Therapy for Eating Disorders; MANTRA= Maudsley Anorexia Nervosa Treatment for Adults; SSCM= Specialist Supportive Clinical Management; FPT= Focal Psychodynamic Therapy; BMI= Body Mass Index

Table 2. Summary of Recommendations for the Treatment of Bulimia Nervosa

Treatment domain	Recommendation	LOE	Refs
Level of care	BN should generally be treated in an outpatient setting. The level of care should be individualized according to clinical severity, medical and psychiatric comorbidities, and previous treatment response. More intensive levels of care should be considered when outpatient treatment is insufficient or when clinical severity warrants a higher level of support.	1	(18)
First-line interventions	**Psychological treatment:** Guided CBT-based self-help should be offered as a first-line intervention for mild to moderate BN within a stepped-care approach. Individual clinician-led CBT-ED should be offered as the first-line psychological treatment for severe or extreme BN.	1	(19, 34,35)
	Nutritional management: Nutritional interventions should be integrated into multidisciplinary care and coordinated with CBT-ED and psychiatric management. Structured meal plans, consisting of three meals and 2–3 snacks at regular intervals,	1-2	(27,28,38)

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Treatment domain	Recommendation	LOE	Refs
	should be implemented to reduce vulnerability to binge eating. Education should address hunger and satiety cues, the risks of dietary restriction, and dietary variety.		
Second-line or adjunctive interventions	Individual clinician-led CBT-ED should be offered when response to guided self-help is inadequate. Alternative psychotherapies, including behavior therapy, interpersonal psychotherapy, dialectical behavior therapy, family-based treatment, psychodynamic therapy, or general individual psychotherapy, may be considered when CBT-ED is unavailable or unsuitable.	1-2	((34,35)
	Gradual, supported exposure to feared foods may be used to reduce binge-eating and purging behaviors. Electrolyte disturbances, particularly potassium and magnesium abnormalities, should be routinely monitored and corrected when present.		(19,25,35)
Pharmacological treatment	Pharmacotherapy should be used as an adjunct to psychological treatment and not as monotherapy. Fluoxetine 60 mg/day is recommended as the first-line pharmacological treatment for BN because it improves binge–purge remission and depressive symptoms and is generally well tolerated. Topiramate may be considered in selected cases, with monitoring for cognitive and neurological adverse effects. Ondansetron should be reserved for exceptional, refractory cases. Other SSRIs have limited evidence and are not formally recommended. Bupropion should not be prescribed because of the increased risk of seizures.	1-3	(31, 36-38, 40.41)

Note: **LOE** = Oxford 2011 Levels of Evidence; **CBT**= Cognitive Behavior Therapy; **CBT-E**= Enhanced Cognitive Behavior Therapy

Table 3. Summary of Recommendations for the Treatment of Binge-Eating Disorder

Treatment domain	Recommendation	LOE	Refs.
Level of care	Most patients with BED can be managed in an outpatient setting. The level of care should be individualized according to clinical severity, psychiatric and medical comorbidities, and response to previous treatment. A higher level of care should be considered only in cases of severe symptoms, significant comorbidity, or failure of outpatient treatment.	1-3	(18)
First-line interventions	**Psychological treatment:** Clinician-led CBT should be offered as the first-line treatment for moderate to severe BED. Guided self-help CBT may be used within a stepped-care approach when access to or adherence with clinician-led CBT is limited.	1	(45-47)
	Nutritional management: Nutritional interventions should be integrated with evidence-based psychotherapy, particularly CBT. Structured meal plans, consisting of three meals and 2–	1	(10, 19, 42, 43)

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Treatment domain	Recommendation	LOE	Refs.
	3 snacks, should be implemented to reduce fasting and vulnerability to binge eating. Interventions should promote recognition of hunger and satiety cues and reduce cognitive restraint.		
Second-line or adjunctive interventions	IPT or DBT may be considered when CBT is unavailable or ineffective. Third-wave therapies, including ACT, mindfulness-based interventions, metacognitive therapy, and compassion-focused therapy, may be used for patients with emotional dysregulation or rumination. Food monitoring, mindful eating, and gradual exposure to trigger foods may support remission. Psychotherapy may be combined with lifestyle and weight-management strategies when obesity is present.	1	(27, 45, 48, 49)
Pharmacological treatment	Pharmacotherapy should be used only as part of a multimodal treatment approach. Lisdexamfetamine is recommended as the first-line pharmacological treatment when medication is indicated, as it reduces binge-eating frequency and increases remission, with small effects on weight loss. Topiramate may be considered off-label in selected cases, particularly in patients with elevated BMI or inadequate response to first-line therapy. SSRIs may reduce binge-eating frequency and depressive symptoms but do not produce meaningful weight loss. Naltrexone–bupropion should be used during the maintenance phase of therapy.	1	(31, 51-54)

Note: LOE = Oxford 2011 Levels of Evidence; CBT= Cognitive Behavior Therapy; IPT= Interpersonal Psychotherapy; DBT= Dialectic Behavior Therapy

CONCLUSION

This guideline represents significant progress in the treatment of EDs in Brazil, providing a systematic framework for adoption by healthcare professionals. It encompasses recommendations for a comprehensive management strategy addressing critical domains, such as treatment settings and nutritional, psychological, and pharmacological interventions. Furthermore, this document is intended to unify clinical treatment practices and support the development of public policies tailored to EDs in Brazil.

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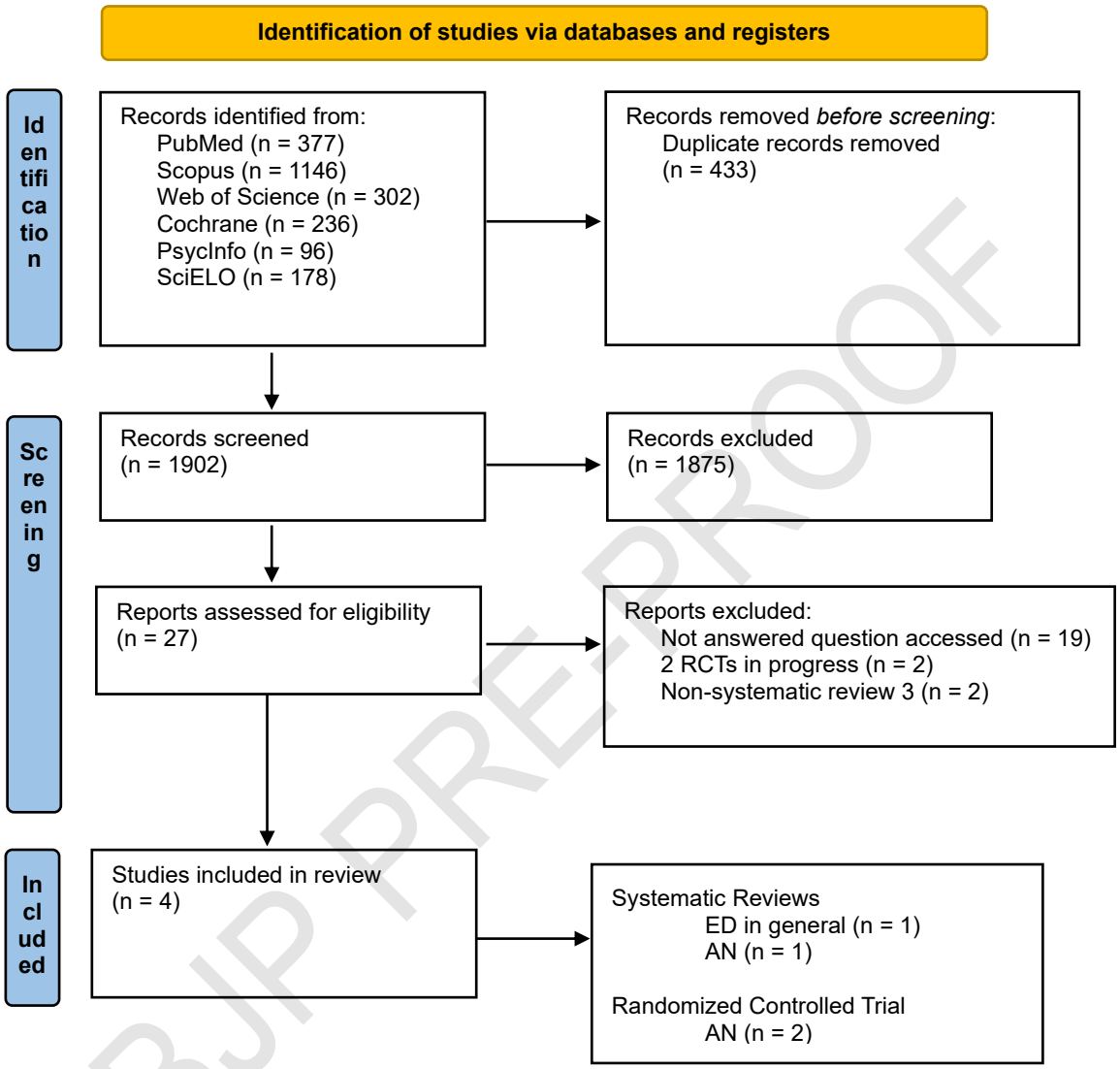
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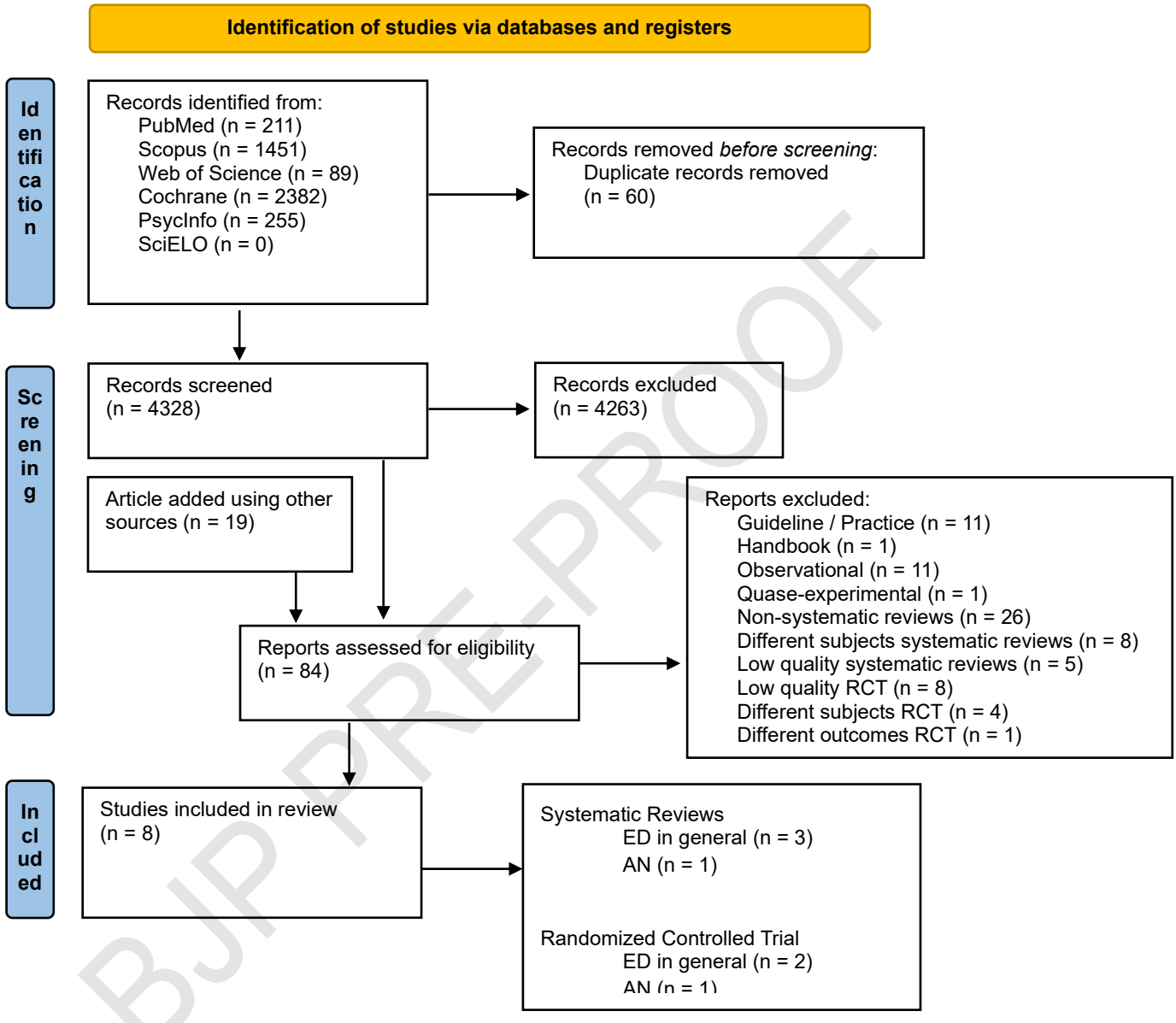
Supplementary Material 1. PRISMA Flow Diagrams

1) PRISMA flow diagram of the study selection process for treatment settings in the treatment of AN, BN and BED.



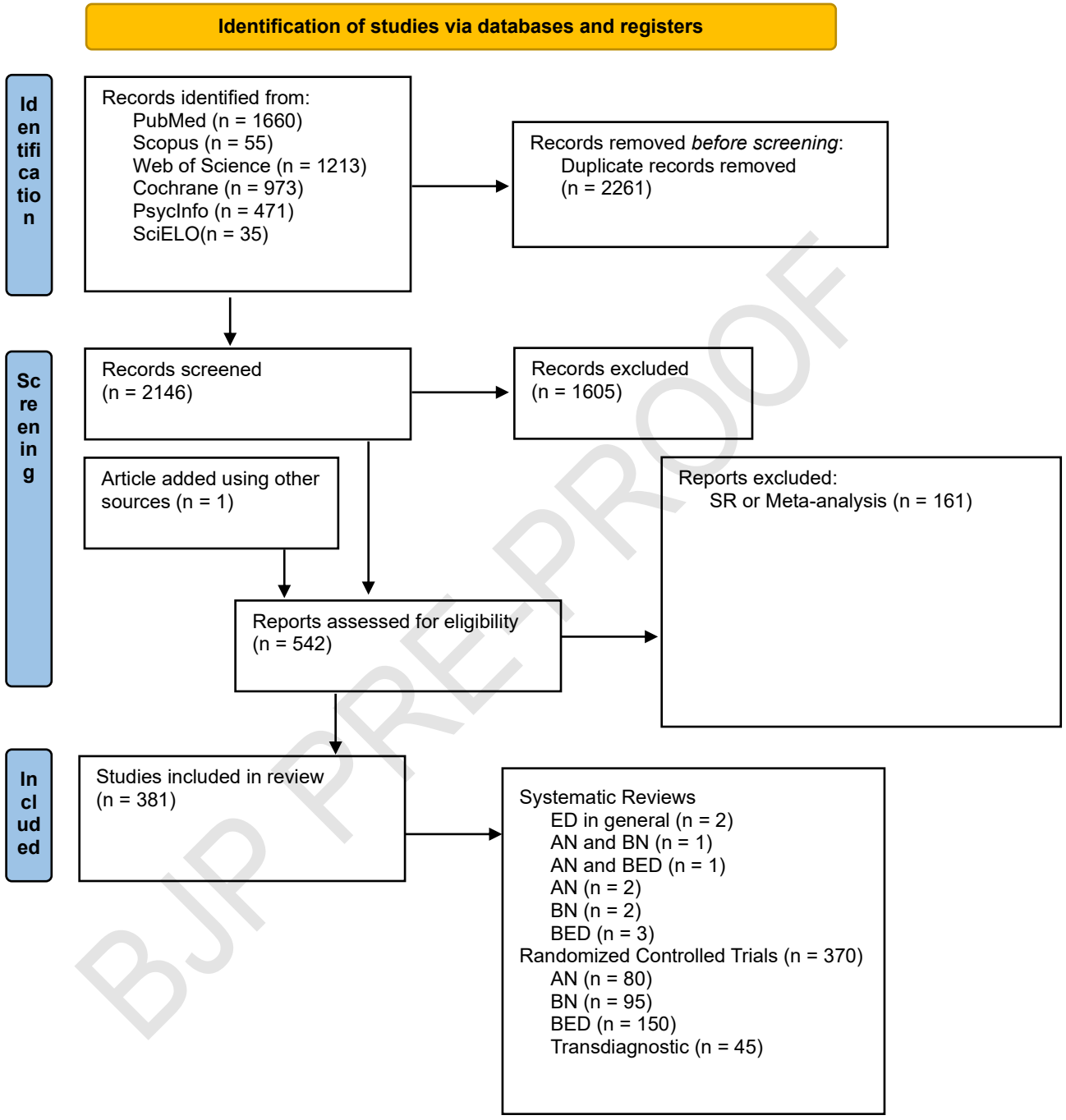
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2) PRISMA flow diagram of the study selection process for nutritional treatment of AN, BN and BED.



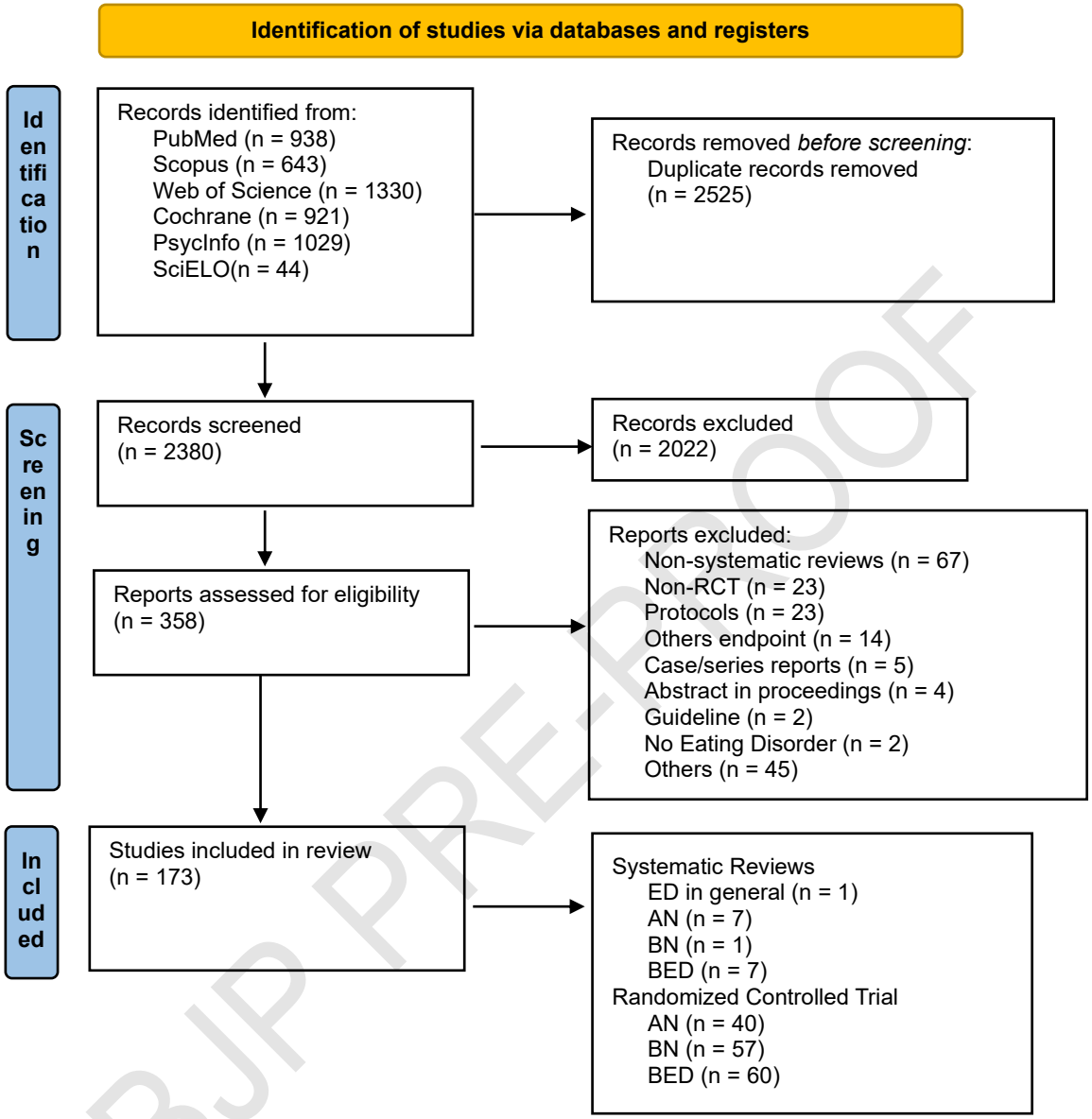
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3) PRISMA flow diagram of the study selection process for psychological treatment of AN, BN and BED



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4) PRISMA flow diagram of the study selection process for pharmacological treatment of AN, BN and BED



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Supplementary Material 2. Search terms

1) Search terms of the study selection process for settings in the treatment of AN, BN and BED

PubMed:
((feeding and eating disorders[MeSH Terms]) OR (eating disorders[Title/Abstract])) OR (feeding disorder*[Title/Abstract])) OR (Disorder*, Eating[Title/Abstract])) OR (anorexia nervosa[Title/Abstract])) OR (anorexia nervosa[MeSH Terms])) OR (avoidant restrictive food intake disorder[MeSH Terms])) OR (avoidant restrictive food intake disorder[Title/Abstract])) OR (ARFID[Title/Abstract])) OR (binge eating disorder[MeSH Terms])) OR (binge eating disorder[Title/Abstract])) OR (bulimia nervosa[MeSH Terms])) OR (bulimia nervosa[Title/Abstract])) OR (bulimia[Title/Abstract])
AND Hospitalization [mh] OR Day Care, Medical [mh] OR Involuntary Treatment [mh] OR Critical Care [mh] OR Inpatients [mh] OR Primary Health Care [mh] OR Secondary Care [mh] OR Ambulatory Care [mh] OR Residential treatment [mh] OR Emergency treatment [mh] OR Outpatient Clinics, Hospital [mh] OR Day Care [tiab] OR Partial Hospitalization [tiab] OR Critical Care [tiab] OR Intensive Care [tiab] OR Inpatient* [tiab] OR Ambulatory Care [tiab]
Filters applied: clinical trials or systematic review or meta-analysis

Web of Science
TS=("Feeding and Eating Disorders" OR "Feeding Disorder*" OR "Eating Disorder*" OR "Anorexia Nervosa" OR "Avoidant Restrictive Food Intake Disorder" OR "Food Neophobia*" OR "ARFID" OR "Binge-Eating Disorder*" OR "Bulimia Nervosa" OR "Bulimia")
AND TS=(“Hospitalization” OR “Day Care” OR “Involuntary Treatment” OR “Critical Care” OR “Inpatient*” OR “Primary Health Care” OR “Secondary Care” OR “Ambulatory Care” OR “Residential treatment” OR “Emergency treatment” OR “Outpatient*” OR “Partial Hospitalization” OR “Intensive Care”)
AND TS=("Meta-Analysis" OR "Systematic Review" OR "Clinical Trial")

Cochrane
#1 MeSH descriptor: [Feeding and Eating Disorders] explode all trees
#2 Avoidant Restrictive Food Intake Disorder
#3 MeSH descriptor: [Anorexia Nervosa] explode all trees
#4 MeSH descriptor: [Binge-Eating Disorder] explode all trees
#5 MeSH descriptor: [Bulimia Nervosa] explode all trees
#6 MeSH descriptor: [Hospitalization] in all MeSH products
#7 MeSH descriptor: [Day Care, Medical] explode all trees
#8 MeSH descriptor: [Involuntary Treatment] explode all trees
#9 MeSH descriptor: [Critical Care] explode all trees
#10 MeSH descriptor: [Inpatients] explode all trees
#11 MeSH descriptor: [Outpatients] explode all trees

BJP PRE-PROOF

#12 MeSH descriptor: [Primary Health Care] explode all trees
#13 MeSH descriptor: [Secondary Care] explode all trees
#14 MeSH descriptor: [Ambulatory Care] explode all trees
#15 MeSH descriptor: [Residential treatment] explode all trees
#16 MeSH descriptor: [Emergency treatment] explode all trees
#17 “Partial Hospitalization”
#18 (Intensive care):ti,ab,kw
#19 #1 OR #2 OR #3 OR #4 OR #5
#20 #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18
#21 #19 AND #20

PsycINFO
"Feeding and Eating Disorders" OR "Feeding Disorder" OR "Eating Disorder" OR "Anorexia Nervosa" OR "Avoidant Restrictive Food Intake Disorder" OR ARFID OR "Binge-Eating Disorder" OR "Bulimia Nervosa" OR Bulimia
in any field
AND “Hospitalization” OR “Day Care” OR “Involuntary Treatment” OR “Critical Care” OR “Inpatients” OR “Primary Health Care” OR “Secondary Care” OR “Ambulatory Care” OR “Residential treatment” OR “Emergency treatment” OR “Outpatients” OR “Partial Hospitalization” OR “Intensive Care”
in any field
filters: Methodology: Clinical Trial OR Systematic Review OR Meta Analysis

Scopus
(Feeding and Eating Disorders) OR (Feeding Disorder) OR (Disorder*, Eating) OR (Eating Disorder) OR (Eating Disorders) OR (Binge Eating Disorder) OR (Anorexia Nervosa) OR (Avoidant Restrictive Food Intake Disorder) OR (ARFID) OR (Bulimia) OR (Bulimia Nervosa) OR (Feeding Disorders)
AND (hospitalization) OR (Day Care) OR (Involuntary Treatment) OR (Critical Care) OR (Primary Health Care) OR (Secondary Care) OR (Ambulatory Care) OR (Residential treatment) OR (Emergency treatment) OR (Outpatient*) OR (Day Care) OR (Partial Hospitalization) OR (Critical Care) OR (Intensive Care) OR (Inpatient*) OR (Ambulatory Care)
AND (systematic review*) OR (meta-analysis) OR (trial*)

SciELO
((Feeding and Eating Disorders) OR (Feeding Disorder) OR (Disorder*, Eating) OR (Eating Disorder) OR (Eating Disorders) OR (Binge Eating Disorder) OR (Anorexia Nervosa) OR (Avoidant Restrictive Food Intake Disorder) OR (ARFID) OR (Bulimia) OR (Bulimia Nervosa) OR (Feeding Disorders))
AND ((hospitalization) OR (Day Care) OR (Involuntary Treatment) OR (Critical Care) OR (Primary Health Care) OR (Secondary Care) OR (Ambulatory Care) OR (Residential treatment) OR (Emergency treatment) OR (Outpatient*) OR (Day Care)

BJP PRE-PROOF

OR (Partial Hospitalization) OR (Critical Care) OR (Intensive Care) OR (Inpatient*) OR (Ambulatory Care))

2) Search terms of the study selection process for nutritional treatment of AN, BN and BED

PubMed

(("Feeding and Eating Disorders"[mh] OR "Feeding and Eating Disorders" OR "Feeding Disorder"OR "Eating Disorder" OR "Disorder, Eating" OR "anorexia nervosa"[mh] OR "anorexia nervosa"* OR "Avoidant Restrictive Food Intake Disorder"[mh] OR "Avoidant Restrictive Food Intake Disorder" OR ARFID OR "Binge Eating Disorder"[mh] OR "Binge Eating Disorder" OR "Bulimia Nervosa"[mh] OR "Bulimia Nervosa" OR Bulimia) AND ("diet therapy"[mh] or "nutrition therapy"[mh] or "nutritional requirements"[mh] or "dietary supplement"[mh] or "feeding behavior"[mh] or "nutritional support"[mh] or "eating behavior" or "nutritional and behavioral management" or "behavioural weight loss therapy" or "nutrition counseling" or "diet therapy" or "nutrition therapy" or "nutritional requirements" or "dietary supplement" or "feeding behavior" or "nutritional and behavioral management" or "nutritional support" or "behavioural weight loss therapy" or "nutrition counseling" or "nutritional rehabilitation") AND (“systematic reviews” or “meta-analysis” or “clinical trials”))

Web of Science

TI=((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”)) OR AK=((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”)) OR TS=((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR

BJP PRE-PROOF

“nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”))

Cochrane
((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”)) in Title Abstract Keyword

PsycINFO
Any Field: (“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND Any Field: (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND Any Field: (“systematic reviews” or “meta-analysis” or “clinical trials”)

Scopus
TITLE-ABS-KEY ((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”))

SciELO
TI=((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or

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“meta-analysis” or “clinical trials”)) OR AK=((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”)) OR TS=((“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia) AND (“diet therapy” OR “nutrition therapy” OR “nutritional requirements” OR “dietary supplement*” OR “feeding behavior” OR “nutritional support” OR “eating behavior” OR “nutritional and behavioral management” OR “behavioural weight loss therapy” OR “nutrition counseling” OR “nutritional rehabilitation”) AND (“systematic reviews” or “meta-analysis” or “clinical trials”))

3) Search terms of the study selection process for psychological treatment of AN, BN and BED

PubMed

((Feeding and Eating Disorders [mh] OR Feeding and Eating Disorders [tiab] OR Feeding Disorder* [tiab] OR Eating Disorder*[tiab] OR Disorder*, Eating [tiab] OR anorexia nervosa [mh] OR anorexia nervosa* [tiab] OR Avoidant Restrictive Food Intake Disorder [mh] OR Avoidant Restrictive Food Intake Disorder [tiab] OR ARFID [tiab] OR Binge-Eating Disorder [mh] OR Binge-Eating Disorder* [tiab] OR Bulimia Nervosa [mh] OR Bulimia Nervosa [tiab] OR Bulimia [tiab])) AND ((Psychotherapy [mh] or Psychotherap* [tiab] or Therapy [tiab] or Cognitive Behavior Therapy [tiab] or Cognitive Behavioral Therapy [mh] or Cognitive Behavioral Therapy [tiab] or Cognitive Therapy [tiab] or Dialectical Behavior Therapy [mh] or Dialectical Behavior Therapy [tiab] or Interpersonal Psychotherapy [mh] or Interpersonal Psychotherapy [tiab] or Psychoanalytic Therapy [mh] or Psychoanalytic Therapy [tiab] or Mindfulness [mh] or Mindfulness [tiab] or Acceptance and Commitment Therapy [mh] or Acceptance and Commitment Therapy [tiab] or Family Based Treatment [tiab] or Family Therapy [mh] or Family Therapy [tiab] or Psychodynamic therapies [tiab] or Self-help [tiab] or Internet-based [tiab])) Filters: Clinical Trial, Meta-Analysis, Systematic Review

Web of Science

#1 TS= (“Feeding and Eating Disorders” OR Feeding Disorder* OR Eating Disorder* OR Disorder*, Eating OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake

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Disorder” OR ARFID OR “Binge-Eating Disorder” OR Binge-Eating Disorder* OR “Bulimia Nervosa” OR Bulimia)
#2 TS= (Psychotherapy or Psychotherap* or Therapy or “Cognitive Behavior Therapy” or “Cognitive Behavioral Therapy” or “Cognitive Therapy” or “Dialectical Behavior Therapy” or “Interpersonal Psychotherapy” or “Psychoanalytic Therapy” or Mindfulness or “Acceptance and Commitment Therapy” or “Family Based Treatment” or “Family Therapy” or “Psychodynamic therapies” or Self-help or Internet-based)
#3 TS= (“Clinical Trial” or “Meta-Analysis” or “Systematic Review”)
Final: #1 And #2 And #3

Cochrane
#1 Feeding and Eating Disorders
#2 (Feeding Disorder*):ti,ab,kw
#3(Eating Disorder*):ti,ab,kw
#4 anorexia nervosa
#5 Avoidant Restrictive Food Intake Disorder
#6 ARFID
#7 Binge-Eating Disorder
#8 Bulimia Nervosa
#9 Bulimia
#10 #1 or #2 or #3 #4 or #5 #6 or #7 or #8 or #9
#11 Psychotherapy
#12 (Psychotherap*):ti,ab,kw
#13 (Therapy):ti,ab,kw
#14 ("cognitive behavior therapy"):ti,ab,kw
#15 Cognitive Behavioral Therapy
#16 Cognitive Therapy
#17 Dialectical Behavior Therapy
#18 Interpersonal Psychotherapy
#19 Psychoanalytic Therapy
#20 Mindfulness
#21 Acceptance and Commitment Therapy
#22 (Family Based Treatment):ti,ab,kw
#23 (Family Therapy):ti,ab,kw
#24 (Psychodynamic therapies):ti,ab,kw
#25 (Self-help):ti,ab,kw
#26 (Internet-based):ti,ab,kw
#27 #11 or #12 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26
#28 #10 AND #27
#29 clinical trials
#30 systematic review
#31 meta-analysis
#32 #29 or #30 or #31
#33 #28 AND #32
#34 children and adolescent
#35 #33 NOT #34
#36 Feeding and Eating Disorders

BJP PRE-PROOF

#37 (Feeding Disorder*):ti,ab,kw
#38 (Eating Disorder*):ti,ab,kw
#39 anorexia nervosa
#40 Avoidant Restrictive Food Intake Disorder
#41 ARFID
#42 Binge-Eating Disorder
#43 Bulimia Nervosa
#44 Bulimia
#45 #36 or #37 or #38 #39 or #40 #41 or #42 or #43 or #44
#46 Psychotherapy
#47 (Psychotherap*):ti,ab,kw
#48 (Therapy):ti,ab,kw
#49 ("cognitive behavior therapy"):ti,ab,kw
#50 Cognitive Behavioral Therapy;
#51 Cognitive Therapy
#52 Dialectical Behavior Therapy
#53 Interpersonal Psychotherapy
#54 Psychoanalytic Therapy;
#55 Mindfulness
#56 Acceptance and Commitment Therapy
#57 (Family Based Treatment):ti,ab,kw
#58 (Family Therapy):ti,ab,kw
#59 (Psychodynamic therapies):ti,ab,kw
#60 (Self-help):ti,ab,kw
#61 (Internet-based):ti,ab,kw
#62 #46 or #47 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61
#63 #45 AND #62
#64 clinical trials
#65 systematic review
#66 meta-analysis
#67 #64 or #65 or #66
#68 #63 AND #67
#69 children
#70 adolescent
#71 #69 or #70
#72 #68 NOT #71

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PsycINFO

Any Field: Feeding Disorder OR Any Field: Eating Disorder OR Any Field: anorexia nervosa OR Any Field: Avoidant Restrictive Food Intake Disorder OR Any Field: ARFID OR Any Field: Binge-Eating Disorder OR Any Field: Bulimia AND Any Field: Psychotherapy OR Any Field: Therapy OR Any Field: Cognitive Behavior Therapy OR Any Field: Cognitive Behavioral Therapy OR Any Field: Cognitive Therapy OR Any Field: Dialectical Behavior Therapy OR Any Field: Interpersonal Psychotherapy OR Any Field: Psychoanalytic Therapy OR Any Field: Mindfulness OR Any Field: Acceptance AND Any Field: Commitment Therapy OR Any Field: Family Based Treatment OR Any Field: Family Therapy OR Any Field: Psychodynamic therapies

OR Any Field: Self-help OR Any Field: Internet-based AND Publication Type: Peer Reviewed Journal AND Methodology: Clinical Trial AND Age Group: Adulthood (18 yrs & older)

Scopus
(TITLE-ABS-KEY (("feeding AND eating AND disorders" OR "feeding AND disorder" OR "eating AND disorder" OR "eating AND disorders" OR "anorexia AND nervosa" OR "avoidant AND restrictive AND food AND intake AND disorder" OR "arfid" OR "binge-eating AND disorder" OR "binge AND eating AND disorder" OR "bulimia AND nervosa" OR “bulimia”)) AND TITLE-ABS-KEY (("psychotherapy" OR "psychotherap*" OR "therapy" AND "cognitive AND behavioral AND therapy" OR "cognitive AND behavior AND therapy" OR "cognitive AND therapy" OR "dialectical AND behavior AND therapy" OR "interpersonal AND psychotherapy" OR "interpersonal AND therapy" OR "psychoanalytic AND therapy" OR "mindfulness" OR "acceptance AND commitment AND therapy" OR "family AND based AND treatment" OR "family AND therapy" OR "psychodynamic AND therapies" OR "self-help" OR "internet-base")) AND TITLE-ABS-KEY ((“clinical AND trial” OR “meta-analysis” OR “systematic AND review”))) AND (LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "ar"))

SciELO
#1 TS= (“Feeding and Eating Disorders” OR Feeding Disorder* OR Eating Disorder* OR Disorder*, Eating OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder” OR Binge-Eating Disorder* OR “Bulimia Nervosa” OR Bulimia)
#2 TS= (Psychotherapy or Psychotherap* or Therapy or “Cognitive Behavior Therapy” or “Cognitive Behavioral Therapy” or “Cognitive Therapy” or “Dialectical Behavior Therapy” or “Interpersonal Psychotherapy” or “Psychoanalytic Therapy” or Mindfulness or “Acceptance and Commitment Therapy” or “Family Based Treatment” or “Family Therapy” or “Psychodynamic therapies” or Self-help or Internet-based)
#3 TS= (“Clinical Trial” or “Meta-Analysis” or “Systematic Review”)
Final: #1 And #2 And #3

4) Search terms of the study selection process for pharmacological treatment of AN, BN and BED

PubMed
("medication therapy management"[MeSH Terms] OR "drug therapy"[MeSH Terms] OR "pharmacologic*"[MeSH Terms] OR "drug therapy"[MeSH Terms] OR "pharmacotherap*"[All Fields] OR "antidepress*"[All Fields] OR ("monoamine oxidase inhibitors"[Pharmacological Action] OR "monoamine oxidase inhibitors"[MeSH Terms] OR ("monoamine"[All Fields] AND "oxidase"[All Fields] AND "inhibitors"[All Fields]) OR "monoamine oxidase inhibitors"[All Fields] OR ("monoamine"[All Fields] AND

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"oxidase"[All Fields] AND "inhibitor"[All Fields]) OR "monoamine oxidase inhibitor"[All Fields]) OR "serotonin and noradrenaline reuptake inhibitor*"[All Fields] OR ("dopamine uptake inhibitors"[Pharmacological Action] OR "dopamine uptake inhibitors"[MeSH Terms] OR ("dopamine"[All Fields] AND "uptake"[All Fields] AND "inhibitors"[All Fields]) OR "dopamine uptake inhibitors"[All Fields] OR ("dopamine"[All Fields] AND "reuptake"[All Fields] AND "inhibitor"[All Fields]) OR "dopamine reuptake inhibitor"[All Fields]) OR (("dopamin"[All Fields] OR "dopamine"[MeSH Terms] OR "dopamine"[All Fields] OR "dopamine s"[All Fields] OR "dopamines"[All Fields]) AND "agent*"[All Fields]) OR ("dopamin"[All Fields] OR "dopamine"[MeSH Terms] OR "dopamine"[All Fields] OR "dopamine s"[All Fields] OR "dopamines"[All Fields]) OR ("antidepressive agents tricyclic"[Pharmacological Action] OR "antidepressive agents, tricyclic"[MeSH Terms] OR ("antidepressive"[All Fields] AND "agents"[All Fields] AND "tricyclic"[All Fields]) OR "tricyclic antidepressive agents"[All Fields] OR "tricyclics"[All Fields] OR "tricycle"[All Fields] OR "tricycles"[All Fields] OR "tricyclic"[All Fields]) OR ("antipsychotic agents"[Pharmacological Action] OR "antipsychotic agents"[MeSH Terms] OR ("antipsychotic"[All Fields] AND "agents"[All Fields]) OR "antipsychotic agents"[All Fields] OR "antipsychotic"[All Fields] OR "antipsychotics"[All Fields] OR "antipsychotic s"[All Fields] OR "antipsychotically"[All Fields]) OR ("antipsychotic agents"[Pharmacological Action] OR "antipsychotic agents"[MeSH Terms] OR ("antipsychotic"[All Fields] AND "agents"[All Fields]) OR "antipsychotic agents"[All Fields] OR "neuroleptic"[All Fields] OR "neuroleptics"[All Fields] OR "neuroleptical"[All Fields] OR "neuroleptically"[All Fields] OR "neuroleptization"[All Fields]) OR ("orexigen"[All Fields] OR "orexigenic"[All Fields] OR "orexigens"[All Fields]) OR ("anticonvulsants"[Pharmacological Action] OR "anticonvulsants"[MeSH Terms] OR "anticonvulsants"[All Fields] OR "anticonvulsant"[All Fields] OR "anticonvulsion"[All Fields] OR "anticonvulsive"[All Fields] OR "anticonvulsives"[All Fields]) OR ("anticonvulsants"[Pharmacological Action] OR "anticonvulsants"[MeSH Terms] OR "anticonvulsants"[All Fields] OR "antiepileptic"[All Fields] OR "antiepileptics"[All Fields]) OR (("affect"[MeSH Terms] OR "affect"[All Fields] OR "mood"[All Fields]) AND ("stabile"[All Fields] OR "stabiles"[All Fields] OR "stabilisation"[All Fields] OR "stabilisations"[All Fields] OR "stabilise"[All Fields] OR "stabilised"[All Fields] OR "stabiliser"[All Fields] OR "stabilisers"[All Fields] OR "stabilises"[All Fields] OR "stabilising"[All Fields] OR "stabilities"[All Fields] OR "stability"[All Fields] OR "stabilization"[All Fields] OR "stabilizations"[All Fields] OR "stabilize"[All Fields] OR "stabilized"[All Fields] OR "stabilizer"[All Fields] OR "stabilizers"[All Fields] OR "stabilizes"[All Fields] OR "stabilizing"[All Fields])) OR ("anorexigen"[All Fields] OR "anorexigenic"[All Fields] OR "anorexigenics"[All Fields] OR "anorexigens"[All Fields]) OR ("psychostimulant"[All Fields] OR "psychostimulants"[All Fields] OR "psychostimulating"[All Fields] OR "psychostimulation"[All Fields] OR "psychostimulator"[All Fields] OR "psychostimulators"[All Fields]) OR ("central nervous system stimulants"[Pharmacological Action] OR "central nervous system stimulants"[MeSH

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Terms] OR ("central"[All Fields] AND "nervous"[All Fields] AND "system"[All Fields] AND "stimulants"[All Fields]) OR "central nervous system stimulants"[All Fields] OR "stimulant"[All Fields] OR "stimulants"[All Fields]) OR (("attention deficit disorder with hyperactivity"[MeSH Terms] OR ("attention"[All Fields] AND "deficit"[All Fields] AND "disorder"[All Fields] AND "hyperactivity"[All Fields]) OR "attention deficit disorder with hyperactivity"[All Fields] OR "adhd"[All Fields]) AND "agent*"[All Fields]) OR "anti-abuse"[All Fields] OR (("antiobese"[All Fields] OR "antiobesity"[All Fields]) AND "agent*"[All Fields]) OR ("anti obesity agents"[Pharmacological Action] OR "anti obesity agents"[MeSH Terms] OR ("anti obesity"[All Fields] AND "agents"[All Fields]) OR "anti obesity agents"[All Fields] OR ("antiobesity"[All Fields] AND "drug"[All Fields]) OR "antiobesity drug"[All Fields]) OR (("serotonin"[MeSH Terms] OR "serotonin"[All Fields] OR "5 ht"[All Fields]) AND "agent*"[All Fields]) OR (("serotonin"[MeSH Terms] OR "serotonin"[All Fields] OR "5 ht"[All Fields]) AND "drug*"[All Fields]) OR (("glucagon like peptide 1 receptor"[MeSH Terms] OR ("glucagon like"[All Fields] AND "peptide 1"[All Fields] AND "receptor"[All Fields]) OR "glucagon like peptide 1 receptor"[All Fields] OR "glp 1 receptor"[All Fields]) AND ("agonist"[All Fields] OR "agonist s"[All Fields] OR "agonistic"[All Fields] OR "agonistically"[All Fields] OR "agonistics"[All Fields] OR "agonists"[MeSH Subheading] OR "agonists"[All Fields]))) AND ("feeding and eating disorders"[MeSH Terms] OR "eating disorders"[Title/Abstract] OR "feeding disorder*"[Title/Abstract] OR ("disorder*"[All Fields] AND "Eating"[Title/Abstract]) OR "anorexia nervosa"[Title/Abstract] OR "anorexia nervosa"[MeSH Terms] OR "avoidant restrictive food intake disorder"[MeSH Terms] OR "avoidant restrictive food intake disorder"[Title/Abstract] OR "ARFID"[Title/Abstract] OR "binge eating disorder"[MeSH Terms] OR "binge eating disorder"[Title/Abstract] OR "bulimia nervosa"[MeSH Terms] OR "bulimia nervosa"[Title/Abstract] OR "bulimia"[Title/Abstract])

Web of Science

#1 ALL=((Feeding and Eating Disorders) OR (Feeding Disorder) OR (Disorder*, Eating) OR (Eating Disorder) OR (Eating Disorders) OR (Binge Eating Disorder) OR (Anorexia Nervosa) OR (Avoidant Restrictive Food Intake Disorder) OR (ARFID) OR (Bulimia) OR (Bulimia Nervosa) OR (Feeding Disorders)) AND ALL=((Medication Therapy Management) OR (Drug Therapy) OR (pharmacologic*) OR (pharmacotherapy) OR (antidepress*) OR (Monoamine Oxidase Inhibitor*) OR (Selective Serotonin Reuptake Inhibitor*) OR (Serotonin and Noradrenaline Reuptake Inhibitor*) OR (Dopamine Uptake Inhibitor*) OR (Dopamine Agent*) OR (Dopamine) OR (Tricyclic*) OR (antipsychotic*) OR (neuroleptic) OR (orexigenic*) OR (anticonvulsant*) OR (antiepileptic*) OR (mood stabilizer) OR (anorexigenic*) OR (psychostimulant*) OR (stimulant*) OR (ADHD agent*) OR (anti-abuse) OR (antiobesity agent*) OR (5-HT agent*) OR (5-HT drug*) OR (GLP-1 receptor agonist*))

#2 ALL=(systematic review* OR meta-analysis OR clinical trial*)

#1 AND #2

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Cochrane
#1 (“Feeding and Eating Disorders” OR “Feeding Disorder*” OR “Eating Disorder*” OR “Disorder*, Eating” OR “anorexia nervosa” OR “Avoidant Restrictive Food Intake Disorder” OR ARFID OR “Binge-Eating Disorder*” OR “Bulimia Nervosa” OR Bulimia)
#2 (Medication Therapy Management) OR (Drug Therapy) OR (pharmacologic*) OR (pharmacotherapy) OR (antidepress*) OR (Monoamine Oxidase Inhibitor*) OR (Selective Serotonin Reuptake Inhibitor*) OR (Serotonin and Noradrenaline Reuptake Inhibitor*) OR (Dopamine Uptake Inhibitor*) OR (Dopamine Agent*) OR (Dopamine) OR (Tricyclic*) OR (antipsychotic*) OR (neuroleptic) OR (orexigenic*) OR (anticonvulsant*) OR (antiepileptic*) OR (mood stabilizer) OR (anorexigenic*) OR (psychostimulant*) OR (stimulant*) OR (ADHD agent*) OR (anti-abuse) OR (antiobesity agent*) OR (5*HT agent*) OR (5*HT drug*) OR (GLP*1 receptor agonist*)
3(systematic review*) OR (meta-analysis) OR (clinical trial*)
1 AND #2 AND #3

PsycINFO
((Feeding and Eating Disorders) OR (Feeding Disorder) OR (Disorder*, Eating) OR (Eating Disorder) OR (Eating Disorders) OR (Binge Eating Disorder) OR (Anorexia Nervosa) OR (Avoidant Restrictive Food Intake Disorder) OR (ARFID) OR (Bulimia) OR (Bulimia Nervosa) OR (Feeding Disorders)) AND ((Medication Therapy Management) OR (Drug Therapy) OR (pharmacologic*) OR (pharmacotherapy) OR (antidepress*) OR (Monoamine Oxidase Inhibitor*) OR (Selective Serotonin Reuptake Inhibitor*) OR (Serotonin and Noradrenaline Reuptake Inhibitor*) OR (Dopamine Uptake Inhibitor*) OR (Dopamine Agent*) OR (Dopamine) OR (Tricyclic*) OR (antipsychotic*) OR (neuroleptic) OR (orexigenic*) OR (anticonvulsant*) OR (antiepileptic*) OR (mood stabilizer) OR (anorexigenic*) OR (psychostimulant*) OR (stimulant*) OR (ADHD agent*) OR (anti-abuse) OR (antiobesity agent*) OR (5-HT agent*) OR (5-HT drug*) OR (GLP-1 receptor agonist*))

Scopus
(Feeding and Eating Disorders) OR (Feeding Disorder) OR (Disorder*, Eating) OR (Eating Disorder) OR (Eating Disorders) OR (Binge Eating Disorder) OR (Anorexia Nervosa) OR (Avoidant Restrictive Food Intake Disorder) OR (ARFID) OR (Bulimia) OR (Bulimia Nervosa) OR (Feeding Disorders)
AND (Medication Therapy Management) OR (Drug Therapy) OR (pharmacologic*) OR (pharmacotherapy) OR (antidepress*) OR (Monoamine Oxidase Inhibitor*) OR (Selective Serotonin Reuptake Inhibitor*) OR (Serotonin and Noradrenaline Reuptake Inhibitor*) OR (Dopamine Uptake Inhibitor*) OR (Dopamine Agent*) OR (Dopamine) OR (Tricyclic*) OR (antipsychotic*) OR (neuroleptic) OR (orexigenic*) OR (anticonvulsant*) OR (antiepileptic*) OR (mood stabilizer) OR (anorexigenic*) OR (psychostimulant*) OR (stimulant*) OR (ADHD agent*) OR (anti-abuse) OR (antiobesity agent*) OR (5-HT agent*) OR (5-HT drug*) OR (GLP-1 receptor agonist*)

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AND "systematic review*" OR "meta-analysis" OR “trial*" (in article title)

SciELO

((Feeding and Eating Disorders) OR (Feeding Disorder) OR (Disorder*, Eating) OR (Eating Disorder) OR (Eating Disorders) OR (Binge Eating Disorder) OR (Anorexia Nervosa) OR (Avoidant Restrictive Food Intake Disorder) OR (ARFID) OR (Bulimia) OR (Bulimia Nervosa) OR (Feeding Disorders)) AND ((Medication Therapy Management) OR (Drug Therapy) OR (pharmacologic*) OR (pharmacotherapy) OR (antidepress*) OR (Monoamine Oxidase Inhibitor*) OR (Selective Serotonin Reuptake Inhibitor*) OR (Serotonin and Noradrenaline Reuptake Inhibitor*) OR (Dopamine Uptake Inhibitor*) OR (Dopamine Agent*) OR (Dopamine) OR (Tricyclic*) OR (antipsychotic*) OR (neuroleptic) OR (orexigenic*) OR (anticonvulsant*) OR (antiepileptic*) OR (mood stabilizer) OR (anorexigenic*) OR (psychostimulant*) OR (stimulant*) OR (ADHD agent*) OR (anti-abuse) OR (antiobesity agent*) OR (5-HT agent*) OR (5-HT drug*) OR (GLP-1 receptor agonist*))

BJP PRE-PROOF

Table 1. Evidence of treatment settings in the treatment of anorexia nervosa, bulimia nervosa and binge eating disorders.

Citation	Patient	Intervention	Comparator	Study Design	Results	LOE
Anorexia nervosa						
Hay PJ et al., 2019	Adults, adolescents (12-18 years) AN, AN binge-purge subtype DSM-IV, DSM-5	Inpatient care (IP) for weight restoration in AN provided by a specialist service for ED and health professionals	Active outpatient care (OP) or combination of brief hospital and OP care.	Rev Sys + Meta	Weight or BMI (after 12 m) Weight gain No clear difference between settings (SMD -0.22, 95% CI -0.49 to 0.05); ES = -0.22 [-0.49, 0.05] Weight restoration to within normal range ≥ 10^{t}percentile at EOT No clear difference between settings (19/41 versus 18/41; RR 1.06, 95% CI 0.65 to 1.70); ES = 1.06 [0.65, 1.70] Follow up Weight or BMI at one year following EOT or two years since baseline No significant difference between settings. (MD -3.72 kg, 95% CI -8.96 to 1.52). ERP Recovery No significant difference between settings (RR 0.93, 95% CI 0.73 to 1.17; ES = 0.93 [0.73, 1.17] GP General No significance difference in symptom severity between settings (MD -0.17, 95% CI -1.04 to 0.69); ES = -0.17 [-1.04, 0.69] Depression (symptoms severity) No significant difference between settings (SMD -0.20 95% CI -0.49 to 0.10); ES = -0.20 [-0.49, 0.10] Acceptability Outpatient care group more likely to complete treatment (RR 0.75, 95% CI 0.64 to 0.88); ES = 0.75 [0.64, 0.88]	1
Hay PJ et al., 2019	Adolescents and Adults (Mean age 21.7 years; SD 1.9 to 4.7)	IP for weight restoration in AN provided by a specialist ED service and health	waiting list (WL), no active treatment, or treatment as usual (TAU).	Rev Sys + Meta	GP No significant difference between settings (MD 0.60, 95% CI -1.74 to 2.94); ES = 0.60 [-1.74, 2.94]	1

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Citation	Patient	Intervention	Comparator	Study Design	Results	LOE
		professionals				
	AN DSM-III					
Hay PJ et al., 2019	Adolescents and children (11 to 18 years; mean age 15.2 SD 1.5). AN, AN binge-purge subtype DSM-IV	Specialist IP care for weight restoration	Partial hospital care	Rev Sys + Meta	Weight or BMI Weight gain Difference was small and not significant (MD -0.30 of a BMI point, 95% CI -0.87 to 0.27; ES = -0.30 [-0.87, 0.27] Weight restoration to within normal range ≥ 10tpercentile at EOT No clear difference between settings (RR 0.99, 95% CI 0.85 to 1.16); ES = 0.99 [0.85, 1.16] ERP Recovery No clear difference between settings (RR 0.96, 95% CI 0.66 to 1.40); ES = 0.96 [0.66, 1.40] GP General- incidence Fewer psychiatric symptoms in IP group versus partial hospital care (MD -2.10, 95% CI -3.05 to -1.15). Acceptability No clear differences between settings. (RR 1.07, 95% CI 1.01 to 1.14); ES = 1.07 [1.01, 1.14]	1
Haas V et al., 2022	<18 years AN	FBT or Inpatient multimodal treatment	Any psychotherapeutic intervention with any control or active treatment arm	Rev Sys	BW metrics, weight gain and EDP Not allow comparisons due to: - significant differences in patient baseline characteristics including pretreated versus non-pretreated patients - use of different psychometric and weight measures - different initial velocity of weight recovery.	2
Bulimia nervosa						

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Citation	Patient	Intervention	Comparator	Study Design	Results	LOE
Hay PJ et al., 2019	Adults, adolescents inpatients: 24.0 years (SD 7.6); day patients; 26.2 years (SD 7.2); BN DSM-IV ICD-10	Specialist IP care	Partial hospital care	Rev Sys (only 1 study)	BE Frequency No clear difference between settings. (MD-0.45, 95% CI -1.04 to 0.14). BE abstinence No clear difference between settings (RR 2.44, 95% CI 0.73 to 8.22). Follow up BE frequency one year following EOT or two years since baseline. No clear difference between settings (MD 0.43,95% CI -0.27 to 1.13). GP No clear difference in symptom severity between settings (MD 0.20, 95% CI -0.08 to 0.48). Acceptability No clear difference between settings (RR 1.04, 95% CI 0.71 to 1.52).	1

AN = Anorexia nervosa; BE = binge episode; BMI = Body Mass Index; DSM-III, DSM-IV, DSM-5 = various versions of the Diagnostic and Statistical Manual of Mental Disorders; EOT = End of Treatment; ERP = Eating Related Psychopathology; IP= Inpatient Care; LOE = level of evidence (Oxford 2011); OR = odds ratio, OP=Outpatient Care; RCT = randomized controlled trial; TAU = treatment as usual

Outcomes: Body weight (BW) and BMI (kg/m^2) - Weight gain, Weight restoration to within normal range ≥ 10^tpercentile at EOT, Follow up -Weight or BMI at one year following EOT or two years since baseline; Eating Related Psychopathology (EDP), General psychopathology (GP) - Recovery - a level of intermediate or better on the Morgan-Russell Outcome Assessment Schedule (MROAS) or 95% of expected BW, Depression; Acceptability = number of participants who completed treatment; Binge Episode-frequency, abstinence

References

- Hay PJ, Touyz S, Claudino AM, Lujic S, Smith CA, Madden S. Inpatient versus outpatient care, partial hospitalization and waiting list for people with eating disorders. Cochrane Database of Systematic Reviews 2019, Issue 1. Art. No.: CD010827. DOI:10.1002/14651858.CD010827.pub2

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- Haas V, Nadler J, Crosby RD, Madden S, Kohn M, Le Grange D, Gonçalves ASO, Hebebrand J, Correll CU. Comparing randomized controlled trials of outpatient family-based or inpatient multimodal treatment followed by outpatient care in youth with anorexia nervosa: Differences in populations, metrics, and outcomes. Eur Eat Disord Rev. 2022 Apr 26. doi: 10.1002/erv.2907

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Table 2. Evidence of nutritional interventions in the treatment of anorexia nervosa, bulimia nervosa and binge eating disorders.

Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Anorexia nervosa						
Garber et al., 2016	AN; adolescents and adults (a form of diagnoses not mentioned)	Different approaches to refeeding in treatment settings	Different approaches to refeeding in treatment settings	Systematic review (N= 27): 26 studies (96%) were observational prospective or retrospective and performed in a hospital	BW and BMI: refeeding is effective. For severely malnourished inpatients to use current standard care. In mildly and moderately malnourished patients the current standard of lower calorie refeeding is too conservative. Refeeding approach could be meal-based (nutrition composition within recommended ranges) and nasogastric - evaluate case by case (severity, team). Parenteral nutrition is not recommended. AE: higher calorie refeeding has not been associated with increased risk for the refeeding syndrome under close medical monitoring with electrolyte correction. Inpatient-focused data, more research is needed in outpatient settings.	1
McMaster, et. al; 2021	AN, BN, BED, or OSFED (ICD-10, DSM III, DSM III-R, DSM IV, or DSM V criteria); Aged 18 years or older; Male or female; (hospitalar or outpatient or community)	Nutrition and dietetic treatment (individual or group nutrition education, counseling, or intervention provided by a clinician)	No nutrition and dietetic treatment (control group, psychological intervention) nutritional treatment in combination with a psychological intervention	Systematic review (9 RCT) - 3 RCT / AN	BW gain: one study demonstrated greater weight gain in the nutritional treatment group and the other study showed greater weight gain in the psychological intervention at 6 months follow up (BDI - mean [SD] - 17.7 [2.4] vs 15.9 [2.7]). EDP or behaviors: greater improvements in the psychological intervention group and the other study showed improvements on different outcome measure subscales in both groups. AR: higher among participants allocated to a nutritional treatment (62.5%) than a psychological intervention (12.1%).	2
Hale and Logomarsino; 2019	AN (restrictive or binge/ purge subtypes) or BN; All ages; Female, male, or mixed gender studies; Inpatient settings (psychiatric, medical, or home setting)	EN intervention	EN and oral refeeding and No comparison	Systematic review (2 RCT, 2 non-RCT, 5 prospective cohort, 13 retrospective reviews, 1 thesis)	BW and BMI: EN utilized for refeeding significantly increased BW gain and/or BMI in all the studies included, - EN compared to oral feeding led to greater BW gain during the treatment period and higher BMI at hospital discharge in most included studies; Long-term effect of EN on BW and/or BMI has inconsistent results. Some studies have shown that the EN group maintained a higher BW at the 1-year follow-up. BEred and CBred: exclusive EN decreases the frequency and severity of BE/purge episodes. One RCT demonstrated that the BE/Purge behaviors were eliminated within 8 days for 78% of the EN group compared to 13% of the oral refeeding group. EN group maintained higher rates of remission (65%) than the oral refeeding group (29%) (p < 0.01) - 3 months.	2

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					Tolerability: - Refeeding syndrome: One study described 3 mild cases in patients with BMI < 11.5 kg/m2 despite very low caloric induction; - Peripheral edema: Seven studies reported the presence of mild edema at some point during treatment, but there was no statistical difference in the frequency of edema or other gastrointestinal complications in EN use; - Gastrointestinal side effects: nausea, minor abdominal cramps and bloating were reported in most studies and resolved quickly with the progression of treatment, being more frequent with oral feeding; - Removal of the tube (5-11% of participants) or tampering with feeding (stopping the pump or manipulating the infusion rate) were reported in 5 of the studies.	
Yang, et. al.; 2021	AN, BN, BED or OSFED (DSM V criteria); Any age; Any gender; Any ethnicity; Any severity of ED.	Nutritional treatment for Specialist dietetic care (meal support, nutrition counseling, nutrition education, etc.) as part of treatment for ED.	Any other ED treatment modality	Systematic review (8 RCT; 3 non-RCT) / 4 studies AN	BW and BMI: increased significantly with nutritional treatment. Balanced eating with a minimum of 1200 calories daily in the first week that gradually increased. EDP: nutritional treatment significantly improved ED symptoms and nutritional treatment achieved significant decreases in fear of fatness. GP: combined CBT and nutritional treatment improved dysfunctional attitudes more than nutritional treatment alone. Functional outcome or quality of life: nutritional treatment and combined CBT performed better than nutritional treatment alone (self-control scale scores)	2
Rigaud et al., 2007	AN (n=81) - (56 restrictive and 25 binge-purge - 1 dropped)	Cyclic enteral nutrition (CEN): 41 patients (97% women)	Control group: 40 patients (98% women)	Prospective 2 month randomized trial	BW gain: 39% higher in the CEN group than in the control group (194 vs 126 g/day; p = 0.01). BMI: at discharge (67-70th day), 16 out of the 41 CEN patients (39%) had reached a BMI of 18.5 kg/(m)^2, as compared with the 3/40 control patients (8%; P =0.02); Fat-free mass gain: greater in the CEN group: 109 vs 61 g/day (p = 0.01). BEred: decrease in BE was higher in the CEN group (p =0.01). EDP: CEN was associated with complete cessation in vomiting and binges in 8/10 patients (80%), as compared to 4/8 control patients (50%; p = 0.01) who had binges/vomiting during the first week from hospital admission. The remaining vomiting/binges per week were lower in the CEN group than in the control.After discharge, the relapse-free period was longer in the CEN group than in the control one: 34.3 (DP 8.2) weeks vs 26.8 (DP 7.5 weeks (p = 0.05). Energy intake was higher in the CEN group than in the control group (p =	2

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					0.05)	
Bulimia nervosa						
McMaster, et. al; 2021	AN, BN, BED, or OSFED (ICD-10, DSM III, DSM III-R, DSM IV, or DSM V criteria); Aged 18 years or older; Male or female; (hospital or outpatient or community setting)	Nutrition and dietetic treatment (individual or group nutrition education, counseling, or intervention provided by a clinician)	No nutrition and dietetic treatment (control group, psychological intervention) nutritional treatment in combination with a psychological intervention	Systematic review (9 RCT) - 5 RCT / BN	BEred and CBred: decrease in the frequency of BE and induction of vomiting for all participants. A study showed a nonsignificant change in BE for both intervention groups and a statistically significant reduction in vomiting frequency in the cognitive therapy group only. EDP: Combined dietetic and psychological interventions improved more than nutritional treatment alone. A study reported significant postintervention improvement for five EDI subscales and EAT for both intervention groups. BW: no significant change in participants' weight, but participants receiving the nutritional treatment had greater reductions in BMI. AR: higher AR among participants allocated to a nutritional treatment (24.7%) than those allocated to a psychological intervention (12.5%). Studies involving interventions combining nutritional treatment and psychological components had a lower AR. OTHERS Diet Quality/Adequacy: reported a significant increase in the number of meals participants consumed per day for both intervention groups, with a greater increase observed in the nutritional treatment group.	2

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Yang, et. al.; 2021.	AN, BN, BED or OSFED (DSM V criteria); Any age; Any gender; Any ethnicity; Any severity of ED.	Nutritional treatment for Specialist dietetic care (meal support, nutrition counseling, nutrition education, etc.) as part of ED treatment.	Any other ED treatment modality	Systematic review (8 RCT; 3 non-RCT) / 3 studies BN	BEred and CBred: nutritional advice was found to be superior to psychotherapy in improving vomiting and purgation symptoms and significant BEred in the dietetic arm. CBT and nutritional treatment significantly reduced BE and vomiting frequency. EDP: nutritional treatment significantly improved ED symptoms. GP: three studies found that dietetic intervention significantly improved psychopathology and three studies found that dietetic intervention did not significantly improve. Functional outcome or quality of life: nutritional treatment and combined CBT performed better than nutritional treatment alone (self-control scale scores) Diet Quality/Adequacy: nutritional treatment significantly improved nutritional intake. Combined nutritional and cognitive treatment significantly improved most outcomes (increasing lipid intake and meal number or caloric intake outside of BE).	2
Burton & Stice, 2006	BN (DSM-IV) and BN and sub-threshold; Female; (n=85) (16 dropped)	6-session "healthy-weight treatment program" (CBT plus weight management to promote caloric restriction); 3-month follow-up	Waitlist comparison group	Treatment randomized trial (preliminary results)	BEred: significantly greater decreases in BE frequency among intervention participants than controls across the four waves of data (F [3/249] = 10.21, *p* = 0.001, r = 0.33) GP - *Social functioning* = a trend for significant improvements from pretest to 3-month follow-up (F [1/83] = 3.63, *p* = 0.06, r = 0.21) *Health care utilization:* significantly greater decreases in health care utilization from pretest to 3-month follow-up (F [1/83] = 5.92, *p* = 0,05, r = 0.26) BW: significant differences in change across 4 waves of data (F [3/249] - 2.98, *p* = 0,05, r = 0.19). This r value translates into a d ¼ .39, which falls in between a small and medium effect size ("Health Weight" (n = 43) wave 1 x 24.19 (3.60) wave 2 x 24.07 (3.41) wave 3 x 23.96 (3.49) wave 4 23.96 (3.42)) / ("Wait List" (n = 42) wave 1 x 23.50 (2.84) wave 2 x 23.54 (2.82) wave 3 x 23.67 (2.90) wave 4 x 123.64 (2.81)).	2
Binge eating disorder						
McMaster, et. al; 2021	AN, BN, BED, or OSFED (ICD-10, DSM III, DSM III-R, DSM IV, or DSM V); 18 years or older; Male or female; (hospitalar or outpatient	Nutrition and dietetic treatment (individual or group nutrition education, counseling, or intervention provided by a	No nutrition and dietetic treatment (control group, psychological intervention) nutritional in combination with a psychological intervention	Systematic review (9 RCT) - 1 RCT / BED	BEred: showed significant reductions in binge frequency for participants receiving psychological intervention and combined with nutritional treatment (greatest and fastest reductions). EDP: Combined nutritional treatment and psychological interventions resulted in greater improvements (decreased 63% BES) than nutritional treatment alone. BW: greatest and the fastest rate of BW loss in participants receiving the combined psychological intervention and nutritional treatment (weight change: -11.4 (5.4) x -5.4 (7.7), *p* < 0.001).	2

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
	or community)	clinician)			AR: higher AR among participants allocated to a dietetic intervention (24.7%) than those allocated to a psychological intervention (12.5%). Studies involving interventions combining nutritional treatment and psychological components had a lower AR.	
Brownley et. al.; 2013	Overweight adults; Diagnosis of BED (DSM-IV); (n=24)	Three treatment arms: dose chromium picolinate	1000 mcg chromium/day ("high dose") - (n=8) or 600 mcg chromium/ day ("moderate dose") (n=9) as chromium picolinate or placebo (n=7).	Double- blind, randomized trial	BEred: declined over time - high dose group: largest magnitude reduction [high dose group [−1.65 (0.76)], moderate dose group [−0.93 (0.70)], placebo group [−0.97 (0.78)] binges/month] - (no significant differences in pairwise comparisons); EDP: EDEQ high dose group x placebo: decline in eating, shape, and weight concerns; global EDEQ score between groups were not significant [high dose [−0.21(0.07)], moderate dose [−0.13(0.07)], placebo [−0.04 (0.07)]; GP: Symptoms of depression - declined over time in the groups but the differences were not statistically significant [high dose [−0.30 (0.21)], moderate dose [−0.41 (0.19)], and placebo [−0.03 (0.21)]. BW: no significant differences were found in any pairwise comparisons between either [high dose [0.19 (0.25)], moderate group [−0.13 (0.23)], placebo group [0.55 (0.25) kg/month] elevated AE and Side effects: - low: headache, tiredness and sleep disturbance - the most commonly reported.	2
Masheb et al, 2011	Adults; Diagnosis of BED (DSM-IV-TR); (n=50)	Nutrition intervention and CBT	CBT+ low-Energy- Density diet (CBT + ED) (n=20) and CBT + Nutrition counseling (not related to lowering energy density or weight loss) (CBT + GN) (n=23).	RCT	BEred: Similar improvements were shown by both treatments. EDP and GP: Both treatments produced similar improvements in BED-related outcomes (less disinhibition and hunger, and greater restraint) and attitudinal (concerns about BW, shape and eating concerns) features of BED as well as symptoms of depression. BW and BErem: two treatments did not differ significantly in weight loss or BErem outcomes. 30% achieved at least a 5% weight loss with rates of BErem ranging from 55% to 75%. DP rate: two treatment groups did not differ in completion rates (80%, n= 20 for CBT + ED and 92%, n= 23 for CBT + GN; $X^2(1) = 1.50$, $p = 0.221$), or in the number of sessions completed (M= 16.8, SD= 7.4 for CBT + ED and M= 19.1, SD= 3.1 for CBT + GN; $F(1, 49) = 2.03$, $p= 0.161$). Dietary outcomes: a significant interaction was found for energy density ($F(1, 35)= 5.17$, $p = 0.029$). Greater reductions in energy	2

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					density for CBT+ ED vs. CBT + GN. No significant interaction was found for energy intake.	

ED = Eating disorder; AN = Anorexia nervosa; BN = Bulimia nervosa; BED = Binge eating disorder; OSFED = Other specified feeding or eating disorder; BE = binge episode; ICD-11 = International Classification of Diseases 11th Revision; DSM-III = Diagnostic and Statistical Manual of Mental Disorders - Third Edition; DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders - Third Edition - Revision; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders Fourth Edition; DSM-5 = Diagnostic and Statistical Manual of Mental Health Disorders 5th edition; CEN = Cyclic enteral nutrition; BMI = Body mass index (kg/m2); BW = Body weight ; BErem = Binge Eating Remission; BEred = Binge Eating reduction; CBred = Compensatory behaviors reduction; EN = Enteral nutrition; CBT = Cognitive-behavioral therapy; CBT + ED = CBT plus a low-Energy-Density diet; CBT + GN = CBT plus General Nutrition counseling not related to lowering energy density or weight loss; RCT = randomized controlled trial; EDP = Eating disorder psychopathology; EDI = Eating Disorder Inventory; EAT = Eating Attitudes Test; GP = General psychopathology; EDE-Q: Eating Disorder Examination-Questionnaire; AE = Adverse events; DP = drop-outs; EDE-Q: Eating Disorder Examination-Questionnaire; AE = Adverse events; AR: Attrition rates.

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Table 3. Evidence from RCTs with psychological treatments for anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED) in adults

Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Anorexia nervosa						
Monteleone et al., 2022	AN (DSM-5; ICD) (without mentioning the AN-type)	BT, BT-BWL, CBT-ED, FAM-i, FBT, IPT, mixed or unspecified Psycho, MULTI [including SSCM], PSDO.	TAU	SR + MA	Efficacy: No significant differences between psychotherapy and TAU for BMI (0.23; 95% CI, 0.06 to 0.40), EDP, or GP. FAM-i was superior to TAU for remission/clinical improvement (RR = 3.50; 95% CI, 1.49 to 8.23).	1
Solmi et al., 2021	AN (acute, DSM-5; ICD)	CBT, MANTRA, FBT, PSDO, CBT-LEAP (CBT targeting compulsive exercise)	TAU	SR + network MA	BMI: No active treatment was superior to TAU (all CIs crossed zero, *e.g.* A&T: Dropout was significantly lower for CBT vs. PSDO (	1
Atwood et al., 2019	AN (DSM-5, DSM-IV-TR (current AN, AN-R or AN-BP)	CBT-ED - pre to posttreat	MANTRA+SSCM; FPT, TAU.	SR	BMI & EDP: Significant pre-to-post BMI increase for CBT-ED, but no significant differences between CBT-ED and comparisons. Remission: No significant differences between treatments at post-treatment or follow-up. A&T: Dropout was lower in TAU compared to CBT-ED or FPT.	1
Zeeck et al., 2018	AN (DSM-5) (without mention the type)	Active treatments CAT; CBT; CBT&X; CBT-E, FPT; FT_AN; IPT; MANTRA; TAU	SSCM Pre to post- treat (1 year F/U)	Network MA	BMI: Network meta-analysis revealed no significant differences between any of the active psychotherapies and the comparator (SSCM), nor among the active treatments themselves (all 95% CIs crossed zero; *e.g.*, CBT-E *vs.* SSCM: 0.31, 95% CI, -1.64 to 2.27; MANTRA vs. SSCM: -0.16, 95% CI, -0.91 to 0.59).	1
Linardon et al., 2017	AN (DSM-5) (without mentioning the AN-type)	Third wave therapy (ACT)	TAU	SR + MA	Remission & EDP: No significant differences between ACT and TAU at post-treatment or across any follow-up intervals up to 5 years (all $p > 0.15$; EDE global $p = 0.71$). Patients receiving ACT had a non-significant trend toward a "good outcome" at post-treatment (OR = 2.50; 95% CI, 0.3 to 16.1) and 24 months (OR = 5.00; 95% CI, 0.5 to 51.8).	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Bulimia nervosa						
Monteleone et al., 2022	BN diagnostic based on DSM/ICD diagnosis	BT, BT-BWL, CBT-ED, FAM, FBT, IPT, mixed or unspecified Psycho, multidisciplinary care [including SSCM] (MULTI), PSD-O.	Psychological intervention (active), TAU, WL or no treat (WL/NT), mixed TAU and WL/NT, mixed active and WL/NT.	MA of RCT Network MA of RCT	**Vs. WL/No Treatment**: Outpatient CBT-ED was significantly superior for binge/compensatory behaviors (RR = 1.29; 95% CI, 1.04 to 1.61) and EDP. In mixed settings, group BT (OR = 28.7) and group CBT-ED (OR = 7.67) showed the highest clinical remission rates. Individual CBT-ED outperformed IP for GP. **Vs. Active/TAU**: Individual CBT-ED was significantly superior to active controls for binge/compensatory behaviors (OR range: 1.20 - 1.70) and EDP.	1
Atwood et al., 2019	BN according to the DSM-5 (APA, 2013) or DSM-IV-TR (APA, 2000) CBT-ED=200 participants	Effectiveness of CBT-ED from pre to posttreat	DTC, SCS, or another psycho; or CBT-E w/ and w/out an + treat component	SR (RCT 3 studies)	**Bingeing & Purging (Abstinence/Reduction):** CBT-ED significantly increased objective binge abstinence (range: 22.5% - 44%) and compensatory behavior abstinence (40% - 42%) compared to delayed treatment controls (DTC), but did not differ significantly from other active treatments, particularly at long-term follow-up. CBT-ED showed large effects on objective binge frequency reduction and was superior to active treatments for compensatory behavior frequency reduction. **EDP, BMI, & Attrition:** No significant differences were found between CBT-ED and active treatments for EDP or BMI. Attrition rates ranged from 20% to 54% at post-treatment.	1
Slade et al., 2018	BN participants (Diagnostic assessment based on DSM-IV and DSM-V criteria) Participants=	Individual CBT-ED, individual IPT, guided CBT-SH, individual BT, non-guided CBT-SH, group CBT-ED, group BT, and SP.	WL or another activity treatment	Networking MA	**Remission (EOT):** Compared to WL, significant increases in full abstinence (no bingeing/purging for 2 weeks) were achieved by individual CBT-ED (OR = 3.89), guided CBT-SH (OR = 3.81), non-guided CBT-SH (OR = 3.49), group CBT-ED (OR = 7.67), and group BT (OR = 28.70). Findings for group formats are limited by small sample sizes.	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
	1,828					
Linardon J et al., 2018	BN (not reported the diagnostic classification method) Participants= 2,789	Psycho	Pre to post- treat and F/U	MA of RCT (45 studies)	**Abstinence Rates (ITT):** Overall post-treatment ITT abstinence rates were 52.0% for binge eating alone, 29.0% for compensatory behaviors alone, and 28.4% for full combined abstinence. Clinician-led individual/group formats achieved higher abstinence than guided SH (13.5%). Behavioral therapy (BT) yielded the highest, and interpersonal therapy (IPT) the lowest, abstinence rates (range: 20% - 40%). **Attrition:** Combined ITT dropout was 29.9% at post-treatment and 28.6% at follow-up.	1
Binge eating disorder						
Monteleone et al., 2022	BED (DSM criteria)	BT, BT-BWL, CBT-ED, FAM, FBT, IPT, mixed or unspecified Psycho, multidisciplinary care [including SSCM]	Psycho (active), TAU, WL or no treat (WL/NT), mixed TAU & WL/NT, mixed active & WL/NT.	MA	Vs. WL/No Treatment: CBT-ED was significantly superior for both BE abstinence (RR = 4.95; 95% CI, 3.06 to 8.00) and BE reduction (MD = 2.32; 95% CI, 0.09 to 4.56). Vs. Active/TAU (Outpatients): CBT-ED significantly outperformed active controls for BE outcomes (MD = 2.04; 95% CI, 0.35 to 3.73). No significant differences were found for behavioral therapy (BT) on BE or BMI outcomes at follow-up. Dropout rates did not differ significantly between psychotherapy conditions and controls.	1
Hilbert et al., 2019	BED (DSM criteria)	CBT, IPT, PSDO, and humanistic therapies and structured SH	Inactive and active control groups.	MA (RCTs)	Vs. Inactive Controls: Both psychotherapy pooled (OR = 9.91) and CBT alone (OR = 10.0) significantly improved BE abstinence (53% for pooled), BE reduction, EDP, and depression ($p < 0.001$), with no effect on BMI. Pure self-help (SH) and CBT-SH also showed significant efficacy across all clinical outcomes ($p < 0.001$) except BMI, though with higher dropout rates than inactive controls (SH OR = 2.08; CBT-SH OR = 2.3). Head-to-Head / Active Comparators: CBT did not outperform IPT or PSDO on any outcome. CBT was superior to humanistic therapies at post-treatment for BE abstinence (OR = 3.6, $p = 0.002$) and depression ($p = 0.028$), but differences vanished at follow-up. Psychotherapy outperformed BWL for BE reduction ($p = 0.03$) and BMI reduction ($p = 0.003$) at post-treatment, but not at long-term follow-up.	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					Moderators: Individual delivery format was significantly superior to group format for BE abstinence ($p < 0.001$). Shorter therapies (<10 weeks) achieved higher BE reduction than longer protocols ($p = 0.023$).	
Hilbert et al., 2019	BED (DSM criteria)	CBT, SH, BWL, SH-WL, CBT-SH and Psycho (pooled)	Inactive and active control groups	MA (RCTs, NRCT and Uncontrolled treat studies	Within-Group Changes over Follow-Up: For both CBT and CBT-SH, improvements in BE abstinence, BE reduction, EDP, and depression were non-significant at post-treatment but became highly significant from post-treatment to long-term follow-up ($p < 0.001$). Pooled Cohort Data (Long-term): Across combined controlled/uncontrolled evidence, psychotherapy maintained robust long-term efficacy ($p < 0.001$) for BE reduction, EDP, depression, and weight loss (measured in kg and BMI). Pure SH maintained significant long-term improvements in BE reduction, EDP, and depression ($p < 0.02$), but had no significant effect on BMI.	1
Linardon et al., 2018	BED 2,349 participants	CBT, BWL, BWL + CBT, IPT, BT, DBT, Non-specific supportive therapy, mindfulness, Psycho, Combined psycho approach	Psycho/ WL	SR and MA of RCTs (39 studies)	Post-Treatment Abstinence (ITT): Overall BE abstinence was 45.1% (vs. 10.3% for WL). The highest abstinence rates were achieved by IPT (63.1%), followed by DBT (56.3%), CBT+BWL (51.1%), and clinician-led CBT (48.4%). Mindfulness performed poorly (18%). Protocols with 16–20 sessions yielded higher abstinence (51.4%). Follow-Up Abstinence (ITT): Overall abstinence was maintained at 42.3%. IPT remained the most effective modality (53.7%), followed by CBT (42.9%) and CBT+BWL (41.5%). Treatment durations >=12 months predicted higher long-term abstinence (42.8%).	1
Linardon et al., 2017	BED participants (Not reported)	Third-wave DBT, ST, ACT, MBI, and CFT	WL or another activity treat, and CBT	SR and MA (Only RCT were considered)	Third-Wave Efficacy (DBT, ST, ACT, MBI): Third-wave therapies showed large pre-to-post improvements for BE reduction ($g = 1.38$), EDP ($g = 1.18$), and depression ($g = 0.59$), all maintained at follow-up. CFT lacked empirical support. Comparisons: Third-wave interventions were significantly superior to WL for BE abstinence (RR = 7.47) and BE reduction ($g = 0.89$). However, they showed no significant benefit over active controls or classic CBT for BE abstinence or reduction at either post-treatment or follow-up (all CIs crossed zero)	1
Palavras et al.,	BED diagnostic	CBT, CBT-E, IPT,	2 or > forms of	SR and MA of	In Patients with Obesity: CBT was superior to inactive controls for BE	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
2017	based on DSM-IV and DSM-V	BWLT, BT, short-term focal Psycho, DBT, SH, PSDO, meditation, mindfulness, or any other Psych	Psycho; Psycho vs WL/DTC or vs to placebo.	RCTs	reduction (3 RCTs) but did not improve BMI (2 RCTs). Vs. Active Controls: CBT did not outperform active controls general clinical settings (7 RCTs) and was inferior to CBT + exercise (1 RCT). DBT was superior to general group therapy (1 RCT). CBT vs. BWLT: CBT was superior to BWLT for BE reduction at post-treatment (MD = 2.04; 95% CI, 0.35 to 3.73), but this advantage was lost at 1-year follow-up. Weight loss outcomes (BMI) and dropout rates did not differ significantly between CBT and BWLT at any time point.	

Abbreviations and Symbols: with: w/; >: superior; < inferior; Δ= variation; Clinical: Abstinence (Abs); Behavior Therapy (BT); Behavior Therapy-Body Weight Loss (BT-BWL); Bulimia nervosa (BN); Compensatory behaviors (CB); Objective binge eating (OBE); Interventions: Behavior therapy: BT; Clinician-Lead (CL); Cognitive Behavior Therapy (CBT): CBT; CBT-ED (Eating Disorders); CBT self-help (SH); Family therapy: FAM, family-based therapy: FBT; Interpersonal therapy: IPT; Psychodynamic-oriented (PSD-O); Psychotherapy (Psycho); Supportive psychotherapy (SP).Third waves treatment: Acceptance and Commitment Therapy (ACT), Compassion-Focused Therapy (CFT), Dialectical Behaviour Therapy (DBT), Mindfulness-based Interventions (MBI), Schema Therapy (ST); Comparators: Delayed treat control (DTC); Multidisciplinary care [including Specialist Supportive Clinical Management (SSCM); Current Standard of Care (CSC)] (MULTI); Wait list (WL); Statistical analysis: End of treatment (EOT); Follow-up (F/U); Intention to treat (ITT); not statistical significant (ns); significant (sign.)/ AN-BP = binging/purging; CAT, Cognitive-Analytic Therapy; CBT=cognitive behavioural therapy; CBT&X consisted of 8 initial sessions of CRT (Cognitive Remediation Therapy) plus CBT;
FAM-I=individual family therapy, FT_AN= Family based treatment for anorexia nervosa; FPT=Focal Psychodynamic Psychotherapy; LEAP=compulsive exercise activity therapy. MANTRA=Maudsley anorexia
treatment for adults.
Outcomes: Efficacy: Binge Eating abstinence (BEabs), - Binge Eating reduction (BEred), Binge Eating Remission (BErem), Compensatory behaviors abstinence (CBabs), Compensatory behaviors reduction (CBred), Eating disorder psychopathology (EDP), General psychopathology (GP), Body weight (BW) and BMI (kg/m2)
Acceptability & tolerability (A&T): Adverse events (AE) and drop-outs (DP)
Effect size was based on D-Cohen calculation. Cohen suggested that g=0.2 could be considered a 'small' effect size, g=0.5 represents a 'medium' effect size and g=0.8 a 'large' effect size. [Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). Hillsdale, NJ: Erlbaum.]; LOE (Level of Evidence Oxford 2011); *(i.e., defined as BMI ≥ 19 and EDE-Q global score ≤ 2.80).

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Table 4: Evidence of pharmacological treatments in anorexia nervosa, bulimia nervosa and binge eating disorder

Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Anorexia nervosa						

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Fornaro M et al., 2023	Adults w/ AN, BN, or BED (DSM or ICD)	SGAD, CNSS, ACV, AOA, OMED	Inactive or active controls	SR + MA	Olanzapine: Olanzapine led to a significant weight gain or at least a faster one vs. placebo, being well-tolerated. No significant improvement vs. placebo in terms ER psychopathology, except for one study. Olanzapine pointed towards a reduction of ruminative thoughts and anorexic conducts without significant weight gain over the 6-8 weeks trials vs. chlorpromazine. BMI change: The Hedges'g for BMI was 0.283 (95%C.I. = 0.051-0.515), I2 = 0 %; *p* = 0.017 EDP - Hedges'g = 0.222 (95%C.I. = □ 0.049-0.494), I2 = 0 %; *p* = 0.109 GP (depression BDI, CES-D) - Non-sign. Hedges'g = 0.191 (95%C.I. = □ 0.078-0.46), I2 = 0 %; *p* = 0.165. (obsessive-compulsive) non-sign. Hedges'g = 0.171 (95%C.I. = □ 0.113-0.455), I2 = 11.02 %; *p* = 0.238; anxiety - sign. trend Hedges'g = 0.263 (95%C.I. = □ 0.007-0.532), I2 = 0 %; *p* = 0.056. Fluoxetine: BMI/WC change = non-sign. Hedges'g was 0.351 (95%C.I. = □ 0.248-0.950), I2 = 63.37 %; *p* = 0.251. EDP (depression, obsessive-compulsive,): Hedges'g = 0.549 (95%C.I. = 0.051-1.047), I2 = 53.38 %; *p* = 0.031 and Hedges'g = 0.416 (95%C.I. = 0.106-0.727), I2 = 0; *p* = 0.009 Others: Dronabinol - patients receiving dronabinol experienced a significantly higher weight gain than those receiving placebo; however, the psychopathology underlying the disorder did not improve with dronabinol treatment. Cyproheptadine was evaluated in 2 RCTs showing higher efficacy vs. placebo in improving weight and psychopathological symptoms, especially depressive ones. Lithium was evaluated in one RCT (Gross et al., 1981), showing higher efficacy than a placebo in weight gain and general psychopathology in patients with AN.	1
Cassioli et al., 2020 (short-term)	AN (DSM -III, IV, IV-TR criteria or clinical diagnosis) acute phase	Antipsychotics Antipsychotics Mood Stabilizers	PLA/TAU/no treatment/other active agent	SR	Antipsychotics: Meta-analyses of OLA compared to PLA: - BMI: non-significant effect of OLA in weight recovery (5 RCTs, MD= 0.25; (95% CI -0.29, 0.79) *p* = 0.38); - EDP: non-significant effect of OLA in reduction of ED symptoms (2 RCTs, SMD=0.41 (95%CI -0.17, 0.99) *p* = 0.17); - GP: non-significant effects for depressive (2 RCTs, SMD= -0.38 (95% CI -0.94, 0.18) *p* = 0.18) or anxiety symptoms (SMD= 0.39 (95% CI -0.17, 0.94) *p* = 0.17); Two RCTs found significant effects of OLA compared to PLA on BMI improvement (rate of weight gain) (Bissada 2008, Attia 2011) and one found an effect of OLA in reducing obsessions (Bissada 2008); Other RCTs did not find effects on weight gain. Antidepressants:	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					Meta-analysis of AMI compared to PLA: No greater effects were found for AMI on weight gain compared to PLA, nor for other antidepressants (citalopram, clomipramine) or antipsychotic drugs (QUE, RIS, Pimozide, Sulpiride, Amissulpride) compared to PLA, other active drug, or no treatment. - GP: Non-significant effect on depression (2 RCTs, SMD= -0.50 (-1.03, 0.02) *p* = 0.06); Non-significant effect of antidepressants (AMI or FLU) for depression (3RCTs; SMD= -0.27 (95% CI -0.37, 0.20) *p* = *ns*). Lithium: One small RCT of poor quality (high risk of bias) reported short term effect of Lithium on weight gain (Gross 1981)	
Blanchet et al., 2019 (Short and long-term)	AN (with or without the mention of the restrictive or binging/purging types) DSM III, IV, IV-TR or DSM-5 criteria or clinical diagnosis All ages	Medication for AN sychotropic or somatic drugs or nutritional) Psychotropic: Antidepressants; Antipsychotics; Lithium; Appetite enhancers (antihistamines, opiates, cannabinoids, ghrelin); Benzodiazepines; Clonidine; NMDA agonists and antagonists; Oxytocin	PLA or active drug or TAU	SR + MA	Antidepressants - Meta-analysis (4 RCTs (AMI, CLO, FLU) 190 participants): no effect on weight gain (acute phase) or maintenance of weight - antidepressants (Tricyclics, SSRIs, IMAO) : have no effect on weight gain, and their impact on eating symptoms or psychopathology is not clear Antipsychotics Meta-analyses: - Weight gain: non-significant effect of antipsychotics in comparison to PLA, whether antipsychotics were pooled or considered individually (4 meta-analysis); - EDP: non-significant effects of antipsychotics in comparison to PLA on eating disorder symptoms (3 meta-analyses) One large RCT (Attia et al.2019) found a modest significant effect of OLA compared with PLA on BMI (0.629 (0.106, 1.151)), na increase difference of 0.165 BMI points more per month. -Non significant differences were found for EDP , clinical global impressions, obsessionality, anxiety and depressive symptoms for OLA compared to PLA	1
Dold et al., 2015 (short-term)	AN-R (64,2%) and AN-BP type (DSM-IV and DSM-IV TR); Adults and adolescents Mean BMI= 16.3 ± 0.5kg/m² (acute-phase)	Second-generation Antipsychotics (SGAP): OLA, RIS, QUE Various combined interventions (In- and outpatient treatments or day-	Placebo/control group (no drug)	SR + MA	BMI change: Effects of SGAP were non-significant compared to placebo or control treatment (Hedges`s g=0.17, 95% CI: -0.14 to 0.48; *p* = 0.28); BMI change: Effects of individual SGAP (Olanzapine, Quetiapine or Risperidone) revealed no significant between-group differences; EDP: Effects of the pooled SGAP were non-significant for YBC-EDS total score changes (Hedges`s g=-0.26, 95% CI: -0.9 to 0.38; *p* = 0.42). Effects of the pooled SGAP group for mean change in EDI total score was statistically significant less efficacious than the control group (N=3, n=62; Hedges`s g=0.61, 95% CI: 0.12 to 1.11; *p* = 0.02). When analyzing the individual SGAPs, the control group outperformed quetiapine	

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
		hospital treatment)			(N=1, n=15; Hedges`s g=1.38, 95% CI: 0.3 to 2.45; *p* = 0.01) but not olanzapine (N=2, n=47; Hedges`s g=0.41, 95% CI: -0.15 to 0.97; *p* = 0.15). A&T: Between-group differences for all-cause discontinuation (participants leaving the study early due to any reason, due to inefficacy of treatment, or due to AE) were non-significant	
Bulimia nervosa						
Fornaro M et al., 2023	Adults w/ AN, BN, or BED (DSM or ICD)	SGAD, CNSS, ACV, AOA, OMED	Inactive or active controls	SR + MA	Fluoxetine proved safe and effective in reducing both the frequency of BEs and CBs, improving the psychopathological outcomes in three studies. Efficacy was higher for 60 mg than 20 mg daily dose. BE red - Hedges'g = 0.203 (95%C.I. = 0.007-0.399), I2 = 0 %; *p* = 0.042 CB red - Hedges'g = 0.328 (95%C.I. = □ 0.061-0.717), I2 = 58.97 %; *p* = 0.099 EP (EDE, EDI) - Hedges'g = 0.147 (95%C.I. = □ 0.157-0.451), I2 = 0 %; *p* = 0.343 GP (BDI, HAMD) - Hedges'g = 0.331 (95%C.I. = 0.115-0.547), I2 = 0 %; *p* = 0.003 WC - Hedges'g = 0.147 (95%C.I. = □ 0.157-0.451), I2 = 0 %; *p* = 0.343 Topiramate was evaluated in one RCT (Nickel et al., 2005), showing good tolerability and efficacy in reducing BEs/PEs frequency, decreasing weight, and improving the perceived quality of life. Ondansetron reduced purging episodes and their duration.	1
Argyrou et al., 2023	BN No restriction of age, gender, chronicity of illness, duration of trial, dose range and system of diagnostic classification	Any type of pharmacotherapy, antidepressants (e.g., SSRIs, tricyclics, MAOIs), topiramate, trazodone, bupropion, and opioid antagonists, administered as monotherapy or in parallel with psychotherapy	PLA	SR + MA	Remission - No statistically significant difference between medication and placebo in achieving remission (RR 1.79, 95% CI 0.19 to 16.94, *p* = 0.61). This finding is based on limited data (4 RCTs) and should be considered inconclusive. BEred - Medication was more effective than placebo (SMD -0.47, 95% CI -0.66 to -0.28, P<0.0001). CBred - Medication reduced the frequency of purge episodes compared to placebo (SMD -0.46, 95% CI -0.64 to -0.29, P<0.0001). Response to Treatment - A significantly higher number of participants responded to treatment in the medication group compared to the placebo group (RR 1.93, 95% CI 1.50 to 2.50, P<0.00001). EDP - No significant difference was found between medication and placebo when the drug was given alone (*p* = 0.09). However, when combined with psychotherapy, medication significantly improved psychopathology compared to placebo (*p* = 0.002). GP - Pharmacotherapy significantly improved depressive symptoms compared to placebo (SMD -0.43, 95% CI -0.67 to -0.19, *p* = 0.0005). Medication showed a borderline significant effect in reducing anxiety (SMD -0.17, 95% CI -0.35 to 0.02, *p* = 0.05). WC - Significant reduction in body weight in pharmacotherapy compared to	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					placebo (SMD -0.41, *p* = 0.002). There was no significant difference in BMI when medication was given alone (*p* = 0.97). A&T - There was no significant difference in all-cause dropouts between the groups. More patients in the placebo group dropped out due to a lack of efficacy (RR 0.34, P<0.00001).	
Yu et al., 2023	BN (DSM-III, III-R, IV, 5 or ICD-10)	SSRI, TCA, MAOIs, TOP, lithium or fenfluramine	PLA	SR + MA	Bered: All drugs combined: significant reduction compared to placebo (SMD = -0.40, 95% CI -0.61 to -0.19). TCAs: SMD = -0.61 (95% CI -0.88 to -0.34). Topiramate: SMD = -0.97 (95% CI -1.37 to -0.56). SSRIs: No statistically significant effect (SMD = -0.01, 95% CI -0.17 to 0.14). CBred: All drugs combined: significant reduction in vomiting episodes (SMD = -0.16, 95% CI -0.30 to -0.03). SSRIs (fluoxetine): SMD = -0.18 (95% CI -0.35 to -0.01). GP: All drugs combined: significant improvement in depressive symptoms (SMD = -0.32, 95% CI -0.51 to -0.13). MAOIs: SMD = -0.50 (95% CI -0.95 to -0.06). TCAs: SMD = -0.52 (95% CI -1.00 to -0.03). WC: All drugs combined led to a significant weight reduction (WMD = -3.05, 95% CI -5.97 to -0.13). Topiramate showed remarkable efficacy in weight loss (WMD = -5.24, 95% CI -7.63 to -2.86). A&T - There was no significant difference in dropout rates due to adverse events between medication and placebo groups (RR = 1.66, 95% CI 1.14 to 2.41)	1
Svaldi J et al., 2019	Adolescents and adults with BN (DSM-IV or DSM-5)	SSRI Multiple agents	Inactive or active controls	SR + MA	BEabs - Small to moderate effect (OR 2.63, CI 1.27-5.46), but also a large heterogeneity between studies. In fact, small and non-significant effects were observed for SSRIs (OR 1.48, CI 0.88-2.50), whereas other medication yielded moderate to large effects [e.g. OR 13.87, CI 1.58-121.91 in one monoamine oxidase inhibitor (MAOI) study]. A particularly large effect was also observed in one study, in which different psychotherapies (i.e. an eclectic approach) were combined (OR 19.09, CI 2.16-169.09). BEred Moderate to large effects (g = 0.61; CI 0.31-0.91), depending on sub-category: SSRIs (g = 0.10; CI −0.08 to 0.29) and MAOIs yielded a small improvement (g = 0.11; CI −0.65-0.87) Other pharmacotherapies revealed large effects (g = 1.00; CI 0.43-1.58). CBabs: Pharmacotherapy yielded a small to moderate effect on average (OR 2.23, CI	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
					1.13-4.40). SSRIs: small effect whereas moderate to large effects occurred for other substance classes. Based on one study, an eclectic approach combining elements of different psychotherapies again revealed a particularly large effect (OR 12.92, CI 1.45-115.57). CBred - Moderate to large (g = 0.69; CI 0.48-0.90). Very large effects were observed for combination (with psychotherapy) therapies (g = 1.09; CI 0.24-1.94). A&T - OR for DP were slightly <1 for pharmacotherapy (OR 0.78, CI 0.50-1.20), and for combination therapies (OR 0.77, CI 0.26-2.26). This reflects that slightly less participants dropped out of the active intervention groups relative to controls	
Faris et al., 2000	Women > 18y with BN puging type (DSM-IV)	Ondansetron 24mg/day	PLA	RCT	BEred and CBred - Clinical group had a mean of 6.5 episodes/week, compared to 13.2 episodes/week in the placebo group. Estimated difference of 6.8 episodes; 95% CI 4.0-9.5; $p < 0.0001$ A&T: One patient in the ondansetron group dropped out due to an accidental injury unrelated to the treatment. All patients in the placebo group completed the treatment	2
Binge eating disorder						
Fornaro M et al., 2023	Adults w/ AN, BN, or BED (DSM or ICD)	SGAD, CNSS, ACV, AOA, OMED	Inactive or active controls	Rev Sys + MA	Lisdexamfetamine (6 RCT with 11-12 months duration and involving 1049 participants) BEabs - No data BEred - (Hedges'g = 0.571, 95%C.I. = 0.282-0.860, $I^2 = 53.84$ %; $p < 0.001$) EP (BES,TEFQ) - (Hedges'g = 0.764 (95%C.I. = 0.474-1.054), I2 = 53.01 %; $p < .001$ GP - depression (Hedges'g= 0.074 (95%C.I. =0.124-0.273), I2 = 0 %; $p = 0.463$], obsessive-compulsive (1.249 (95%C.I. = 0.612-1.886), I2 = 95.44 %; $p < .001$) BW or BMI - (Hedges'g = 0.259, 95%C.I. = 0.071-0.446, $I^2 = 0$ %; $p = 0.007$) A&T - No data Topiramate (2 RCT) showing efficacy in reducing BE frequency, weight, and general and ED-specific psychopathology at a mean dose of 212 to 300 mg/day. Topiramate showed good tolerability, although associated with paresthesia, dry mouth, headache, dyspepsia, dizziness, and drowsiness.	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Hilbert A et al., 2019	Adults w/ BED (DSM-IV or DSM-5)	SGAD, CNSS, ACV, OMED *[1]	Inactive or active controls	Rev Sys + MA	Results of Pharmacotherapy (all agents) with RCT with inactive control BEabs - For abstinence from BE, the pooled odds ratio was significant in pharmacotherapy and pharmacological WLT with small odds ratios. BEred - BE was reduced with small effect sizes by pharmacotherapy and pharmacological WLT vs. PLA EP - Effects for pharmacotherapy and pharmacological WLT vs. PLA in EP were nonsignificant. BW - BW was significantly reduced with large effect size in pharmacological WLT (3.6 kg), with medium effect size in combined treatment (-3.6 kg), and with small effect size in pharmacotherapy (- 2.3 kg) BMI - BMI was significantly reduced with small effect sizes in pharmacotherapy and pharmacological WLT vs. PLA. A&T For pharmacotherapy vs PLA, the incidence rate ratio for adverse events was 2.1 (95% CI [1.8 -2.5], $p < .001$). 184 patients terminated treatment due to AE (10.1%), while 68 patients (4.8%) in PLA. There is an odds ratio of 2.2 (95% CI [1.6 -3.1], $p < .001$) for discontinuing pharmacotherapy vs. PLA because of adverse events. Results with active control: Pharmacotherapy (fluoxetine, fluvoxamine) showed a lower reduction of BE at posttreatment and 6- to 12- month follow-up than combined treatment with CBT.	1
Hilbert A et al., 2020	Adults w/ BED (DSM-IV or DSM-5)	SGAD, CNSS, ACV, OMED*[1]	Inactive or active controls	Rev Sys + Meta	BE and BMI- For pharmacotherapy, the significant posttreatment reductions of BE and BMI were no longer significant at 6-12 months in the few studies providing data, suggesting a tendency to relapse after withdrawal of the pharmacological agent	1
Ghaderi A et al., 2018	BED (DSM-IV or DSM-5) regardless of age or weight status	SSRI, lisdexamfetamine, mood stabilizer, anorexiants), combination of drug and CBT/CBT-gsh vs. PLA,	Inactive or active controls	Rev Sys + Meta	BErem - SSRI = RD = 0.15 was in favor of SSRI treatment vs. PLA. LIS = RD = 0.25 in favor of LIS vs. PLA BE res - SSRI= SMD = -0.45 in favor of SSRI treatment vs. PLA. LIS = BE frequency significantly reduced vs. PLA GP = Symptoms of depression w/ no significant difference between SSRI and PLA. BMI = SSRI w/ no significant difference between SSRI and PLA in BMI. BW= significantly reduced with LIS vs. PLA (SMD= -5.23) A&T - SSRI with significantly more adverse events vs. PLA; LIS (>80%) and the PLA group (>50%) reported side effects. In PLA, 0-3% discontinued due to side effects vs. 3-6% in LIS group. One participant died in LIS group.	1

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Reas DL, Grilo CM.,2008	BED (DSM-IV)	Antidepressants: (SSRI/ SNRI) Anticonvulsants, and Antiobesity agents. *[2]	Inactive or active controls	Rev Sys + Meta	BE remission - Pooled results = 48.7% of patient's w/ medication achieved 100% remission vs. 28.5% of PLA. Significant difference between medication and PLA for remission, with medication (48.7%) being superior (N = 13; n = 1,254; RR = 0.74; 95% CI: 0.66-0.84) with a RR of 0.74. WC - Pooled results: Meta-analysis showed a significant weight reduction of 3.4 kg by medication compared to PLA (*N* = 8; *n* = 1,236; WMD = −3.42; 95% CI: −4.25 to −2.58). ES for the different medication classes varied: from modest effects (WMD = −1.7) for SSRIs to larger effects for antiepileptic (WMD = −4.6) and antiobesity (WMD = −3.6) agents. Combination or Comparative Addition of pharmacotherapy to CBT did not enhance binge-eating outcomes but might have enhanced weight loss outcomes. Addition of topiramate to CBT, and orlistat to diet (30), resulted in clinically significant (not just statistically) weight losses.	1
Appolinario et al., 2003	BED (DSM-IV)	Sibutramine	PLA	RCT	BEabs - Estimated odds of remission with sibutramine was significantly greater vs. PLA. BEred - Reduction in BE associated with sibutramine was significantly superior compared to PLA. Change from baseline in binge days with sibutramine was 66% vs 41% in the PLA. GP - Change of BDI scores was significantly greater with sibutramine (43%) vs. PLA (4%) BW - Weight change: −7.4 kg W/ sibutramine and +1.4 kg w/ PLA (*P*<.001) A&T - No significant differences in incidence of AE, except for dry mouth and constipation in the sibutramine group. Sibutramine was not associated with a clinically or statistically significant change in systolic or blood pressure. There was a minor but significant increase of heart rate (mean ± SD, week 12 vs week 0, 87.1 ± 10.9 vs 79.8 ± 8.7 beats/min[*P* =.007]).	2
Wilfley DE et al., 2008	BED (DSM-IV)	Sibutramine	PLA	RCT	BEabs - Significant abstinence from binges: 58.7% (LOCF) for sibutramine and 42.8% (LOCF) for PLA. BEred - Sibutramine significantly reduced frequency of binges compared with PLA, with an effect size of 0.46 (small). EP - Sibutramine improved significantly eating disorder psychopathology vs PLA (two Three-Factor Eating Questionnaire subscales) BW - Sibutramine significantly reduced weight vs PLA w/ an effect size of 0.87 (moderate) A&T- Sibutramine vs. PLA treatment was associated with significantly higher incidence of headache, dry mouth, constipation, insomnia, and dizziness	2

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Citation	Patient	Intervention	Comparator	Study Design	Results (effect size - ES)	LOE
Milano W et al., 2005	BED (DSM-IV)	Sibutramine	PLA	RCT	BEred - Sibutramine significantly reduced BE frequency from 4.4 (1.0) to 1.0 (1.0) day/week vs PLA (from 4.7 [1.3] to 4.4 [0.5] days/week (*P*<.001). EP - Binge Eating Scale score w/sibutramine was reduced significantly from 28.4 (3.6) to 17.4 (3.5) (*P*<.001), compared to PLA (from 29.4 [3.6] to 28.7 [2.3])). BW - Weight reduction w/ sibutramine was 4.48 compared to 0.59 w/ PLA (sign.) A&T: AE w/ sibutramine: 40% had dry mouth, 20% had constipation, and 10% had tachycardia, insomnia, cephalalgia, or nausea.	2
Grilo CM et al., 2021	BED (DSM-5)	Naltrexone + Bupropion	PLA	RCT	BE, EDP, GP, W - Analyses revealed non-significant reductions from baseline in binge-eating, eating-disorder psychopathology, depression, and weight. A&T: The mean number of AE per patient reported was significantly higher in the group that received NB vs. PLA	3

Abbreviations (alphabetical order): A&T = Acceptability and Tolerability; AN-BP = Anorexia nervosa binge-purging subtype; AN-R = Anorexia nervosa restricting subtype; AMI = Amitryptiline; BE = binge episode BMI = body mass index; CBT = cognitive behavioral therapy; CLO=clomipramine; DSM-III, DSM-IV, DSM-IV-TR, DSM-5 = various versions of the Diagnostic and Statistical Manual of Mental Disorders; EDP = Eating Disorder Psychopathology; FLU= fluoxetine; OLA = olanzapine; OR = odds ratio, PLA = placebo; QUE = quetiapine; RCT = randomized controlled trial; SGAP= Second-generation antipsychotics; RIS = risperidone; TAU = treatment as usual

Outcomes: Efficacy: Binge Eating abstinence (BEabs), - Binge Eating reduction (BEred), Binge Eating Remission (BErem), Compensatory behaviors abstinence (CBabs), Compensatory behaviors reduction (CBred), Eating disorder psychopathology (EDP), General psychopathology (GP), Body weight (BW) and BMI (kg/m^2)

Acceptability & tolerability (A&T): Adverse events (AE) and drop-outs (DP)

*1 = Second Generation Antidepressants (SGAD) - [Fluoxetine (3), Fluvoxamine (3), Sertraline (2), Citalopram (1), Escitalopram (1), Duloxetine (1), Bupropion (1)]; Central Nervous System Stimulants (CNSS) - [Lisdexamphetamine (5), Atomoxetine (1)]; Anticonvulsants (ACV) - [Topiramate (2), Zonizamide (1), Lamotrigine (1)]; and Other Medications (OMED) - [Chromium (1), Acamprosate (1), ALKS-33 (1)];

*2 = SSRI Antidepressants (7) vs. placebo [fluoxetine (2), fluvoxamine (2), sertraline (1), citalopram (1), escitalopram (1) SNRI Agent vs. placebo Atomoxetine (1); Anticonvulsants vs. placebo: Topiramate (2) zonisamide (1); Antiobesity agents vs. placebo: Sibutramine (3)

Weight Loss Treatment (WLT) LOE (Level of Evidence Oxford 2011)

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