NICE National Institute for Health and Care Excellence

Eyes on Evidence

expert commentary on important new evidence

Psychotherapy for anorexia nervosa

A randomised controlled trial in Germany reports that focal psychodynamic therapy and enhanced cognitive behavioural therapy are no better than usual psychotherapy for weight gain in women with anorexia nervosa.

Overview: Anorexia nervosa is when a person tries to keep their body weight as low as possible; for example, by starving themselves or exercising excessively (NICE Clinical Knowledge Summary 2009). Clinical features of anorexia nervosa include a weight at least 15% below that expected (in adults usually a BMI of less than 17.5 kg/m^2).

Anorexia nervosa is not very common, but the disorder is associated with serious medical morbidity and high mortality. The incidence of anorexia in the UK is estimated to be 13.6 cases per 100,000 population in women and 1.3 cases per 100,000 population in men (Micali et al. 2013). Young people with anorexia have a mortality rate after hospital discharge more than 11 times higher than people without eating disorders (Hoang et al. 2014).

Outpatient psychological therapies are usually the first-line treatment for people with anorexia nervosa, coupled with physical monitoring. One approach is cognitive behaviour therapy (CBT), which focuses on changing how someone thinks about a situation and in turn how they act. Another psychological method is focal psychodynamic therapy – counselling that concentrates on how a person's life experiences, especially in childhood, influence their current thoughts, feelings, relationships and behaviour.

See the NICE Evidence Services topic page on eating disorders for a general overview of these conditions.

Current advice: NICE guidance on eating disorders (currently being updated) recommends the following therapies for the psychological treatment of anorexia nervosa: CBT; cognitive analytic therapy; interpersonal psychotherapy; focal psychodynamic therapy; and family interventions focused explicitly on eating disorders. The aims of psychological treatment should be to reduce risk, to encourage weight gain and healthy eating, to reduce other symptoms related to the eating disorder, and to facilitate psychological and physical recovery.

The guidance adds that most people with anorexia nervosa should be managed on an outpatient basis, with psychological treatment (with physical monitoring). Outpatient psychological treatment for anorexia nervosa should normally be of at least 6 months' duration.

The NICE Pathway on eating disorders brings together all related NICE guidance and associated products on the conditions in a set of interactive topic-based diagrams.

New evidence: Zipfel et al. (2014) conducted a multicentre randomised controlled trial of focal psychodynamic therapy or CBT versus optimised treatment as usual in outpatients with anorexia nervosa. Women aged 18 years or older with a diagnosis of anorexia nervosa and a BMI of 15–

18.5 kg/m^2 were recruited from 10 institutions in Germany. Participants were randomly assigned to 10 months of treatment with focal psychodynamic therapy, enhanced CBT or optimised treatment as usual. The focal psychodynamic therapy centred on interpersonal relationships and their link to eating behaviour, whereas the enhanced CBT focused on self-efficacy and education of patients about being underweight and starvation. Optimised treatment as usual allowed patients to access any type of psychotherapy in any setting, and included active treatment and monitoring by the patients' family doctor.

Of the 727 women screened for inclusion, 242 (33%) were randomly assigned to focal psychodynamic therapy (n=80), enhanced CBT (n=80) or optimised treatment as usual (n=82). A total of 54 patients (22%) were lost to follow-up at the end of treatment (10 months) and 73 (30%) had dropped out by the 12-month follow-up. Mean increase in BMI at the end of treatment was 0.73 kg/m^2 in the focal psychodynamic therapy group, 0.93 kg/m^2 in the enhanced CBT group, and 0.69 kg/m^2 in the optimised treatment as usual group. At 12 months these values were 1.64 kg/m^2, 1.30 kg/m^2, and 1.22 kg/m^2, respectively. In adjusted intention-to-treat analyses, these increases in BMI did not differ significantly between treatment groups at either the end of treatment or 12-month follow-up. Patients assigned focal psychodynamic therapy were less likely to need additional inpatient treatment during follow-up (p=0.044) and had a higher recovery rate at 12 months (p=0.036).

The authors concluded that focal psychodynamic therapy, enhanced CBT and optimised treatment as usual result in relevant weight gains in women with anorexia nervosa, although no one approach was superior. The study was limited by the high proportion of patients lost to follow-up in the treatment as usual group (44% compared with 28% of the focal psychodynamic therapy group and 19% of the enhanced CBT group) and the limited follow-up after the end of treatment (2 months).

Commentary: "This is the first randomised controlled trial of outpatient psychological therapy for anorexia nervosa that was sufficiently powered to show a difference between active treatments. It is an impressive achievement. As in other less well powered trials comparing active therapies (for example, Schmidt et al. 2012 and Carter et al. 2011), there were no differences in the primary outcome.

"However, participants assigned to optimised treatment as usual were significantly less likely to achieve a full recovery at 1 year follow-up and were more likely to need additional inpatient treatment than those allocated to psychodynamic psychotherapy. This tends to support use of one of the active therapies, as advised in current NICE guidelines. The focal psychodynamic therapy manual is, however, less accessible than enhanced CBT, for which training in the UK can be accessed through the CREDO group.

"Furthermore, as in many therapy trials, participants were not blind to treatment group and those in the optimised treatment as usual arm may have had lower expectations for efficacy of treatment. Overall rates of full psychological as well as weight recovery were low for all groups (around 23% at 12 months). Further research, including secondary analysis of data from this trial, needs to be done to determine 'what works for whom' and how to enhance recovery rates." ***– Professor Phillipa Hay, Foundation Chair of Mental Health, Centre for Health Research, School of Medicine, University of Western Sydney, Australia***

Study sponsorship: German Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung [BMBF]) and the German Eating Disorders Diagnostic and Treatment Network (EDNET).

About this article: This article appeared in the August 2014 issue of the Eyes on Evidence e-bulletin. This free monthly e-bulletin from NICE Evidence outlines interesting new evidence and what it means for current practice. They do not constitute formal NICE guidance. The opinions of contributors do not necessarily reflect the views of NICE.

To receive the Eyes on Evidence e-bulletin, please complete the online registration form.

Visit Evidence Search