NKR46 PICO 4: focus on core symptoms in the treatment of anorexia

Review information

Authors

The Danish Health Authority[1]

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Citation example: TDHA. NKR46 PICO 4: focus on core symptoms in the treatment of anorexia. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Characteristics of studies

Characteristics of included studies

Agras 2014

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Fokus på kernesymtomer ● *Alder (SD)*: 15.1 (1.7) ● *Antal piger/kvinder (%)*: 67 (85.9) ● *Varighed af AN i måneder (SD)*: 11.6 (9.8) ● *Antal i psykofarkalogisk behandling (%)*: 14 (17.9) Bredt fokus (ej kernesymptomer) ● *Alder (SD)*: 15.6 (1.8) ● *Antal piger/kvinder (%)*: 74 (92.5) ● *Varighed af AN i måneder (SD)*: 15.4 (16.9) ● *Antal i psykofarkalogisk behandling (%)*: 16(20.0) **Included criteria:** Adolescents (12-18 years). Meeting diagnostic criteria for the DSM-IV definition of AN, except for the amenorrhea criterion, and with weight up to 87% of their IBW. **Excluded criteria:** Current psychotic illness, mental retardation, bipolar disorder, pregnancy, dependence on drugs or alcohol, previous family therapy for AN, taking medications that may induce weight loss, and medical instability, including being at a weight at or below 75% of the IBW. **Pretreatment:** There were no significant differences between groups forany demographic or baseline variable.
Interventions	**Intervention Characteristics** Fokus på kernesymtomer ● *Behandlingsfokus*: Family-based therapy is a focused treatment that engages the family to facilitate weight restorationin their child. ● *Terapiform*: FBT Bredt fokus (ej kernesymptomer) ● *Behandlingsfokus*: In SyFT, thefocus is placed on the family system. Difficulties arise not in individuals themselves but in the relationships, interac-tions, and language that develop between individuals. ● *Terapiform*: SyFT
Outcomes	*Psykologiske spiseforstyrrelsessymptomer, EOT* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Partially reported ● **Scale**: EDE, global score ● **Range**: 0-6 ● **Unit of measure**: points ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: EOT=end of treatmentEDE ved baseline er ikke signifikant forskellig. SDs are baseline values *Psykologiske spiseforstyrrelsessymptomer, LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Partially reported ● **Scale**: EDE, global score ● **Range**: 0-6 ● **Unit of measure**: points ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: LFU=længste follow-upSDs are baseline values *Adfærdssymptomer (restriktiv spisning, tvangsmotion, binge, purge), EOT* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: Agras 2014: ikke rapporteret

	Adfærdssymptomer (restriktiv spisning, tvangsmotion, binge, purge), LFU (1 år) ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: Agras 2014: ikke rapporteret *Andel af sund kropsvægt/BMI, EOT* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Partially reported ● **Scale**: andel af IBW ● **Range**: 0-100 ● **Unit of measure**: % ● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: SDs are baseline values *Andel af sund kropsvægt/BMI, LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: andel IBW ● **Range**: 0-100 ● **Unit of measure**: % ● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: SDs are baseline values *Recovery rate, LFU (1 år)* ● **Outcome type**: DichotomousOutcome ● **Scale**: antal ● **Range**: 0-100 ● **Unit of measure**: % ● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: Agras 2014: Recovery defineret som ≥ 95% af IBW *Dropout* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Scale**: dropouts og withdrawn ● **Unit of measure**: antal ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: Både dropouts og withdrawn from treatment pga. prolonged medical instability *Indlæggelser (antal dage)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Partially reported ● **Scale**: median antal ● **Unit of measure**: dage ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: Agras 2014: kun median oplyst: FBT=8.3, SyFT=21 dage. Ingen means.
Notes	*Nkr 46 Anoreksi* on 04/03/2016 15:52 **Interventions** Agras 2014: Behandling med fokus på kernesymptomer=manualiseret FBT. Behandling med bredt fokus = systemisk familieterapi (SyFT)

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence generation	Low risk	Participants were randomized within sites to one of the 2 family therapies using a computer-generated program.
Allocation concealment	Unclear risk	Judgement Comment: Not reported
Blinding of personel and participants	High risk	blinding of participants and therapists not possible.
Blinding of outcome assessors	Low risk	Assessors were blinded to treatment assignment
Incomplete outcome data	Low risk	Missing data points were treated as missing at random conditional on observed information using maximum likelihood estimation. Dropout er lav, og analyser tager højde for missing data.
Selective outcome reporting	High risk	Judgement Comment: Der er ikke opgivet estimat for usikkerked for EOT og FU data, kun for baseline data. Alle planlagte outcomes rapporteres.

Other bias	Unclear risk	no information

McIntosh 2005

Methods	
Participants	
Interventions	
Outcomes	
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence generation	Low risk	From Hay 2015
Allocation concealment	Low risk	From Hay 2015
Blinding of personel and participants	High risk	(not included in Hay 2015)
Blinding of outcome assessors	Low risk	From Hay 2015
Incomplete outcome data	Low risk	From Hay 2015
Selective outcome reporting	Low risk	From Hay 2015
Other bias	High risk	From Hay 2015

Robin 1999

Methods	
Participants	
Interventions	
Outcomes	
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence generation	Low risk	From Fisher 2010
Allocation concealment	Low risk	From Fisher 2010
Blinding of personel and participants	High risk	From Fisher 2010
Blinding of outcome assessors	High risk	From Fisher 2010
Incomplete outcome data	High risk	From Fisher 2010
Selective outcome reporting	High risk	From Fisher 2010
Other bias	High risk	From Fisher 2010

Touyz 2013

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Fokus på kernesymptomer ● *Alder (SD)*: 34.6 (9.0) ● *Antal piger (%)*: 31 (100) ● *Varighed af AN i år (SD)*: 17.7 (7.5) ● *Antal i psykofarkalogisk behandling (%)*: 12 (38.7) Bredt fokus (ej kernesymptomer) ● *Alder (SD)*: 32.3 (10.0) ● *Antal piger (%)*: 32 (100) ● *Varighed af AN i år (SD)*: 15.5 (9.3) ● *Antal i psykofarkalogisk behandling (%)*: 14 (43.8) **Included criteria:** Severe and enduring AN (SE-AN). Aged ≥ 18 years and met DSM-IV criteria for AN, excluding criterion D (amenorrhea),for more than 7 years. Patients were also included if they met all DSM-IV criteria but presented with a BMI between 17.6 and18.5 kg/m2. **Excluded criteria:** Current manic episode or psychosis, current alcohol or substance abuse or dependence, significant current medical or neurological illness (including seizure disorder), with the exception of nutrition-related alterations that impact on weight, were currently engaged in psychotherapy and not willing to suspend treatment for the duration of their participation in the study, had plans to move beyond commuting distance from the study site in the following 12 months, or did not live within commuting distance to the study site. **Pretreatment:** Twelve participants in CBT-AN (38.7%)and 14 in SSCM (43.8%) were taking psychotropicmedication.

Interventions	**Intervention Characteristics** Fokus på kernesymptomer ● *Behandlingsfokus*: spise-adfærd, livskvalitet, vægtøgning sekundært. ● *Terapiform*: modified CBT-AN Bredt fokus (ej kernesymptomer) ● *Behandlingsfokus*: livskvalitet, hvad patienten bringer til sessionen, vægtøgning sekundært. ● *Terapiform*: modified SSCM
Outcomes	*Psykologiske spiseforstyrrelsessymptomer, EOT* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: EDE, global score ● **Range**: 0-6 ● **Unit of measure**: points ● **Direction**: Lower is better ● **Data value**: Endpoint *Psykologiske spiseforstyrrelsessymptomer, LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: EDE, global score ● **Range**: 0-6 ● **Unit of measure**: points ● **Direction**: Lower is better ● **Data value**: Endpoint *Adfærdssymptomer (restriktiv spisning, tvangsmotion, binge, purge), EOT* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Adfærdssymptomer (restriktiv spisning, tvangsmotion, binge, purge), LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Andel af sund kropsvægt/BMI, EOT* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Unit of measure**: BMI ● **Direction**: Higher is better ● **Data value**: Endpoint *Andel af sund kropsvægt/BMI, LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Unit of measure**: BMI ● **Direction**: Higher is better ● **Data value**: Endpoint *Recovery rate, LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported *Dropout* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Unit of measure**: antal ● **Direction**: Lower is better ● **Data value**: Endpoint *Indlæggelser (antal patienter) (LFU)* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Unit of measure**: antal patienter ● **Direction**: Lower is better ● **Data value**: Endpoint ● **Notes**: OBS: studiet angiver, at 7 behøvede indlæggelse før EOT, mens yderligere 11 modtog ambulant/dag-hospital(døgnindlæggelse i follow-up perioden. Antallet ikke fordelt på grupper men oplyser, at der ikke er signifikant forskel på hospitalsindlæggelser ved EOT.Her er det samlede antal (7+11) fordelt ligeligt mellem de to interventionsarme. *Livskvalitet, LFU (1 år)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Partially reported ● **Scale**: EDQOL ● **Unit of measure**: points ● **Direction**: Higher is better ● **Data value**: Change from baseline ● **Notes**: EDQOL=Eating Disorder Quality of Life Instrument: a standardized and validated 25-item instrument assessing quality of life in ED populations across four subscales: psychological, physical and cognitive, financial, and work or school.

Notes	*Nkr 46 Anoreksi* on 04/03/2016 02:29 **Select** Studiet undersøger CBT-AN overfor SSCM - dvs begge to studier med fokus på kernesymptomer. *Nkr 46 Anoreksi* on 04/03/2016 03:21 **Select** konsensus: subgruppe til SE-AN: SSCM er kun ganske let kerne-fokuseret men meget ikke-direktiv *Nkr 46 Anoreksi* on 04/03/2016 15:58 **Interventions** Both treatments involved 30 individual treatment sessions provided over 8 months in an out-patient setting. Focus of treatment was improving quality of life and minimize harm, rather than weight gain per se. OBS: ingen af behandlingsarmene har fokus på vægtøgning pga. populationen, men CBT-AN mere aktivt og dirigerende fokus på at udfordre kernesymptomer.The treatments were distinct in that CBT-AN made use of specific cognitive and behavioral strategies whereas SSCM made use of more general, supportive therapeutic strategies.Fokus på kernesymptomer: CBT-ANCBT-AN was modified: treatment goals were set collaboratively and weight gain was encouraged but not identified as the primary goal. Eating behaviors are directly challenged through use of behavioral experiments and cognitive strategies. Changes to eating behaviors are encouraged using advice and education around nutrition rather than specific strategies. Highly structured, therapist-directed. Patients are given homework in each session.Bredt fokus:Fostering a therapeutic relationship that promotes adherence to treatment. Aims to assist the patient through use of praise, reassurance and advice. Changes to eating behaviors are encouraged using advice and education around nutrition rather than specific strategies. SSCM was modified for this trial such that weight gain was not prioritized. Instead, SSCM encouraged patients to make changes to improve their quality of life and physical well-being.Less structured sessions, based on what the patient brings to the session.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence generation	Low risk	Randomization was performed by a biostatistician in the Data and Coordinating Centre (DCC, The University of Chicago), independent from either inter- vention site.
Allocation concealment	Unclear risk	Judgement Comment: Not reported
Blinding of personel and participants	High risk	Blinding of participants and therapist not possible.
Blinding of outcome assessors	Low risk	Independent assessors blind to treatment assignment conducted all assessments.
Incomplete outcome data	Low risk	All outcome analyses were based upon an intention-to-treat (ITT) approach. Missing data for con- tinuous outcome measures at EOT and follow-ups were imputed using multiple imputation based upon fully conditional Markov chain Monte Carlo modeling (Schafer, 1997). COMMENTS Dropout er lav, og der tages højde for missing data i analyser.
Selective outcome reporting	High risk	Judgement Comment: All intended outcomes are reported. Der oplyses ikke usikkerheds-estimater.
Other bias	Low risk	no comments

Treasure 1995

Methods	
Participants	
Interventions	
Outcomes	
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence generation	Low risk	From Hay 2015
Allocation concealment	Unclear risk	From Hay 2015
Blinding of personel and participants	High risk	(not included in Hay 2015)
Blinding of outcome assessors	High risk	From Hay 2015
Incomplete outcome data	Unclear risk	From Hay 2015
Selective outcome reporting	Low risk	From Hay 2015
Other bias	High risk	From Hay 2015

Zipfel 2014

Methods	
Participants	
Interventions	
Outcomes	
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Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence generation	Low risk	From Hay 2015
Allocation concealment	Low risk	From Hay 2015
Blinding of personel and participants	High risk	(not included in Hay 2015)
Blinding of outcome assessors	Low risk	From Hay 2015
Incomplete outcome data	Low risk	From Hay 2015
Selective outcome reporting	Low risk	From Hay 2015
Other bias	Low risk	From Hay 2015

Footnotes

Characteristics of excluded studies

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

Summary of findings tables

Additional tables

References to studies

Included studies

Agras 2014

Agras W.S.; Lock J.; Brandt H.; Bryson S.W.; Dodge E.; Halmi K.A.; Jo B.; Johnson C.; Kaye W.; Wilfley D.; Woodside B.. Comparison of 2 family therapies for adolescent anorexia nervosa: A randomized parallel trial. JAMA Psychiatry 2014;71(11):1279-1286. [DOI:]

McIntosh 2005

Robin 1999

[Empty]

Touyz 2013

Touyz S.; Le,Grange D.; Lacey H.; Hay P.; Smith R.; Maguire S.; Bamford B.; Pike K.M.; Crosby R.D.. Treating severe and enduring anorexia nervosa: a randomized controlled trial. Psychological medicine 2013;43(12):2501-2511. [DOI:]

Touyz,S.; Le Grange,D.; Lacey,H.; Hay,P.; Smith,R.; Maguire,S.; Bamford,B.; Pike,K. M.; Crosby,R. D.. "Treating severe and enduring anorexia nervosa: a randomized controlled trial": Corrigendum.. Psychological medicine 2013;43(12):2512. [DOI:]

Treasure 1995

Zipfel 2014

Published and unpublished data

Excluded studies

Studies awaiting classification

Ongoing studies

Other references

Additional references

Other published versions of this review

Classification pending references

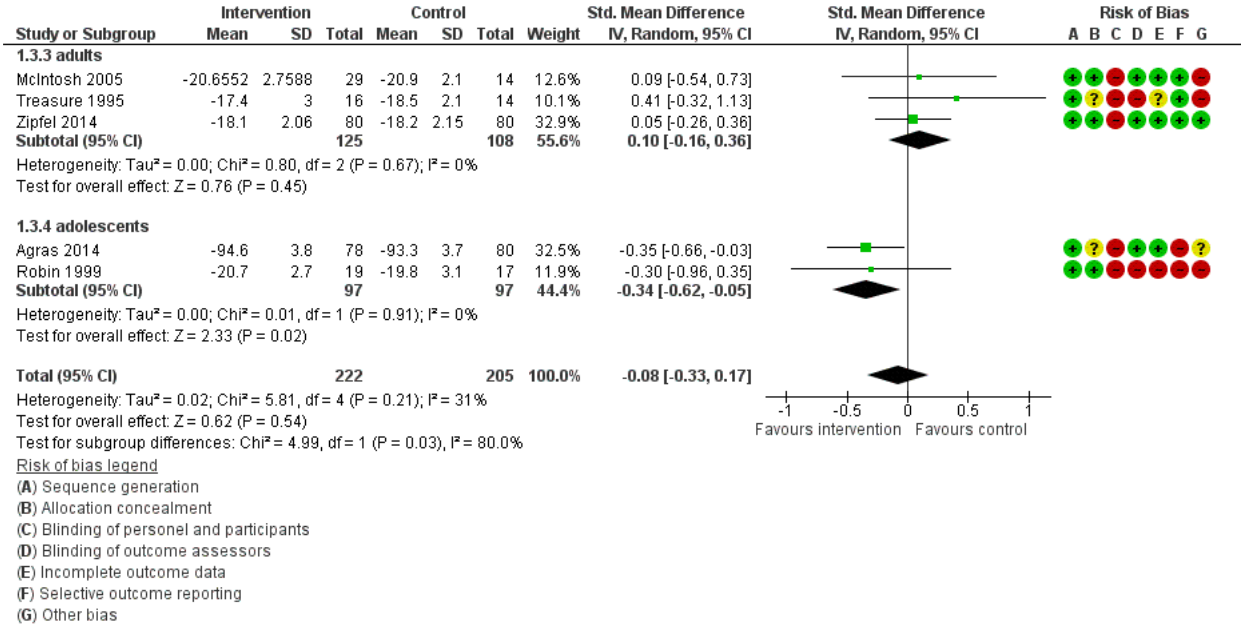
Data and analyses

1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer)

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Adfærdssymptomer (restriktiv spisning, tvangsmotion, binge, purge), LFU (1 år)	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable
1.2 Adfærdssymptomer (restriktiv spisning, tvangsmotion, binge, purge), EOT	0	0	Mean Difference (IV, Fixed, 95% CI)	Not estimable
1.3 Andel af sund kropsvægt/BMI, LFU (1 år)	5	427	Std. Mean Difference (IV, Random, 95% CI)	-0.08 [-0.33, 0.17]
1.3.3 adults	3	233	Std. Mean Difference (IV, Random, 95% CI)	0.10 [-0.16, 0.36]
1.3.4 adolescents	2	194	Std. Mean Difference (IV, Random, 95% CI)	-0.34 [-0.62, -0.05]
1.4 Andel af sund kropsvægt/BMI, EOT	4	410	Std. Mean Difference (IV, Random, 95% CI)	-0.27 [-0.47, -0.08]
1.4.3 adults	2	216	Std. Mean Difference (IV, Random, 95% CI)	-0.24 [-0.51, 0.03]
1.4.4 adolescents	2	194	Std. Mean Difference (IV, Random, 95% CI)	-0.31 [-0.59, -0.03]
1.5 Psykologiske spiseforstyrrelsessymptomer, LFU (1 år)	4	396	Std. Mean Difference (IV, Random, 95% CI)	0.04 [-0.21, 0.28]
1.5.6 adults (EDE restraint and EDI total)	2	203	Std. Mean Difference (IV, Random, 95% CI)	0.13 [-0.15, 0.41]
1.5.7 adolescents (EDE global and EAT cognitive distortion)	2	193	Std. Mean Difference (IV, Random, 95% CI)	0.01 [-0.56, 0.59]
1.6 Psykologiske spiseforstyrrelsessymptomer, EOT	4	409	Std. Mean Difference (IV, Random, 95% CI)	-0.15 [-0.54, 0.23]
1.6.6 adults (EDE restraint and EDI total)	2	216	Std. Mean Difference (IV, Random, 95% CI)	-0.44 [-1.30, 0.42]
1.6.7 adolescents (EDE global and EAT cognitive distortion)	2	193	Std. Mean Difference (IV, Random, 95% CI)	0.05 [-0.23, 0.33]
1.7 Recovery rate, LFU (1 år)	4	237	Risk Ratio (M-H, Random, 95% CI)	0.90 [0.73, 1.10]
1.7.1 Adults (Recovery not achieved according to Morgan and Russell narrow categories or similar)	3	202	Risk Ratio (M-H, Random, 95% CI)	0.91 [0.74, 1.11]
1.7.2 adolescents (Remission not achieved)	1	35	Risk Ratio (M-H, Random, 95% CI)	0.67 [0.22, 2.09]
1.8 Dropout, end of treatment	4		Risk Ratio (IV, Random, 95% CI)	Subtotals only
1.8.2 adults	3	246	Risk Ratio (IV, Random, 95% CI)	0.69 [0.46, 1.05]
1.8.3 adolescents	1	158	Risk Ratio (IV, Random, 95% CI)	0.87 [0.55, 1.38]
1.9 Livskvalitet, LFU (1 år)	1	158	Std. Mean Difference (IV, Random, 95% CI)	0.15 [-0.16, 0.46]
1.9.2 adolescents (Quality of Life and Enjoyment Scale (SF) (higher=better))	1	158	Std. Mean Difference (IV, Random, 95% CI)	0.15 [-0.16, 0.46]
1.10 Indlæggelser (antal patienter) (LFU)	4		Risk Ratio (IV, Random, 95% CI)	Subtotals only
1.10.2 adolescents	1	158	Risk Ratio (IV, Random, 95% CI)	0.63 [0.34, 1.18]
1.10.3 adults	3	185	Risk Ratio (IV, Random, 95% CI)	0.77 [0.10, 5.87]

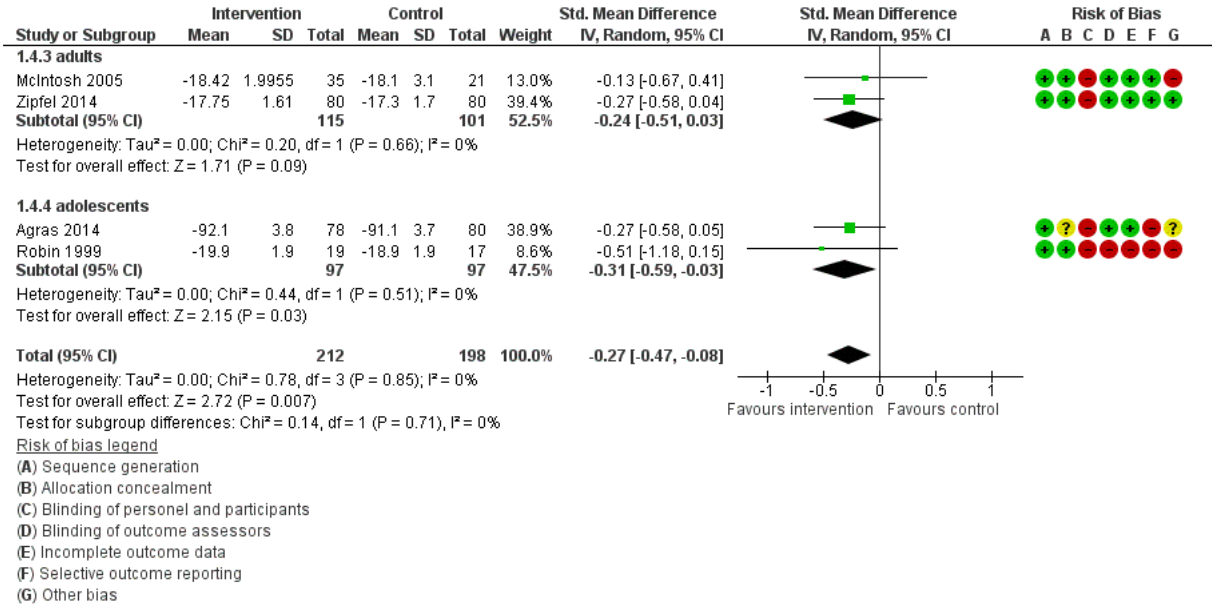
Figures

Figure 1 (Analysis 1.3)



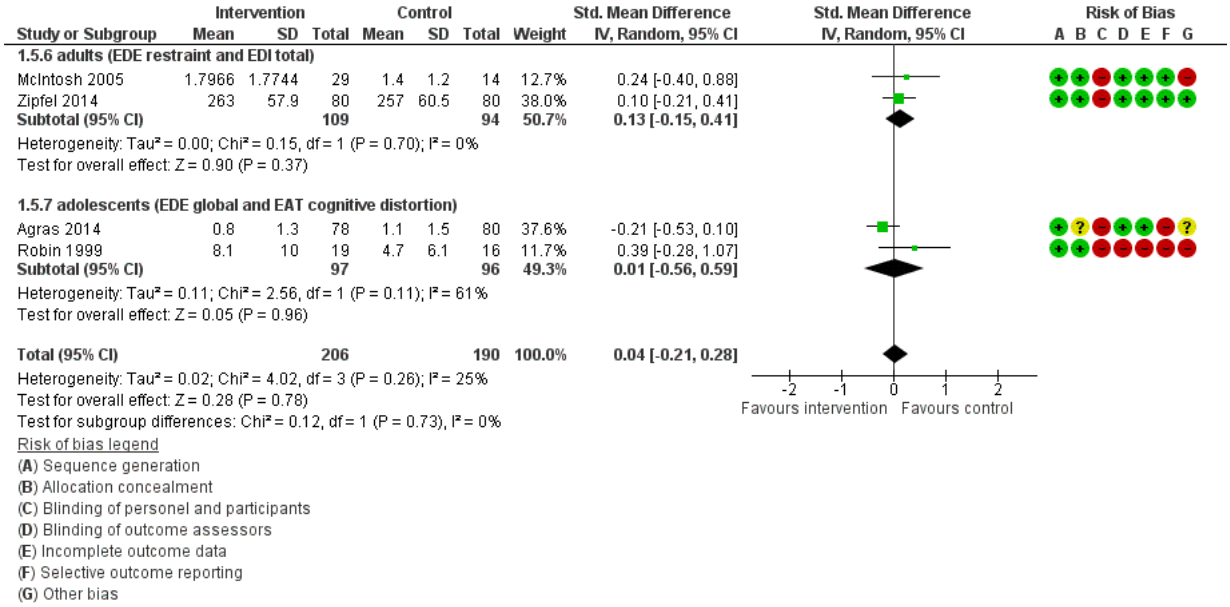
Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.3 Andel af sund kropsvægt/BMI, LFU (1 år).

Figure 2 (Analysis 1.4)



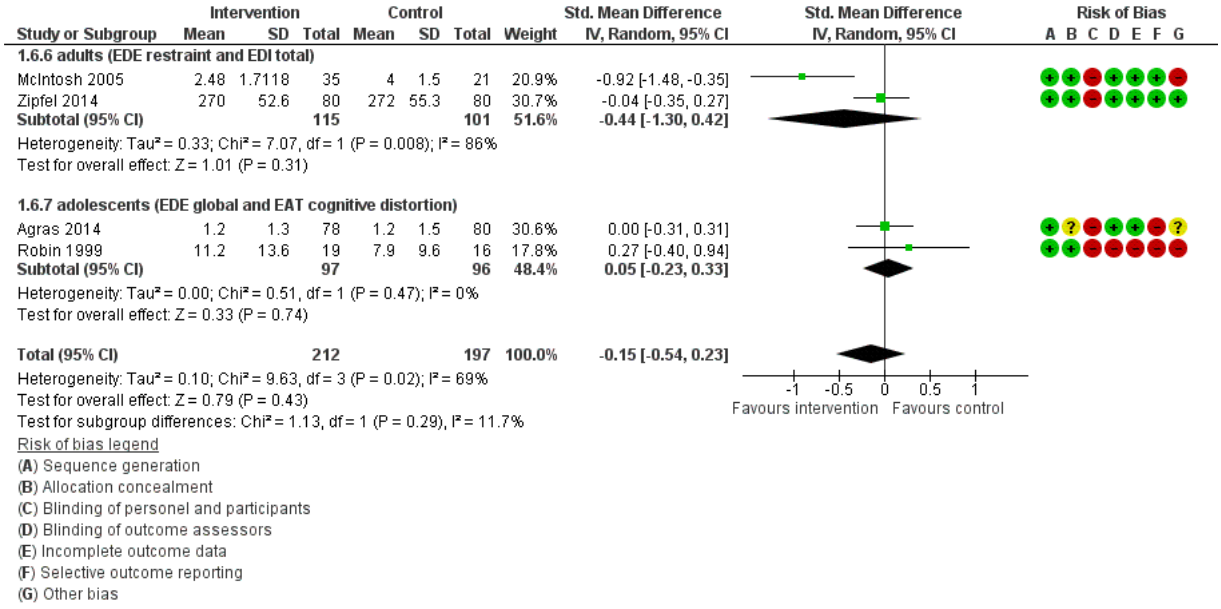
Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.4 Andel af sund kropsvægt/BMI, EOT.

Figure 3 (Analysis 1.5)



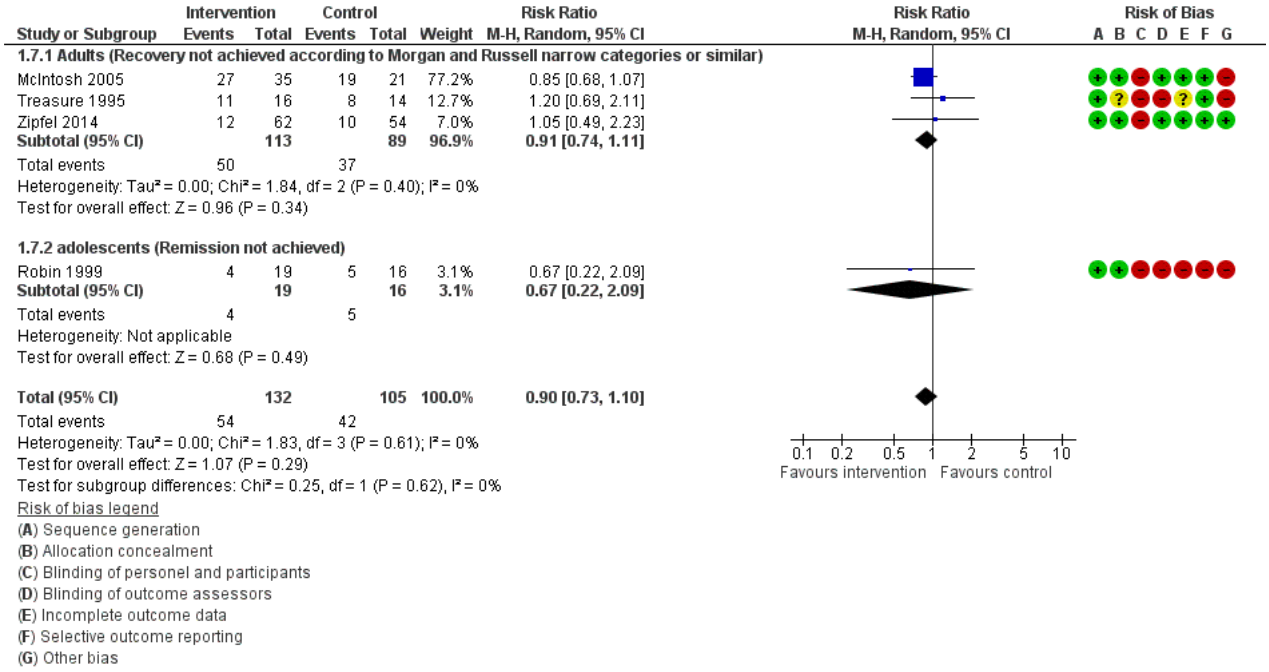
Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.5 Psykologiske spiseforstyrrelsessymptomer, LFU (1 år).

Figure 4 (Analysis 1.6)



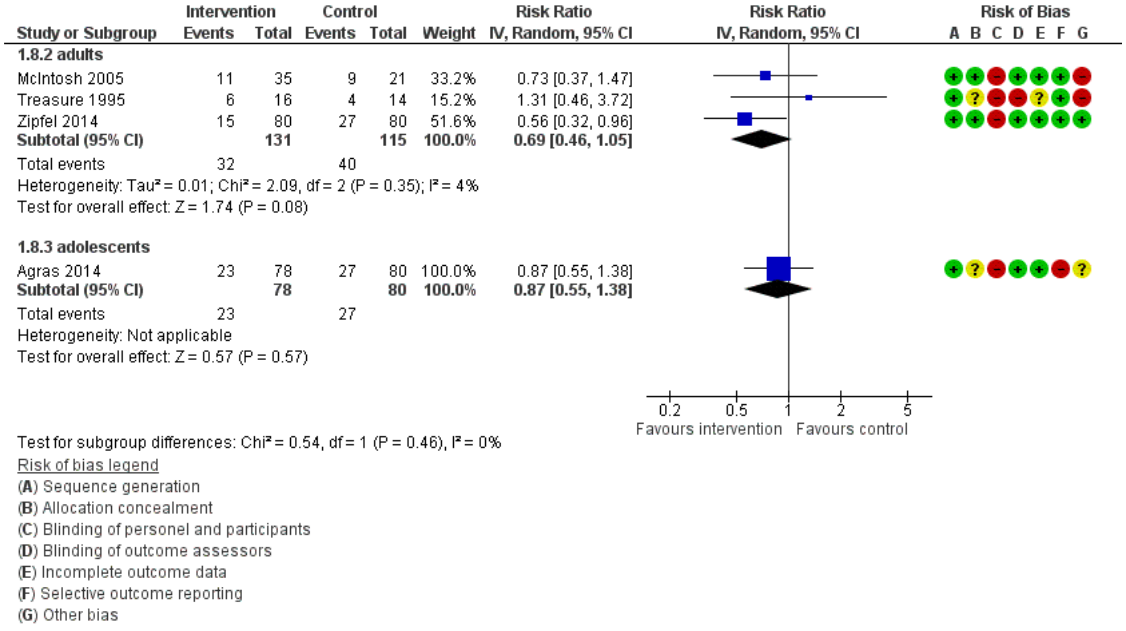
Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.6 Psykologiske spiseforstyrrelsessymptomer, EOT.

Figure 5 (Analysis 1.7)



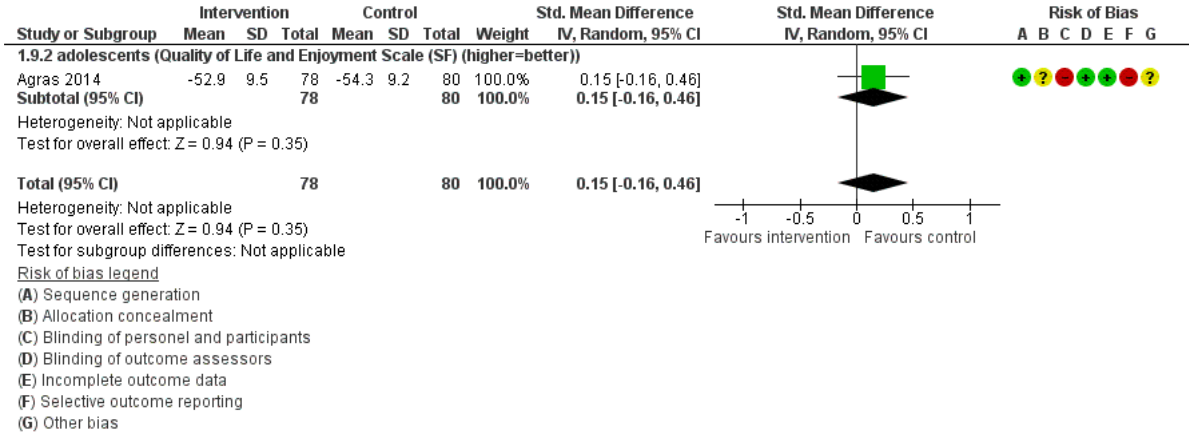
Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.7 Recovery rate, LFU (1 år).

Figure 6 (Analysis 1.8)



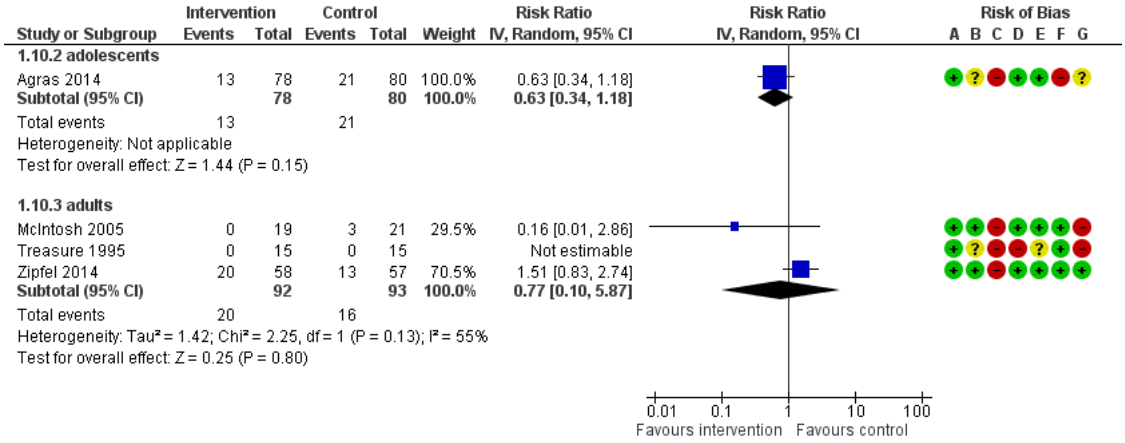
Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.8 Dropout, end of treatment.

Figure 7 (Analysis 1.9)



Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.9 Livskvalitet, LFU (1 år).

Figure 8 (Analysis 1.10)



Forest plot of comparison: 1 Fokus på kernesymptomer vs Bredt fokus (ej kernesymptomer), outcome: 1.10 Indlæggelser (antal patienter) (LFU).