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Cognitive Behavioural Therapy for anorexia nervosa: A systematic review

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HIGHLIGHTS

- Patients treated with CBT showed improvements in physical and psychological outcomes.
- CBT did not appear to be superior to other types of treatment on these outcomes.
- CBT showed promise in reducing dropout compared to other treatments.

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ABSTRACT

Evidence for the effectiveness of psychological therapies for anorexia nervosa (AN) is inconsistent. There have been no systematic reviews solely on the effectiveness for Cognitive Behavioural Therapy (CBT) for AN. This review aimed to synthesise and appraise the recent evidence for CBT as a treatment for AN. Using specific search criteria, 16 relevant articles were identified which evaluated CBT alone or as part of a broader randomised/non-randomised trial. Various formats of CBT were utilised in the reviewed papers. Studies were evaluated using established quality criteria.

The evidence reviewed suggested that CBT demonstrated effectiveness as a means of improving treatment adherence and minimising dropout amongst patients with AN. While CBT appeared to demonstrate some improvements in key outcomes (body mass index, eating-disorder symptoms, broader psychopathology), it was not consistently superior to other treatments (including dietary counselling, non-specific supportive management, interpersonal therapy, behavioural family therapy). Numerous methodological limitations apply to the available evidence.

Further research and ongoing review is needed to evaluate the settings, patient groups and formats in which CBT may be effective as a treatment for AN.

Contents

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1. Introduction

Anorexia nervosa (AN) is characterised by deliberate weight loss through food restriction and/or compensatory strategies including excessive exercise, bingeing and purging. It is accompanied by a distortion of body image and an intense fear of gaining weight despite emaciation. Outcomes for individuals with AN have improved little in the second half of the past century (Crow & Peterson, 2003), and AN continues to be associated with poor prognosis and significant physical and psychological complications. This review intended to evaluate the evidence for one particular approach to the treatment of AN: Cognitive Behavioural Therapy (CBT).

Longitudinal research has suggested fewer than 50% of individuals diagnosed with AN recover fully; 20–30% continue to experience residual symptoms, 10–20% remain significantly ill and 5–10% die from their illness (Steinhausen, 2002). Mortality rates in AN are ten times that of the general population (Morris, 2008), and are the highest of all psychiatric disorders (Harris & Barraclough, 1998). Such statistics highlight the importance of research into developing effective prevention and treatment strategies for AN.

Evidence for drug therapy alone in eating disorders is weak–moderate (Hay & Claudino, 2012); although low-dose antipsychotic medication has been found to be beneficial in some trials, it has long been recognised that treatments for AN need to target both physical (i.e. promotion of weight gain, reducing risk of physical complications) and psychological aspects of the disorder (e.g. working with disordered cognitions, harmful behaviours, body image issues and associated emotional disturbances). Current guidance suggests a range of psychological therapies to consider for the treatment of AN, including cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions (NICE, 2009).

A number of reviews have been conducted on the effectiveness of psychological therapies for eating disorders (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Hay, Touyz, & Sud, 2012; Kaplan, 2002; Lock & Fitzpatrick, 2007; Peterson & Mitchell, 1999; Rosenblum & Forman, 2002; Rutherford & Couturier, 2007; Watson & Bulik, 2012; Wilson, 2005; Wilson, Grilo, & Vitousek, 2007). The consensus of these reviews was of a paucity of evidence (specifically RCTs) to support any particular treatment for adults with AN. This is in contrast to bulimia nervosa, where CBT is considered the treatment of choice (National Institute for Health and Clinical Excellence [NICE], 2004).

There are methodological difficulties in conducting RCTs with people with AN, particularly with respect to recruitment and compliance (Treasure & Kordy, 1998), so RCTs are relatively rare: "making the attempt to reach for a 'gold standard' of treatment for AN difficult to achieve" (Goldstein et al., 2011, p.29). NICE (2004) made over 100 recommendations for eating disorders. CBT for bulimia and binge-eating disorder received strong empirical support, however no specific recommendations were made for AN.

CBT seeks to help patients overcome difficulties by identifying and altering dysfunctional thinking, behaviour, and emotional responses/behaviours. CBT has been shown to be effective in treating many of the problems which are often a feature of AN (depression, anxiety, low self-esteem, obsessions/compulsions). Cognitive and attentional biases towards food/eating/shape-related stimuli are a significant feature in eating disorder presentations (e.g. Brooks, Prince, Stahl, Campbell, & Treasure, 2011), therefore CBT would appear to be a logical choice for treatment. Furthermore, the stylistic features of CBT (structured, time-limited, directive, focused on the present) appear suited to the 'typical' individual with AN who is described as comfortable with order and control, and not prepared to delve into the past (Freeman, 2002). CBT appears to have been accepted by professionals as a useful intervention for AN. Herzog et al. (1992) reported that 88–92% of clinicians at eating disorder conferences considered CBT (alone or combined with a psychodynamic approach) to be indicated in AN. However, despite the apparent theoretical suitability and acceptability of CBT for AN, evidence for its effectiveness is limited.

Previous reviews have evaluated the evidence for a range of treatments for AN with CBT as one type of treatment. Kaplan (2002) reported three RCTs which included CBT. Two of these RCTs suggested a positive effect on outcome for CBT compared to other treatments, while the third study showed no difference in outcome between treatments. However, Kaplan (2002) noted the methodological limitations of these studies (e.g. small samples, power issues, the impact of dropout on results). A Cochrane review (Hay et al., 2003) evaluated multiple psychotherapies for AN but did not identify any additional studies to those in Kaplan (2002) and unsurprisingly, this review drew similar conclusions. A later review by Bulik et al. (2007) identified one additional RCT which suggested that outcomes in the CBT condition were superior to one of the comparison treatments but inferior to a second. After summarising the methodological limitations of the reviewed papers, Bulik et al. (2007) concluded there was "tentative evidence that CBT reduces relapse risk for adults, after weight restoration has been accomplished" (p.317).

These previous reviews are themselves open to a number of methodological limitations. The Kaplan (2002) paper is a descriptive rather than a systematic review and it is unclear how papers were selected, assessed for quality and appraised. The Bulik et al. (2007) review was more systematic but employed a subjective and unvalidated rating scale to evaluate strength and quality of evidence. While previous reviews represent considerable breadth of treatments, there are no specific reviews of the effectiveness of CBT for AN. Given the rarity of (and methodological difficulties associated with) RCTs in AN, previous