Psychoanalytisch orientierte Behandlung der Anorexia nervosa: eine methodenkritische Literaturübersicht unter Verwendung meta-analytischer Methoden [Psychoanalytically oriented treatment of Anorexia nervosa: methodology-related critical review of the literature using meta-analysis methods]

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Authors' objectives
To make available and evaluate psychoanalytic orientated contributions to the treatment of anorexia nervosa.

Searching
The authors searched MEDLINE, PsycLIT, PSYNDEX and their own database of studies published until the end of 1995. They also handsearched the International Journal of Eating Disorders, the Chicago Psychoanalytic Literature Index, diverse monographs and reviews, and 18 further psychoanalytic orientated journals. The authors included studies in German, English or French, in addition to a few classic publications in other languages.

Study selection
Study designs of evaluations included in the review
Studies with more than 4 patients and which had formally defined outcome criteria were eligible for inclusion in the review.

Specific interventions included in the review
Studies on psychoanalytic treatments implemented or supervised by a psychoanalyst following a psychodynamic approach were eligible for inclusion. The included studies varied on several dimensions, e.g. in the duration of the therapy (12 to 92 weeks), in-patient versus out-patient treatment, or which therapy orientation was emphasised (e.g. symptom, relationship focused). Information was often missing.

Participants included in the review
Studies on patients who were clearly identified as being anorexic were eligible for inclusion. Females accounted for 85 to 100% of the patients in the included studies.

Outcomes assessed in the review
The outcomes had to be formally defined in order to measure the results of therapy. The included studies assessed body weight and other factors, such as menstruation, nutrition, psychopathology, and sexual, social and global adaptation.

How were decisions on the relevance of primary studies made?
The authors did not state how the papers were selected for the review, or how many reviewers performed the selection.

Assessment of study quality
The authors assessed the study type, methodology, description of therapy, patient selection and drop-outs. The authors did not state how the papers were assessed for validity, or how many reviewers performed the validity assessment.

Data extraction
The authors did not state how many reviewers performed the data extraction.

The reviewers transformed all weight measures into the Body Mass Index, and missing values were calculated or estimated. They reported individual values for the outcomes and stated the number of patients classified with a good (symptom remission or nearly remittent), intermediate (better but still anorexic), or poor (no difference or symptom exacerbation) therapy outcome at the end of the therapy and at katamnesis. Effect sizes for weight, depression and
general psychopathology were calculated for the end of therapy, up to 2 years and for longer follow-ups.

**Methods of synthesis**

**How were the studies combined?**

The studies were combined in a narrative review and presented in tabular format.

**How were differences between studies investigated?**

Effects of individual factors (e.g. patient selection) that explained differences in the results were discussed.

**Results of the review**

Thirteen studies (n=470) were included in the review, of which six were controlled trials (n=219).

The effect sizes for weight gain varied from 0.52 to 4.05 directly after therapy (based on 5 studies, 7 treatment groups), from 0.47 to 2.00 after 2 years (4 studies, 9 treatment groups), and from 0.57 to 3.02 (7 studies, 9 treatment groups) for longer follow-ups. Confidence intervals were not reported. The authors summarised that the weight development was acceptable or good, with a tendency of small but relatively stable effects over time.

Three of the controlled trials allowed anorexia classification of the patients according to the percentage with good, intermediate or poor outcomes after therapy, or at a later follow-up evaluation. The percentage of good outcomes varied between 20 and 82%, intermediate outcomes between 17 and 50%, and poor outcomes between 15 and 40%.

A symptom-orientated psychodynamic treatment showed better results than the standard psychodynamic treatment (1 trial), as did a combination of single and family therapy plus dietician consultation (1 trial). A social-skills training addition showed no better results than a placebo addition (1 trial). A family therapy approach showed better results at follow-up, but not directly after therapy, than the individual therapy arm (1 trial).

Young patients with a higher weight at admission showed more good and intermediate results. Mortalities were reported in studies with longer follow-up, older patients and patients with lower weight at admission.

**Authors' conclusions**

Psychodynamic treatment in anorexia nervosa is more pragmatic and disorder orientated than generally acknowledged. Specialised treatment programmes delivered by experienced teams show better results. Less cachectic patients can be treated as out-patients by a specialised team. The specific contribution of psychodynamic orientation on the treatment outcome is unclear and more research is needed.

**CRD commentary**

The review question and inclusion criteria were clear. The reviewers undertook extensive searches, with great emphasis on handsearching to locate relevant studies, but only looked at three languages; this could have introduced language bias into the review. In addition, since only selective studies in other languages were eligible for inclusion in the review, potentially the review could present only data from a biased selection of studies. It was unclear what measures were taken to reduce bias and errors in the study selection and data extraction processes, e.g. through independent selection by two reviewers.

Most of the included studies integrated other therapeutic elements like family therapy and dieticians into the treatment approach, so the individual effect of a psychoanalytic treatment was difficult to evaluate. The data from the individual studies were well presented and the calculation of the chosen effect size measures allowed comparisons between studies. Many characteristics were only reported by a small proportion of the studies. The authors' conclusions are based on very few studies with small samples, which makes the stated need for more research more reliable than the rest of the conclusions.

**Implications of the review for practice and research**
Practice: The authors stated that anorexic patients should receive in-patient treatment in specialised clinics; less cachectic patients can be treated with low frequency, disease-specific ambulant interventions. A symptom-orientated approach is essential, at least at the beginning. A clinic treatment can be followed by a long-term ambulant intervention which, in single cases, can be the analytical standard treatment. The authors advocate the approach suggested by Bruch.

Research: The authors stated that prospective studies with appropriate follow-up and explicit outcome criteria, and valid and reliable assessment methods using study-independent measures, are needed. Such studies should answer questions regarding the differential indication for settings, duration and intensity of treatment, and the time and format of transfer between in-patient and out-patient treatment.

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This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.