Les troubles alimentaires
Stratégies de traitement

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Recommandations

Royal Australian and New Zealand **College of Psychiatrists clinical practice guidelines** for the treatment of eating disorders. Australian & New Zealand Journal of Psychiatry 2014, Vol. 48(11) 977–1008

- **Les traitements ambulatoires ou en centre de jour (dans le milieu le moins restrictif possible), et l'hospitalisation pour les personnes à risque médical et/ou psychologique,**
- une approche multiaxiale et collaborative, associant l'examen des aspects nutritionnels, médicaux et psychologiques,
- l'utilisation de la « Family Based Therapy » chez les jeunes et, pour tous les groupes d'âge, des psychothérapies spécialisées, conduites sur la base de manuels, et qui comprennent une évaluation de suivi à long terme,
- **dans l'anorexie mentale chronique, une approche qui minore les dommages,**
- **dans la boulimie et l'hyperphagie boulimique, la psychothérapie cognitivo-comportementale pour laquelle les preuves sont très élevées (CBT-E),**
- la CBT délivrée par Internet et la CBT sous une forme de self-help ont une place utile,
- les médicaments qui peuvent être utiles, soit comme une option d'appoint ou comme une alternative de traitement, sont les antidépresseurs, le topiramate,
- Aucun traitement spécifique n'est recommandé pour ARFID car il n'y a pas d'étude pour recommander une pratique spécifique.

Introduction

« 1/ ***Les thérapies psychologiques*** **sont essentielles au** ***traitement efficace des troubles alimentaires*** **… mais seulement…**

2/ ***un nombre limité de patients bénéficient … de thérapies ambulatoires basées sur les données les plus probantes*** **… »**

Clinician adherence to guidelines in the delivery of family-based therapy for eating disorders Stacey Kosmerly, Glenn Waller and Adele Lafrance Robinson Int. J. Eat. Dis. Vol.48 , 2 , 223-229 , mars 2015

Un nombre limité de patients bénéficient … de thérapies ambulatoires basées sur les données les plus probantes …

- *Banalisation des conduites de régime et de contrôle du poids*
- *Retard du diagnostic (crise d'adolescence), sous-estimation des conséquences de la dénutrition*
- *Méconnaissance des ressources thérapeutiques*
- *Thérapeutes non formés*
- *Non intégration des parents (et de la fratrie) , du conjoint ou culpabilisation de ceux-ci durant la thérapie*
- *Absence de multidisciplinarité*
- *Thérapie non intensive*
- *Thérapies inadéquates (diététiques ou nutritionnelles) ou sans suffisamment de fondement (approches corporelles, hypnose) qui retardent l'engagement dans une procédure thérapeutique spécialisée*
- *Coût de la prise en charge ambulatoire*

Introduction

« 1/ *Les thérapies psychologiques* sont essentielles au *traitement efficace des troubles alimentaires* … mais seulement

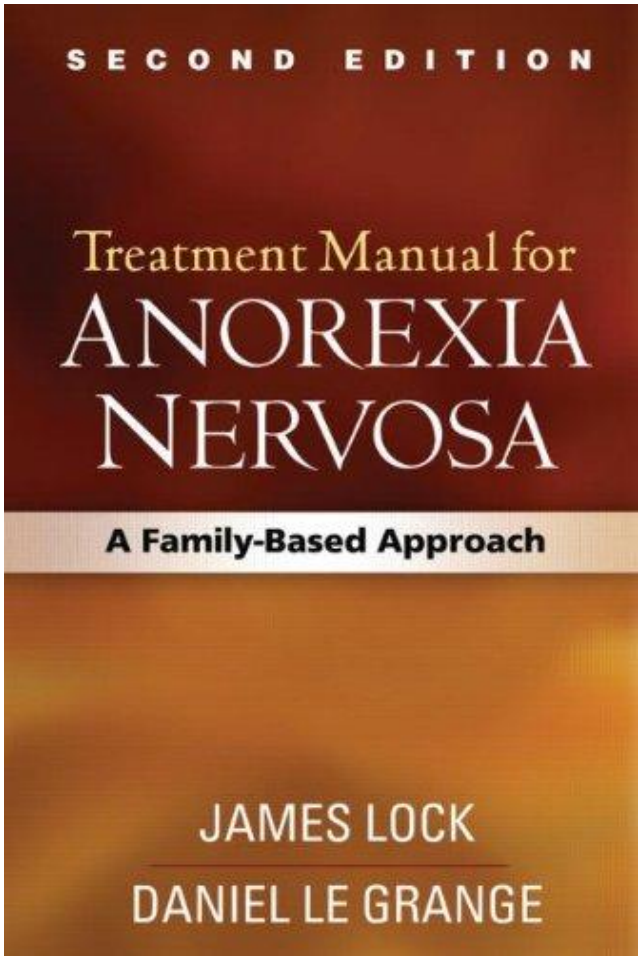
2/ *un nombre limité de patients bénéficient … de thérapies ambulatoires basées sur les données les plus probantes* …

3/ ***La thérapies cognitivo-comportementale (CBT-E) … et la thérapie basée sur la famille (FBT) … Utilisant un protocole manualisé … se sont montrées … plus efficaces que les versions moins structurées de thérapies*…** **Cependant,**

4/ *elles ne fonctionnent pas pour tous les cas et ne peuvent pas être considérées comme les seules méthodes de traitement.* »

Clinician adherence to guidelines in the delivery of family-based therapy for eating disorders Stacey Kosmerly, Glenn Waller and Adele Lafrance Robinson Int. J. Eat. Dis. Vol.48 , 2 , 223-229 , mars 2015

Family Based Therapy



Daniel Le Grange

James Lock

Christopher Dare

Ivan Eisler

Journal of Family Therapy (2005) **27**: 104–131
0163-4445 (print); 1467-6427 (online)

The empirical and theoretical base of family therapy and multiple family day therapy for adolescent anorexia nervosa

Ivan Eisler[a]

There is growing empirical evidence that family therapy is an effective treatment for anorexia nervosa, particularly in adolescence. This is in spite of the fact that the theoretical model from which most of the empirically based treatments are derived appears flawed. This paper provides a brief overview of the research evidence from treatment studies and studies of family functioning. It suggests that the main limitation of earlier theoretical models is their focus on aetiology rather than on an understanding of how families become organized around a potentially life-threatening problem. An alternative conceptual model is presented, and its application to family therapy and multiple-family therapy for adolescent anorexia nervosa is described. The treatment approach focuses on enhancing the families' own adaptive mechanism and mobilizing family strengths.

Le postulat de base est qu'un adolescent souffrant d'un trouble alimentaire n'est plus en mesure de prendre des décisions rationnelles au sujet de sa nourriture et de son poids, tant qu'il se trouve en état de dénutrition

Phase 1 (4-5 mois)	Phase 2 (4 mois)	Phase 3 (3 mois)
Réalimentation dans le contexte familial Le parents reprennent le contrôle de la symptomatologie anorexique et l'adolescent est maintenu dans son cadre développemental	**Organisation et fonctionnement de la famille** Les parents supervisent la symptômatologie de l'anorexie mentale	**Le développement personnel dans le contexte familial** L'adolescent est autonome dans la prise alimentaire

La maladie est le principal organisateur des interactions familiales

- Accueillir la famille d'une manière sincère et sérieuse
- Le thérapeute receuille l'historique familiale qui engage chaque membre de la famille dans le processus
- Le thérapeute recueille une historique centrée sur l'anorexie mentale plutôt qu'une historique générale
- **Séparer la maladie du patient (externalisation)**
- Orchestrer une scène intense autour de la gravité de la maladie et de la difficulté de la guérison
- **Aider la famille à réduire la culpabilité et les blâmes**
- **Rester agnostique concernant la cause**
- **Arrêter les critiques parentales et de la fratrie**
- **Chargez les parents de la tâche de réalimentation**
- **Fournir une rétroaction au patient et à sa famille en ce qui concerne le poids**
- Receuillir l'historique des modèles familiaux du choix des aliments, de la préparation des repas et de qui sert à table, de la structure des repas. Receuillir l'historique des discussions familiales à propos de l'alimentation et plus spécialement celles qui concernent le patient
- Aider la famille à comprendre les besoins nutritionnels du patient
- **Aider les parents à établir entre eux la meilleure façon de travailler pour conduire leur enfant à se réalimenter (alliance parentale)**
- **Aider les parents à convaincre leur enfant de manger au moins une bouchée plus qu'il / elle s'y était préparé**
- Conduire les parents à travailler ensemble dans la renutrition du patient
- Aligner le patient dans la fratrie pour qu'il puisse bénéficier de son soutien
- **Garder la focalisation sur l'anorexie mentale et le trouble du comportement alimentaire**
- Diriger, rediriger et focaliser la discussion thérapeutique sur les aliments, les comportements alimentaires et de leur gestion jusqu'à ce que les préoccupations et les comportements concernant la nourriture, la prise alimentaire et le poids soient apaisés.
- Discuter, soutenir et aider la dyade parentale dans leur gestion commune de la réalimentation

Phase 1 session 4-8

- Discuter et soutenir les efforts déployés par les parents y compris les incitatifs et les injonctions à la réalimentation et à la réduction des rituels

- Continuer à séparer la maladie du patient et à réduire les critiques familiales

- Evaluer l'état de préparation pour la phase de 2

Phase 2 session 9-16

- Les critères de la phase 2 sont réunis (percentile 95)
- Retour graduel à une prise alimentaire indépendante
- La famille est encouragée à examiner le lien entre les problèmes de l'adolescent et le développement de l'anorexie mentale
- Continuer à séparer la maladie du patient et à réduire les critiques familiales

Phase 3 session 17-20

- Explorer les questions de l'adolescence avec la famille et planifier les prochaines questions
- Evaluer la manière dont les parents forment un couple
- Terminer le traitement

REGULAR ARTICLE

Efficacy of Family-Based Treatment for Adolescents with Eating Disorders: A Systematic Review and Meta-analysis

Jennifer Couturier, MD, FRCPC[1,2,3,4]*
Melissa Kimber, MSW[3,4]
Peter Szatmari, MD, FRCPC[1,2,3,4]

ABSTRACT

Objective: To systematically review and quantitatively evaluate the efficacy of Family-Based Treatment (FBT) compared with individual treatment among adolescents with eating disorders.

Method: The literature was reviewed using the MEDLINE search terms "family therapy AND Anorexia Nervosa," and "family therapy AND Bulimia Nervosa". This produced 12 randomized controlled trials involving adolescents with eating disorders and family therapy which were reviewed carefully for several inclusion criteria including: allocation concealment, intent-to-treat analysis, assessor blinding, behavioral family therapy compared with an individual therapy, and adolescent age group. References from these articles were searched. Only three studies met these strict inclusion criteria for meta-analysis. A random effects model and odds ratio was used for meta-analysis, looking at "remission" as the outcome of choice.

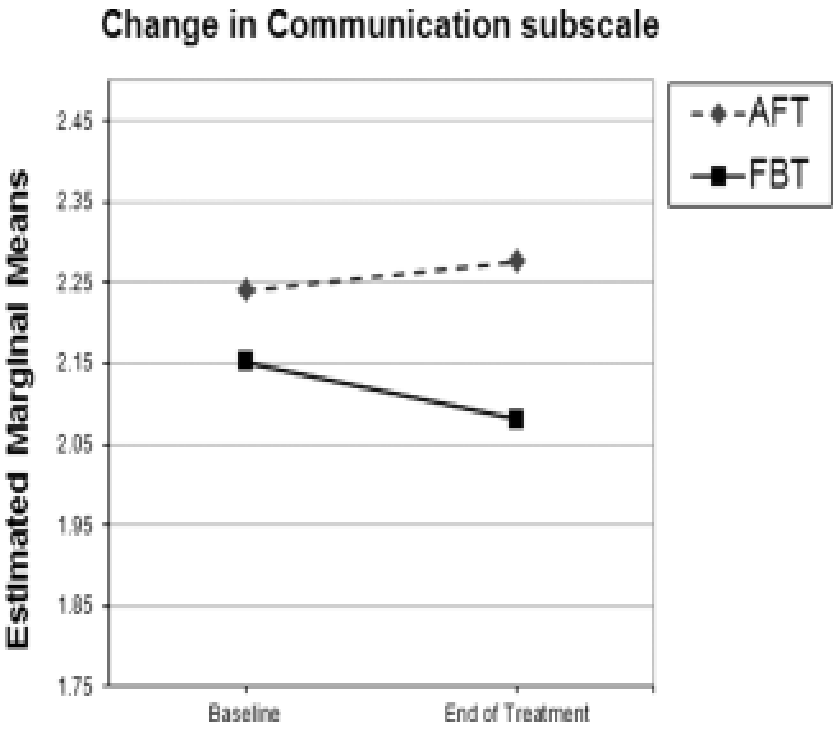
Results: When combined in a meta-analysis, end of treatment data indicated that FBT was not significantly different from individual treatment ($z = 1.62$, $p = 0.11$). However, when follow-up data from 6 to 12 months were analyzed, FBT was superior to individual treatment ($z = 2.94$, $p < 0.003$), and heterogeneity was not significant ($p = 0.59$).

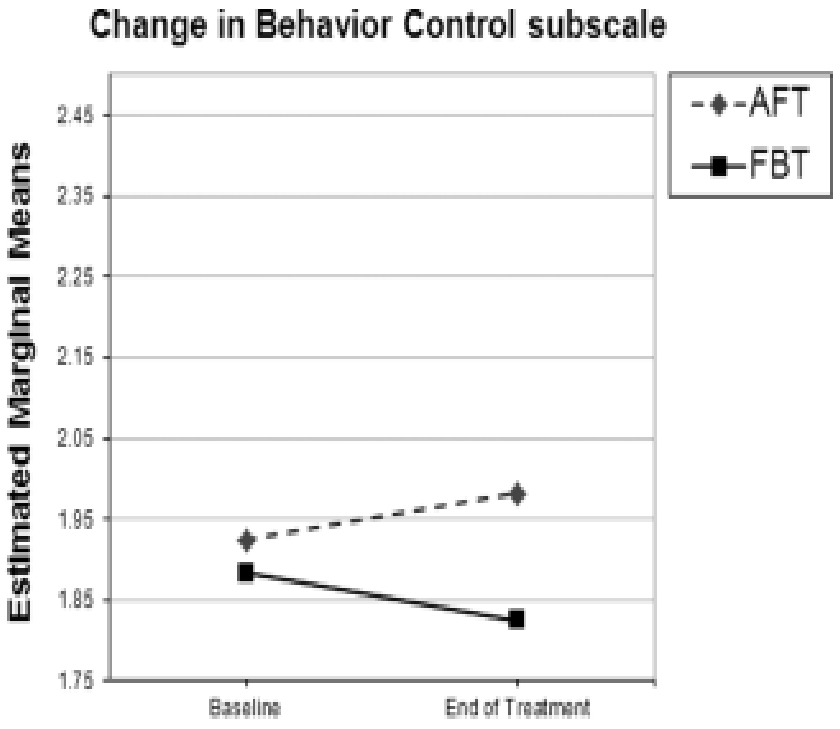
Discussion: Although FBT does not appear to be superior to individual treatment at end of treatment, there appear to be significant benefits at 6–12 month follow-up for adolescents suffering from eating disorders.

Keywords: adolescents; family-based

(Int J Eat Disord 2012; 00:000–000)

Family functioning in two treatments for adolescent anorexia nervosa

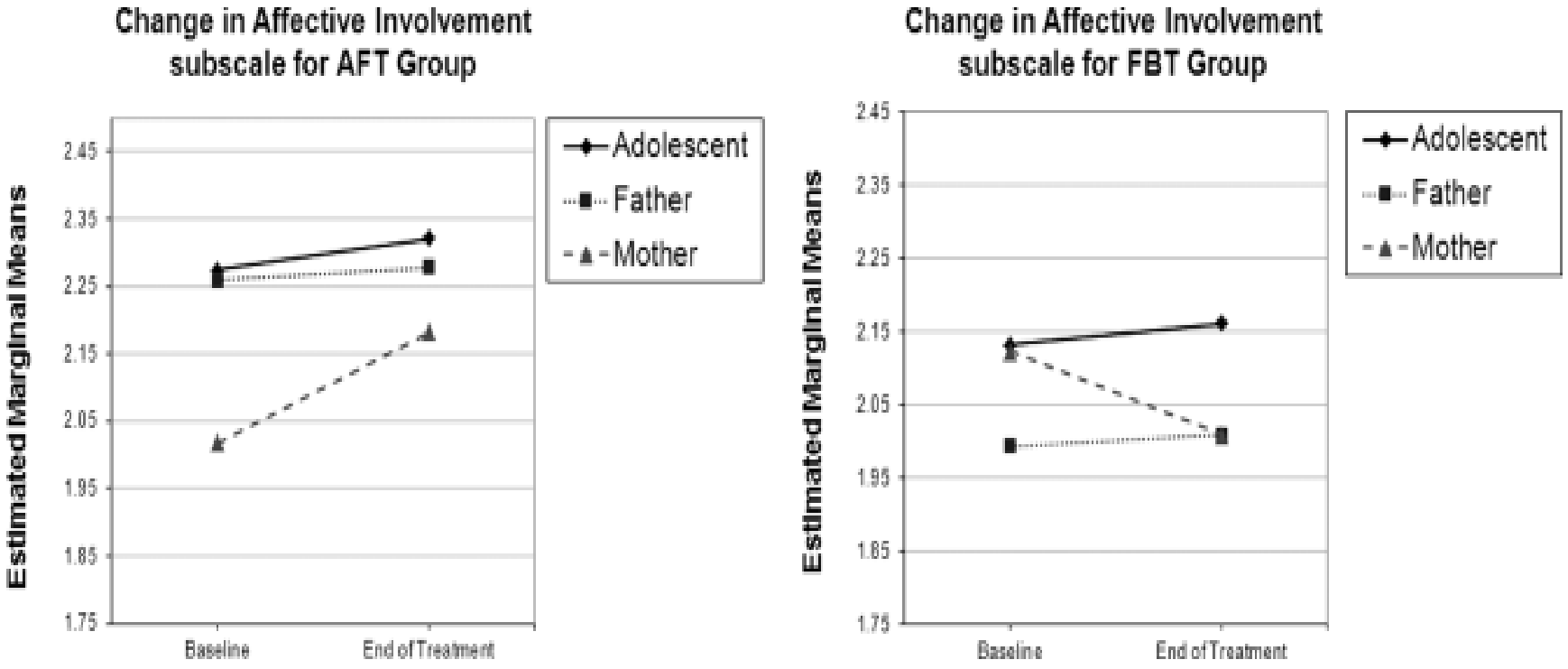




Mean scores on Communication and Behavior Control subscales of the Family Assessment Device at baseline and end of treatment by treatment group; Adolescent-Focused Therapy; Family-Based Treatment. Higher scores indicate greater impairment.

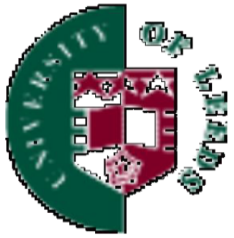
International Journal of Eating Disorders 5 JUN 2014 DOI: 10.1002/eat.22314

Family functioning in two treatments for adolescent anorexia nervosa



Mean scores on the Affective Involvement subscale of the Family Assessment Device by informant (father, mother, or adolescent) at baseline and end of treatment for the Adolescent-Focused Therapy (AFT) and the Family-Based Treatment (FBT). Higher scores indicate greater impairment.

International Journal of Eating Disorders 5 JUN 2014 DOI: 10.1002/eat.22314



Systemic Family Therapy Manual

Ms. Helen Pote
Dr. Peter Stratton
Prof. David Cottrell
Ms. Paula Boston
Prof. David Shapiro
Ms Helga Hanks

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Original Investigation

Comparison of 2 Family Therapies for Adolescent Anorexia Nervosa
A Randomized Parallel Trial

W. Stewart Agras, MD; James Lock, MD, PhD; Harry Brandt, MD; Susan W. Bryson, MA, MS; Elizabeth Dodge, MSc; Katherine A. Halmi, MD; Booil Jo, PhD; Craig Johnson, PhD; Walter Kaye, MD; Denise Wilfley, PhD; Blake Woodside, MD

IMPORTANCE Anorexia nervosa (AN) is a serious disorder with high rates of morbidity and mortality. Family-based treatment (FBT) is an evidence-based therapy for adolescent AN, but less than half of those who receive this approach recover. Hence, it is important to identify

RESULTS There were no statistically significant differences between treatment groups for the primary outcome, for eating disorder symptoms or comorbid psychiatric disorders at the EOT or follow-up. Remission rates included FBT, 33.1% at the EOT and 40.7% at follow-up and SyFT, 25.3% and 39.0%, respectively. Family-based therapy led to significantly faster weight gain early in treatment, significantly fewer days in the hospital, and lower treatment costs per patient in remission at the EOT (FBT, $8963; SyFT, $18 005) An exploratory moderator analysis found that SyFT led to greater weight gain than did FBT for participants with more severe obsessive-compulsive symptoms.

primary outcome, for eating disorder symptoms or comorbid psychiatric disorders at the EOT or follow-up. Remission rates included FBT, 33.1% at the EOT and 40.7% at follow-up and SyFT, 25.3% and 39.0%, respectively. Family-based therapy led to significantly faster weight gain early in treatment, significantly fewer days in the hospital, and lower treatment costs per patient in remission at the EOT (FBT, $8963; SyFT, $18 005). An exploratory moderator analysis found that SyFT led to greater weight gain than did FBT for participants with more severe obsessive-compulsive symptoms.

CONCLUSIONS AND RELEVANCE The findings of this study suggest that FBT is the preferred treatment for adolescent AN because it is not significantly different from SyFT and leads to similar outcomes at a lower cost than SyFT. Adolescents with more severe obsessive-compulsive symptoms may receive more benefits with SyFT.

TRIAL REGISTRATION clinicaltrials.gov. Identifier NCT 00610753

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Sheppard Pratt Health System, Baltimore, Maryland (Brandt); Department of Psychological Medicine, University of Otago, Otago, New Zealand (Dodge); Department of Psychiatry, Weill Medical College, Cornell University, New York, New York (Halmi); Eating Recovery Center, Denver, Colorado (Johnson); Center for Eating Disorders, Department of Psychiatry, University of California, San Diego (Kaye); Department of Psychiatry, Washington University, St Louis, Missouri (Wilfley); Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada (Woodside).

Corresponding Author: W. Stewart Agras, MD, Department of Psychiatry and Behavioral Sciences, Stanford University, Room 1322, 401 Quarry Rd, Stanford, CA 94305 (sagras@stanford.edu).

FAMILY PROCESS

The Effects of a Multiple Family Adolescents with Eating Disord Study

Multiple Family Therapy (MFT) has eating disorders and many programs ha is little evidence in the literature on the The present study examines the effects on eating disorder symptoms, quality (%EBW) in adolescents with eating disc between 11 and 19 years, were assessed ders Inventory 2 (EDI-2), the Outcom showed a significant increase in %EBW a large effect size. 52.4% of patients ach EDI dimensions (except for bulimia) si dimensions related to quality of life ass the end of treatment, 70.7% of patients This study suggests that Multiple Famil orders, with improvement on several ou ity of life). However, the lack of a c conclusions.

Keywords: Multiple Family Therapy; E Effectiveness

ELSEVIER

Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice 21 (2014) 470-484

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Contains Video [1]

Exposure-Based Family Therapy (FBT-E): An Open Case Series of a New Treatment for Anorexia Nervosa

Tom Hildebrandt, Terri Bacow, Rebecca Greif, and Adrianne Flores, *Mount Sinai School of Medicine*

the development of anxiety-based etiological models of AN ly-based treatment (FBT) is an efficacious intervention for lishes parent-facilitated exposure and habituation to food tly altered to include an explicit exposure component that This case series examines the application of FBT with an riteria for AN (n = 4) and eating disorder not otherwise nean age: 15.28) participated in a course of FBT-E. reatment and responses to self-report measures of eating epression and anxiety. Parent reports of their adolescents' ce that FBT-E may effectively target disordered eating and ications and future directions are discussed.

Behaviour Research and Therapy 69 (2015) 63–74

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An open trial of Acceptance-based Separated Family Treatment (ASFT) for adolescents with anorexia nervosa

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Keywords:
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ABSTRACT

Family based-treatments have the most empirical support in the treatment of adolescent anorexia nervosa; yet, a significant percentage of adolescents and their families do not respond to manualized family based treatment (FBT). The aim of this open trial was to conduct a preliminary evaluation of an innovative family-based approach to the treatment of anorexia: Acceptance-based Separated Family Treatment (ASFT). Treatment was grounded in Acceptance and Commitment Therapy (ACT), delivered in a separated format, and included an ACT-informed skills program. Adolescents (ages 12–18) with anorexia or sub-threshold anorexia and their families received 20 treatment sessions over 24 weeks. Outcome indices included eating disorder symptomatology reported by the parent and adolescent, percentage of expected body weight achieved, and changes in psychological acceptance/avoidance. Half of the adolescents (48.0%) met criteria for full remission at the end of treatment, 29.8% met criteria for partial remission, and 21.3% did not improve. Overall, adolescents had a significant reduction in eating disorder symptoms and reached expected body weight. Treatment resulted in changes in psychological acceptance in the expected direction for both parents and adolescents. This open trial provides preliminary evidence for the feasibility, acceptability, and efficacy of ASFT for adolescents with anorexia. Directions for future research are discussed.

Implementation of Family-Based Treatment for Adolescents With Anorexia Nervosa

Elizabeth K. Hughes, BAppSci (Hons), PhD,
Daniel Le Grange, PhD, Andrew Court, MBBS, FRANZCP,
Michele Yeo, MBBS, PhD, FRACP, Stephanie Campbell, BNurs,
Melissa Whitelaw, BAppSc (PhysEd), BAppSc (HlthSc), BNutrDiet, APD,
Linsey Atkins, BA (Hons), DPsych, & Susan M. Sawyer, MBBS, MD, FRACP

Clinical outcomes were positive, including a 56% decrease in admissions, a 75% decrease in readmissions, and a 51% decrease in total bed days. Of families referred to FBT, 83% completed treatment and 97% of completers achieved >90% of their expected body weight. Despite these gains, many challenges were experienced, including misgivings about the suitability of FBT and difficulties in adhering to changes in professional roles. We describe these challenges, describe how they were overcome, and review factors perceived to be critical to the program's success, including integration of medical and mental health services, communication, and training. (Journal of Pediatric Health Care, 2014)

3 types de zone	Centre spécialisé dans les TCA	CAMHS avec une compétence pour les TCA	CAMHS Sans compétence pour les TCA
Nombre de premières consultations/an/ 100.000 jeunes de 13 à 17 ans	62,6	74,4	26,9
Nombre de patients hospitalisés	15%	19%	40%
Compliance au traitement	83%	75%	41,70%

REGULAR ARTICLE (CE ACTIVITY)

Comparison of Specialist and Nonspecialist Care Pathways for Adolescents with Anorexia Nervosa and Related Eating Disorders

Jennifer House, PhD[1]
Ulrike Schmidt, PhD, MD[2]
Meghan Craig, CPsychol[1]
Sabine Landau, PhD[3]
Mima Simic, MD[4]
Dasha Nicholls, MD[5]
Pippa Hugo, MRCPsych[6]
Mark Berelowitz, FRCPsych[7]
Ivan Eisler, PhD[1]*

ABSTRACT

Objective: To explore the role of specialist outpatient eating disorders services and investigate how direct access to these affects rates of referral, admissions for inpatient treatment, and continuity of care.

Method: Services beyond primary care in Greater London retrospectively identified adolescents who presented with an eating disorder over a 2-year period. Data concerning service use were collected from clinical casenotes.

Results: In areas where specialist outpatient services were available, 2–3 times more cases were identified than in areas without such services. Where initial outpatient treatment was in specialist rather than nonspecialist services, there was a significantly lower rate of admission for inpatient treatment and considerably higher consistency of care.

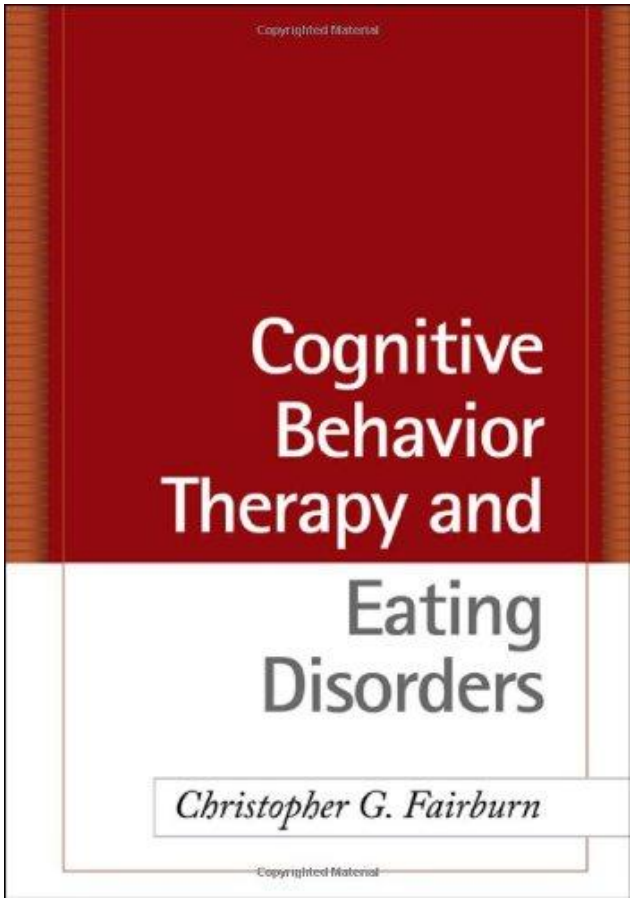
Discussion: Developing specialist outpatient services with direct access from primary care is likely to lead to improvements in treatment and reduce overall costs. © 2012 by Wiley Periodicals, Inc.

Keywords: adolescents; anorexia nervosa; care pathways; inpatient treatment; outpatient treatment; service organization

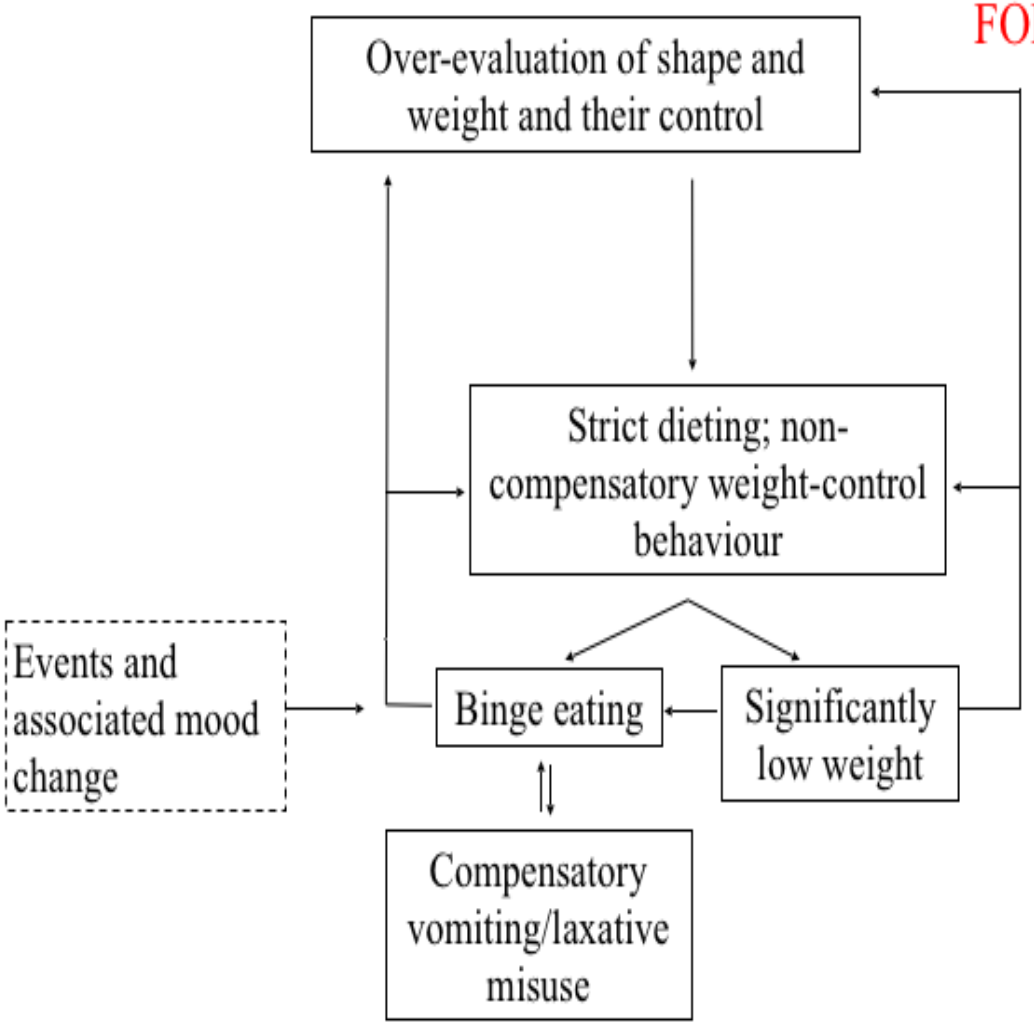
(Int J Eat Disord 2012; 45:949–956)

Chris Fairburn

Professor of Psychiatry, University of Oxford



COMPOSITE TEMPLATE FORMULATION



Available as a pdf from www.psychiatry.ox.ac.uk/credo

La thérapie cognitive et comportementale CBT-E

- **Pour les patients ayant un BMI situé entre 15 et 40**
- **2 versions**
  - Version focalisée sur la psychopathologie du TCA
  - Version élargie avec des modules supplémentaires centrés sur le perfectionnisme, la basse estime de soi et les difficultés interpersonnelles
- **2 intensités**
  - 20 séances lorsque le BMI est >17,5 (80% des thérapies)
  - 40 séances lorsque le BMI se situe entre 15 et 17,5
- **Thérapie de durée limitée et fixée en début de traitement**
- **Thérapie évaluée**
  - EDE-Q (Eating Disorders Examination Questionnaire)
  - Clinical Impairment Assessment Questionnaire (CIA 3.0)
- Thérapie en **4 étapes**

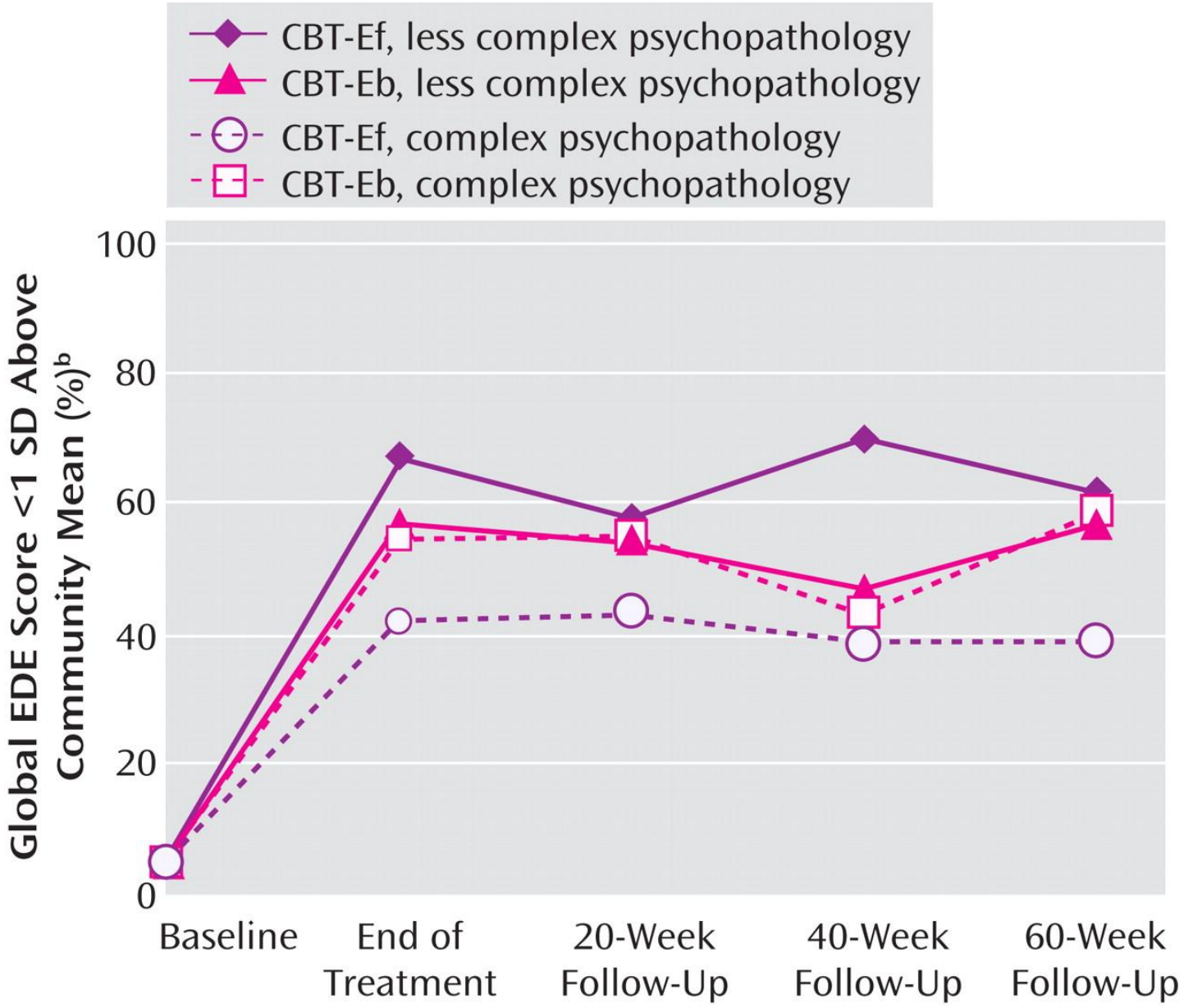
Contre-indications

- Dépression clinique
- Abus de substance significatif
- Trouble stress post-traumatique
- Problème majeur qui conduit à éluder les problèmes de vie et nécessite un engagement concurrentiel

CBT-E : 1ère étape

- **L'alimentation régulière : la structure alimentaire**
  - Petit-déjeuner
  - (Collation)
  - Déjeuner
  - Goûter
  - Souper
  - Collation

- **Points à retenir**
  - Ne mangez pas entre les repas et les collations
  - Ne sautez aucune de ces prises alimentaires.
  - Ne restez pas plus de 4 heures sans manger.
  - *Mangez ce que vous aimez dans ces repas et collations, tant que vous ne vomissez pas ou ne prenez pas de laxatifs pour compenser*
  - Si vous vomissez, le repas ou la collation ne compte pas; vous devez remanger
  - Vous devez toujours savoir à l'avance le moment où vous allez manger, et ce que vous allez manger (approximativement)



Fairburn C et al.Transdiagnostic Cognitive-Behavioral Therapy for Patients With Eating Disorders 60-Week Follow-Up 2009. Am J Psychiatry, Mars; 166: 311 - 319.

A Randomized Controlled Trial of Psychoanalytic Psychotherapy or Cognitive-Behavioral Therapy for Bulimia Nervosa

Stig Poulsen, Ph.D.

Susanne Lunn, M.Sc.

Sarah I. F. Daniel, Ph.D.

Sofie Folke, M.Sc.

Birgit Bork Mathiesen, Ph.D.

Hannah Katznelson, M.Sc.

Christopher G. Fairburn, F.Med.Sci., F.R.C.Psych.

Objective: The authors compared psychoanalytic psychotherapy and cognitive-behavioral therapy (CBT) in the treatment of bulimia nervosa.

Method: A randomized controlled trial was conducted in which 70 patients with bulimia nervosa received either 2 years of weekly psychoanalytic psychotherapy or 20 sessions of CBT over 5 months. The main outcome measure was the Eating Disorder Examination interview, which was administered blind to treatment condition at baseline, after 5 months, and after 2 years. The primary outcome analyses were conducted using logistic regression analysis.

Results: Both treatments resulted in improvement, but a marked difference was observed between CBT and psychoanalytic psychotherapy. After 5 months, 42% of patients in CBT (N=36) and 6% of patients in psychoanalytic psychotherapy (N=34) had stopped binge eating and purging (odds ratio=13.40, 95% confidence interval [CI]=2.45–73.42; p<0.01). At 2 years, 44% in the CBT group and 15% in the psychoanalytic psychotherapy group had stopped binge eating and purging (odds ratio=4.34, 95% CI=1.33–14.21; p=0.02). By the end of both treatments, substantial improvements in eating disorder features and general psychopathology were observed, but in general these changes took place more rapidly in CBT.

Conclusions: Despite the marked disparity in the number of treatment sessions and the duration of treatment, CBT was more effective in relieving binging and purging than psychoanalytic psychotherapy and was generally faster in alleviating eating disorder features and general psychopathology. The findings indicate the need to develop and test a more structured and symptom-focused version of psychoanalytic psychotherapy for bulimia nervosa.

Am J Psychiatry Poulsen et al.; AiA:1–8

Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): randomised controlled trial

*Stephan Zipfel, Beate Wild, Gaby Groß, Hans-Christoph Friederich, Martin Teufel, Dieter Schellberg, Katrin E Giel, Martina de Zwaan, Andreas Dinkel, Stephan Herpertz, Markus Burgmer, Bernd Löwe, Sefik Tagay, Jörn von Wietersheim, Almut Zeeck, Carmen Schade-Brittinger, Henning Schauenburg, Wolfgang Herzog on behalf of the ANTOP study group**

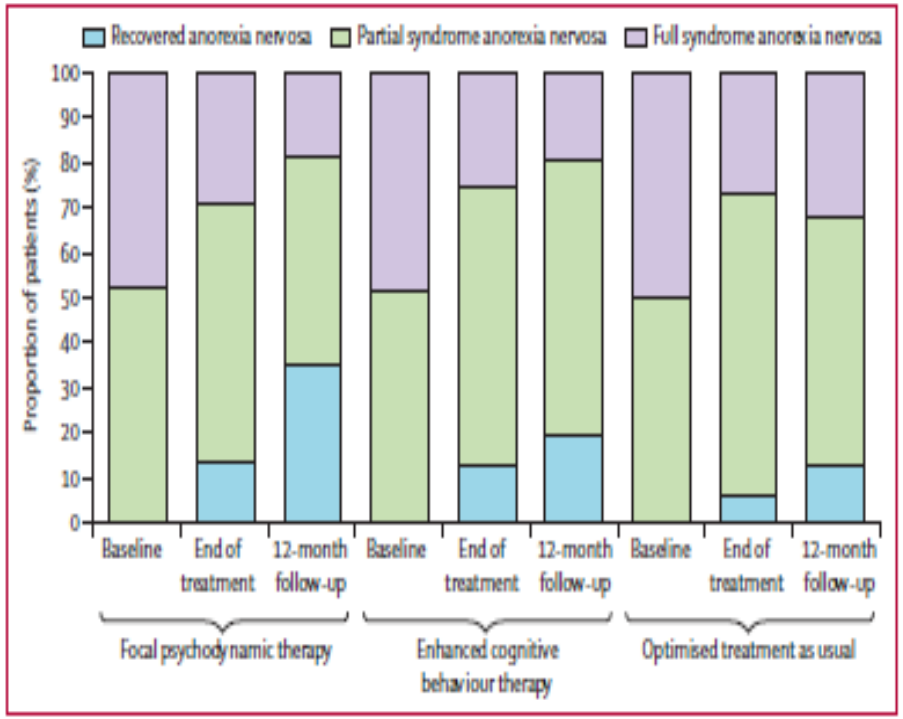


Figure 3: Recovery rates during treatment and follow-up, by treatment group

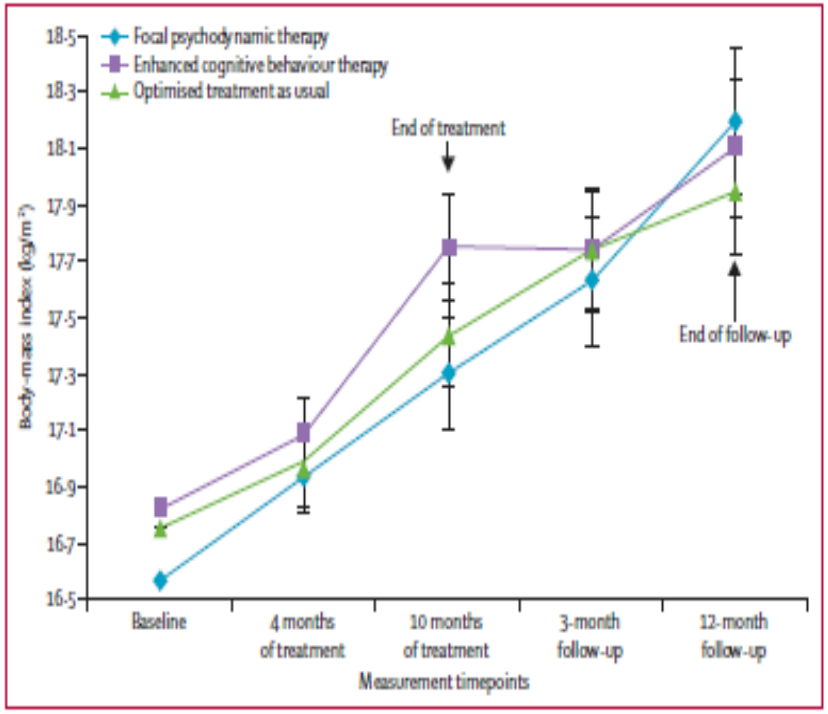


Figure 2: Course of weight gain during treatment and follow-up, by treatment group
Data are least square means (Ls-mean). Error bars show SE.

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Summary

Background Psychotherapy is the treatment of choice for patients with anorexia nervosa, although evidence of efficacy is weak. The Anorexia Nervosa Treatment of OutPatients (ANTOP) study aimed to assess the efficacy and safety of two manual-based outpatient treatments for anorexia nervosa—focal psychodynamic therapy and enhanced cognitive behaviour therapy—versus optimised treatment as usual.

Methods The ANTOP study is a multicentre, randomised controlled efficacy trial in adults with anorexia nervosa. We recruited patients from ten university hospitals in Germany. Participants were randomly allocated to 10 months of treatment with either focal psychodynamic therapy, enhanced cognitive behaviour therapy, or optimised treatment as usual (including outpatient psychotherapy and structured care from a family doctor). The primary outcome was weight gain, measured as increased body-mass index (BMI) at the end of treatment. A key secondary outcome was rate of recovery (based on a combination of weight gain and eating disorder-specific psychopathology). Analysis was by intention to treat. This trial is registered at http://isrctn.org, number ISRCTN72809357.

Findings Of 727 adults screened for inclusion, 242 underwent randomisation: 80 to focal psychodynamic therapy, 80 to enhanced cognitive behaviour therapy, and 82 to optimised treatment as usual. At the end of treatment, 54 patients (22%) were lost to follow-up, and at 12-month follow-up a total of 73 (30%) had dropped out. At the end of treatment, BMI had increased in all study groups (focal psychodynamic therapy 0·73 kg/m², enhanced cognitive behaviour therapy 0·93 kg/m², optimised treatment as usual 0·69 kg/m²); no differences were noted between groups (mean difference between focal psychodynamic therapy and enhanced cognitive behaviour therapy –0·45, 95% CI –0·96 to 0·07; focal psychodynamic therapy *vs* optimised treatment as usual –0·14, –0·68 to 0·39; enhanced cognitive behaviour therapy *vs* optimised treatment as usual –0·30, –0·22 to 0·83). At 12-month follow-up, the mean gain in BMI had risen further (1·64 kg/m², 1·30 kg/m², and 1·22 kg/m², respectively), but no differences between groups were recorded (0·10, –0·56 to 0·76; 0·25, –0·45 to 0·95; 0·15, –0·54 to 0·83, respectively). No serious adverse events attributable to weight loss or trial participation were recorded.

Interpretation Optimised treatment as usual, combining psychotherapy and structured care from a family doctor, should be regarded as solid baseline treatment for adult outpatients with anorexia nervosa. Focal psychodynamic therapy proved advantageous in terms of recovery at 12-month follow-up, and enhanced cognitive behaviour therapy was more effective with respect to speed of weight gain and improvements in eating disorder psychopathology. Long-term outcome data will be helpful to further adapt and improve these novel manual-based treatment approaches.

Funding German Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung, BMBF), German Eating Disorders Diagnostic and Treatment Network (EDNET).

Conclusions

La thérapies cognitivo-comportementale (TCC)… et la thérapie basée sur la famille (FBT)... Utilisant un protocole manualisé... se sont montrées... plus efficaces que les versions moins structurées de thérapies… Cependant, *elles ne fonctionnent pas pour tous les cas et ne peuvent pas être considérées comme les seules méthodes de traitement.* »

- Manuels de traitement et agenda thérapeutique
- Publications scientifiques sur leurs effets (évaluation quantitative)
- Publications scientifiques sur les modérateurs et les médiateurs d'effet (évaluation quantitative)
- Publications scientifiques sur leur faisabilité (implémentation)
- Publications scientifiques sur le modèle théorique
- Pouvoir comparer sa pratique

TABLE 2. Frequency of use of specific FBT techniques (1 = 0%–10%; 10 = 91%–100%) among clinicians who report using or not using a treatment manual when delivering FBT

	Use Manuals		Do Not Use Manuals		*t*-Test		Effect Size
	Mean	(*SD*)	Mean	(*SD*)	*t*	*p*	*d*
Central Methods							
All family attend	7.06	(3.61)	4.89	(4.24)	2.22	.03	0.577
Parents refeed	9.10	(2.05)	6.89	(3.63)	3.40	.001	0.903
Weigh client	9.00	(2.19)	7.32	(3.76)	2.47	.02	0.644
The family meal	6.37	(3.96)	3.39	(3.33)	2.91	.005	0.778
Direct discussion	8.80	(1.60)	7.11	(3.55)	2.94	.004	0.783
Other Methods							
Food diaries	2.44	(2.74)	4.26	(4.01)	2.29	.03	0.596
Motivational work	2.40	(2.50)	2.89	(2.45)	0.76	NS	0.198
Reflecting team	2.04	(2.50)	2.53	(2.99)	0.71	NS	0.185
Individual work	3.27	(2.57)	6.26	(3.09)	4.29	.001	1.115
Mindfulness	3.60	(3.11)	5.32	(3.25)	2.10	.04	0.546
Suggest solutions	7.32	(2.70)	8.16	(2.83)	1.18	NS	0.307

Clinician adherence to guidelines in the delivery of family-based therapy for eating disorders Stacey Kosmerly, Glenn Waller and Adele Lafrance Robinson IJED Article first published online: 20 MAR 2014 | DOI: 10.1002/eat.22276

Conclusions

La faible adhésion à la formation et de l'utilisation des manuels de traitement sont relativement communes dans le traitement des troubles alimentaires. Les psychothérapeutes se sentent intimidés et inquiets de l'utilisation des manuels et les utilisent de façon partielle (par exemple, ne pesant pas le client ; ne pas terminer le repas en famille, ne pas respecter l'agenda). Certains cliniciens considèrent qu'utiliser des manuels est inapproprié. Cependant, même pour les cas complexes, il n'existe aucune preuve pour soutenir cette hypothèse.