Developing and Evaluating Cognitive Remediation Therapy (CRT) for Adolescents with Anorexia Nervosa: A Feasibility Study

Camilla Lindvall Dahlgren, M.Sc.¹, Bryan Lask, MD¹,²,³, Nils-Inge Landrø, PhD⁴ & Øyvind Rø, MD, PhD¹

¹ Regional Department for Eating Disorders, Division of Mental Health and Addiction, Oslo University Hospital, Ullevål HF, Norway
² Feeding and Eating Disorders Service, Department of Child and Adolescent Mental Health, Great Ormond Street Hospital for Children, NHS Trust, London, UK
³ Care UK, London, UK
⁴ Center for the Study of Human Cognition, Department of Psychology, University of Oslo, Norway

Running head: Developing and evaluating CRT for adolescents with AN

Words: 5908
**Abstract**

**Background:** Cognitive Remediation Therapy (CRT) aims at improving neuropsychological weaknesses and associated thinking styles in patients with anorexia nervosa (AN). It has only recently been developed for adolescents with AN, and evidence of its applicability for this particular patient group is limited. This study aimed to test the feasibility of individually tailored and delivered CRT for young females with AN. **Methods:** A sample of 20 in- and outpatients (13-18 years) with AN participated in once- or twice weekly individual CRT sessions. The CRT materials used were available in a “CRT Resource Pack”. Feasibility was assessed with regards to the recruitment process, the delivery of the intervention, the materials used and clinical experiences. **Results:** Overall results indicate that the intervention was feasible with regards to i) the recruitment of both in- and outpatients, ii) individual tailoring and delivery, iii) the CRT materials adapted to suit young females with AN, and iv) the acceptability for clinicians involved in the study. There were no voluntary dropouts with 19 of 20 patients completing the entire course of treatment. **Conclusions:** The findings have implications for the refinement of CRT for the youngest AN population, and strengthens our understanding of the core components in the development and evaluation of novel interventions targeting AN. This study will help inform the design of a subsequent randomized controlled trial. **Keywords:** Cognitive Remediation Therapy, Anorexia Nervosa, Adolescents, Neuropsychology, Treatment
Anorexia nervosa (AN) is a serious and multifaceted illness with high co-morbidity and high lifetime mortality rates (Papadopoulos, Ekbom, Brandt, & Ekselius, 2009). Onset of illness usually occurs in early adolescence, and for many of those affected, recovery will be a lifelong, and often ambivalent struggle between recovery and disorder maintenance. Cognitive Remediation Therapy (CRT) is a relatively new form of treatment for eating disorders with techniques originating from brain lesion interventions. More recently, it has been used in the treatment of schizophrenia (Eack et al., 2010; Wykes et al., 2003), ADHD and learning disabilities (Stevenson, Whitmont, Bornholt, Livesey, & Stevenson, 2002) and obsessive compulsive disorders (Buhlmann et al., 2006; Park et al., 2006). In AN, the intervention was originally developed with the aim of motivating and engaging chronically ill patients who responded poorly to traditional interventions (Tchanturia, Davies, & Campbell, 2007). Targeting one particular aspect of this illness - the process of thinking - it aims to reduce cognitive rigidity and excessive occupation with detail, core cognitive features of the illness (Brewerton, Frampton, & Lask, 2009; Holliday, Tchanturia, Landau, Collier, & Treasure, 2005; Lopez et al., 2008; Lopez, Tchanturia, Stahl, & Treasure, 2008; Tchanturia, et al., 2007).

Given the relative novelty of CRT for patients with AN, its applicability across ages is still unclear. In the adolescent population, evidence of neuropsychological functioning is not as extensive, and reports available do not appear to support the same characteristic neurocognitive profile (i.e. weak central coherence and poor cognitive flexibility) as in adults, but rather a more varied profile (Allen et al., 2012; Fitzpatrick, Darcy, Colborn, Gudorf, & Lock, 2012; Shott et al., 2012; Stedal, Rose, Frampton, Landro, & Lask, 2012). However, as the onset of AN usually occurs in adolescence, a time during which both cognitive and biological developmental changes occur, it has been suggested that CRT could be useful in
altering less favorable behavioral manifestations of these changes (Tchanturia & Lock, 2010). Also, previous studies have stressed its potential for detecting therapeutically significant variables such as the lack of metacognitive skills in younger patients with AN (Easter & Tchanturia, 2011) and its importance for creating a positive therapeutic relationship (Wood, Al-Khairulla, & Lask, 2011).

Preliminary results regarding treatment outcome in adults are encouraging, albeit best interpreted by their relevance to patient and clinician acceptability, (Easter & Tchanturia, 2011; Whitney, Easter, & Tchanturia, 2008; Wood, et al., 2011) and through the interpretation of repeated neuropsychological assessments (Abbate-Daga, Buzzichelli, Marzola, Amianto, & Fassino, 2012; Tchanturia et al., 2008). To date, little is known of the direct effects of the intervention, nor of its applicability for the younger AN population. To our knowledge, only three reports on CRT for adolescents with anorexia nervosa have been published, two of which focus on group CRT (Pretorius & Tchanturia, 2007; Wood, et al., 2011), and one case study reporting individual CRT (Cwojdzinska, Markowska-Regulska, & Rybakowski, 2009). Similar to results from adult-oriented CRT studies, there is limited exploration of the effectiveness of the intervention for adolescent patients, and existing results are primarily concerned with establishing the acceptability of the intervention, and changes in neuropsychological functioning over time.

To investigate the applicability of CRT for young patients with AN, we adopted the feasibility/piloting phase from the Medical Research Council framework for developing and evaluating complex interventions (Craig et al., 2008) (Figure 1) as an essential step before a randomised controlled study. Our aim was to describe the technicalities of our feasibility study, and systematically to evaluate the key aspects of this research phase. We were
particularly interested in two specific elements: i) estimating the likely rate of recruitment and retention and ii) the testing procedures, including: treatment delivery, the materials used, and feasibility for the clinicians involved in the study.

[Figure 1]
Methods

Recruitment

We aimed to investigate the applicability of the intervention for both in- and outpatients. Inpatients were recruited from a regional eating disorders service approximately five weeks after admission. Outpatients were recruited from a pediatric hospital unit, and had been in treatment for approximately 15 months at the time of recruitment. Our sample size was based on an estimation of how many patients we thought we would be able to recruit during the course of the 2-year recruitment process. Inclusion criteria were: i) in treatment for anorexia nervosa, ii) female (in line with previous studies) and iii) between 13 and 18 years. Ethical approval was obtained from the Regional Committee for Medical Research Ethics. Consent was sought from all participants. Participants below the age of 16 were asked for parental approval to participate in the study.

Twenty-four patients (13 inpatients and 11 outpatients) were informed about the study, and given the opportunity to participate. A total of twenty inpatients (N=10) and outpatients (N=10) aged 13-18 accepted the invitation. All participants were diagnostically evaluated by experienced clinicians and had completed the Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn & Beglin, 2008) prior to CRT initiation. Hospital medical records revealed that patients were severely underweight when first admitted to treatment (T0) (see Table 1) but at the time of recruitment (T1), underweight had reduced significantly, t (19) = 2.41, p = .026. Descriptive data are presented in Table 1. There were no significant differences between in- and outpatients on any of the baseline assessment variables.
Procedure

Treatment Delivery

We adopted the structure described in a CRT manual (Tchanturia et al. 2010) proposing 10 once- or twice-weekly individual sessions, each lasting approximately 30-40 minutes. During these sessions, the goal was to i) identify the participant's cognitive style(s) and to acknowledge the strengths and weaknesses of these, ii) challenge ineffective thinking patterns and explore new ways of thinking, iii) promote thinking about thinking (i.e. meta-cognition) and iv) implement small behavioral changes as a result of all of the above. The intervention was offered as a complementary therapy to treatment as usual. Parents were invited to the initial information meeting during which the aim of the intervention, the structure of delivery and session contents were discussed. Parents were also informed about the possibility of taking part in the final CRT session, and were encouraged to discuss their potential participation with their child as the treatment progressed.

Materials

Given CRT for AN was originally developed for adults and tends to use adult-oriented materials, it became necessary to develop, apply and evaluate more age-appropriate materials for adolescents. Games and puzzles suitable for identifying and challenging weaknesses in cognitive flexibility-, central coherence- and visio-spatial abilities were purchased from web
based retailers. Additional tasks originating from the manual (Tchanturia & Davies, 2010) were adapted for a young AN population. A few tasks selected from the Wechsler Intelligence Scale for Children (WISC-II) (Wechsler, 1992) were considered appropriate. Also, a large selection of additional board games, puzzles and paper and pencil tasks designed for brain exercises were used. An overview of the materials used can be found in the electronic version of the “CRT Resource Pack” (Lindvall, Owen, & Lask, 2010) and in Lindvall & Lask (2011).

Clinical Preparations

To engage patients with anorexia nervosa in treatment is often challenging, and ambivalence towards recovery might hinder both initiation and completion of any course of treatment (DeJong, Broadbent, & Schmidt, 2012). Engaging patients in a research-based intervention, additional to treatment as usual, therefore requires good collaboration with each patient's clinical team. To lay the groundwork for a good recruitment process, clinicians on the two recruiting units were fully informed about the study, its rationale, the potential advantages and disadvantages of participating, and each person’s role.
Results

Delivery

All participants received individual CRT delivered by the same therapist. Our initial aim was for all participants to receive 10 twice-weekly sessions, each lasting approximately 45 minutes. After having recruited 12 participants, we concluded that the delivery structure should be altered, especially with regard to the number and intensity of sessions. For some participants, discharge was close at hand which meant they would not been able to complete all 10 sessions. For others, there was an evident need, and wish, for more than 10 sessions in order to finalize ongoing tasks and discussions. We therefore decided that all patients would initially offered eight sessions, and that we would subsequently evaluate the need for additional sessions. The number of sessions each participant received ranged from 7 to 12, with an average of 10. The delivery intensity (i.e. twice a week) proved to be feasible for inpatients in the sense that incorporating these sessions into their weekly schedule went smoothly and allowed for treatment to be completed during relatively short admissions. Outpatients were often accompanied by their parents who had to take time off work to bring their children to therapy sessions, and were generally busier with school and leisure activities. An intensity of one session a week proved more suitable for them.

Despite low BMI’s, participants were able to focus on the tasks presented, and were actively participating during the sessions. This is in line with previous research failing to show weight related effects on neuropsychological task performance (Tchanturia et al., 2004). The pre-set session length of 45 minutes worked well for all patients. All courses of CRT were initiated with an introductory meeting in which process, structure and session content were discussed.
Subsequently, 2-4 sessions were used to identify cognitive style(s) and thinking patterns, which aided the patient and therapist in deciding the focus of the therapy. The final session was a summary and consolidation of all previous sessions.

By promoting thinking about thinking (i.e. meta-cognition), challenging ineffective thinking patterns and exploring new ways of thinking, patients achieved new knowledge regarding their problem solving strategies and techniques. Implementations of small behavioral changes were a crucial part of therapy, and an important aspect of “testing” newly adopted cognitive strategies in real life settings. When deciding upon which domain(s) to focus, the treatment structure was individually tailored and based on clinical impressions with regards to neurocognitive functioning during the initial sessions. Most commonly, one or two tasks were presented each session followed by discussions regarding the participant's choice of methods when tackling the task, the pros and cons of those particular strategies, possible alternative strategies and application to everyday life. This way of structuring the sessions proved to be feasible for all patients.

Either one or both parents accompanied all outpatients to the initial information meeting. This was repeated for three out of ten outpatients at the final CRT session. Inpatients’ parents were informed about the study via the clinical team on the unit, and were also updated about the session progression through the hospital record system, communicated through the inpatients’ treatment team. The CRT-therapist had regular contact with the parents at the inpatient unit. This contact was generally informal of nature, and usually revolved around setting up new, or rescheduling existing sessions.
There were no voluntarily dropouts from the study, and 19 out of 20 participants completed the entire course of treatment. The one patient who failed to complete all sessions was discharged before the final CRT meeting, and received only seven out of the eight sessions.

**Materials**

The choice of materials was primarily guided by the tasks in the CRT Resource Pack (Lindvall, et al., 2010). However, throughout the entire treatment delivery phase, new tasks were developed, tested and evaluated. The various board games (see Lindvall et al., 2010) were found to be most useful in delivering CRT, and suitable for all participants in spite of the age variation in the sample. Several of these games had “challenge cards” with different difficulty levels, making it easy to tailor sessions according to the participants’ needs and progress, as well as revisiting games and building upon “old” knowledge. Also, the majority of the board games were appropriate for working with multiple cognitive domains, which generated an integrated awareness of the relationship both within, and between these domains. A few of the domain specific tasks described in Tchanturia & Davies (2010) were modified to suit a younger patient population, and were used in treatment (e.g. geometric figures, Stroop- and switching attention tasks). However, although these tasks were found to be useful, the board games appeared to suit our younger patient group better. These were more engaging, yielded more detailed information on cognitive strategies and were more efficient in stimulating metacognitive processes, especially regarding similarities between in-session task performance and every day life contextual thinking.
Clinical Experiences

Feedback from the clinical staff was communicated through two face-to-face meetings, and information was recorded continuously throughout the meeting by the CRT-therapist. The staff reported being satisfied with the recruitment process, and felt they had been properly informed about the aims of the study, the structure and the practicalities of its implementation. The flexibility of the CRT therapist was mentioned as being highly important for CRT treatment adherence, especially on the inpatient unit where patients were severely ill, and occasionally had to re-schedule appointments. On this unit, the therapist was perceived as belonging to the treatment team, partially due to the sharing of information through the hospital patient records system, and also through the continuous face-to-face communication on the ward. At the outpatient clinic, the intervention was described as a catalyst for many patients in terms of expressing novel thoughts and ideas in a non-threatening environment, and also for sharing information related to other aspects of their lives beside food, weight, exercise etc. Neither unit reported having negative experiences with their patients participating in the intervention, and both units were interested in continuing offering CRT to their patients after the study had been completed.

Like the health care professionals, the CRT therapist experienced the intervention as being well perceived, and a much-appreciated therapeutic supplement for both in- and outpatients. Inpatients reported that the sessions were a welcome break in their daily routines on the ward, and a safe arena where topics other than those related directly to their eating disorder could be discussed. Outpatients voluntarily reported thoughts and behaviors related to food, body and exercise routines. As the aim was to create an intervention individually tailored to each patient’s specific needs, the therapist accommodated accordingly. However by keeping the
focus on the cognitive processes (although occasionally related to the ED per se), the therapist could steer the session towards the cognitive processes rather than its content, and helping the patient staying on the right "CRT track".
Discussion

Evidence of applicability for CRT in adolescents with AN is very limited. To our knowledge, this is the first study testing the feasibility of individually delivered and tailored CRT for this population. It is also the first study reporting CRT data from a mixed sample of in- and outpatients, and the first to use materials other than those described in the original CRT manual for patients with AN. Our results indicate that the intervention was feasible with regards to i) the recruitment strategy, ii) the structure of delivery, iii) the materials and iv) the acceptability for clinicians involved in the study.

Delivering CRT in Different Treatment Settings

Most commonly, CRT has been delivered on inpatients units (Easter & Tchanturia, 2011; Genders & Tchanturia, 2010; Pretorius & Tchanturia, 2007; Tchanturia, et al., 2008; Whitney, et al., 2008; Wood, et al., 2011) and only a few studies have explored outpatient delivery (Abbate-Daga, et al., 2012; Pitt, Lewis, Morgan, & Woodward, 2010; Pretorius et al., 2012). In contrast to earlier studies, ours is the first to explore CRT in both in- and outpatient treatment settings. Results indicated that CRT appealed to both patient groups, and confirm those of previous studies supporting the notion that although originally intended for severely and chronically ill patients, the intervention is also found useful for patients who are much earlier in the illness, but who struggle with maladaptive cognitions and accompanying behaviors.

CRT was originally proposed as an add-on treatment, and no previous studies have used it as a stand-alone treatment. In the current study, this standpoint was adhered to, and supported.
All inpatients were involved in high-intensity treatment programs usually combining both physical and psychological interventions. Outpatients were engaged in less intense treatment, which was primarily oriented towards physical aspects of the illness. In the current study, we observed a difference between inpatients and outpatients in terms of the impact CRT had on former treatment engagements. Whereas CRT for inpatients became an additional therapeutic intervention to treatment as usual, six out of ten outpatients experienced CRT as their primary therapeutic intervention. Four of these six outpatients reported favoring CRT over treatment at their local outpatient clinic and in these cases, both the content of the CRT intervention and the therapeutic alliance between the patient and the therapist, were mentioned as contributing factors. For these participants, it became important to stress the significance of a treatment approach focusing on both AN specific themes (e.g. food, exercise, weight) and non-specific ones (i.e. the thinking process), but also on the role of the CRT deliverer as she was often experienced as the “good guy” in not addressing the most difficult or emotional charged themes such as weight and food.

Treatment Retention

Whereas treatment adherence in adolescent patients with AN has shown to be associated with better outcome (Crisp et al., 1991; Gowers et al., 2007), dropping out from treatment is a common phenomenon for many such patients (Fassino, Piero, Tomba, & Abbate-Daga, 2009). In previous studies exploring CRT for AN, drop-out levels have ranged from 0 % (Abbate-Daga, et al., 2012) to 40 % (Genders & Tchanturia, 2010). In the current study, there were no voluntarily dropouts, and 19 out of 20 patients completed the entire treatment program. As ambivalence towards treatment is common for patients with AN, it is not unlikely that the already intense inpatient treatment program, and the practicalities of attending sessions for
outpatients (i.e. transport to and from sessions, combining CRT sessions with school and social activities) could have had a negative effect on treatment retention. This proved not to be the case in our study. As for parental influences, it is possible that parents’ involvement from the early stage in intervention might have contributed to treatment adherence. As all parents were perceived as positive with regards to their child’s participation in the study, it is possible that this encouraged patients to stay in treatment. Also, had patients not experienced the intervention as practical and useful it is likely that treatment adherence would have been lower.

Individually Tailored CRT – A New Mode of Delivery

The current study is the first to offer patients an individually tailored CRT intervention. Whereas previous studies have been guided primarily by the structure found in the original CRT manual (Tchanturia & Davies, 2010) proposing a pre-set number of sessions and assignments, this study used new materials described in the CRT Resource Pack (Lindvall, et al., 2010). This resource pack is developed in a way that allows the CRT deliverer freely to pick and choose from a large variety of tasks and exercises during any session, and to do so informed by the patients age, developmental status and cognitive style. Potential benefits from using such a resource pack, rather than a manual, are that it gives the therapist the choice of tailoring the treatment to each patient’s specific needs and cognitive status, and decreases the risk of targeting cognitions or deficits that the patient does not need to alter. Also, by using a design that allows for individual modifications, the risk of tasks being repetitive, irrelevant or boring, as reported by patients in previous CRT studies (Pretorius, et al., 2012; Wood, et al., 2011), might be avoided. A potential disadvantage from using a "pick and choose" type of therapy is that no patients will receive exactly the same form of CRT. Whereas cognitive
flexibility, central coherence and visio-spatial abilities will serve as the basis for all patients receiving the treatment, the choice of specific tasks and homework assignments will differ significantly between patients.

**How Many Sessions are Adequate?**

The majority of previous research studies on CRT in AN have applied its proposed 10-session structure described in Tchanturia & Davies (2010). To our knowledge, only two studies have experimented with less than 10 sessions, both addressing the necessity of offering more than those 4 sessions provided to obtain intervention related changes (Genders & Tchanturia, 2010; Pretorius, et al., 2012). The 10-session intervention dates back to the earliest stages of CRT development for patients with AN (Davies & Tchanturia, 2005), but has yet to be thoroughly evaluated in terms of potential advantages and drawbacks. The current study is the first to optimize treatment delivery in terms of the number of sessions offered. This was done primarily because of the difficulties in predetermining the number of sessions before knowing the specific cognitive weaknesses that needed to be addressed, and the severity of these. Where some of our patients experienced considerable change after just a few sessions, others needed to engage in several sessions in order to understand their own cognitive processes and make changes accordingly. Three patients also expressed their interest in continuing CRT after they had completed the last study session. Ultimately, the numbers of sessions should reflect the goal of the intervention, and preferably be chosen based on each patient’s particular needs.
Benefits of Delivering CRT Individually

Earlier CRT studies have focused primarily on individually delivered CRT, and only a few have explored its applicability in group-format. Undoubtedly, group-based interventions have the advantages of being cost-efficient and practical in terms of utilizing fewer resources to treat a larger number of patients. Also, several positive observations from group delivered CRT have been reported, such as sharing difficulties and learning from other patients (Genders & Tchanturia, 2010; Wood, et al., 2011). In the current study, several similarities to earlier findings from individually-delivered CRT were found. Firstly, it was also found to be helpful in increasing the ability to think and behave more flexibly (Davies & Tchanturia, 2005; Tchanturia, et al., 2007), for increasing metacognitive awareness (Pretorius & Tchanturia, 2007) and was positively related to not focusing on traditional therapy themes such as eating and food (Whitney, et al., 2008). Also, the majority of the patients in the current study reported favoring being treated individually rather in a group, and that identifying maladaptive thinking processes and challenging their cognitive style(s) were more comfortable when alone with the therapist. There is reason to believe that the individual format enhances the chances of creating a good client-therapist during a fairly short time period. Further it more quickly focuses on the cognitive issues that should be addressed. Also, when treating adolescents in varying age ranges such as in the current study, it is not unlikely that these young girls will differ in levels of cognitive development, and thus require an intervention that can be adapted to suit their level of cognitive abilities and meta-cognitive skills. This is more likely to be achieved when the intervention is delivered on a one-to-one basis.
Strengths and Limitations

There are a number of strengths to this study. It is the first to systematically evaluate the feasibility of individually tailored and delivered CRT for young adolescents with AN using a well established framework specifically designed for improving health. Also, in contrast to earlier studies, dropout levels were much lower. The study has good ecological validity as it reflects a sample consisting of both in- and outpatients, and allowed us to test the feasibility of the intervention for patients in different treatment settings. In addition, this was the first study evaluating the novel materials developed for this patient group - the CRT Resource Pack, which was positively received by the patients.

However there are also a few limitations to note. Firstly, generalisability is limited due to a small sample. Also, only one therapist delivered CRT, and it is possible that the findings were in part therapist-, rather than therapy-specific. Further, at this point, we are not in a position to infer that the feasibility of the study concurs with the recovery of the patients, nor do we have adequate knowledge regarding the distinct features associated with the low dropout rate. An additional limitation concerns the clinician feedback which, had it been systematically collected, could have given us more detailed knowledge relevant for the continuous development of CRT. This is also true for additional measures such as co-morbid representations, which were not diagnostically evaluated in the current study.
Implications for Future Research

Replications of this study are needed to refine its design. Such replications would benefit from using multiple therapists, and from structurally collecting data from the delivery of the intervention, the materials used and clinician feedback. It will also be of interest to investigate parental experiences with CRT, and qualitative work exploring the patients’ perception of treatment is needed to establish user feasibility. Finally, future studies should focus on examining appropriate methods for measuring the effect of the intervention, and ultimately, that randomized controlled trials are used to do so.
Conclusion

This research was a feasibility study to investigate the applicability of a novel form of CRT for adolescents with AN. The study strengthens our understanding of the similarities and differences between adult- and youth-oriented CRT, and provides a clearer understanding of how CRT can be applied for young women suffering from AN. It also outlines the advantages of delivering the intervention individually, and the importance of tailoring the treatment to suit young women at various stages in their cognitive development. The findings will have implications for further development of CRT for this population, and will inform the design of potential future randomized controlled trials.

Acknowledgements

The authors gratefully acknowledge all patients, parents and health care professionals who took part in this research study. Also, thanks to Dr. Kate Tchanturia who has inspired us in our work, and to Tone Seim Fuglset and Hilde Kapstad for their valuable assistance.
Key points

- Previous studies exploring cognitive remediation therapy (CRT) for adult patients with anorexia nervosa (AN) is encouraging, yet to date, little is known of its applicability for adolescents with AN.

- The present study indicates that CRT is feasible for young women with AN, especially with regards to the recruitment strategy used, the structure of delivery, the materials used and the acceptability for clinicians involved.

- Findings enhance our understanding of factors contributing to the successful development and evaluation of novel interventions for patients with AN, and will inform the design of a potential future randomized controlled trial.
References


Figure 1. The key elements of the development and evaluation process (Craig et al., 2008)

<table>
<thead>
<tr>
<th>Table 1. Demographic and Clinical Characteristics by Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Sample</strong> (N=20)</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>Duration of illness* (years)</td>
</tr>
<tr>
<td>BMI Percentile (T0)</td>
</tr>
<tr>
<td>BMI (T0)</td>
</tr>
<tr>
<td>BMI Percentile (T1)</td>
</tr>
<tr>
<td>BMI (T1)</td>
</tr>
<tr>
<td>Global EDE-Q</td>
</tr>
</tbody>
</table>

Means and standard deviations (SD) are presented. * = Self-reported. BMI = Body Mass Index. T0 = Admission to the in- or outpatient unit. T1 = Shortly prior to Cognitive Remediation Therapy initiation. Global EDE-Q = Eating Disorder Examination Questionnaire Global Score