

IS FAMILY THERAPY THE MOST EFFECTIVE TREATMENT FOR ANOREXIA NERVOSA?

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SUMMARY

Introduction: Anorexia nervosa is a mental health disorder characterised by deliberate weight loss (through restrictive eating, excessive exercise and/or purging), disordered body image, and intrusive overvalued fears of gaining weight. The National Institute for Clinical Excellence recommends that family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

Aims: To perform a literature review to assess whether family therapy is a more effective intervention than other treatments in the management of adolescents with anorexia nervosa.

Method: Search of PubMed, The Cochrane Library and NHS Evidence for randomised controlled trials that compared a family intervention with another treatment for anorexia nervosa in adolescence.

Results and discussion: This literature search revealed only six randomised controlled trials investigating the use of family therapy in the treatment of adolescents with anorexia nervosa, and these all had small sample sizes. Some, but not all, of these trials suggest that family therapy may be advantageous over individual psychotherapy in terms of physical improvement (weight gain and resumption of menstruation) and reduction of cognitive distortions, particularly in younger patients. Due to the small sample sizes and the significant risk of bias (particularly information bias) in some of the studies the evidence in favour of family therapy over individual therapy is weak. In the future, larger randomised controlled trials with long term follow-up are required to assess whether family therapy is the most effective treatment for anorexia nervosa in adolescence.

Key words: anorexia nervosa - family therapy - adolescence

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INTRODUCTION

Anorexia nervosa is a mental health disorder characterised by deliberate weight loss (through restrictive eating, excessive exercise and/or purging), disordered body image, and intrusive overvalued fears of gaining weight (ICD10 2007). Patients show refusal to maintain a normal body weight with secondary endocrine and metabolic changes and disturbances of body function. The disorder most commonly begins in adolescent girls with a point prevalence in this population of 0.9% (Hoek & van Hoeken 2003). The long term outcome for patients is often poor, with severe medical, developmental and psychosocial complications, and significant relapse and mortality rates (Berkman et al. 2007).

The National Institute for Clinical Excellence recommends that 'family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa' (NICE 2004). 'Family interventions' include family therapy, which has many forms; each has a different emphasis on causative family dynamics, the impact of the illness on the family, maintaining factors, and behavioural recovery with strategies to encourage weight gain (Fisher et al. 2010).

AIMS

The aim of this literature review was to assess whether family therapy is a more effective intervention than other treatments in the management of adolescents with anorexia nervosa.

METHOD

A PubMed search was carried out using the MeSH terms "family therapy" and ("anorexia nervosa" or "eating disorder"), which found 343 results. After limiting these to randomised controlled trials in children (age 0-18), there were 23 results of which 4 were relevant.

The Cochrane Library was searched using the same MeSH terms and found 33 clinical trials of which two were relevant and in addition to those found on PubMed.

A search of NHS evidence using the same MeSH terms returned 66 primary research results but none of these were randomised controlled trials in addition to those above.

RESULTS

Summaries of each of the studies included in this literature review are given below in table 1.

Table 1. Summaries of each of the studies included in this literature review

Citation	Intervention	No. of patients	Defined Outcome of Study	Key Results	Comment
Ball & Mitchell 2004	12 months of outpatient individual cognitive behavioural therapy versus behavioural family therapy	25 female adolescents and young adults	BMI, menstruation, eating psychopathology, mood, self-esteem, family functioning	No significant differences between treatment groups. The majority of patients did not reach symptomatic recovery.	Small sample size. Included patients above 85% of healthy BMI so may have been milder illness. Reporting bias in subscales. Range of anorexia nervosa subtypes. Patients who had to be admitted during trial were excluded.
Geist et al. 2000	4 months of outpatient family group psycho-education versus family therapy	25 previously hospitalised female adolescents	BMI, menstruation, eating psychopathology, family functioning	Weight restoration was successful for both treatments, with no significant difference between groups. No significant improvement on other outcome measures including psychopathology.	Small sample size and short period of therapy. All previous inpatients so severe illness. No control group with no family intervention. Over half the patients were readmitted.
Robin et al. 1999	16 months of outpatient ego-orientated individual therapy versus behavioural family systems therapy	37 female adolescents	BMI, menstruation, family interactions, eating psychopathology, ego functioning, depression	Behavioural family systems therapy produced greater increases in BMI and higher rates of menstruation resumption than ego-orientated individual therapy. No significant difference between treatments for other outcome measures but all showed improvement	Small sample size. No blinding of clinician-rated outcomes. Mixture of outpatient and inpatient treatment Uneven treatment duration. Mean age in ego-orientated therapy group much younger
Eisler et al. 1997	12 months of individual supportive therapy versus family therapy	80 adolescents 5 years following treatment	BMI, eating psycho-pathology, cognitive distortion	Family therapy more effective for patients with early onset and short history AN. Individual therapy more effective for patients with later-onset illness.	Larger trial. 75% had a good outcome but improvements most likely due to natural history of anorexia nervosa. Severe cases as all in-patients
Robin et al. 1994	16 months of outpatient Ego-orientated individual therapy versus behavioural family systems therapy	22 young female adolescents	BMI, eating psycho-pathology, body shape attitudes, depression, family conflict.	Family therapy produced greater change in BMI than ego-orientated therapy. Both treatments produced comparable improvements on other outcome measures.	Small sample size. No blinding. Mixture of outpatient and inpatient treatment
Russell et al. 1987	1 year of outpatient individual supportive therapy versus family therapy	57 male and female adolescents and young adults who had completed in-patient admission	BMI, menstruation, eating psychopathology, general psychopathology and obsessionality	Family therapy more effective than individual therapy in young adolescent patients with non-chronic illness in inducing remission, increasing BMI and reducing cognitive distortions. No significant difference at 5-year follow-up	Did not report 3-year outcome data despite collecting. Uneven duration of treatment. The same therapist provided both types of treatment. Poor blinding of clinician-rated outcomes. No overall group results (subgroups reported)

DISCUSSION

There are only a small number of randomised controlled trials investigating the use of family therapy in the treatment of adolescents with anorexia nervosa, and these all have small sample sizes (Ball & Mitchell 2004, Geist et al. 2000, Robin et al. 1999, Eisler et al. 1997, Robin et al. 1994, Russell et al. 1987). Some, but not all, of these trials suggest that family therapy may be advantageous over individual psychotherapy (Robin et al. 1999, Eisler et al. 1997, Robin et al. 1994, Russell et al. 1987) in terms of physical improvement (weight gain and resumption of menstruation) and reduction of

cognitive distortions, particularly in younger patients. Due to the small sample sizes and the significant risk of bias (particularly information bias) in some of the studies the evidence in favour of family therapy over individual therapy is only weak.

There is also insufficient evidence to know whether the benefits perhaps seen initially persist in the long term (Eisler et al. 1997, Russell et al. 1987) as the long term outcomes were not reported in most trials or showed no significant benefit of family therapy. Given the chronicity of anorexia nervosa, long term impact is an important clinical consideration. In practice, combined family and individual therapy is usually given

to adolescents with an eating disorder. However, no trials have tested whether such combined therapy is more effective than single therapy. In the future, larger randomised controlled trials with long term follow-up are required to assess whether family therapy is the most effective treatment for anorexia nervosa in adolescence.

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