COCHRANE CORNER

Family therapy approaches for anorexia nervosa: a Cochrane Review†

Caroline A. Fisher, Sonja Skocic, Kathleen A. Rutherford & Sarah E. Hetrick

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See commentary in this issue.

Background

Anorexia nervosa (AN) is characterised by a failure to maintain a normal body weight due to a paucity of nutrition, an intense fear of gaining weight or behaviour that prevents the individual from gaining weight, or both. The long-term prognosis is often poor, with severe developmental, medical and psychosocial complications, high rates of relapse and mortality. 'Family therapy approaches' indicate a range of approaches, derived from different theories, that involve the family in treatment. We have included therapies developed on the basis of dominant family systems theories, approaches that are based on or broadly similar to the family-based therapy derived from the Maudsley model, approaches that incorporate a focus on cognitive restructuring, as well as approaches that involve the family without articulation of a theoretical approach. This is an update of a Cochrane Review first published in 2010.

Objectives

To evaluate the efficacy of family therapy approaches compared with standard treatment and other treatments for AN.

Search methods

We searched the Cochrane Common Mental Disorders Controlled Trials Register (CCMDCTR) and PsycINFO (OVID) (all years to April 2016). We ran additional searches directly on Cochrane Central Register for Controlled Trials (CENTRAL), MEDLINE, Ovid Embase, and PsycINFO (to 2008 and 2016 to 2018). We searched the World Health Organization (WHO) trials portal (ICTRP) and ClinicalTrials.gov, together with four theses databases (all years to 2018). We checked the reference lists of all included studies and relevant systematic reviews. We have included in the analyses only studies from searches conducted to April 2016.

Selection criteria

Randomised controlled trials (RCTs) of family therapy approaches compared to any other intervention or other types of family therapy approaches were eligible for inclusion.

We included participants of any age or gender with a primary clinical diagnosis of anorexia nervosa.

Data collection and analysis

Four review authors selected the studies, assessed quality and extracted data. We used a random-effects meta-analysis. We used the risk ratio (with a 95% confidence interval) to summarise dichotomous outcomes and both the standardised mean difference and the mean difference to summarise continuous measures.

Main results

We included 25 trials in this version of the review (13 from the original 2010 review and 12 newly-included studies). Sixteen trials were of adolescents, eight trials of adults (seven of these in young adults aged up to 26 years) and one trial included three age groups: one adolescent, one young adult and one adult. Most investigated family-based therapy or variants. Reporting of trial conduct was generally inadequate, so that in a large number of studies we rated the risk of bias as unclear for many of the domains. Selective reporting bias was particularly problematic, with 68% of studies rated at high risk of bias in this area, followed by incomplete outcome data, with 44% of studies rated at high risk of bias in this area. For the main outcome measure of remission there was some low-quality evidence (from only two studies, 81 participants) suggesting that family therapy approaches might offer some advantage over treatment as usual on rates of remission, post intervention (risk ratio (RR) 3.50, 95% confidence interval (CI) 1.49 to 8.23; $I^2 = 0\%$). However, at follow-up, low-quality evidence from only one study suggested this effect was not maintained. There was very low-quality evidence from only one trial, which means it is difficult to determine whether family therapy approaches offer any advantage over educational interventions for remission (RR 9.00, 95% CI 0.53 to 153.79; 1 study, N = 30). Similarly, there was very low-quality evidence from only five trials for remission post-intervention, again meaning that it is difficult to determine whether there is any advantage of family therapy approaches over psychological interventions (RR 1.22, 95% CI 0.89 to 1.67; participants = 252; studies = 5; $I^2 = 37\%$) and at long-term follow-up (RR 1.08, 95% CI 0.91 to 1.28; participants = 200; studies = 4 with 1 of these contributing 3 pairwise comparisons for different age groups; $I^2 = 0\%$). There was no indication that the age group had any impact on the overall treatment effect; however, it should be noted that there were very few trials undertaken in adults, with the age range of adult studies included in this analysis from 20 to 27. There was some evidence of a small effect favouring family based therapy compared with other psychological interventions in terms of weight gain post-intervention (standardised mean difference (SMD) 0.32, 95% CI 0.01 to 0.63; participants = 210; studies = 4 with 1 of these contributing 3 pairwise comparisons for different age groups; $I^2 = 11\%$) . Overall, there was insufficient evidence to determine whether there were any differences between groups across all comparisons for most of the secondary outcomes (weight, eating disorder psychopathology, dropouts, relapse, or family functioning measures), either at post-intervention or at follow-up.

Authors' conclusions

There is a limited amount of low-quality evidence to suggest that family therapy approaches may be effective compared to treatment as usual in the short term. This finding is based on two trials that included only a small number of participants, and both had issues about potential bias. There is insufficient evidence to determine whether there is an advantage of family therapy approaches in people of any age compared to educational interventions (one study, very low quality) or other psychological therapies (five studies, very low quality). Most studies contributing to this finding were undertaken in adolescents and youth. There are clear potential impacts on how family therapy approaches might be delivered to different age groups and further work is required to understand what the resulting effects on treatment efficacy might be. There is insufficient evidence to determine whether one type of family therapy approach is more effective than another. The field would benefit from further large, well-conducted trials.