

continuity of care from the most experienced therapists. I am not sure we can say anything at all yet about choice of specific therapy.

**Dare, C., Eisler, I., Russell, G., et al (2001)**

Psychological therapies for adults with anorexia nervosa. Randomised controlled trial of out-patient treatments. *British Journal of Psychiatry*, **178**, 216–221.

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The paper by Dare *et al* (2001), on a trial of psychological treatments for anorexia nervosa, has two major shortcomings. The investigators planned for a year of weekly sessions of 50 minutes of psychoanalytic therapy; a year of weekly to 3-weekly sessions (60 to 75 minutes) of family therapy; 23 sessions (50 minutes) of cognitive-analytic therapy (CAT), and an unstated frequency of 30 minute sessions for 1 year for the 'routine treatment' group. The patients in the psychoanalytic arm ended up receiving a mean of 24.9 sessions as opposed to 12.9 for the CAT, 13.6 for the family therapy and 10.9 for the 'routine' arm. The differences in the numbers of sessions planned and those actually taking place has not been taken into account in evaluating the results. As summarised by Bergin & Garfield (1994), a large number of different studies show that more sessions are associated with greater improvements. However, the relationship is not linear and begins to taper off after 26 sessions: a figure almost reached by the patients in the psychoanalytic arm but far removed from that of the other three groups.

Not only did the 'control' group receive the fewest number of sessions, with each session lasting only 30 minutes, but as noted and implied by the authors: therapists assigned to this group had the least commitment to and experience in treating anorexia nervosa. The paper does not state how many therapists each patient 'went through' during the course of the study. All these factors would predispose to the formation of poor working alliances compared with the other groups. Thus, the poor results obtained by the 'control' group could be accounted for by a combination of fewer sessions of shorter duration and weak therapeutic alliances, rather than the superiority of specific psychological treatment models.

**Bergin, A. E. & Garfield, S. (1994)** *Handbook of Psychotherapy and Behaviour Change* (4th edn), pp. 58–61. New York: John Wiley & Sons.

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I would like to comment on the Maudsley trial evaluating three psychotherapies for anorexia nervosa compared with routine treatment (Dare *et al*, 2001). I congratulate the team on their efforts in this study in a research area fraught with difficulties and for their major contribution to knowledge in the eating disorders field. The authors rightly conclude that little can be drawn from the study regarding the differential impact of the therapies used. However, the paper did not make clear the differences between the conditions other than the models of therapy. The experience and qualifications of therapists were stated for focal psychoanalytic therapy and family therapy but not for cognitive-analytic therapy (CAT) and one can only conclude that the CAT therapists were not trained or qualified in CAT. Also, the total contact hours in each condition varied widely. The longer the contact hours the more impact the therapy. Perhaps the trial indicates that to treat moderately severe anorexia nervosa effectively, trained and experienced therapists and/or over 15 contact hours (over 18 × 50-minute sessions) are required. The need for experienced staff delivering therapies of adequate length is well known within the field (e.g. Palmer *et al*, 2000) but may not be fully appreciated by those commissioning or funding services. These are perhaps more important variables affecting outcome than the specific therapeutic modality used.

**Dare, C., Eisler, I., Russell, G., et al (2001)**

Psychological therapies for adults with anorexia nervosa. Randomised controlled trial of out-patient treatments. *British Journal of Psychiatry*, **178**, 216–221.

**Palmer, R. L., Gatward, N., Black, S., et al (2000)**

Anorexia nervosa: service consumption and outcome of local patients in the Leicester service. *Psychiatric Bulletin*, **24**, 298–300.

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**Author's reply:** We agree in part with the points made in these letters. Dr Okhai comments on the different treatment intensity between the conditions and in particular in the 'control' condition. The 'control' treatment was intended as a surrogate for placebo treatment. It is ethically difficult to have a placebo treatment for anorexia nervosa given the high morbidity of the condition and the lack of any placebo response. Our aim, therefore, was to have a 'control' condition similar to treatment as usual that would/could be offered in general adult psychiatry units. It could be argued that this therapy was better than that offered in many such positions in that regular supervision was given by an expert in eating disorders. Furthermore, the patients (2–3 per psychiatrist) were offered treatment for up to a year. We agree that in anorexia nervosa as in other conditions the therapeutic alliance is a key factor in response to therapy. We would argue that the specialist treatments have a specific focus on the therapeutic alliance. Indeed, it is perhaps noteworthy that the results of this study led to a change in the practice of cognitive-analytic therapy on the unit in that it is now preceded by a short course of motivational enhancement therapy to facilitate engagement (Treasure & Ward, 1997).

The number of sessions attended may be a sensitive marker of the therapeutic alliance in anorexia nervosa. For example, in a previous study comparing cognitive-behavioural therapy for anorexia nervosa with dietary management all patients dropped out of the dietary management group early in treatment (Serfaty, 1999).

We agree with Dr Morris that the important 'take-home message' is that specialised therapists following a specific therapeutic approach offer the best outcome in anorexia nervosa. This complements the analysis made by Nielsen *et al* (1998), in which he found that mortality was lower in regions of the country with specialised services. It is, therefore, of concern that such skills are in limited supply.

**Nielsen, S., Møller-Madsen, S., Isager, T., et al (1998)**

Standardized mortality in eating disorders – a quantitative summary of previously published and new evidence. *Journal of Psychosomatic Research*, **44**, 413–434.

**Serfaty, M. A. (1999)**

Cognitive therapy versus dietary counselling in the outpatient treatment of anorexia nervosa: effects of the treatment phase. *European Eating Disorders Review*, **7**, 334–350.