Effective treatment of eating disorders

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ego-orientated individual therapy (EOIT) for this age group precisely because more work needs to be done to investigate efficacious treatments for AN. However, I suspect that Dr Bergh and her colleagues might argue that a comparison of two active treatments, as is the design of our current study, one of which is an individual therapy, should be reconsidered. They would probably profit two reasons for such a 'design flaw': (1) lack of a 'no treatment control group', and (2) 'patients become worse' with individual treatment, thereby giving FBT an unfair advantage. Both arguments are quite irresponsible; first, and as I have already stated, all patients with a diagnosis of AN are seriously ill, regardless of age and/or duration of illness, and second, it would be unethical to justify withholding treatment for control purposes on any grounds, but especially on the unfounded assertion that individual therapy has deleterious consequences. There is no evidence for the latter, quite the contrary, Robin and his colleagues have shown that EOIT is a feasible alternative to FBT (Robin et al., 1999).

Dr Bergh and her colleagues are correct in reminding us that FBT has not been established as the gold standard treatment for adolescents with AN. Much more work needs to be undertaken in which we should keep an open mind about other viable treatments for this patient population. However, I find their analysis of existing data often inaccurate, and their roadmap for future inquiry unconvincing.

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Response to Response ***Effective Treatment of Eating Disorders***

There *is* a 'credible alternative' for the effective treatment of eating disorders (Bergh, Brodin, Lindberg, & Södersten, 2002). It rests on the assumption that anorexic symptoms are reversible responses to starvation. Patients re-learn how to eat, their physical activity is reduced, they rest in warmth and they are trained socially. The randomized controlled trial showed that 75% of the severely affected

patients developed normal eating patterns, normal psychiatric profiles, normal physiological status, were back to school/work and regarded their disorder as being fully resolved. Ninety per cent remained in remission during a 5-year follow-up. Patients do not develop bulimia or other problems. Apparently, patients treated with FBT do but rather than having a trait related chronic disorder as is often assumed, we suggest that they are only in partial remission.

There seems to be no reason to treat eating disorders with a marginally effective approach when an effective one exists.

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Final Response
Le Grange Response

There is general consensus that only modest and insufficient effort has been devoted to the exploration of psychosocial treatments for AN. However, for adolescent AN, FBT has been tested more than any other treatment. This numerical advantage does not imply that FBT is the only treatment for AN, but it is an inaccurate interpretations of available data to describe FBT as a 'marginally effective approach', or at this time, for the approach advocated by Per Södersten to be described as a 'credible alternative'. It is *only* adequately powered randomized controlled trials that will highlight which treatment or treatments are the most efficacious for this patient population. To explore this question, my colleagues and I are investing 5 years to conduct a trial that compares FBT with an individual psychotherapy. As a scientist, I keep an open mind about the possible findings of this RCT - ultimately, only the data will tell.

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