Correspondence

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Hospitalisation and adolescent anorexia nervosa

Gowers *et al*'s (2000) study of the impact of hospitalisation on the outcome of anorexia nervosa in adolescence is a useful and important contribution to a debate that is difficult to resolve meaningfully, because of lack of useful evidence. As the authors note, randomised controlled trials are both lacking and extremely difficult to perform, for both practical and ethical reasons. However, the significant mortality and morbidity associated with these disorders is such that this problem must not be ignored.

Although the paper raises some very important questions, we are concerned that the suggestion that in-patient treatment is associated with a poor outcome is premature, and may be taken by some to mean that in-patient treatment should not be considered. This view would be particularly worrying if adopted by cash-strapped health authorities that are already often reluctant to finance treatment of what is still sometimes seen as a trivial condition.

We believe that three questions need to be answered before making any general pronouncement on the appropriateness of in-patient treatment; (a) what factors lead to admission? (b) what is the relationship between these factors and outcome? and (c) what constitutes in-patient treatment, and is it a uniform concept?

Our experience of over 500 admissions of young people suffering from anorexia nervosa leads us to the view that many of the factors which lead to admission, but which are also predictive of poor outcome, are systemic. They will not therefore be measured by the Morgan–Russell Assessment Schedule (Morgan & Hayward, 1988) or other individual-based predictor variables. Such systemic variables include major psychosocial stresses within the family, and the health and strength of the professional network, but we have found it hard to find instruments that adequately measure these factors.

In other words, the measures used to assess severity in this study are all individual to the patient and do not sufficiently take account of the complex network of relationships within which anorexia nervosa takes root and either flourishes or dies. In our experience, the severity of symptoms such as weight loss does not bear a linear relationship to outcome because of highly complex intervening contextual variables, which need to be addressed by any outcome study.

We certainly share the view that in-patient treatment is not the only response, and that we need to be continually reflecting on the style and content of such treatment. However, we think it highly premature to conclude that it should be discouraged. It should be remembered that at present it is often a life-saver for many young people who are seriously ill.

Gowers, S. G., Wheetman, J., Shore, A., *et al* (2000) Impact of hospitalisation on the outcome of adolescent anorexia nervosa. *British Journal of Psychiatry*, **176**, 138–141.

Morgan, H. G. & Hayward, A. E. (1988) Clinical assessment of anorexia nervosa: the Morgan–Russell Outcome Assessment Schedule. *British Journal of Psychiatry*, **152**, 367–371.

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Author's reply: We are grateful to Drs Wood & Flower for contributing to the debate on treatment setting in adolescent anorexia nervosa. Our aim was indeed to open rather than close discussion.

We agree that it is of paramount importance that anorexia nervosa is seen for the serious condition with high morbidity and mortality that we know it to be, rather than the trivial disorder sometimes portrayed by the media. It is right, however, for commissioners to expect an evidence-based case for expensive treatments. Despite the questions raised in our paper, our service treats a large number of adolescents as in-patients and continues to make and support significant numbers of referrals to specialist eating disorder in-patient services.

Nevertheless, it is extraordinary that the following questions are so rarely addressed:

(a) Could it be that in-patient treatment has negative (side-)effects?

(b) Could there be some intrinsic features of anorexia nervosa, such as ineffectiveness, low self-esteem or past history of abuse, which might make those with anorexia nervosa particularly vulnerable to these negative effects?

(c) Might these negative effects sometimes outweigh the benefits?

We would take these questions for granted in evaluating a new drug therapy.

The point Drs Wood & Flower make about systemic factors as predictors of outcome is an important one that our group has previously researched (Gowers & North, 1999). Where there is family or social difficulty, however, does this mean that the adolescent is better treated within or outwith the family home? Does this difficulty add to the case for admission or the case against? In view of the high rates of relapse after weight restoration in hospital, we contest that one could form testable hypotheses either way.

The National Health Service Executive has rightly judged that further evidence of the effectiveness of treatment in different settings is required. We are pleased to report that our group was awarded a Health Technology Assessment grant to conduct a randomised controlled trial of treatment setting covering the north-west of England. We hope in the course of the 4-year pragmatic study to contribute to the debate on when specialist eating disorder in-patient units may be helpful and for whom. We are also examining family satisfaction and acceptability. Of course, this large study will not provide the last word on the issue, but we must avoid the negativism which suggests it is better not to carry out research in case the results are misinterpreted.

Almost certainly in-patient admission sometimes saves lives. Nevertheless, almost all series show high rates of relapse after discharge (Crisp *et al*, 1991; Eisler *et al*, 1997) and however loaded with poor

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