Table DS2) show that coordinated treatment is typically lacking even in higher-income countries. Indeed, the median number of visits in the past 12 months among patients receiving treatment for mental disorders in general medical services is no different in high-income (1.5) than in low-/lower-middle-income (1.4) countries and only slightly higher in upper-middle-income countries (2.1). We also found that the proportion of patients prematurely terminating primary care treatment of mental disorders is quite high in high-income countries (35.4%) as well as in lower-income countries (52.5% for both groups).

Although Basu & Arya consider the World Mental Health question on stopping treatment irrelevant to relationships with spiritual or religious healers, great care was taken in crafting the question sequence in which this question was embedded to be broadly applicable across treatment sectors and countries. The sequence began by asking respondents whether they ever in their life saw any of the professionals on a long country-specific customised list, for problems with their emotions, nerves, or use of alcohol or drugs. Respondents who reported having done so were asked whether they saw each type of professional for such problems in the past 12 months and, if so, number of visits, perceived helpfulness and whether or not they were still seeing the professional for these problems. Only those who said they had stopped seeing the professional were then asked, 'Did you complete the full recommended course of treatment? Or did you quit before the [provider] wanted you to stop?' I agree with Basu & Arya that the framing of this question and of the response options may not have been the most natural way to describe an on-going relationship with a spiritual or religious healer, and I agree that customisation might well yield important new information. However, we would expect reports of having 'stopped' to be lower-bound estimates of the extent to which care for on-going emotional problems lacked continuity, so the high proportions of patients in lower-income countries who gave such reports are cause for deep concern. Basu & Arya also note correctly that data on reasons for terminating treatment, including stigma, were not reported in the paper. Such data exist in the World Mental Health Surveys and will be presented in future reports.

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Psychological therapies in anorexia nervosa: on the wrong track?

Recently, in a randomised controlled trial, specialist supportive clinical management (SSCM) has proven to be more effective than the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), a treatment specially designed to address the disorder according to a rather complex rationale in comparison with SSCM.[1] Specialist supportive clinical management, originally 'non-specific supportive clinical management' administered to a control group in a previous randomised controlled trial,[2] was found to be more effective than two specialised treatments – cognitive–behavioural therapy and interpersonal therapy – and was as effective as these treatments at 5-year follow-up.[3]

Specialist supportive clinical management was originally defined as clinical management and supportive psychotherapy, as revealed by its original definition:

> 'Non-specific supportive clinical management was developed for the present study, and its aim was to mimic outpatient treatment that could be offered to individuals with anorexia nervosa in usual clinical practice. It combined features of clinical management and supportive psychotherapy. Clinical management includes education, care, and support and fostering a therapeutic relationship that promotes adherence to treatment. Supportive psychotherapy aims to assist the patient through use of praise, reassurance and advice. The abnormal nutritional status and dietary patterns typical of anorexia nervosa were central to non-specific supportive clinical management, which emphasised the resumption of normal eating and the restoration of weight and provided information on weight maintenance strategies, energy requirements and relearning to eat normally. Information was provided verbally and as written handouts.' (p. 742)[2]

In contrast, MANTRA claims to be novel in several respects: (a) it is biologically informed and trait-focused, drawing on neuropsychological, social cognitive and personality trait research; (b) it includes both intra- and interpersonal maintaining factors and strategies to address these; and (c) it is modularised with a hierarchy of procedures tailored to the individuals (as described in the authors' online Table DS1).[1]

Current treatment of anorexia nervosa is disheartening. Following successful weight restoration, almost 50% of patients relapse after 1-year follow-up, and pharmacological or psychological treatment persistently fails to neutralise the purported mechanisms underlying anorexia psychopathology.[4] Against this backdrop, according to the American Psychological Association Task Force criteria for the Promotion and Dissemination of Psychological Procedures, SSCM could be the first treatment for adult anorexia to attain the consideration of a well-established psychosocial intervention. However, the acronym SSCM disguises the fact that it has entered the stage through the back door of non-specific supportive treatments originally assigned to control groups, and SSMC efficacy over advanced treatments that have a sound theoretical basis raises perplexing questions. Maybe we are on the wrong track by persistently failing to understand either the fundamental features articulating the current concept of the disorder in terms of symptoms, personality traits, psychopathology and neuropsychological profile, or that these features are an epiphenomenon of malnutrition and are thus irrelevant as targets for treatment. Rather than delving into the self, perhaps the focus should be on the starvation side of self-starvation.[5]

1 Schmidt U, Oldershaw A, Jichi F, Sternheim L, Startup H, McIntosh V, et al. Out-patient psychological therapies for adults with anorexia nervosa: randomised controlled trial. *Br J Psychiatry* 2012; **201**: 392–9.

2 McIntosh VV, Jordan J, Carter FA, Luty SE, McKenzie JM, Bulik CM, et al Three psychotherapies for anorexia nervosa: a randomized, controlled trial. *Am J Psychiatry* 2005; **162**: 741–7.

3 Carter FA, Jordan J, McIntosh VV, Luty SE, McKenzie JM, Frampton CM, et al. The long-term efficacy of three psychotherapies for anorexia nervosa: a randomized, controlled trial. *Int J Eat Disord* 2011; **44**: 647–54.

4 Attia E, Walsh BT. Behavioral management for anorexia nervosa. *N Engl J Med* 2009; **360**: 500–6.

5 Gutierrez E. A rat in the labyrinth of anorexia nervosa: contributions of the activity-based anorexia rodent model to the understanding of anorexia nervosa. *Int J Eat Disord* 2013; doi: 10.1002/eat.22095. (Epub ahead of print.)

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Authors' reply: We share Gutierrez & Carrera's frustration about the difficulty in treating adults with anorexia nervosa. However, we disagree with their interpretation of our findings, and several other points they make.

First, in our trial specialist supportive clinical management (SSCM) was not superior to our new treatment, the Maudsley Model of Anorexia Treatment for Adults (MANTRA). In fact, outcomes for both interventions were similar. Moreover, in the

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subgroup of patients with lower initial body mass index ($<17.5\,kg/m^2$ at the beginning of treatment) there was some suggestion that patients receiving MANTRA showed greater weight gain than those receiving SSCM, but this was not statistically significant ($P=0.15$) as the study was not powered to detect subgroup differences. Second, the original New Zealand trial – where SSCM compared well against cognitive–behavioural treatment and interpersonal therapy – included many patients who had a relatively mild, less chronic form of anorexia. In this earlier trial, SSCM effects seemed to wane in the long term.[1]

Second, contrary to Gutierrez & Carrera's assertion, there is plenty of evidence that the personality features, neuropsychological profile (thinking style) and aspects of altered socioemotional processing found in anorexia are not just an epiphenomenon of malnutrition but have trait characteristics which are accentuated in the starved state.[2]

Taken together these findings suggest a definite place for SSCM, especially in the treatment of less severe cases of anorexia. It may be that a more complex treatment such as MANTRA, which is trait-focused and where patients are taught skills that help them to tackle a range of maintaining factors, is more effective in more severe cases. Our trial was too small to tease this out. However, a larger study is now under way that should be able to answer this question.[2]

To suggest an 'either/or' dichotomy between a treatment focus on self or starvation seems remarkably simplistic to us. In fact, if an exclusive focus on reducing starvation was the key curative step in treatment, in-patient refeeding for anorexia should be used much more often, as this reverses poor nutrition most quickly. Yet, in-patient treatment has significant problems: it is unacceptable to many patients and has high relapse rates.

In a large-scale international survey of patients with eating disorders and their families, there was strong agreement between these stakeholders that specialist expertise and personal qualities of staff, expert psychological interventions and nutritional assistance (advice and intervention) combined are the key components of effective treatments and services.[3]

Clearly, we are a long way away from having a cure for adults with anorexia. Given the very limited evidence base, there is still much to learn about what works for whom and at which stage of illness. The past few years have seen the burgeoning of neuroscience data related to anorexia nervosa, which opens the way to treatments targeted at dysfunctional neurocircuitry.[4,5] Ultimately, we predict that significant improvements in treatment outcomes in adults with anorexia are only going to be achieved through adding such 'targeted brain-directed' adjuncts to talking therapies and nutritional intervention.

1 Carter FA, Jordan J, McIntosh VV, Luty SE, McKenzie JM, Frampton CM, et al. The long-term efficacy of three psychotherapies for anorexia nervosa: a randomized, controlled trial. *Int J Eat Disord* 2011; **44**: 647–54.

2 Treasure J, Schmidt U. The Cognitive-Interpersonal Maintenance Model of Anorexia Nervosa revisited: a summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors. *Int J Eat Disord* 2013; in press.

3 Nishizono-Maher A, Escobar-Koch T, Ringwood S, Banker J, van Furth E, Schmidt U. What are the top five essential features of a high quality eating disorder service? A comparison of the views of US and UK eating disorder sufferers, carers and health professionals. *Eur Eat Disord Rev* 2010; 20 Dec. (Epub ahead of print.)

4 Van den Eynde F, Guillaume S, Broadbent H, Campbell IC, Schmidt U. Repetitive transcranial magnetic stimulation in anorexia nervosa: a pilot study. *Eur Psychiatry* 2013: **28**: 98–101.

5 Lipsman N, Woodside DB, Giacobbe P, Hamani C, Carter JC, Norwood SJ, et al. Subcallosal cingulate deep brain stimulation for treatment-refractory anorexia nervosa: a phase 1 pilot trial. *Lancet* 2013; doi: 10.1016/S0140-6736(12)62188-6. (Epub ahead of print.)

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Spirituality is not bad for our mental health

We note with interest the conclusion of King *et al*'s study,[1] which states that 'people who have a spiritual understanding of life in the absence of a religious framework are vulnerable to mental disorder'. A second, equally important finding is that 'religious people were similar to those who were neither religious nor spiritual with regard to the prevalence of mental disorders, except that the former were less likely to have ever used drugs [...] or be a hazardous drinker'. This lack of difference, as with the key conclusion concerning those who are spiritual but not religious, runs counter to the substantial body of evidence collated by Koenig *et al*,[2–4] who conclude that religion/spirituality are generally associated with better mental health.

King *et al* point out that 'the cross-sectional nature of the data means that we cannot attribute cause and effect to any relationship between spiritual beliefs and mental health', and they draw attention to important differences between the UK and North America (where the bulk of previous research has been conducted). The headline conclusion of the study may nonetheless leave professionals and others with the impression that 'spirituality' is bad for one's health, an impression that we believe would be mistaken.

Our post-modern culture is geared increasingly to a way of life that does not question deeply such things as the meaning of birth and death, why we are here and what it is all for. Instead, social norms often emphasise aspiration to goals of material ambition and success. For many, it seems that this can result in estrangement from the most fundamental spiritual needs and values of humankind (a theme that comes up at meetings of the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group).

With the decline in religious observance, the numbers of 'spiritual but not religious' (19% in this study) are rising, and perhaps more so in the UK than in the USA. Wrestling with the deepest questions about life is in the nature of the human condition. However, without a religious faith that can also provide a person with both community and support, the road is long and hard and the journey often a lonely one. Previous research (Pargament,[5] pp. 111–128) suggests that spiritual struggles have the potential for either good or bad mental health outcomes, and we wonder whether the kind of society in which we are now living is less than supportive of the good outcome.

We know that spiritually informed therapies are effective in the field of substance misuse,[6] and mindfulness-based approaches derived from spiritual practice are now recommended by the National Institute for Health and Clinical Excellence for relapse prevention of depression.[7] Further, we believe that spirituality has an important secular dimension which is finding expression in the recovery movement in psychiatry.

We must therefore guard against any misreading of this study by King *et al* that would suggest spirituality is bad for mental health. We do, however, support strongly research that is able both to delineate causal pathways and provide comparison between the cultures and contexts of the USA and the UK.