(i.e., cardiac protection versus pain control). Thus, in our opinion, it is not justifiable to compare the risk of gastrointestinal bleeding between the two drugs.

In the Dall et al. article (1), the authors actually found that SSRIs in combination with NSAIDs had higher odds ratios for gastrointestinal bleeding than SSRIs with aspirin (8.0 and 3.0, respectively), a similar trend to our results. It was in the subgroup analysis or stratum-specific analysis that they found contradictory results as described above (odds ratios of 1.79 and 2.2).

We do agree with the author that over-the-counter drugs can be a confounding factor. But this limitation is almost always unavoidable in all studies using a population-based database, since information about over-the-counter usage was not available in the data. This limitation would eventually underestimate the bleeding risk in both aspirin and NSAIDs in combination with SSRIs. We agree that the use of clopidogrel may confound the results. However, the number of patients receiving clopidogrel in our study was too small to conduct further subgroup analysis. In addition, although some SSRIs may inhibit the activity of P450, leading to decreased antiplatelet effect of clopidogrel, a recent population-based study (2) found that SSRIs with dual antiplatelet therapy of both clopidogrel and aspirin would actually increase the risk of bleeding (odds ratio=2.35) than with either clopidogrel (odds ratio=1.76) or aspirin (odd ratio=1.46).

Finally, Kuo et al. claimed that there exists evidence to support the lower bleeding risk in high-dose users. However, we found that such description could not be identified in either the provided citation (reference 4) or other literature. Actually, a prospective study has shown that the risk of gastrointestinal bleeding was strongly related to higher aspirin doses (3).

In summary, short-term SSRI use is associated with increased risk of gastrointestinal bleeding. Combining either aspirin or NSAIDs with SSRIs would further increase such risk. To compare the gastrointestinal bleeding risk between aspirin and NSAIDs in combination with SSRIs may not be justifiable, since the main clinical applications of the two drugs are different.

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CHING-LIANG LU, M.D.

From the Division of Gastroenterology, Department of Medicine, Taipei General Veterans Hospital, Taipei, Taiwan.

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Psychoanalytic Psychotherapy or Cognitive-Behavioral Therapy for Bulimia Nervosa

To the Editor: Poulsen and colleagues' article in the January issue of the *Journal* (1) reported that enhanced cognitive-behavioral therapy (CBT) had better outcomes than psychoanalytic psychotherapy for binge eating and purging. We believe these results should be considered in context.

As Poulsen et al. described elsewhere (2), the psychoanalytic psychotherapists did not examine binging and purging symptoms unless the patients spoke about them or unless there was an obvious reason to do so (e.g., the patient avoided any mention or was overly focused on symptoms). By contrast, enhanced CBT therapists focused primarily on binging and purging (1). As the primary outcome was binge and purge remission, differential results by treatment condition are not surprising. Evidence suggests that focused interventions across psychotherapies yield specific benefit in the particular symptom areas that are targeted (3).

Poulsen et al. (1) do not compare a bona fide psychodynamic treatment for eating disorders as practiced in the real world, which clinicians report to include symptom-focused interventions (4). However, the authors possess process data that can shed light on these issues and how to best direct practice. Did psychoanalytic and enhanced CBT therapists differ in their within-session focus on binge and purge symptoms, and was the amount of focus on each symptom class related to improvements in that domain both within and across treatments?

A notable example of an efficacious manualized psychodynamic therapy that is consistent with applied practice in encouraging focal examination of eating disorders symptoms is the research by Zipfel et al. (5). These authors demonstrated equivalent outcomes to CBT in the treatment of anorexia nervosa.

Other findings in the Poulsen et al. trial indicated that psychoanalytic psychotherapy and enhanced CBT were similarly effective for outcomes such as depression and interpersonal functioning. These comparable outcomes may be attributable to the enhancements to CBT, which included consideration of mood and interpersonal problems (1).

The best available treatments result in symptom remission for fewer than half of patients with bulimia nervosa. It would be unfortunate for patients if they had access to only a limited range of interventions that provide such modest outcomes.

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GIORGIO A. TASCA, PH.D.
MARK HILSENROTH, PH.D.
HEATHER THOMPSON-BRENNER, PH.D.

From the Department of Psychiatry, University of Ottawa, Ontario, Canada; the Department of Psychology, Derner Institute Adelphi University, Garden City, N.Y.; and the Department of Psychology, Boston University, Center for Anxiety and Related Disorders, Boston.

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Response to Tasca et al.

TO THE EDITOR: We thank Drs. Tasca, Hilsenroth, and Thompson-Brenner for their comments on our study. The letter gives us the opportunity, as the clinicians and researchers responsible for developing the psychoanalytic treatment and designing the randomized controlled trial, to emphasize that the psychoanalytic therapy employed in our trial is one particular version of psychodynamic psychotherapy. As we pointed out in the article, other psychodynamic approaches to the treatment of bulimia nervosa exist, and among these are treatments integrating more structured behavioral interventions directed specifically toward the core symptoms of bulimia nervosa (1). Thus, while our study does not support the efficacy of the specific version of psychoanalytic psychotherapy for bulimia nervosa used in the trial, in our opinion the obvious implication of the study is that a psychodynamic therapy with a more directive approach to the bulimic symptoms should be tested in future clinical trials. This would be in accordance with the continuous development and enhancement of cognitive-behavioral therapy (CBT) for bulimia through the previous decades.

In this sense, we fully agree with Tasca et al. that the approach toward symptoms recommended in our treatment guideline was not optimal. We do, however, want to stress that binging and purging was indeed addressed systematically in the psychoanalytic psychotherapy. In the treatment guideline, it is underscored that "the question of how to address the symptoms is an issue of particular importance," and while we stated that a narrow focus on the behavioral symptoms might impede the process of psychoanalytic psychotherapy, we also pointed out that "it is the task of the therapist to get a picture of the frequency and intensity of the symptoms and to try to involve the patient in a mutual reflection upon the symptoms … as psychological phenomena carrying a meaning and function in the patient's life" (2).

With regard to the criticism that the psychoanalytic psychotherapy used in the study is not a bona fide treatment practiced in the real world, we have found that this kind of treatment has been practiced relatively widely in Denmark and other European countries. Thus, in our opinion the finding that this is not a sufficiently efficacious approach is highly relevant to dynamically oriented practitioners.

Tasca et al. call attention to the Anorexia Nervosa Treatment of OutPatients (ANTOP) study (3), which demonstrated equivalent outcomes between psychodynamic therapy and CBT. While we agree that this study is highly important, the fact that the ANTOP study concerns the treatment of anorexia nervosa makes it hard to compare this study to ours. Anorexia and bulimia are indeed closely related disorders with many characteristics in common, but the treatments of the two disorders pose very different challenges. Perhaps most importantly, whereas patients with anorexia nervosa are typically highly ambivalent toward giving up the anorectic symptoms, patients with bulimia nervosa are more often motivated toward change and may be engaged in the directive behavioral approach of CBT more easily than patients with anorexia nervosa. Thus, we would caution against drawing too firm conclusions about the treatment of bulimia nervosa based on treatments of anorexia nervosa.

All in all, we sincerely hope that our study will give the impetus for further studies of psychodynamic psychotherapy for bulimia nervosa. We thank Drs. Tasca, Hilsenroth, and Thompson-Brenner for the suggestion to investigate the relationship between a focus on symptoms and improvement within and across treatments. Furthermore, we hope that when the results from our ongoing studies of patient attachment style and reflective functioning measured through the treatment are published, they will add to the understanding of the specific contributions of psychodynamic approaches to bulimia nervosa.

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STIG POULSEN, PH.D.
SUSANNE LUNN, M.SC.

From the Department of Psychology, University of Copenhagen, Denmark.

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Genetic Counseling for Common Psychiatric Disorders: An Opportunity for Interdisciplinary Collaboration

TO THE EDITOR: In their timely review of recent important genetic findings in psychiatric disorders—specifically, common