Family-Based Therapy Highly Effective for Most Anorexia Patients

Anorexia nervosa, which affects about 2 percent of young women and 1 percent of adolescent males, has challenged clinicians for decades. The disorder profoundly alters the lives of patients, interfering with growth, development and fertility and commonly co-occurs with substance use and mood and anxiety disorders. The mortality rate — an estimated 20 percent — is the highest of any psychiatric illness.

Yet traditional psychodynamic models such as adolescent-focused individual therapy (AFT), which stresses autonomy, self-efficacy and individuation, have met with little success. Less than half of patients treated with AFT recover physically and psychologically over the long term; the rest continue to experience symptoms of varying severity throughout life.

Several factors account for these poor outcomes, according to Leslie A. Sim, Ph.D., L.P., a psychologist specializing in eating disorders at Mayo Clinic’s campus in Rochester, Minnesota. “Many of these kids are very ill; they’re not thinking clearly or flexibly and aren’t capable of engaging in traditional psychotherapy,” she says. “Then, too, as clinicians, we’re trying to reduce their control over weight and eating, which in many cases they have incorporated into their identity as a moral value. So in essence, we are asking a child to stop the behavior that in her eyes makes her a good person.”

Family-based therapy (FBT) also known as the Maudsley approach, was developed as an alternative to traditional interventions. It is an intensive outpatient program that seeks to avoid hospitalization and instead actively engages parents in the process of restoring their child to a healthy weight at home. FBT treats anorexia first and foremost as a medical illness and uses food as a therapeutic agent.

“Children and teens with anorexia aren’t capable of making good choices about their health. Their brains are hijacked by starvation, so the parents have to step in and make those choices for them,” Dr. Sim explains. “The choice they make is that kids have to eat. We don’t have any good pharmacology for anorexia; food is the medicine, and we know that it works.”

Results of the first randomized controlled trial to demonstrate the effectiveness of FBT appeared in JAMA Psychiatry (formerly Archives of General Psychiatry) in 2010. In that study, researchers found that FBT was superior to AFT on most clinically significant measures, including relapse rate from full remission — 10 percent and 40 percent, respectively. Subsequent studies and clinical experience have confirmed those findings.

Feast or famine

FBT is a challenging and labor-intensive process that requires loving support and remarkable patience and persistence from parents, one of whom must be present to monitor each meal and snack, no matter how long a child takes to eat it.

“There is no one right way to do it, but the key is not to let children out of the demand that they consume a certain amount of food at every meal,” Dr. Sim says, adding that the goal is to regain weight quickly and...
Adult ADHD Presents Diagnostic and Therapeutic Challenges

Current evidence suggests that attention-deficit/hyperactivity disorder (ADHD), the most common neurodevelopmental disorder of childhood, often persists throughout life and may affect 4 to 5 percent of U.S. adults. Yet adult ADHD remains controversial — a clinically heterogeneous, multifactorial syndrome with no set of consistent findings to support its diagnosis and no single etiology to explain its pathology. This complexity may make providers reluctant to assess for ADHD, potentially leading to underdiagnosis and undertreatment.

Inattention symptoms predominate

Several studies, including a 2009 study in The Journal of Clinical Psychiatry, have demonstrated that ADHD symptoms in adults differ considerably from those in children. More than 90 percent of adults with ADHD have attention issues, including difficulty with planning, follow-through, organization and time management. Hyperactivity may decline or disappear in adulthood, but impulsivity remains a significant problem. In adults, manifestations can be subtle, including symptoms as diverse as restless, driven activity, an inability to relax or sexual impulsivity.

These important distinctions are not reflected in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The revised criteria for adult ADHD remain child-focused, and only about one-third of adults meet them. Furthermore, many patients continue to have problems with executive functioning — the neurologically based skills involving mental control and self-regulation — even when the core symptoms outlined in DSM-5 are effectively treated.

For adults, the consequences of lifelong functional difficulties can be devastating, says J. Michael Bostwick, M.D., a psychiatrist at Mayo Clinic’s campus in Rochester, Minnesota. “Little people, little problems; big people, big problems,” he observes.

Diagnosis is also complicated when behavioral, mood and medical disorders, including depression, anxiety, substance use, thyroid problems and sleep apnea are present. Medical conditions can mask symptoms of adult ADHD, and psychiatric comorbidities make treatment more difficult. By some estimates, more than half of adults who had childhood ADHD have one or more psychiatric disorders.
**Diagnostic criteria**
ADHD is a clinical diagnosis, so a detailed history and exam are critical. Adult ADHD should be suspected when:

- Core symptoms are present but don’t meet full ADHD criteria
- Residual symptoms cause serious functional difficulties
- Substance use or mood and anxiety disorders combine with core symptoms
- A long history of psychosocial dysfunction exists, including disrupted education, employment and relationships
- A discrepancy exists between intelligence and achievement

“When ADHD hasn’t been previously diagnosed, it’s usually possible to trace behavioral and attentional difficulties back to preschool,” Dr. Bostwick says. “When people mature, ADHD manifests as underachievement. Many adult patients are failing in life; they may have a history of work and relationship issues and an inability to function at a level equal to their intelligence. They may recognize that they are as intelligent as their friends but may be painfully aware they have not had the same success.”

**Challenges of treating adult ADHD**
Therapy for adult ADHD can be challenging and is a matter of some debate. As in pediatric ADHD, stimulants are considered a first line treatment, but they tend to be less effective in adults, are associated with a slight cardiovascular risk, and are more likely to be abused or diverted, especially among adolescents and college students. Although medications can improve social and behavioral function, they rarely normalize behavior completely. Even when core symptoms of ADHD are successfully managed, functional improvements may be relatively modest.

In addition to medications, an integrated treatment plan should include identifying a patient’s strengths and weaknesses, assessing for residual symptoms, and employing psychosocial interventions such as time management and cognitive behavioral therapy. “We try to tailor medications to a patient’s needs and mitigate abuse potential,” Dr. Bostwick says. “Then we work very hard to build skills that will bring order to a disordered life.”

**For more information**

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**Expanding the Collaborative Care Model**
Most adults in the United States receive mental health care from nonspecialist providers, mainly in the primary care setting. Yet primary care physicians have limited time, and access to evidence-based psychotherapy is especially challenging in primary care practices. Not only is referral to mental health specialists much more complex than to other providers, but patients often choose not to see them. In one small Mayo Clinic study, just half of patients referred to the Department of Psychiatry and Psychology kept their appointments.

An evidence-based alternative to this approach is a collaborative model that integrates mental health professionals and care managers into primary care. More than 70 robust, randomized controlled trials, including the pivotal 2002 Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study, which appeared in the Journal of the American Medical Association, have demonstrated that collaborative care for depression is far more effective than usual care in a variety of treatment settings.

In Minnesota, the Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program for adults with diagnosed mental health needs demonstrates the effectiveness of collaborative care.
depression is based on the IMPACT model. Like IMPACT, DIAMOND adds a care manager and consulting psychiatrist to the health care team and uses the Patient Health Questionnaire (PHQ-9) for assessment at the first primary care visit. Other program components include systematic monitoring using repeat PHQ-9 measurements and a patient registry, a stepped-care approach to treatment, and a relapse prevention plan. Patients who don’t respond to treatment or have an acute crisis can receive same-day specialty mental health care but are referred back to primary care when stable.

Data from Mayo show that many more people reach remission in DIAMOND than those not in DIAMOND do — 26 percent of patients at DIAMOND sites compared with 5.8 percent of patients at primary care and behavioral health clinics combined. Mayo Clinic and other DIAMOND sites consistently report the best depression outcomes in the state.

David J. Katzelnick, M.D., chair of the Division of Integrated Behavioral Health at Mayo Clinic’s campus in Rochester, Minnesota, notes the significant effect of collaborative care on adherence. “In the DIAMOND program, care coordinators have weekly follow-up contact with patients where they address adherence and barriers to treatment. Frequent contact — virtually impossible in usual primary care — keeps patients engaged and improves the likelihood of remission,” he says.

In 2011, based on the success of DIAMOND, Mayo Clinic initiated a pilot program for adolescent depression called Early Management and Evidence-Based Recognition of Adolescents Living With Depression (EMERALD). The program has received excellent results on all standard patient-reported outcomes, and there are plans to expand it across Mayo’s primary care departments. “By treating medical and psychiatric issues in primary care, we can look at the whole person and have real potential to help people by catching problems early on,” Dr. Katzelnick says.

Reaching more patients
The next challenge, Dr. Katzelnick adds, is extending collaborative care to patients with anxiety disorders and mental health problems other than depression. One such evidence-based program, the Coordinated Anxiety Learning and Management (CALM) Tools for Living Program, was piloted at Mayo and aims to treat four common anxiety disorders including generalized anxiety disorder, social anxiety disorder, panic disorder and posttraumatic stress.

Dr. Katzelnick is also interested in the development of primary care programs for patients with early substance abuse and chronic pain issues and is currently developing a program for Olmsted County, Minnesota, that would provide integrated care to patients with borderline personality disorder. “We need to think not only about the person sitting in front of us but also about all those who aren’t receiving treatment and extend care to everybody,” he says. “To do that, we have to work together.”

For more information

Resources
MayoClinic.org/medicalprofs
Clinical trials, CME, Grand Rounds, scientific videos and online referrals

Education Opportunities
For more information or to register for courses, visit https://ce.Mayo.edu/psychiatry-and-psychology, call 800-323-2688 (toll-free) or email cme@mayo.edu.

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