Gambling on treatment is not an option

Professor Janet Treasure, Professor of Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience in London, reviewed the latest developments in the treatment of eating disorders – from anorexia nervosa to binge eating disorder.

Lifetime prevalence of anorexia nervosa is 0.6%, while bulimia nervosa is 1% and binge eating disorder stands at 3%.1–4 There is a range of atypical eating disorders that do not meet the criteria for the other three disorders but occur with a lifetime prevalence of about 15%. However, only around 20% of eating disorder cases present for treatment, Professor Treasure explained.

There was a real paucity of level A evidence to support management strategies for eating disorders – none for anorexia nervosa, one for bulimia nervosa and two for binge eating disorder. Indeed, most of the evidence for anorexia nervosa was level C. That has improved but there is still a lot of uncertainty and some studies are difficult to do.

Despite evidence that cognitive behavioural therapy (CBT) is effective in treating symptoms the remission rate is only around 30% in most studies or clinical practice. That can rise to 50% when delivered by specialists in the best trials with the best supervision, and that seems to hold true for other therapies as well.5

Pharmacotherapy

Comorbid disorders such as depression, anxiety and obsessive compulsive disorder are common in people with eating disorders and these have been the target of pharmacological therapy with drugs such as antidepressants, anticonvulsants, atypical antipsychotics and stimulants, for example.

Selective serotonin re-uptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) have been shown to be effective in bulimia nervosa and binge eating disorder but not in anorexia nervosa.6–8 However, with antidepressants alone the overall remission rate is just 19% in bulimia nervosa, for example. There is some evidence that combining CBT with pharmacotherapy might be helpful. In binge eating disorder there is weak evidence for orlistat. Anticonvulsants seem to be moderately effective.9,10 More recently, opiate antagonists such as ALKS-33,11 nutrients such as chromium12 and psychostimulants like lisdexamfetamine13 have been tested.

World Federation of Societies of Biological Psychiatry (WFSBP) guidelines6 cite grade A evidence for the use of sertraline, fluoxetine and citalopram for binge eating disorder, along with atomoxetine and antiepileptics topiramate and zonisamide.

Professor Treasure’s group has been examining the effect of training in an attempt to interrupt the pattern of craving and overeating seen in patients with eating disorders. The aim is to train people away from binge eating foods such as chocolate, has shown promise in patients with binge eating, for example. Other approaches in the early stages of testing include neuromodulation techniques such as transcranial magnetic stimulation (TMS).17,18

Anorexia nervosa

The clinical needs and preferences of patients with anorexia have an important bearing on treatment because of the range of cases, from those who are severely ill to those who are functioning quite well, from someone who has had anorexia for 20 years to patients diagnosed only a few months before. So, medical severity, age, stage of illness, psychosocial functioning and comorbidity are all important factors to consider when choosing a treatment strategy.

Family therapy was found to be more effective than individual therapy in patients with early onset (<3 years) disease. In those with more enduring disease the effect of family-based therapy was less clear.19 The rationale behind the approach is to empower the family (particularly parents) to re-feed the child/adolescent, employing strategies such as family meals, weekly weighing and parental support to change eating patterns. Family-based therapy has been found to be effective in bulimia nervosa as well as anorexia nervosa.

Reflecting on the involvement of carers and their interaction with the patients and the disease, Professor Treasure and colleagues developed the idea that caregivers themselves...
patients’ lack of insight. However, in anorexia nervosa because of well in bulimia but Wilson (2010) Self management has worked in 10–30% of adult cases. and inpatient treatment is required preferred by the team offering it. a little depending on the method etc although efficacy seems to vary a little depending on the method preferred by the team offering it. Typically 20–40 sessions are needed and inpatient treatment is required in 10–30% of adult cases. Self management has worked well in bulimia but Wilson (2010) advised that it should not be used in anorexia nervosa because of patients’ lack of insight. However, adding self management to other forms of treatment is being tested and seems to offer some benefit.

**Future therapies**

Treatment with oxytocin and cannabinoids shows some promise in early studies, as do training techniques for cognitive, motivational and social aspects.

**Neuromodulation with TMS** has been found to have some short-term effect but needs to be studied in longer-term trials. Deep brain stimulation has also attracted some attention as a possible intervention.

**Gambling disorder**

Dr Henrietta Bowden-Jones, Consultant Psychiatrist in Addictions at Central and North West London NHS Foundation Trust, described her work as director of the National Problem Gambling Clinic in London, the only NHS clinic for people with pathological gambling in the UK.

In ICD-10 pathological gambling is grouped with habit and impulse disorders but that is likely to change in line with DSM-5 where it has become the first behavioural addiction to be listed along with substance-related and addictive disorders. DSM-5 describes gambling disorder as:

‘Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

- Needs to gamble with increasing amounts of money in order to achieve the desired excitement
- Is restless or irritable when attempting to cut down or stop gambling
- Has made repeated unsuccessful efforts to control, cut back, or stop gambling
- Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).

People with gambling disorder:

- Often gamble when feeling distressed (e.g., helpless, guilty, anxious, depressed)
- After losing money gambling, often returns another day to get even (“chasing” one’s losses)
- Lie to conceal the extent of involvement with gambling
- Have jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling
- Rely on others to provide money to relieve desperate financial situations caused by gambling.

The disorder is often associated with domestic abuse – physical and emotional, and there is a high level of anxiety in children of pathological gamblers.

Patients who present at the national clinic have usually lost everything, which is why it was important for Dr Bowden-Jones to be able to offer a free service.

Data from the 2012 Health Survey for England, for which 9000 people were interviewed, showed that 68% of men and 61% of women gambled in the previous 12 months, with problem gambling being seen in 0.8% of men and 0.2% of women. Dr Bowden-Jones commented that since the survey was done the amount of advertising for gambling and the revenues for the industry have increased so it will be interesting to see the figures produced by the next household survey, due to be published later in 2016.

Pathological gambling is associated with impulsivity, which is a strong predictor of problems at a young age. It is also associated with impaired functioning in brain regions associated with decision making such as the ventromedial prefrontal cortex and the striatum – the reward pathway areas that show significant difference in pathological gamblers compared with controls.

Genetics plays a significant role in determining the vulnerability to problem gambling, as it does in other addictions. Gambling tends to run in families and twin studies
suggest it may be more of a factor in men than in women.

Treatment
Dr Bowden-Jones recommended the 2011 Monash Guideline for Screening, Assessment and Treatment in Problem Gambling (www.med.monash.edu.au/sphc/pgtc/guideline/) from Australia as a good source of information. CBT is the evidence-based treatment of choice for problem gambling. Eight sessions is standard; in groups or one-to-one.

Research indicates CBT is most effective in terms of a sustained clinical and statistical improvement. Even minimal cognitive behavioural interventions can significantly reduce gambling behaviour. No differences have been found between group and individual therapy.

Patients who do not benefit from psychological treatment may find that treatment with naltrexone is beneficial, although it is not licensed for the indication. Dr Bowden-Jones prescribes it at a dosage of 50mg daily and she said it has transformed the lives of some patients.

More details of the clinical aspects of treatment in which Dr Bowden-Jones interviews a service user can be found at www.youtube.com/watch?v=ow5buwxP1jA.

Revised BAP depression guidelines
Professor Anthony Cleare, Professor of Psychopharmacology and affective disorders at the Institute of Psychiatry, Psychology and Neuroscience in London, gave an update on the revised British Association for Psychopharmacology (BAP) guidelines for depression.

While it is true that in milder depression of short duration there is uncertainty about the efficacy of drug treatment, it is not the case that drugs do not work in milder depression of shorter duration, Professor Cleare said.

The BAP guidelines state that antidepressants are an option in short-duration mild major depression in adults and should be considered if there is a prior history of moderate to severe recurrent depression or the depression persists for more than two or three months. Antidepressants are not the first-line option for short duration subthreshold depression in adults but should be considered if the depression persists for more than two to three months or there is a prior history of moderate or severe recurrent depression.

Recently the idea that all antidepressants are of approximately equal efficacy has been challenged. An analysis by Cipriani found escitalopram, sertraline, mirtazapine and venlafaxine to be more efficacious than other antidepressants. A meta-analysis by Machedo, et al. found a 5.7% advantage for serotonin–noradrenaline re-uptake inhibitors (SNRIs) over SSRIs (number needed to treat [NNT] approximately 17.5), which although not in line with the usual NNT of around 10 would be considered to endow clinical advantage, in Professor Cleare’s experience; in more difficult-to-treat patients small additional advantages begin to add up and could be the difference between someone responding to treatment or not responding.

BAP conducted a review of all the meta-analyses and the few head-to-head studies and found that clomipramine, escitalopram, venlafaxine, sertraline, amitriptyline and mirtazapine seem to have small benefits over other treatments.

There are, of course, a number of factors to take into account when choosing an antidepressant, including patient preference. For example, a study comparing treatment with sertraline with treatment with psychotherapy over 10 weeks showed that patients had better outcomes when given the treatment they preferred.

Psychological therapies
Many studies of psychological therapies use a waiting list control, which is not in itself unreasonable. However, when studies using the method are compared with those using placebo control there is a large difference in effect size: waiting list control gives a much bigger effect size than placebo. Also, for people randomised to go on waiting list control, the outcomes are worse than placebo, ie no treatment.

There appears to be little difference in the efficacy of the main psychological therapies for depression – behavioural activation, cognitive therapy and interpersonal psychotherapy.

Combining drugs and psychological therapies appears more effective than either one alone, particularly for more severe patients and those with chronic depression.

Treatment-resistant depression
There is little evidence to support dose increase for patients with treatment-resistant depression. The strategy may be effective for TCAs, venlafaxine and escitalopram. Switching drugs may be a helpful approach, either to another drug of the same class or to one of another class. The evidence seems to suggest that people who do not respond to an antidepressant within the first two weeks of treatment are unlikely to respond later. A recent randomised controlled trial showed that non-responding patients switched from escitalopram to duloxetine at four weeks rather than eight weeks achieved higher remission rates at 12 weeks (43.3% versus 35.6%). However, that might not be the case in older patients or those with treatment-resistant depression. Treatment augmentation can also be effective.
Relapse and recurrence
Around 75% of patients show recurrence of depression over 10 years. Indeed, patients who have had more than five lifetime episodes of depression or two episodes in two years should continue antidepressant therapy for two years to life.

Residual symptoms are an important predictor of recurrence, so it is important to continue treatment in those patients with residual symptoms. CBT can be helpful in these cases as an adjunct to pharmacotherapy.51

There are emerging potential treatment options, which include ketamine, s-adenyl methionine, pramipexole, triple uptake inhibitors, modafinil, antiglucocorticoids and anti-inflammatories.

NICE guideline CG178 for schizophrenia – is it evidence based and realistic?
Dr Mark Taylor, Consultant Psychiatrist with the intensive home treatment team at the Royal Edinburgh Hospital, questioned some of the recommendations in the recent NICE guideline for schizophrenia.

Guidelines from bodies such as NICE and SIGN are evidence-based, in contrast with other guidelines, which are based on consensus of clinical experts, Dr Taylor explained. One drawback with evidence-based guidelines is that there can be large omissions where data is lacking, for example on the question of how long a medicine should be taken for, he said.

The 2009 version of the NICE schizophrenia guideline (CG82) was not particularly directive. It recommended: ‘For people with newly diagnosed schizophrenia, offer oral antipsychotic medication. Provide information on the benefits and side effects of each drug.’ The latest guideline for adults (CG178) has shifted the title to psychosis and schizophrenia with no real explanation other than perhaps moving the language away from the stigmatised term schizophrenia. Dr Taylor commented that psychosis is used in common parlance but it does not appear in any diagnostic rubric. And although NICE declares that it is ‘committed to keeping guidelines current’, with updates undertaken every four years at least, the 2014 NICE meta-analyses contain no trials published after 2008.

Development of the latest NICE guideline on schizophrenia is predominantly a psychologist-led publication. Dr Taylor commented, so perhaps it is no surprise that psychological interventions are emphasised, but there seems to be little consideration of the potential harm, fidelity or availability of these. McKenna et al writing in the British Journal of Psychiatry noted that only one in five of the meta-analyses NICE chose supported the statement in the NICE guideline that ‘when compared with standard care, CBT was effective in reducing rehospitalisation rates up to 18 months following the end of treatment’.52

CG178 devotes a whole new chapter on at-risk mental states (ARMS). Yet researchers such as Van Os and Murray declare the concept to be an unreliable construct with little predictive validity.53 Experts on the DSM-5 steering committee rejected it as a diagnostic entity. Yet CG178 recommends that people with ARMS should be offered cognitive behavioural therapy for psychosis (CBTp). However, even in well-resourced cities such as Edinburgh the waiting list for CBTp is one to two years.

Also, for the first month of a first episode of schizophrenia or psychosis CG178 recommends offering CBTp alone – in a group where the risk of suicide is between 5% and 10%, Dr Taylor added. The guideline does acknowledge that some people may want medication and suggests CBTp works better with medication.

A Cochrane analysis of CBT covering 20 trials compared CBT with other psychological therapies and concluded that trial-based evidence suggests no clear and convincing advantage for CBT over other – and sometimes much less sophisticated – therapies for people with schizophrenia.54

Dr Taylor concluded by saying that psychosocial interventions do have a place in the treatment of schizophrenia alongside medication. He has no doubt that guidelines such as those produced by NICE are well-intentioned and laudable. However, that does not mean that their methodologies and recommendations should not be debated.

Diagnosis and treatment of ADHD in adults
Services for adults with ADHD in the UK are patchy but the condition is increasingly being recognised, Professor Philip Asherson, Professor of Molecular Psychiatry and Honorary Consultant Psychiatrist, MRC Social Genetic Developmental Psychiatry at the Institute of Psychiatry, told the meeting.

The prevalence of adult ADHD in the general population is around 2.5%. However, rates of ADHD within adult mental health services vary from around 26% in prison to 6% in anxiety units. In primary care the rate among non-psychotic patients seems to be around 11% and in secondary care about 15%.55

ADHD symptoms in adults overlap with other conditions, with common symptoms including emotional instability (anger, irritability, temper control, mood liability), initial insomnia, feeling restless (agitated when severe), talking excessively or tangentially (severe ADHD), low self-esteem, concentration difficulties, distractibility, impulsivity, mind wandering and ceaseless mental activity.56 The key feature is that symptoms are not episodic, they are chronic trait-like symptoms. So the
most difficult differentiation should be from a personality disorder, Professor Asherson explained.

Professor Asherson has recently become interested in the phenomenon of excessive mind wandering, which is subjectively described in at least 80% of cases of adult ADHD. It relates to ordinary everyday thoughts but they are ongoing all the time, flitting from one topic to another with multiple lines of thought happening at the same time. It differs from bipolar disorder in that there is nothing unusual or atypical about the content – it is a distracted mental state.

It is known that when the brain is in a resting state the default mode network is active, which becomes inactive when the brain engages in a task. In ADHD it is thought that perhaps the default mode network is not switched off by less demanding or boring tasks. Brain-imaging studies in children with ADHD show that incentivising them to undertake a task has a similar effect to medication in switching off the default mode network when they engage in a task that is relatively boring. That chimes with what is known about ADHD where children with the condition are good at football, for example, where they are highly incentivised but tend to cope less well in situations of low stimulus where they may be bored. Meta-analyses confirm that methylphenidate, amphetamines and atomoxetine are effective in the treatment of symptoms of adult ADHD, with NNTs between 2 and 5. Atomoxetine and lisdexamfetamine are licensed for use in adults but NICE recommends unlicensed methylphenidate as first-line treatment.

Emotional instability is a feature of adult ADHD. Adults with the condition seem to exhibit more variation in their mood states during the day, particularly in the domains of anger, frustration and irritability, compared with controls. About 20% of people with personality disorder meet diagnostic criteria for ADHD but it is not known whether there are differences in the pattern of emotional lability between the two disorders, and it will be interesting to see what effect treatment with atomoxetine has in that group of patients, Professor Asherson said.

ADHD is a risk factor for the development of co-occurring conditions later in life such as antisocial behaviour, personality disorder, anxiety and depression and substance-use disorders. It is, as yet, unclear whether it is the ADHD itself that leads to these behaviours or whether a range of other factors has an impact such as educational failure, peer influence, parenting (unstructured, maltreatment), drug and alcohol abuse, traumatic brain injury, specific and general learning difficulties or genetic components.

Some light may be shed on the issue when looking at treatment of adults with ADHD. Professor Asherson noted that such studies are hard to do, but in Sweden, for example, where criminal records can be linked to medical records, there is evidence that people with ADHD are six times more likely to have a criminal conviction than those who do not have ADHD. Looking at similar datasets it can be seen that there is a 32% reduction in crimes among men and a 41% reduction in crimes among women when they were taking medication. In an open study Professor Asherson’s group found that treatment of prisoners with ADHD with slow-release methylphenidate reduced symptoms. Reports on prisoner behaviour seemed to confirm improvement in behaviour among prisoners receiving drug treatment for ADHD symptoms. A randomised controlled trial is planned to further investigate treatment of prisoners with ADHD.

References


