Fallacies About Anorexia Undermine Treatment

Rethinking psychosocial model can help stop parents from blaming themselves for children’s condition.

BY ROBERT FINN
San Francisco Bureau

PORTLAND, Ore. — Despite com-
mon perceptions among medical profes-
sionals and the general public, anorexia nervosa is not a psychosocial disease, Julie K. O’Toole, M.D., said at a conference sponsored by the North Pacific Pediatric Society.

Rather, it is a brain disorder and should be seen as such, said Dr. O’Toole, medical director of the Kartini Clinic for Dis-
ordered Eating, Portland, Ore. She discussed several of the fal-
cacies surrounding anorexia ner-
vosa:

► Anorexia nervosa is caused by over-enmeshed mothers. Dr. O’Toole said she has seen no evidence of any single pattern of mothering in her pa-
tients. While it may be true that mothers draw closer to their children with anorexia, this is probably a consequence rather than a cause of the disease. Throughout the animal kingdom, mothers draw clos-
er to offspring who are ill or otherwise in danger.

► Children choose anorexia to look like models, because of the extreme exam-
ple of thinness in the press. The Karti-
ni Clinic treats children who were home-
schooled on farms with no television and no access to fashion magazines. Their anorexia is identical to that of other chil-
dren.

“This is not a volitional disease, and we find [this explanation] extremely trav-

eling of a severe brain disorder,” Dr. O’Toole said.

Nevertheless, the dominant images of thinness in the media do make it much harder to get children into treatment. Dr. O’Toole likened it to swimming upstream against the prevailing images of what women should look like. But these images are not causal.

► Anorexia nervosa is a condition of spoiled, upper-class kids. Several formal epidemiologic studies have failed to find any link between anorexia and social class. At the Kartini Clinic, therapists engage an in-
formal “map epidemiol-
ogically,” placing a flag cor-
responding to the homes of their patients in a map of the three counties of Portland. What’s striking is the evenness of the dis-
tribution, with no con-
centration of flags in wealthier neighborhoods.

► Anorexia nervosa is a condition of Western and Western societies. The disease has certainly been seen in non-Westernized Arab girls, as well as Asians.

“We rarely see African American chil-
dren in our Oregon practice.

“Yet even if this was the universal ex-
perience, and anorexia nervosa was a disease of Westernized whites only, that wouldn’t make it a psychosocial disease,” said Dr. O’Toole.

You won’t see many whites in a clinic for sickle-cell disease, but that doesn’t make that disorder psychosocial in nature, she said.

Likewise, acute lymphocytic leukemia is more common among white children who have middle-class or upper-middle-class backgrounds, but that doesn’t make it a psychosocial illness.

► Anorexia is all about control. This is the dominant paradigm these days, and even parents will attribute their disease to a need to control one thing in their lives. Dr. O’Toole regards this as too facile an explanation that implies a level of control that patients only wish that they had.

Moreover, it’s dangerous to trust a pa-
tient’s own explanations of the etiology of her disease, she said. In the 16th century, people with leprosy were likely to at-
tribute their disease to some offense they committed against God, but that didn’t make it true.

“I’ve always been puzzled about why parents cling to the notion that they did something wrong,” Dr. O’Toole com-
mented.

“We tell them, ‘You didn’t cause this. You couldn’t cause this.’ We would rather blame ourselves than believe that horrible things could happen to our children, and we are powerless to affect it.”

The Kartini Clinic’s opening message is, “We treat children and adolescents in the belief that parents do not cause and chil-
dren do not choose to have eating disor-
ders.”

Rethinking the purely psychoanalytic model has a number of implications. For one thing, parents can quit blaming them-

► The disease is the evenness of the dis-
tribution. As a brain disorder, anorexia ner-
vosa is not amenable to rational thought.

In addition, everyone can stop treating the patient as if it were a volitional disease, and useless “arguing with the disease” can cease. As a brain disorder, anorexia nervosa is not amenable to rational thought.

Furthermore, family and physicians can focus on creating a safe medical environ-
ment in which the child can achieve re-
mission and minimize the sequelae of the disease.

Finally, rejecting the purely psychoana-
lytic paradigm allows the patient to re-
ceive the same compassion and under-
standing as do victims of other medical diseases.

A child with anorexia nervosa should be hospitalized when presenting with cer-
tain signs and symptoms. (See box.)

Of course, weight restoration is key; she added.

Selective serotonin reuptake inhibitors are not useful for anorexia nervosa as such but do treat concomitant anxiety, panic, depression, and obsessive-compulsive disorder.

The antipsychotics olanzapine (Zyprexa, 2.5 mg) and risperidone (Risperdal, 0.5 mg) are useful but have side effects including sedation, hyperprolactinemia, type 2 diabetes, and extrapyramidal symp-
toms. Dr. O’Toole prefers starting with a low dose (25 mg) of Seroquel (quetiapine) at bedtime.

Prescribing Exercise May Help Cognition in Obese Kids

BY DIANA MAHONEY
New England Bureau

BOSTON — A prescription for exercise may do more than boost obese children’s physical health. It also may improve how they think, results of a study have shown.

The findings are consistent with recent work demonstrating exercise-induced improvements in cognition in older adults and add fuel to the argument for in-
creasing physical education re-
quirements in schools and com-
munity-based opportunities for physical activity, according to Mathew Gregoski of the Georgia Prevention Institute of the Med-
cal College of Georgia in Au-
gustine, Fla.

As part of an ongoing inves-
tigation of a possible dose-re-
spose relationship between a 3-
month exercise program and adi-
posity, insulin sensitivity, and ex-
ecutive functioning in overweight youth, 30 children aged 8-11 years with a body mass index at or above the 85th percentile for their age and gender were randomized to one of three inter-
vention conditions— no exercise, low-dose exercise (20 min/5 day), and high-dose exer-
cise (40 min/day) — to test the ef-
fect of aerobic exercise training on cognitive measures.

Both of the exercise conditions included 16 aerobic activi-
ties and games that maintained average heart rate above 150 beats per minute. Mr. Gregoski reported the results at the annual meeting of the Society for Behavioral Medi-
cine.

Before and after the interven-
tions, all participants underwent stan-
dardized mental functioning testing using the Cognitive As-
sessment System (CAS). The in-
vestigators calculated the changes from baseline in four scales of the CAS, including plan-
ning, attention, successive, and si-
multaneous, said Mr. Gregoski, who con-
ducted the investigation under the direction of Catherine Davis, Ph.D.

The planning scale measures an individual’s ability to generate hypotheses and to use decision-making structures to evaluate them.

This aspect of mental func-
tioning is thought to underlie cognitive control, intentionality, and self-regulation—all of which have been identified as challenges for obese children.

The attention scale measures an individual’s ability to focus attention, take in information, and maintain suffi-
cient alertness to at-
tempt problem solving.

The successive scale is associ-
ated with the ability to integrate information in serial order, and the simultaneous scale is associ-
ated with operations that require consideration of all ele-
ments of a complex stimulus concurrently.

Analysis of variance revealed significant improvement follow-
ing both exercise interventions in the planning scale of the CAS, with the high-dose exercise group experiencing the most change from baseline. The other cognitive measures did not show any effect, Mr. Gregoski said.

That a significant cognitive benefit was observed with the 20-minute intervention in addi-
tion to the longer duration is no-
table in that such a program could readily be introduced dur-
ing regular physical education sessions, he said at the confer-
ence.

These results “provide evi-
dence for a direct relationship be-
 tween physical activity and chil-
dren’s cognitive development,” Mr. Gregoski said.

The findings may be important not only for developing inter-
ventions targeting this popula-
tion, but also for breaking down the barriers to physical educa-
tion and activity in schools.

Indications for Hospitalization

- Weight less than 75% of the mini-
 mum weight for height.
- Heart rate less than 45 beats per min-
ute with orthostatic hypoten-
sion.
- QTc interval greater than 0.444 ms.
- Temperature less than 97.3°F (36.3°C).
- Decrease in systolic blood pres-
 sure from lying to standing of 10 mm Hg or more.
- Increase in heart rate from lying to standing after 2.4 minutes of 35 bpm or more.
- Potassium level less than 3.0 mEq/L.

Source: Dr. O’Toole

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