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 common perceptions among medical professionals 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 Disordered Eating, Portland, Ore. She discussed several of the fallacies surrounding anorexia nervosa:

Olanzapine and risperidone are useful but have side effects, including sedation, hyperprolactinemia, type 2 diabetes, and extrapyramidal symptoms.

► **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 patients. 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 closer to offspring who are ill or otherwise in danger.

► **Children choose anorexia to look like models, because of the extreme examples of thinness in the press.** The Kartini Clinic treats children who were homeschooled on farms with no television and no access to fashion magazines. Their anorexia is identical to that of other children.

"This is not a volitional disease, and we find [this explanation] extremely trivializing 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 remission. 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, workers engage in an informal "map epidemiology," placing a flag corresponding to the homes of their patients in a map of the three counties of Portland. What's striking is the evenness of the distribution, with no concentration of flags in wealthier neighborhoods.

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

"We rarely see African American children in our Oregon practice.

"Yet even if this were the universal experience, and anorexia nervosa were 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 patients 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 volition that patients only wish that they had.

Moreover, it's dangerous to trust a patient's own explanations of the etiology of her disease, she said. In the 16th century, people with leprosy were likely to attribute 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 commented.

"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 children do not choose to have eating disorders."

Rethinking the purely psychoanalytic model has a number of implications. For one thing, parents can quit blaming themselves, family dysfunction, or careless comments for causing their children's anorexia.

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 environment in which the child can achieve remission and minimize the sequelae of the disease.

Indications for Hospitalization

► Weight less than 75% of the minimum weight for health.
► Heart rate less than 45 beats per minute (bpm).
► QTc interval greater than 0.444 ms.
► Temperature less than 97.3° F (36.3° C).
► Decrease in systolic blood pressure 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

Finally, rejecting the purely psychoanalytic paradigm allows the patient to receive the same compassion and understanding as do victims of other medical diseases.

A child with anorexia nervosa should be hospitalized when presenting with certain 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 symptoms. Dr. O'Toole prefers starting with a low dose (25 mg) of Seroquel (quetiapine) at bedtime. ■

Prescribing Exercise May Improve 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 increasing physical education requirements in schools and community-based opportunities for physical activity, according to Mathew Gregoski of the Georgia Prevention Institute of the Medical College of Georgia in Augusta.

As part of an ongoing investigation of a possible dose-response relationship between a 3-month exercise program and adiposity, insulin sensitivity, and executive 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 intervention conditions—no exercise, low-dose exercise (20 min/day), and high-dose exercise (40 min/day)—to test the effect of aerobic exercise training on cognitive measures.

A significant cognitive benefit was observed among children in both the low-dose exercise (20 min/day) and high-dose exercise (40 min/day) groups.

Both of the exercise conditions included vigorous aerobic activities and games that maintained average heart rate above 150 beats per minute, Mr. Gregoski reported at the annual meeting of the Society for Behavioral Medicine.

Before and after the interventions, all participants underwent standardized mental functioning testing using the Cognitive Assessment System (CAS). The investigators calculated the changes from baseline in four scales of the CAS, including planning, attention, successive, and simultaneous, said Mr. Gregoski, who conducted the investigation under the direction of Catherine Davis, Ph.D.

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

This aspect of mental functioning 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 sufficient alertness to attempt problem solving.

The successive scale is associated with the ability to integrate information in serial order, and the simultaneous scale is associated with mental operations that require consideration of all elements of a complex stimulus concurrently.

Analysis of variance revealed significant improvement following 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 an effect, Mr. Gregoski said.

That a significant cognitive benefit was observed with the 20-minute intervention in addition to the longer duration is notable in that such a program could readily be introduced during regular physical education sessions, he said at the conference.

These results "provide evidence for a direct relationship between physical activity and children's cognitive development," Mr. Gregoski said.

The findings may be important not only for developing interventions targeting this population, but also for breaking down the barriers to physical education and activity in schools. ■

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