

Higher-Weight Anorexia Nervosa

By Sarah K. Ravin, Ph.D.
Licensed Psychologist

The term Anorexia Nervosa (AN) often conjures up a mental image of an emaciated girl. In popular jargon, many people incorrectly use the word “anorexic” as an adjective to mean “skinny,” as in: “Those fashion models all look anorexic.” Given these stereotypes, many people are surprised to learn that individuals who suffer from AN come in all shapes and sizes.

Many people who present for treatment at hospitals and eating disorder clinics suffer from all of the symptoms of AN - restrictive eating patterns, weight loss, excessive preoccupation with food and weight, distorted body image, compulsive exercise, loss of menstrual periods, low heart rate, depressed mood, and severe anxiety around eating - despite having bodies that appear to be “normal weight” or “overweight.” The new diagnostic term of “Atypical Anorexia Nervosa (AAN)” has been used for those who have AN but are not underweight. Personally, I dislike the term Atypical Anorexia Nervosa because it implies that higher-weight AN is rare, unusual, less severe, or somehow different from “typical” AN. This is simply not the case.

A recent study published in the Journal of Adolescent Health found that nearly 1/3 of adolescent patients hospitalized for medical complications of AN were not underweight. Importantly, higher-weight patients with AN had medical complications, eating disordered behaviors, and cognitive symptoms that were just as severe as those experienced by underweight patients with AN.

This study highlights a very important message: we cannot tell whether a person has AN by looking at them or by weighing them. Further, we cannot judge the severity of AN by body size. People who suffer from AN in emaciated bodies are not necessarily “sicker” or “more symptomatic” than those in normal weight bodies or higher weight bodies. This is, in part, because human bodies naturally come in a variety of shapes and sizes. Thus, a person may appear to be “overweight” based on societal standards of attractiveness, or compared to some arbitrary population norm, but may be below his or her optimal body weight, and may suffer from physical and psychological symptoms as a result of this weight suppression.

Individuals with higher-weight AN usually suffer from their eating disorder for many months or years before receiving a diagnosis or treatment. Due to this delay, these individuals often become even more medically compromised and suffer from more severe psychological symptoms than those who developed AN at lower weights and were able to receive diagnosis and treatment earlier in the course of their illness. Further, individuals with higher-weight AN are likely to be discharged from treatment prematurely, before they have reached full recovery, which is a recipe for prolonged suffering and leaves them more vulnerable to relapse.

Why is higher-weight AN more difficult to recognize, diagnose, and treat? The answer is weight stigma: the discrimination or stereotyping of individuals based on their weight. Weight stigma reflects internalized attitudes such as “thin is good and fat is bad,” “thin people are healthy and attractive whereas fat people are unhealthy and less attractive,” “weight gain is a bad thing and weight loss is a good thing,” and “fat people should lose weight.” Weight stigma, both subtle and overt, is rampant in our culture, and it affects all of us – even those of us who are doctors,

psychologists, dietitians, and eating disorder treatment professionals. If an entire culture holds the view that all people should be thin and that weight loss in heavier people is a great thing because it makes them healthier, happier, and prettier, then the symptoms of AN are normalized, justified, or even encouraged in heavier people.

Consider the following two case descriptions of adolescent girls with AN:

Case 1: Angela

Angela, a 14-year-old girl, weighs 115 pounds at the end of her 8th grade year. She goes away to camp for the summer, begins dieting and jogging every morning, and returns home 15 pounds lighter at the end of the summer. Her periods have stopped, her skin is pale, and she is constantly cold even in the summer heat. When she steps off the bus in her hometown, her mother is horrified at the sight of her now-skeletal daughter. Angela's concerned parents bring her to her pediatrician for an urgent appointment the day after she comes home from camp. The pediatrician diagnoses Angela with AN and refers her to a psychologist who specializes in eating disorders. Angela begins outpatient eating disorder treatment the next week. By Christmas of her 9th grade year, Angela is fully weight restored and eating normally. She is discharged from eating disorder treatment in the spring of her 9th grade year.

Case 2: Mariah

Mariah, a 14-year-old girl, weighs 200 pounds at the end of her 8th grade year. Her concerned parents send her to a weight loss camp for the summer, hoping to help their daughter "get healthy" and improve her self-esteem. Determined to lose weight and improve her appearance before starting high school, Mariah adheres rigidly to the 1200 calorie diet plan she is prescribed at camp and goes jogging every morning. At the end of the summer, Mariah returns home 30 pounds lighter. When she steps off the bus in her hometown, her parents embrace her and gush with pride about how gorgeous she looks. They praise her for her hard work and dedication.

In the weeks that follow, Mariah's parents frequently compliment her for making "healthy choices," such as cutting out all carbohydrates, eating only salad for dinner, and jogging 5 miles every morning, rain or shine. Mariah's friends gush that she looks beautiful. When Mariah visits her pediatrician for her annual checkup, the pediatrician commends Mariah for her weight loss and encourages her to "keep up the good work."

Over the course of her 9th grade year, Mariah continues dieting and exercising daily, and drops another 30 pounds. As her weight drops, her confidence soars. The summer after her 9th grade year, she is asked out by a senior football player. In 10th grade, Mariah tries out for, and makes, the varsity soccer team. She continues to run every morning in addition to 2-hour soccer practices every afternoon. She begins experiencing panic attacks when friends invite her out to eat, deliberating over whether she should accept their invitation and eat a few bites or just forgo the outing altogether. She experiences frequent headaches, dizziness, and lightheadedness. Her menstrual periods become very light and then stop altogether. When her weight loss stalls, she becomes frustrated and even more strict with her diet, limiting herself to only vegetables, hard boiled eggs, diet coke, and coffee. She loses another 10 pounds during her 10th grade year and feels frantic to lose more weight in preparation for summer. She begins purging daily and loses 10 more pounds that summer. Starved and dehydrated, Mariah faints while hiking with her family and is taken to her pediatrician later that day. Her doctor attributes her heart rate

of 42 to her athletic training, commends Mariah for her now-slim physique, encourages her to drink more water, and sends her home.

By 11th grade, Mariah weighs 130 pounds and has become depressed, anxious, and very socially withdrawn. She collapses on the soccer field during a varsity game and is rushed to the emergency room. She is admitted to the hospital with severe bradycardia, orthostatic hypotension, malnutrition, and dehydration. Following a 2-week hospitalization for medical stabilization, she is transferred to a residential treatment program, where she spends the next 3 months. She spends the rest of her 11th grade year and all of her 12th grade year going back and forth between residential treatment and day treatment programs, completing her high school courses online.

What are the differences between these two girls? The very same behaviors that caused alarm and concern in Angela brought praise and compliments to Mariah. Angela received prompt diagnosis and treatment within 3 months of the onset of symptoms, which allowed her to avoid costly and disruptive inpatient treatment and led to full recovery through outpatient treatment within a relatively short period of time. Mariah was ill for a much longer time, and became much more medically and psychologically compromised. Angela spent all of her high school years at home with her family, participating fully in the high school experience, and enjoying friends and activities. Mariah spent her first 2.5 years of high school in the grips of AN and the last 1.5 years of high school largely away from her family at an out-of-state treatment center.

The eating disorder treatment field does not yet know how to prevent AN, or whether it is even possible to prevent AN. We do know, beyond the shadow of a doubt, that early diagnosis and prompt, aggressive treatment early in the course of the illness is associated with better outcomes. For this reason, it is imperative that treatment professionals and parents become aware that AN occurs in people across the weight spectrum. We must recognize that severe food restriction in people of any size is hazardous to physical and mental health. We must understand that weight loss in a child or adolescent of any size may signal the beginning of an eating disorder or other serious health problem. We must not use arbitrary population norms or weight criteria to make diagnoses or to tell people what they “should” weigh. We must stop insisting that heavier people lose weight and instead encourage full and balanced nutrition, enjoyable physical activity, and body acceptance for people of all shapes and sizes. Above all, we must be willing to challenge our own weight biases in order to provide people across the weight spectrum with appropriate diagnosis and treatment.

Reference

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