ACADEMIC LITERATURE REVIEW

Review of DSM-5 Diagnostic Criteria for Anorexia Nervosa and Recommendations to Improve Inclusivity

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ABSTRACT

This article reviews issues with the diagnostic criteria for anorexia nervosa. This article discusses how the diagnostic criteria for Anorexia Nervosa (AN) can be vague and exclude specific populations who can be affected by this eating disorder. After this discussion, suggestions are made to improve inclusivity in the AN diagnostic criteria. This article is meant to provide a new perspective on how the current diagnostic criteria have some limitations. This implies that all the affected individuals who need help are not receiving it. In addition, the current criteria are directed towards a particular subset of the population who live with anorexia nervosa, and do not include other subsets who present with different symptoms.

INTRODUCTION

Anorexia nervosa (AN) is an eating disorder estimated to have a mortality rate of 5.1 to 5.8%,[1] making it the most lethal psychiatric disorder.[2] Current literature on anorexia nervosa within adolescents focuses primarily on females since males tend to have a later onset.[3] With the current diagnostic criteria for AN, three conditions need to be met in order to receive a diagnosis: “significantly low weight due to restriction of energy intake relative to requirements”, “intense fear of gaining weight”, and “disturbance in the way in which an individual views their body weight or shape”.[4] Furthermore, severity is based on body mass index (BMI), with a BMI of 17 viewed as mild AN while a BMI of 15 is considered extreme AN.[4] The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria for AN has faced controversies due to its ambiguous nature and the fact that it does not consider individual differences, such as differences in body mass index at the onset of symptoms of disorder into consideration.[5],[6] This article will review the literature to discuss difficulties that arise from the current diagnostic criteria for AN. The paper will then conclude with suggestions to promote inclusivity within the criteria for AN.

1.1 Energy requirements for a patient.

Criterion A of the diagnostic criteria for AN states that the person must demonstrate “restriction of energy intake relative to requirements, leading to significantly low body weight”.[4] There is no specific guideline for clinicians to follow to determine the required energy intake of an individual. The clinician must decide the appropriate energy intake based on growth expectations, weight, and age.[7] There are several approaches and tools that clinicians may use in addition to the DSM-V criteria when assessing and diagnosing individuals with eating disorders. Some examples include conducting clinical interviews, psychological testing, and taking family histories, among others. However, the DSM-V does not mention a standard procedure providers can follow to determine the required amount of energy intake for an individual and it is unclear how to determine whether the person’s energy intake is too low. Additionally, the criterion does not consider children’s developmental level. According to Knoll et al,[8] children often struggle with understanding the concept of required energy intake, which could make it even more difficult to determine the amount of energy they are taking in.

1.2 Agreeable Restlessness.

There is also the implication within the standard diagnosis criteria for AN that reduced energy intake would lead to decreased activity,[8] thus ignoring the subset of AN patients who experience hyperactivity due to their state of energy restriction. This hyperactivity has been termed “agreeable restlessness” and it seems to have an evolutionary basis whereby a scarcity of food results in more physical activity in foraging for food.[9] In particular, male patients with AN tend to

experience more of this hyperactivity compared to their female counterparts, often engaging in exercise as a means to reduce the hyperactivity they experience.[10] Thus, the diagnosis criteria is not inclusive of those patients who experience hyperactivity due to their limited intake of energy.

1.3 Severity of Anorexia Nervosa.

AN severity should not be based on body mass index (BMI) since individuals with low BMI and those within or above the normal range face the same physical and psychological consequences.[11] According to Sawyer et al.,[12] people with normal or high BMI might experience more significant distress regarding body image, thus showing more eating disorder psychopathology. Basing the severity of the disorder on BMI can have damaging consequences as patients might feel like they are not sick enough to qualify for a diagnosis of AN. Hence, they will not receive access to the appropriate treatment they need. The DSM-V severity marker fuels the idea that AN is physically recognizable due to emaciation or malnutrition. [13] However, people who do not fit this image might not reach out for help and are less likely to receive inpatient care.[14] In addition, family and peers might applaud weight loss, dieting, and restrictive eating behaviours for these people due to the societal appreciation for thinness[15]. This focus that the DSM-V severity marker has on an individual's physical appearance is a clear limitation that has many unintended consequences.

The DSM-V criteria also do not present considerations for patients in partial remission.[4] Partial remission refers to patients previously diagnosed with AN who no longer meet the diagnostic criterion of being at a significantly low body weight.[4] The criteria for AN promotes the idea that BMI should be very low to be treated, which could potentially be life-threatening for patients in partial remission who may still experience the negative effects of AN fully despite not meeting criterion A. This could lead to patients restraining their energy intake and cause even more distress regarding their body image and fear of gaining weight. Moreover, individuals who do not present with low BMI often endure a longer duration of illness, which leads to a poorer prognosis.[16] The focus of the DSM-V criteria on a very low BMI is a limitation that can cause patients' symptoms to worsen.

1.4 Suggestions to Improve the Criteria.

It is generally agreed upon in the medical community that self-reports can be useful for understanding an individual's thoughts, feelings, and behaviours, but they may be limited by biases and may not provide a holistic understanding of the patient.[17] To ensure proper diagnoses of AN, self-reports can be supplemented with behavioural measures, but they cannot be alternatives to each other.[17] Behavioural measures that can be assessed include body-checking, which refers to the "repeated checking of shape or weight", and food- and eating-related tendencies such as having meals alone.[18] The advantage to such measures is that they are examined from a patient's daily life, which paints a representative picture of the patient's behaviours in a natural setting.[19] By complementing self-reports with behavioural measures, providers can get a whole picture of what a patient feeling and how they are behaving, without the issue of biases in self-reporting. Behavioural measures can also fill in the gaps when younger children might not understand certain topics addressed in self-reports such as energy intake. Additionally, pediatricians should recognize that behavioural changes in children, such as food refusal, require nuanced approaches as they are complex and could reflect changes in mental status. [20]

The severity marker for AN should be based on the speed and amount of weight loss in patients, rather than BMI. According to Garber,[21] adolescents who have lost a greater amount of weight at a faster rate over a longer period, present with worse medical and nutritional status, regardless of admission weight. This finding supports the suggestion that clinicians should pay attention to weight history prior to hospitalization, instead of focusing on admission weight. At the same time, basing severity on weight history will allow people who are in the healthy to obese weight range to feel more comfortable to reach out for help. There is an increasing prevalence of overweight and obese children and adolescents in the United States, [22] along with societal pressures to strive for thinness.[2]Correspondingly, it should be expected that many patients presenting for AN diagnoses will not have a low BMI and their weight loss might start from them being overweight or obese.[24]

CONCLUSION

The DSM-V diagnostic criteria for AN does not provide a specific guideline that providers can follow to measure energy intake and it does not consider the developmental levels of children. The DSM-V criteria do not consider the subset of AN patients who present with agreeable restlessness or are in partial remission, and the severity of AN is primarily based on patient's BMI at admission. This article recommends that self-reports can be supplemented with behavioural measures such as body-checking and food- and eating-related tendencies to provide a more comprehensive understanding of an individual's functioning and may be particularly useful for younger children or adolescents who may not easily understand certain topics addressed in self-reports. This report also suggests basing the severity marker of AN on weight loss and weight history, rather than solely on BMI. Further investigations need to be carried out to determine an appropriate standard that clinicians can follow to measure the energy intake of patients with AN. More research is also needed to explore hyperactivity within a subset of patients with AN to conclude whether this subset needs to be added as a subtype to the diagnostic criteria of AN.

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Keywords: eating disorder, anorexia nervosa, health, diagnosis, psychology, psychological disorder

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