COMMENTARY

What does weight have to do with Atypical AN? A commentary on weight outcomes for adolescents with atypical anorexia nervosa in family-based treatment

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Abstract

Atypical anorexia nervosa (AAN) has historically been underrecognized by clinicians due to traditional markers of low weight as indicative of malnutrition. Inadequate case identification can lead to treatment delays while placing children and adolescents with AAN at further risk of medical and psychiatric sequelae. The accompanying article in this journal issue examines the challenges of determining weight-based treatment goals for this population. In this commentary, we elaborate on this discussion and question the validity of weight stabilization as a treatment target in child and adolescent AAN. Furthermore, we address: (1) the role of weight and historical, variable, and stable growth curves in shaping treatment goals; (2) future growth targets, including numeric and remission targets; and; (3) the impact of weight stigma and implicit weight bias in clinical decision-making. We argue that target weights must take a secondary role in the treatment of AAN, shifting the focus to the mental, behavioural, and nutritional aspects of this disorder. In addition, we recommend that clinicians acknowledge and mitigate fears around weight gain and weight-based social rejection for young people and families in treatment.

Key Words: atypical anorexia nervosa, eating disorders, weight stabilization, weight gain, children and adolescents

Résumé

L'anorexie mentale atypique (AMA) a été historiquement sous-reconnue par les cliniciens en raison des marqueurs traditionnels de poids faible comme indicateurs de malnutrition. L'identification de cas inadéquate peut mener à des retards de traitement tout en plaçant les enfants et les adolescents souffrant d'AMA à un risque accru de séquelles médicales et psychiatriques. L'article d’accompagnement dans ce numéro du journal examine les défis de la détermination des buts du traitement basé sur le poids pour cette population. Dans ce commentaire, nous élaborons cette discussion et questionnons la validité de la stabilisation du poids comme cible de traitement dans l’AMA chez les enfants et les adolescents. En outre, nous abordons (1) le rôle du poids et de la variable historique, et les courbes de croissance stable dans la définition des buts du traitement; (2) les cibles de croissance futures, y compris les cibles numériques et de rémission; et (3) l’effet de la stigmatisation liée au poids et du biais implicite lié au poids dans la prise de décision clinique. Nous soutenons que les poids cibles doivent jouer un rôle secondaire dans le traitement de l’AMA, en mettant l’accent sur les aspects mentaux, comportementaux et nutritionnels de ce trouble. De plus, nous recommandons que les cliniciens reconnaissent et atténuent les peurs de prendre du poids et du rejet social basé sur le poids pour les jeunes personnes et les familles en traitement.

Mots clés: anorexie mentale atypique, troubles alimentaires, stabilisation du poids, prise de poids, enfants et adolescents

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Introduction

In presenting their data on clinical outcomes for youth with atypical anorexia nervosa (AAN), Quon & Kelly [1] navigate the ubiquitous challenge of determining weight-based treatment goals for this population. In this commentary, we elaborate on the discussion of this challenge and question the validity of weight stabilization as an intentional target of treatment, particularly in children and adolescents. Historically, the constellation of clinically-significant eating disorder (ED) symptoms more recently categorized as AAN has been under-recognized by clinicians - trained to use low weight as the primary marker for malnutrition – leading to delay in treatment as well as increased risk for medical and psychiatric sequelae. Such risk is not just equivalent to that seen in “typical” anorexia nervosa (AN); studies have demonstrated that medical complications, ED cognitive disturbances, anxiety, psychosocial impairment, and suicidality in AAN can be even more severe than in AN [2-6]. What distinguishes these two groups appears to be demographic diversity factors [6,7] which would not warrant a separate diagnosis. Thus, while AAN is associated with controversy about the importance of a weight-based differential diagnosis, its formal recognition as an ED is critically important in circumventing obstacles to case identification and care.

We acknowledge that there can also be ambiguity about weight-based treatment objectives in AN [8,9]. That said, to the extent that internalization of weight bias might contribute to disagreement among clinicians about what is “enough” weight gain for individuals with AN, it is even more likely to influence treatment targets in AAN. Thus, we closely examine the goal of weight stabilization in Quon & Kelly’s [1] study of AAN, a recommendation not seen in AN. We ask whether weight restoration can ever not apply to criteria for remission from a disorder for which diagnosis is predicated on “significant weight loss” [DSM-5-TR].

Weight and AAN

As emphasized above, the distinction between AN and AAN resides in weight status. By extension, there are four time periods for which weight, stature, body mass index (BMI), and corresponding percentiles, respectively, must be examined for each individual child or adolescent patient presenting for treatment: (1) the historical growth curve trajectories, prior to any signs or symptoms of an ED; (2) the changes in these trajectories from onset of the ED to clinical presentation (discussed above); (3) the expected reversal of ED-driven deviations in growth, from baseline presentation through conclusion of treatment (often referred to as weight “targets”); and (4) expectations for continued development through age 20, which is when the growth curves cease and body size indicators are meant to stabilize.

Weight, stature, and BMI-for-age percentiles ranges in growth history warrant scrutiny in part because they can inform a hypothesis regarding where on the curves a patient will exhibit indicators of recovery. When a patient with AAN has tracked at high percentiles, questions arise about whether return to prior trajectories is recommended or necessary [10]. Clinicians and parents might cite health or bullying risks as reasons for concern, while weight bias is likely also at play [11]. Nonetheless, there are circumstances in which historical growth curves might be an unreliable or invalid benchmark. Marked variability within an individual’s trajectories can be secondary to some specific factors, which can be assessed in the process of obtaining a patient’s psychiatric history. For example, known correlates of higher weight - perhaps beyond one’s “natural” body size - include loss-of-control eating, depression, poor sleep, and internalized weight stigma [12-15]. It is critical to distinguish between useful versus potentially bias-influenced resistance to premorbid largest body size restoration in AAN.

Future Growth “Targets”

Numeric Targets

Like in AN, AAN is characterized by significant weight loss or, in some children or adolescents, failure to make expected weight gain milestones over time. Reversing these processes requires weight gain, the amount of which must increase in tandem with aging and height growth. That said, specific, numeric weight targets are problematic for individuals with AN and AAN disorders across the lifespan and are particularly misleading and harmful for child and adolescent patients. Citing a single number (e.g., “to be well, you must gain to 120 lbs.”) contradicts the reality that weight fluctuates in the human body at any age, and citing a fixed numeric range (e.g., “to be well, you need to weigh between 115 and 125 lbs.”) fails to consider the “moving target” nature of growth values from infancy to young adulthood. The numbers corresponding to weight expectations will increase continuously during treatment for AAN, as a function of duration of the renourishment process, corresponding aging over time, and the likelihood of natural or catch-up growth in stature during this period. Even for someone who has already reached their adult height, weight...
should continue to rise in reflection of externally-visible maturation as well as internal “construction” (e.g., bones, muscles, organs). Quon & Kelly [1] laudably employed a comprehensive individualized approach in setting treatment target weights, factoring in age- and sex-based norms; historical growth curve data; family report of pre-morbid height, weight, and eating habits; medical history; and family history [9].

Remission Targets

Even thoughtfully constructed numeric targets ignore the fact that a “right” weight can only really be determined post-hoc, after a patient exhibits all functional markers of remission. Full recovery includes resolution of the cognitive, emotional, and behavioral elements of a restrictive eating disorder, which is thought to be predicated on sufficient weight restoration [17]. As in the treatment of AN, it may be reasonable to briefly pause weight gain efforts when a patient with AAN is securely within their expected/premorbid percentiles and watch for ensuing psychological improvements before deciding to continue. Ultimately, the patient’s body and mind will inform the treatment team when the weight is sufficient, not the reverse. This is especially important to recognize in the treatment of AAN, where pre-morbid weight and BMI percentiles are often incorrectly deemed excessively high by healthcare providers.

Weight Stabilization as the Target Outcome in AAN

Quon & Kelly [1] categorized the AAN patients in their study into two groups based on treatment goal (weight gain recommended or weight stabilization recommended). Based on the factors outlined above, and the research gaps in our understanding of AAN, we argue that problematic to a priori designate weight stabilization as the target outcome for a patient with AAN. To do so is antithetical to the diagnostic criteria for AAN, which presume significant weight loss, as well as to the study inclusion criterion of at least 10% body weight loss. While individuals in the stabilization-recommended group had a higher baseline percent mean BMI compared to those in the weight gain-recommended group, the two groups did not differ in degree of weight suppression, duration of illness, age, comorbidity, or inpatient admissions. In other words, the two groups were indistinguishable on severity indices yet given different weight goals for treatment. There may be some patients with AAN for whom normalization of eating naturally leads to weight restoration, and others who require an active program of weight gain to get well.

Regardless, for all individuals on the AN spectrum, the “right weight” is a range that: restores a body to its “meant-to-be” size; corresponds to the full complement of recovery indices; develops with the patient over time; and is sustainable without dietary restriction or compensatory behaviors. If a patient or their family resists these ideas, the next phase of clinical work should focus on acceptance strategies.

Challenging Weight Stigma

Young people with AAN may experience weight stigma from providers and families alike preventing them from accessing services in a timely manner. Even when they access care, many report not feeling entitled to receive services if their weight appears “normal” and their weight loss minimal [18]. Weight stigma is exacerbated by other forms of discrimination including sexism, homophobia and racism [19]. For example, research demonstrates that transgender and non-binary (TNB) young people experience EDs at higher rates than cisgender people [20-22] and a high level of stigma and weight stigma when seeking treatment [23]. In a study examining gender diverse young people with eating disorders, a greater percentage of participants were found to have AAN than any other ED, and their BMI presenting at hospitalization were typically higher than their cisgender peers [24]. Harrop and colleagues [19] also note that weight stigma has particularly harmful consequences for TNB young people due to the weight loss requirements or BMI thresholds that must be met in order to receive gender-affirming surgeries. This can often lead to “denying people in larger bodies access to gender-affirming surgeries or other care” (p. 3) which are life-saving medical treatments [19]. It is imperative that we recognize the individual and broader social context that makes discussions about target weights more complex and potentially harmful; especially in the case for young people in larger bodies who may experience systemic inequities in healthcare by being expected to lose weight to access care.

Conclusions

The authors of this commentary strongly contend that as providers, we prioritize resolution of the mental, behavioral, and nutritional components of AAN, without prejudice about the weight/BMI percentile or body size at which...
those indices of recovery are achieved [25]. Indeed, pre-morbid growth trajectories are our most valuable predictors of when a patient is likely to be well, regardless of their specific values, just as is the case for “classic” AN. It is imperative that as a field we closely examine the biases that can influence our clinical decision-making in the context of body size diversity. By challenging our own assumptions about weight, we will be better equipped to identify and address weight stigma in parents/caregivers who may reluctantly or outright refuse to participate in a treatment where a higher BMI is acknowledged as a prerequisite to recovery. In addition, our current empirical knowledge about the role of weight restoration in AAN treatment and AAN more broadly remains limited; further to addressing weight stigma, future research should prioritize examining AAN to guide current treatment approaches in clinical practice.

References


