Anorexia Nervosa DSM-5 307.1 (F50.01) (F50.02)

DSM-5 Category: Feeding and Eating Disorders

Introduction

Anorexia nervosa (AN) is an eating disorder characterized by a person's refusal to maintain a minimally normal weight for one's age and height, or failure to make the average weight gain over a period of growth. It is one of five eating disorders under the umbrella Feeding and Eating Disorders category of the DSM-5. Under DSM-5, a body weight percentage less than normal weight is no longer specified. Instead, 'low weight' is specified. A person with anorexia nervosa has a distorted view of their body and overvalue their body image. They perceive themselves as overweight and fear gaining weight. These and other psychological drivers contribute to emotion-driven under-eating behavior. The two major types of AN are binge-eating/purging type and restricting type. Anorexics who engage in binge-eating/purging behavior are more difficult to treat. Anorexia nervosa afflicts all personality types but is more common in females and those involved in a body image conscious lifestyle, such as athletes, models, and adolescents.

Symptoms of Anorexia Nervosa

An underweight appearance is the most obvious sign of anorexia nervosa. Other symptoms linked to malnutrition and poor diet are lack of energy, dizziness, dry skin, hair loss, brittle nails, hypotension, and cardiac arrhythmias.

The DSM-5 criteria for anorexia nervosa includes the following (APA, 2013):

- Persistent restriction of energy intake leading to significantly low body weight (relative to minimally expected for age, sex, developmental trajectory, and physical health).
- Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low in weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight

DSM-5 has removed the criterion of amenorrhea.

Anorexia Nervosa in Daily Life

Anorexia nervosa is associated with severe health effects. Individuals who have AN have higher rates of mortality, suicide, and cardiac and renal complications. The heath risks in adolescents who are not yet fully developed is higher. They are at a higher risk of growth arrest, including irregular menstruation. Long-term effects can include lack of menstruation, heart disease, nerve disorders, and osteoporosis.

Those with eating disorders have a higher mortality rate than the general population, and the rate for anorexia nervosa is the highest among the eating disorders. The mortality rate of persons with lifetime anorexia nervosa is almost double that of those with lifetime bulimia nervosa. Anorexics have a higher risk of premature death, especially in the first 10 years of the illness (Franko, 2013). Damage and failure to organs is a risk. A challenge is that laboratory findings in an anorexic person may not be abnormal. Lack of medical evidence can delay diagnosis, especially in an adolescent culture obsessed with being thin. Self-induced vomiting and the use of laxatives can go undetected by others until health dangers are posed. Paying close attention to mood changes can help in early detection. The anorexic may become easily irritated, withdrawal socially, and become depressed. The eating disorders primarily have an underlying psychological driver. Similar to persons who engage in substance abuse, those with eating disorders have problems with regulatory self-control and reward systems. Under DSM-5, only one eating disorder can be diagnosed at a time.

The cost of AN to a family is significant in terms of stress and resources. Anorexics have a high physical and psychological dependence on parents. They typically withdraw socially even in the formative adolescent years. Parents must always be vigilant of the fragile physical and mental health of their child. The family is under pressure to influence positive health behavior in their child. The age of the anorexic, length of the illness, and hospitalization history can all have a negative influence on the course of treatment.

Family dynamics are often implicated in the cause of the disorder. If the family's behavior does not change, the anorexic's behavior and thought patterns also may not change. Motivation to change has a significant effect on the success of anorexia nervosa therapy (Abdelbaky, Kay, & Touyz, 2013).

Therapy for Anorexia Nervosa

Until DSM-5, anorexia and bulimia nervosa were the only two disorders officially recognized. The addition of pica, rumination disorder and avoidant/restrictive food intake disorder under the umbrella of Feeding and Eating Disorders helps to distinguish between their symptoms and different courses and treatment outcomes.

The central role of the family in the life of the anorexic and his/her treatment course has made the family an integral part of treatment. Family-based treatment (FBT) is the most popular form of treatment for anorexia nervosa. In anorexics with more severe symptoms, FBT has been shown to be more effective than individual therapy. Those with higher levels of obsession and eating disorder specific psychopathology respond better to FBT than individual therapy (Le Grange et al., 2012). The focus of the therapy also has an important effect on the success and maintenance of treatment. Focusing on intra-familial dynamics in FBT treatment instead of the eating disorder has produced better outcomes in girls with severe AN 18 months after the treatment (Godart et al., 2012).

Cognitive behavioral therapy is one of the most popular treatments for anorexia nervosa. A weakness of therapy for AN is the high rate of relapse. An Italian research team established a

20-week inpatient treatment program applying enhanced cognitive behavior therapy (CBT-E). The 26 patients showed improvements in weight, eating disorder symptoms and psychopathology. These improvements were maintained 12 months after discharge (Dalle_grave, Calugi, El_ghoch, Conti, & Fairburn, 2014).

Many individuals with anorexia nervosa report anxiety disorders before the full onset of AN. They may begin to indulge in substance abuse while developing symptoms. CBT-E is a form of cognitive behavioral therapy specifically developed for the treatment of eating disorders. It focuses on the eating disorder psychopathology rather than the eating disorder diagnosis. To maintain the positive eating behavior, CBT-E sets realistic expectations, identifies potential setbacks, and develops strategies to allow the patient to respond to setbacks. The final stage of the four-stage treatment process focuses on how to maintain progress and develop strategies for relapses.

References

Abdelbaky, G., Hay, P., & Touyz, S. (2013). A systematic review of treatment attrition in anorexia nervosa. Journal of Eating Disorders, 1(Suppl 1), P1.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Dalle_grave, R., Calugi, S., El_ghoch, M., Conti, M., & Fairburn, C. (2014). Inpatient cognitive behaviour therapy for adolescents with anorexia nervosa: immediate and longer-term effects. Name: Frontiers in Psychiatry, 5, 14.

Franko, D. L., Keshaviah, A., Eddy, K. T., Krishna, M., Davis, M. C., Keel, P. K., & Herzog, D. B. (2013). A longitudinal investigation of mortality in anorexia nervosa and bulimia nervosa. American Journal of Psychiatry, 170(8), 917-925.

Godart, N., Berthoz, S., Curt, F., Perdereau, F., Rein, Z., Wallier, J., ... & Jeammet, P. (2012). A randomized controlled trial of adjunctive family therapy and treatment as usual following inpatient treatment for anorexia nervosa adolescents. PloS one, 7(1), e28249.

Le Grange, D., Lock, J., Agras, W. S., Moye, A., Bryson, S. W., Jo, B., & Kraemer, H. C. (2012). Moderators and mediators of remission in family-based treatment and adolescent focused therapy for anorexia nervosa. Behaviour research and therapy, 50(2), 85-92.