

“Anorexia-lite”: the dangers of weight classification in diagnosis

Atypical anorexia nervosa is increasingly diagnosed and is often indistinguishable from its cousin, anorexia nervosa, except that it presents with so-called normal or above normal body-mass index (BMI), even when there has been significant weight loss, bone density loss, and amenorrhea. Atypical anorexia nervosa often goes unnoticed, undiagnosed, and untreated due to this appearance of a healthy weight and weight bias in the public and healthcare professionals. Having experienced eating disorders, we have strong opinions about diagnosis and treatment.

Although its name suggests it is unusual, atypical anorexia nervosa accounts for around 25–45% of all admissions for eating disorder treatment, and the prevalence is probably higher because many people with atypical anorexia will not present to services, potentially due to fears of not being thin or sick enough. Medical complications and eating disorder psychopathology in people with atypical anorexia nervosa can be just as severe as those with anorexia nervosa, and further discussion is needed to better understand its prevalence and impact.

Weight classification has long guided eating disorder conceptualisation, diagnosis, care, and treatment, especially consideration of unusually low bodyweight; anorexia is commonly associated with a BMI of less than 18.5 kg/m². Weight restoration guides treatment, with outcomes defined by quantifiable physical parameters. The stereotype of extreme thinness in anorexia is problematic as it guides health-care professionals’ perception of people with eating disorders. Anorexia research also excludes participants above a certain BMI (often 18.5 kg/m²)—a large population who will share the same psychopathology and experiences as those below the cutoff.

The undeniable similarities between the two conditions lead many people to debate whether there should be a more stringent weight cutoff to differentiate between them, or whether they can be conflated. Researchers and clinicians are concerned about the nosology of the two types of anorexia nervosa, and some of them suggest more strict weight classifications for differentiation. This is, in some ways, perfectly understandable. Weight allows practitioners to contextualise someone’s eating disorder, their personal recovery or relapse from their usual weight, and their physical danger. Yet the utility of weight to understand an individual does not adequately justify its use for diagnosis when it is the only differentiating factor. Being anorexic does not equal thinness.

Caroline’s story: *I was diagnosed with atypical anorexia nervosa in 2023. I found myself experiencing near constant urges and preoccupations to exercise. Exercising made me feel acceptable to myself as I had lost my sense of self and identity, and the compliments for looking “lean” reinforced my compulsions. I lost around 15% of my body weight in 5–6 months, however my BMI did not dip below 20 kg/m². The malnutrition meant it was the most physically unwell I have ever felt, and this awoke a sense that something was extremely wrong. Instead of numbers on a scale, the subjective experience and conceptualisation of my eating disorder arises from a lost sense of self and the intractable feeling that I am wrong in my own body. This is an embodied and inescapable sense of imperfectionism that sits in my entire physicality and, while having a circumstantial impact on my weight, impacts most negatively on my identity.*

I suspected I had anorexia nervosa, but having worked as a nurse on an eating disorders unit, I was aware of the weight bias in psychiatry. I therefore feared I was too “heavy” to access treatment. I even purposely lost more weight in an effort to appropriately fit the anorexic label before my eating disorder assessment. I felt a need to justify my experience to deserve the diagnosis and I often precluded discussions about my condition with saying “I have never been underweight”.

Although receiving an atypical diagnosis gave me validation, it also created an acute sense of shame and inadequacy that I was not sufficiently thin. This weight bias in eating disorders services becomes apparent as people who are “normal” weight or weight-restored experience eating disorder thoughts and behaviours, and feel dismissed by clinicians as a lesser physical risk. While returning to a higher BMI, I realised the importance of re-learning peace and self-compassion in my body as it is meant to be. Overreliance on BMI and weight perpetuates categorical thinking and positivistic notions of mental distress indicative of mainstream psychiatry: that only through severe physical expression can a person be sufficiently unwell, and that eradicating such symptoms determines clinical recovery. This approach to diagnosis and treatment alienates a community already experiencing protracted suffering and recurrent relapse, who may leave psychiatric services at a “healthy” weight but without the skills to acclimatise to having more of themselves to contend with. It is time that UK guidance and research remove the atypical prefix, conflate the diagnoses, and eliminate BMI as an indicator to acknowledge the shared, difficult, and embodied experience of people with eating disorders.

Georgie’s story: *I was diagnosed with anorexia nervosa in 2012. Once I started losing weight, the huge amount of positive reinforcement I received from others spurred me on to continue. I felt delighted with the “new and improved” me. My body had changed so much, childhood bullies no longer recognised me. As I regularly attended hospital clinics, my weight loss was spotted early. I was referred to a clinical psychologist who diagnosed me and referred me to an eating disorders clinic.*

Despite being diagnosed with anorexia nervosa, I still felt like a fraud; I wasn’t thin enough to need help. And I have continued to carry this feeling of not being a true eating disorder sufferer with me my whole life. Because I never reached a sufficiently low weight to be an in-patient, I partly feel that I must have exaggerated it in my memory. Maybe I never had a problem. I can only imagine how much more powerful the fraudulent feelings would be with an atypical diagnosis. To me, this is equivalent to saying to someone, “you can’t even be anorexic properly”.

I believe cognitive presentations are what is important and characteristic of eating disorders, regardless of bodyweight, as they impact everything you do, and they seep into every aspect of your life. Should you be denied help because you are currently a “healthy” weight? After all, for most people with anorexia nervosa, there is a point where the eating disorder cognitions are present, and you are losing weight, but are not yet underweight. However, even if you successfully manage to avoid becoming underweight despite experiencing eating disorder thoughts, you still deserve support, both to improve current functioning and to prevent decline. People with eating disorders already perceive themselves as insufficiently unwell; we do not need this reinforced by our clinicians and diagnoses. It is time the diagnosis of atypical anorexia nervosa is abolished, to be replaced simply by anorexia nervosa, focusing on the psychological impact of the condition rather than a perpetual fixation on BMI and weight.

Lois’s story: *I was never diagnosed with anorexia nervosa or atypical anorexia nervosa. My eating disorder experience was even more vaguely defined due to overlapping anxiety disorders. I have lived with emetophobia (fear of vomiting) and generalised anxiety from young childhood. It stopped me from living a full and independent life until very recently. My eating disorder began by playing a substantial role in my phobia, including avoidant and restrictive behaviours adhering to extensive eating-related rules. As I got older, my awareness of body image and insecurity developed, the eating disorder changed motivation. The desire to remain thin led me to ignore and actively avoid resolving the eating disorder and phobia. In a sordid way, it was nice to perceive my phobia as a tool instead of a barrier to achieving a fulfilled life. For years on and off until my early 20s, I was underweight, fatigued, had dizzy spells, and at my worst, held a BMI of 15 kg/m² and had amenorrhea for 2 years.*

Ever since first seeking treatment at age 13, my cognitions and behaviours derivative of anorexia nervosa were not once addressed, despite me expressing concern. While I do not contend that I should have been diagnosed with anorexia nervosa, I believe that addressing the shared influence typical of anorexia nervosa would have hastened my recovery. Overcoming my eating disorder has equally involved combating phobic beliefs and bodily self-acceptance. Weight classification was not the determining factor in denying me access to care and invalidating my experiences; it was the insufficiently pure anorexia nervosa diagnosis due to my additional mental health problems. In this same way, weight classification gatekeeps service users from their ideal treatment due to one indifferent criterion.

The criterion of low weight for anorexia is indicative of researchers and clinicians without lived experience aligning mental distress with mainstream psychiatric understanding of conditions as a group of symptoms. Yet people with mental distress frequently emphasise other influential factors in eating disorders' origin, maintenance, and resolution. The condition's reality is often embodied, reflecting suffering and identity disruption, with continual eating disorder thoughts despite weight restoration. Although "significant" weight loss is often considered the marker for pathology, research suggests even "minor" weight loss of around 5% can cause psychological distress. Lived experience narratives often indicate that inpatient admission aids only weight restoration and fails to provide adequate support for emotional, psychological, and behavioural expressions of the eating disorder, impairing quality of life and increasing risk of relapse. To continue emphasising weight classification in eating disorder experience is inaccurate, damaging, and undermining for survivors. People with eating disorders often report feelings of imposter syndrome: that they are not sick or thin enough to deserve treatment, due to internalising mainstream psychiatric conceptualisations.

We argue that further stringent weight classification to differentiate between the two types of anorexia nervosa is not an effective means of guiding diagnosis and treatment, but rather incentivises people to maintain their eating disorder. People with lived experience have noted the problematic inclusion of BMI in eating disorder definitions and recovery, emphasising the flawed nature of this metric as body type differs substantially between people, such that it does not reflect physical health. In our experience, excessive emphasis on weight classification has been detrimental by reinforcing self-perpetuating and unhealthy conceptualisations of our own bodies and gatekeeping treatment. The focus on numbers when diagnosing and treating eating disorders intends to increase consistency across clinicians, but it fails to account for the thoughts and feelings experienced by the person they are trying to help. The diagnosis of atypical anorexia nervosa is not only stigmatised and interpreted as less severe by the general population, but is also internalised by the survivor, reinforcing their disordered thoughts. Researchers and clinicians must listen to those with lived experience and stop quantifying mental distress in eating disorders with BMI, which cannot represent felt distress. It is time to remove the low weight criterion for anorexia nervosa and the unhelpful diagnostic label of atypical anorexia nervosa.

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For the linkages between weight loss and psychological distress see *Int J Eat Disord* 2017; 50: 952–62
For more on lived experience perspectives on BMI and eating disorder diagnoses see *J Eat Disord* 2022; 10: 149