



## Research paper

# Modification of the medical exclusion criterion in DSM-5 social anxiety disorder: Comorbid obesity as an example



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## ABSTRACT

**Background:** The DSM 5 modified the medical exclusion criterion from DSM-IV, which now allows for a diagnosis of social anxiety disorder (SAD) to be given if the fears are related only to the medical condition (e.g., obesity) yet cause significant impairment or distress.

**Methods:** To examine this modification, the current study compared bariatric surgery candidates with DSM-IV SAD ( $n=135$ ), modified SAD (clinically significant social fears related to obesity only;  $n=40$ ), and no history of Axis I disorders ( $n=616$ ) on variables related to pre-surgical problematic eating behaviors, body image dissatisfaction, functional impairment, and other characteristics related to bariatric surgery. Participants were referred by their surgeon for a psychiatric evaluation as part of the clearance process, and completed a comprehensive, semi-structured diagnostic interview and self-report measures.

**Results:** There were several differences between those with DSM-IV SAD and modified SAD compared to those with no disorder (e.g., on binge and emotional eating), but the two SAD groups did not differ from each other on any of the comparisons.

**Limitations:** Results may not generalize to individuals suffering from obesity in the general population or those seeking other types of weight loss treatment. Because they were seeking psychiatric clearance, they also may have underreported symptoms/problems for fear that they would not get cleared.

**Conclusions:** Overall, the modified SAD group more closely resembled the DSM-IV SAD group rather than the no disorder group, providing further support for diagnosing SAD even when the social fears are related to obesity only.

## 1. Introduction

Social anxiety Disorder (SAD) is a fear of being embarrassed or humiliated in social or performance-based situations, to the point at which there is significant functional impairment or distress regarding the anxiety (American Psychiatric Association, 2013). Previously, the DSM-IV (American Psychiatric Association, 1994) did not allow for a diagnosis of SAD in the presence of medical conditions, even if the fear was considered excessive. This criterion was modified in the DSM-5, allowing for a diagnosis of SAD if the fear related to the medical condition was excessive. This criterion (criterion J) specifically lists obesity as an example.

Individuals with SAD often fear that they will say or do something “wrong” in social or performance situations, and that they will be negatively evaluated by others (American Psychiatric Association, 2013). Many also fear that they will be judged negatively by others

based on their appearance, a concept known as “social appearance anxiety” (Levinson and Rodebaugh, 2011). Therefore when obesity is present, some individuals might experience significant social anxiety related to their weight especially given the presence of obesity stigma and discrimination in society (Chen and Brown, 2005; Puhl and Heuer, 2009). For example, some studies have indicated a lifetime or past-year prevalence rate of SAD at 6–9% among obese individuals (Kalarchian et al., 2007; Mather et al., 2008; Petry et al., 2008). This is similar to the past-year prevalence rate of SAD in the general population (7%), in which SAD is the fourth most common psychiatric disorder in epidemiological samples (Kessler et al., 2005). SAD may be particularly comorbid with binge eating disorder (BED), as approximately 36% of individuals with BED also meet criteria for SAD (Wittchen et al., 1999). Furthermore, one study of over 3500 psychiatric outpatients found that female gender moderated the relationship between a higher BMI and the presence of SAD but not other common Axis I disorders, suggesting

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that SAD or social anxiety concerns may be particularly relevant to individuals (especially females) with weight problems (Dalrymple et al., 2015). Another study found that SAD was the most common Axis I disorder within a sample of women diagnosed with polycystic ovarian syndrome (PCOS), and it was suggested that physical changes associated with PCOS (including weight gain) may contribute to anxiety about one's appearance and how it is perceived by others (Sahingoz et al., 2013).

Lifetime prevalence rates of SAD also range from 3.2% to 9.4% in bariatric surgery candidates specifically (Dalrymple et al., 2011; Kalarchian et al., 2007; Mauri et al., 2008; Muhlhans et al., 2009). For example, SAD was the second most prevalent disorder in a sample of nearly 2000 bariatric surgery candidates (after specific phobia), with a lifetime prevalence rate of 7.5% (Dalrymple et al., 2011). A prior study from this group found that bariatric surgery candidates with significantly impairing social anxiety related to weight only (labeled as “modified SAD”) showed levels of social anxiety severity that were greater than those with no lifetime Axis I disorder, and comparable to individuals meeting full criteria for DSM-IV SAD (Dalrymple et al., 2011). Therefore, many individuals with weight-related social anxiety concerns experience anxiety that is just as severe as the anxiety experienced by individuals with non-weight-related SAD, yet this anxiety would not have been adequately recognized in DSM-IV.

Obesity-related social anxiety remaining unrecognized could have potential implications for bariatric surgery candidates, as there is some evidence to suggest that the presence of psychological problems can negatively affect outcomes in bariatric surgery (de Zwaan et al., 2011; Lier et al., 2013; White et al., 2010). Although some studies have shown that mental health improves following bariatric surgery (Herpertz et al., 2003; Karlsson et al., 2007; Lier et al., 2013), many patients continue to experience significant psychological symptoms and poor quality of life following bariatric surgery particularly as the length of the post-surgical period increases (Mathus-Vliegen, 2007; Sarwer et al., 2008). In addition, one study indicated that anxiety severity specifically did not decrease one year following bariatric surgery (Lier et al., 2013).

Individuals with social anxiety-obesity comorbidity may be prone to engaging in a vicious cycle of overeating to manage emotions, which may lead to weight gain and resulting feelings of shame, and further overeating to manage feelings of shame. Shame and self-perceived inadequacy have been shown to be maintaining factors for patients with psychiatric disorders undergoing bariatric surgery (Lier et al., 2013). Fear of negative evaluation, a key feature of SAD, has been linked to disordered eating (McClintock and Evans, 2001) and increased food intake (Levinson and Rodebaugh, 2015), has longitudinally predicted bulimic attitudes (Gilbert and Meyer, 2005), and has predicted body image dissatisfaction and dysfunctional eating attitudes (Lundgren et al., 2004). In a sample of college females with social anxiety symptoms, fear of negative evaluation significantly and independently accounted for the relationship between social anxiety symptoms and eating pathology (e.g., body dissatisfaction; (Menatti et al., 2015). Social appearance anxiety has been shown to be elevated in individuals with bulimia nervosa compared to healthy controls (Koskina et al., 2011), and has predicted body dissatisfaction and disordered eating after controlling for depression, perfectionism, body mass index (BMI), and other facets of social anxiety (e.g., social interaction anxiety; (Levinson and Rodebaugh, 2012; Levinson et al., 2013). The presence of SAD specifically has been shown to be correlated with binge eating frequency (Koskina et al., 2011; Sawaoka et al., 2012), and it has been shown to be significantly associated with binge eating and emotional eating (but not restrained eating) in a cross-sectional sample (Ostrovsky et al., 2013).

Based on this potential link between SAD/social anxiety and problematic eating behaviors, it is important to continue to examine the implications of identifying SAD in obese individuals as this comorbidity pattern may affect bariatric surgery outcomes.

Previously, our group compared bariatric surgery candidates with DSM-IV SAD, modified SAD, and no psychiatric disorder on variables related to social anxiety such as social functioning, overall functioning, age of onset of SAD, and distress about the social anxiety. Results showed that both SAD groups differed from the no disorder group on social and overall functioning, and there were few differences between the two SAD groups. Thus, results suggested that those with social anxiety related to weight only may experience social anxiety that is comparable to those meeting full DSM criteria for SAD, which supported the DSM 5 Workgroup's recommendation to alter the medical condition criterion to allow a diagnosis of SAD in the presence of a medical condition such as obesity (Dalrymple et al., 2011). However, this prior study did not examine variables related to eating behaviors or other characteristics related to bariatric surgery.

Therefore the current report from the Rhode Island Bariatric Surgery (RIBS) study of the Methods to Improve Diagnostic Assessment and Services (MIDAS) Project seeks to extend this work by comparing surgery candidates meeting full DSM-IV criteria for SAD to those who have significantly impairing social anxiety related to weight only (i.e., “modified SAD”) on the presence of problematic eating behaviors (binge and emotional eating), age at onset of weight problems, functional impairment, body image dissatisfaction, overall self-esteem, perceived reasons for the weight problem, and reasons for having bariatric surgery. As in the prior study, we included a comparison group of surgery candidates with no lifetime history of a psychiatric disorder. We hypothesized that based on our previous study and findings from other studies, the modified SAD group would differ from the no disorder group but would be similar to the DSM-IV SAD group on these variables, therefore supporting the modification of the medical exclusion criterion in the DSM-5.

## 2. Methods

### 2.1. Participants

Participants were drawn from a larger sample of 1800 individuals seeking bariatric surgery in Rhode Island. Due to changes in assessment procedures over the course of this ongoing project, the current study reports findings from 791 participants out of the larger sample of 1800. Out of this sample of 791 participants, the majority were Caucasian, female, married, and had graduated high school (Table 1). The most frequent current Axis I diagnoses out of the total sample of 1800 were: specific phobia ( $n=152$ ; 8.4%); SAD ( $n=135$ ; 7.5%); eating disorders ( $n=105$ ; 5.8%); and impulse control disorders ( $n=51$ ; 2.8%). In addition, 40 (2.2%) participants were labeled as having “modified SAD” when clinically significant social anxiety was present but only related to weight concerns. Out of the larger sample of 1800 surgery candidates, 616 (34.2%) had no current or lifetime Axis I diagnosis. Of the 135 patients with DSM IV SAD, 18 met criteria for a lifetime eating disorder (8 with binge eating disorder; 7 with eating disorder not otherwise specified; 3 with bulimia nervosa). Out of the 40 with modified SAD, 7 met criteria for a lifetime eating disorder (all binge eating disorder). Average BMI for the sample was 47.7 and ranged from 32.1 to 81.5, indicating that all of the participants were obese based on criteria from the National Institutes of Health (1998). As described in our previous report, there were no significant differences between those with DSM-IV SAD, modified SAD, or no disorder on BMI (Table 2) (Dalrymple et al., 2011).

### 2.2. Procedure

Participants were referred by their surgeons to undergo a comprehensive pre-surgical psychiatric diagnostic evaluation as part of the surgical clearance process. The evaluations were conducted at the outpatient psychiatry practice of Rhode Island Hospital. The RIBS program was developed as an integrated clinical-research program;

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