Just out of curiosity how many of you treat or see folks with eating disorders? Oh, there are a lot of you. Okay, well that’s good because actually eating disorders certainly are less common than those with depression for example, and I often find that folks rarely see eating disorders in their practices, particularly the more serious variants of anorexia nervosa. But with that said let’s get started and we will talk about the DSM-5 feeding and eating disorders.

I’d like to acknowledge the DSM-5 Eating Disorders Work Group, Dr. Kupfer alluded to the fact that about 20% of the work group members for the DSM-5 were women, but in the DSM-5 Eating Disorders Work Group let me point out that our leader, Dr. Timothy Walsh, made sure that at least half of the working group were women. And I think this is fitting since women are differentially affected by these disorders.

Okay, in the DSM-IV the TR here stands for Text Revision and it was not any change in criteria from the DSM but it was included here on my slide because it was the most recent version of the DSM but I will eliminate mention of TR. The DSM-IV Eating Disorders were just anorexia nervosa, which is a disorder characterized by severe starvation leading to emaciation and the inability to maintain a minimally acceptable body weight. It also is paired with cognitive correlates that deal with the importance of thinness and the overvaluation of eating, weight and shape. Bulimia nervosa, which is a syndrome characterized by recurrent aberrant overeating, binge eating paired with efforts to undo the effect of the aberrant overeating, usually in the form of self-induced vomiting; also accompanied by overvaluation of eating, weight and shape. And a third category, eating disorders not otherwise specified known in the eating disorders trade as ED NOS. One of the major
challenges for the Eating Disorders Work Group was the fact that something over half of all patients presenting for specialty care met criteria for neither anorexia nor bulimia but were diagnosed with ED NOS. So one of our major directives was to see what could be done to reduce Ed NOS in DSM-5.

Now in the DSM-5 the chapter has been expanded and is now called Feeding and Eating Disorders. As Dr. Kupfer mentioned to reflect a lifespan approach to diagnosis the DSM-IV chapter, Disorders First Usually Diagnosed and Usually First Diagnosed During Infancy, Childhood or Adolescence was eliminated and the disorders distributed throughout the book. There were three feeding disorders in that chapter, Pica, rumination and feeding disorder of infancy and early childhood. These are uncommon disorders that were given, that were usually seen in infants and very, very small children that were given to the Eating Disorders Work Group for review primarily because the disorders are not limited to infancy and early childhood but are see throughout the life span. So now we have an expanded chapter called Feeding and Eating Disorders.

Now let me just give you the DSM-5 definition of feeding and eating disorders. This is just the general definition. Feeding and eating disorders are characterized by a persistent disturbance in eating or eating related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. The reason that that’s worth mentioning is that we live in a culture, don’t we, where it’s very hard to get eating straight. People have lots of beliefs about eating, they have lots of practices that vary across eating and it’s virtually impossible to pick-up a newspaper or a magazine and not see something about eating disorders.
Certainly we live in a time where anyone who has a tendency to develop disturbed eating has a perfect soil in which to flourish because we value thinness, muscularity, appearance and there are lots of strange ideas about how people should eat in the context of a culture where food is cheap and plentiful and we struggle to manage and self manage eating and weight. So it’s important to remember that the psychiatric diagnoses included in the DSM-5 represent a very small fraction of people who are eating, weight and shape concerned.

So the expanded chapter as I’ve already mentioned includes pica or as the Brits say peca and I quite like that pronunciation, it sounds kind of exotic, but pica, rumination disorder there is a new expanded diagnosis that I’ll spend a bit of time on which replaces the earlier diagnosis of the infant feeding disturbance that’s called Avoidant Restrictive Food Intake Disorder. It’s quite a mouthful. We call it ARFID, so that’s how I will refer to it because it’s too hard to say otherwise. And I’ll say a bit more about that. Then of course there is anorexia nervosa, bulimia nervosa, a new disorder, binge eating disorder which was in an appendix of the DSM-IV as a disorder requiring further study. It’s now been moved to the front of the book; and then two categories of other eating disorders, other specified feeding or eating disorder and unspecified feeding or eating disorder.

What I’m going to do is spend most of my time talking to you about ARFID because it’s brand new, a bit about anorexia nervosa because I think there were some struggles in dealing with what constitutes a significantly low weight, and binge eating disorder.
Okay, just a brief overview of what the disorders are in case you ever see them. Pica is a disorder characterized by the persistent eating of nonnutritive, nonfood substances that requires clinical attention. It is essentially unchanged in the DSM-5. So this refers to an individual, often someone with an intellectual developmental disorder or other mental disorder who eats a nonnutritive food substance. This can be anything, people eat chalk, they eat dirt, they eat starch, etc. It is not culturally related and cannot be explained by other disorders.

Rumination disorder is also uncommon, often seen in the context of other intellectual developmental disorders. It’s the repeated regurgitation of food after feeding or eating. The words have been modified slightly in the DSM-5 but essentially the diagnosis is unchanged.

Now I already have mentioned that feeding disorder of infancy and childhood now has been expanded to include older children and adults and it is called ARFID. Okay, let’s talk about what ARFID is. I think that when the DSM-5 field trials were conducted this diagnosis was examined by the Society of Adolescent Medicine physicians and they found it extremely useful in that it was helpful in identifying kids who needed treatment that did not meet criteria for anorexia nervosa. So in many ways that is the toughest differential if it is seen in a school aged or early adolescent child is the differentiation between ARFID and anorexia nervosa. Let me give you a hint, it doesn’t entirely solve the problem but in ARFID there is no concern about eating, shape and weight. Okay, the cognitive correlates seen in anorexia nervosa they are absent and there is no concern about gaining weight, they just don’t want to eat. So what this is it’s a feeding, an eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional or energy needs.
Now there are different types of presentation that meet this criteria, some will be folks who just appear to have very little interest in eating. Have any of you ever seen anyone like this? They just don’t want to eat, okay. Another is a group of people who are often termed picky eaters, selective eaters where they are – they don’t like the sensory characteristics of most foods. They don’t like the mouth feel, it doesn’t feel like food to them. They don’t like anything except white foods. They don’t like the smell of many foods, so there is something about the sensory characteristics about the food. Presentations like this are often seen in kids with autism spectrum disorder where there are lots of sensory concerns about touching and being touched and other kinds of phenomena. It would be diagnosed, ARFID would not be diagnosed unless it became the target of clinical attention.

And some people develop the problems because of the concerns about aversive consequences of eating, this typically would be a kid who was worked up for GI problems, had an unpleasant experience with endoscopy or had an unpleasant experience with vomiting after eating meat, something like this and then started to avoid foods. In any event there is very little known about these presentations past early adolescence, but they do occur in adults, there is just very little information about them.

Anyway this persistent failure to meet appropriate nutritional or energy needs must have one or more of the following clinical correlates: significant weight loss or failure to achieve expected weight gain or faltering growth in children, so this is the diagnosis for failure to thrive now, okay; and significant nutritional deficiency, the dependence on enteral feeding or oral nutritional supplements
or finally market interference with psychosocial functioning. I’ve got to tell you that usually once you are past middle childhood or at middle childhood the diagnosis made on the basis of marked interference with psychosocial functioning.

The disturbance is not explained by a culturally sanctioned practice. I mentioned already that none of the cognitive correlates about eating, shape and weight that are seen in anorexia or other eating disorders. And by the way the diagnosis of AN would trump this diagnosis, it’s hierarchical. And it’s not attributable to a medical disorder, okay.

There are specifiers and in the case of ARFID you can specify whether or not the disorder is in remission, that is the full criteria for disorder were met and they no longer are met and they have not been met for a sustained period of time. You might ask what is a sustained period of time? And actually – just how long do you think is a sustained period of time? Six months. Yeah, that would be a common guess. Really it was left vague on purpose, it’s up to the clinician. And why was it left vague? It’s because we have absolutely no data to inform us, and I think that this left to the wisdom of the diagnosing clinician. I wouldn’t give it probably for just one month but if over the last 6, 8 months this has not been a problem in the family or for a youngster I probably would give it in remission. And you’ll see this throughout the disorders.

Okay, another question that comes up is how does one diagnose nutritional deficiency? Well in an extreme case this is not difficult, I can give you an example of an ARFID case where there is clear nutritional deficiency. This is a case of a 14 year old boy who lives in London, actually this was
presented by one of my colleagues, and for the last several years his intake has been restricted to wine, soda and potato chips, so that at 14 he has fallen off the growth chart and he has severe osteopenia, signs of osteoporosis. It’s a clear nutritional deficiency. In other situations nutritional deficiency is less obvious, and this too is left to the diagnosing clinician. Typically you would be asking the youngster and/or the family for information about typical daily intake over time, the list of foods, the adequacy of the list of foods. It is not uncommon for young people with this diagnosis to refuse to eat all fruits, vegetables, many kinds of meats or mixed food, okay. So that you have to get a fairly clear picture and then there may be physical signs and symptoms of malnutrition or starvation similar to those that you’d see in anorexia nervosa: dry skin and hair, emaciation and other kinds of physical signs and symptoms.

So this can be quite severe and I think where folks get some concern is in cases where it isn’t clear that there is marked nutritional deficiency, particularly in middle childhood. A child may have presented a picture at 2 or 3 with severely selective eating that persisted over time and growth was inadequate. They may add foods to their repertoire but it is still very limited; but oftentimes what happens with young kids with limited repertoires they tend to eat a lot of junk. They’ll eat chips or snack foods, they may eat pizza, so they are no longer underweight, often a school aged kid with this problem can actually be a little overweight and it comes from overeating of snack or highly palatable foods. Now let me make another important differential comment about ARFID, this is not meant to be diagnosed in 2 year olds or 1½ year olds who say no to everything except hot dogs. This is normal development and most kids will outgrow it.
Okay, that is ARFID and maybe if we have a little time if there are a couple questions we can diagnosis this. I just will say as we move on that I became really curious about adults who present with this picture and there are those and they have active chat lines so I’ve been kind of a really interested lurker in kind of what goes on on this chat line. Oh, by the way, I lurk with permission of the organizer, who is very happy about the ARFID diagnosis by the way he’s really pleased that this has been added to the DSM. I’ve never heard anyone so happy to have a mental disorder.

Well you know this is the irony isn’t it in the states, Dr. Kupfer mentioned that the ICD folks are going to take gender identity disorder out of the mental illness classification and into another section of the ICD. For these folks unless there is a diagnosis they can’t get treated, and many folks with gender identity disturbance wanted to stay in the DSM because if they are – if it was not in the DSM there would be no reimbursement for sexual assignment surgery, so these are complicated issues.

Anyway the overview of changes for AN, as I mentioned the core criteria have remained unchanged except for the fact that the amenorrhea criterion has been eliminated. It was eliminated for two reasons. First of all many people met criteria for anorexia nervosa and retain cycle menstrual cyclicity so that it isn’t universally present. And then second and probably even more important an absence of menstrual cyclicity is impossible for males, so it does not, did not apply to males with the disorder. The major concern of critics of the work of the Eating Disorder Work Group had to do with that none of the diagnostic criteria included the physical consequences of starvation, of which amenorrhea is one. The kinds of things that we see developing like changes in brain, changes in
bone, starvation affects virtually every organ system and there was unhappiness that this was not mentioned in core criteria, but it is too hard to include all of them. There is explanatory text added.

Okay, the next major brouhaha had to do with defining significantly low weight and never has been, never has so much been said by so many people about what constitutes a minimally adequate body weight. I’ll go on about this but in the DSM-IV the core criteria of inadequate body weight, there was an example given which was example, less than 85% of that expected which was given as an example but quickly became reified by clinicians and others mainly insurance companies. There was a time when we would admit patients at 84% of ideal weight to our inpatient unit and two days later our reviewers told us they no longer had anorexia nervosa. So that does not obviate the fact that that is a problem. Depending on where you live in the States or in Europe there are different references for ideal body weight and a lot of difficulty getting agreement. There are certain racial ethnic groups, for example some Asian populations tend to be smaller than European or African American or Hispanic folks so that the 85% of what is how is this diagnosed? And we spend an awful lot of time and had an awful lot of feedback from an awful lot of people who took exception to our approach.

There are wording improvements and there is a change in the characteristic of the AN subtypes. Now I’m not going to read these criteria, I’ve already essentially told you what the syndrome is about, but let me tell you about I will expand a bit as we go on about what low body weight is and I’ll just note a couple of changes in the words. So we have the restriction of energy intake relative to requirements. That was changed by unwillingness to maintain and minimally (inaudible) with body
weight. It was criticized, unwillingness is something that you infer and could be considered judgmental. And in fact I don’t think anorexia patients are unwilling, I think they are unable. So it just – we changed the words of the criteria to reflect observable behavior. Similarly when we talked about persistent lack of recognition of the seriousness of the current low body weight it used to be denial. Again you can’t necessarily infer what the patient is thinking, but you can observe that there is persistent lack of recognition and lack of concern about low body weight. So for adults it’s inability to maintain minimal body weight, and for children it’s inability to maintain body weight or less than adequate growth or expected growth for children. And I will say a bit more about that.

Okay, the coding for the subtypes differs slightly. There is a restricting type and a purging, binge eating/purging type of anorexia nervosa. The restricting type maintains the body weight strictly through calorie restriction and the binge eating/purge type engages in these behaviors to help maintain low body weight. The way it was changed was to say that it is during the last 3 months the individual presents with this picture. This was guided by research findings documenting crossover from one type to the other. We used to think you just went from the restricting to the binge/purging type, we now know you can go back the other way. So the ability to subtype is retained because it gives clinicians information about current symptom pictures.

Okay, now there are specifiers, as you’ve already heard that in the DSM-5 there are specifiers and for eating disorders there are severity ratings. You can specify if there is partial or full remission. Partial remission refers to the patient who has regained weight but still has the cognitive correlates and other symptoms of anorexia nervosa. Full remission refers to no symptoms for a sustained
period of time. How long is sustained? Again I actually would give it a year for anorexia nervosa, but that’s an opinion, that is not required by the DSM-5. And then you specify current severity on the basis of the seriousness of the low weight. This got a lot of criticism but please note that the level of severity can be increased to reflect clinical symptoms. That is the degree of functional disability or the need for supervision, or other kinds of concerns. So this is based on body mass index, most of you probably know this is calculated by formula and if you don’t know your BMI you can Google it and there are a million good calculators. It’s a formula based on height and weight and accounts for height, not just weight. So it gives you a bit more information. Okay, Sandy weighs 200 pounds, is Sandy 5’5” or is Sandy 6’5”, it makes a big difference doesn’t it? So BMI incorporates information about height.

So you can rate anorexia nervosa from mild to extreme based on presentation BMI. In children this is done by BMI percentile and the text guidance gives clinicians information about how to ask -access rather that information. Okay, just to give you an idea, in adults the Centers for Disease Control, our own CDC, and the World’s Health Organization consider 18.5, a BMI of 18.5 to indicate the lower range of adequate adult body weight. A BMI lower than 17 has been considered by WHO to indicate moderate or severe thinness. So we as a rule of thumb use between 17, you know less than 18.5 as, less than 17.5 often as anorexia nervosa, but it varies somewhere between 17 and 18.5. Okay, for children and adolescents as I’ve already mentioned you use a BMI for age percentile, and you can go to the CDC website to look at those percentiles.
Okay, bulimia nervosa. I am not going to tarry long on bulimia nervosa. There is only one major change which I will tell you momentarily but the criteria are virtually identical to those seen in DSM-IV. To have bulimia nervosa you must have recurrent binge eating. A binge is characterized by two things: eating a large amount of food in a constrained period of time, more than most people would eat given the circumstances; so that’s a tough one. Okay so on Thanksgiving you start in the morning and you don’t finish until after football and you eat 10 times as much as you ever would eat on another day of the year, is that a binge? No, because most people under those circumstances also eat that amount of food. So the contextual point is not trivial, but you do get into arguments, okay, I’ve done this for probably 30 years, more than most people would eat given the circumstances. So it’s Friday night, you had dinner, is a whole pizza a binge? How many of you think so, a large pizza? See not that many of you. I don’t know, a large pizza is a lot of pizza. Maybe if you are a 19 year old guy, okay, but for most women that would represent more than most people would eat under the circumstances, but you see that it’s easy to see in the extremes it’s not so easy. You know I can start with donuts too, okay 12 donuts, how many of you think it’s a binge? Okay, everybody thinks that’s a binge. 8? You get it. How many of you think 6 is a binge? This is often the tipping point. Okay, but that overeating okay is not just overeating and you are okay with it, it’s paired with this terrible distress and this sense of being out of control about what and where and how much one is eating without loss of control no matter how egregious the overeating it’s not a binge. It’s important to understand that binge eating for sufferers is extremely aversive and painful, okay. There is distress and oftentimes dysfunction.
Okay, it’s paired with recurrent inappropriate compensatory behavior. Now here is the change, in the DSM-5 the binge eating and inappropriate behaviors which usually are paired very few people with bulimia nervosa ever will binge unless then can purge, have to occur on average at least once a week for 3 months. In the DSM-IV it was twice a week. There was a lot of comment on this from external observers of the DSM process saying that we would be psycho-pathologizing too many people and adding too many people to the diagnosis. In fact this is a research evidence based change, there are substantial data documenting that the difference between those who binge eat once and twice a week is trivial and insignificant and in fact people with a once weekly frequency have similar distress impairment and comorbidity.

Okay, there are specifiers again, you can go in partial or full remission. Severity in bulimia nervosa is based on the frequency of inappropriate compensatory behaviors, not number of binges, number of compensatory behaviors per week ranging from mild, 1 to 3, to extreme, 14 or more episodes. So that individual would be vomiting for example at least twice a day.

Okay, binge eating disorder, here too it was in the DSM-IV in a research appendix. The criteria for the DSM-5 are identical except for the fact that binge eating has been reduced as well to once weekly instead of twice weekly over the course of 3 months instead of 6 months. Those are the only two changes from the DSM-IV criteria. Again, this – the whole decision to move BED into the front of the book occasioned great controversy, concern about pathologizing people who overate in general. Again I think this is based on a misconstruction of what binge eating is because for those who suffer binge eating disorder it’s extremely aversive and painful. The other interesting thing to
those of us who were participating in the process putting this BED diagnosis in a research appendix had exactly the effect that it was intended to have. I don’t remember the exact number but during the life of the DSM-IV there were probably 15,000 studies or more that lent credence to the validity and reliability of the diagnosis, probably the best study diagnosis – that’s not true but you get my point. One of the better study diagnosis that has been added to the DSM-5 compare and contrast with the disorder that Dr. Frank specified that came out of Dr. Liebenluft’s laboratory. You can see where my mind is. The laboratory at the NIH, you know this has been replicated in many centers, in many places.

Okay, so it’s the same thing, it’s recurrent binge eating that is uncompensated, okay. It is now followed by the compensatory behaviors seen in bulimia nervosa. The index patient with bulimia nervosa is normal weight, it does occur in overweight and sometimes even obese folks but the average patient with bulimia nervosa undoes the effects of binge eating and is normal weight. The index patient with BED is overweight or obese. It does occur in normal weight folks but generally it is associated with overweight and obesity. Okay, there is a specifier in partial remission and full remission and then severity in binge eating disorder is rated by the number of binge eating episodes in contrast to bulimia nervosa which you rate severity on the basis of the frequency of compensatory behavior.

Then there are two other categories. The first one is other specified disorder, it is a presentation consistent with eating or feeding disorder. The clinician that doesn’t meet criteria for any of the specific diagnoses but here the clinician must specify what the presentation is and why it’s not one of
the other eating disorders. So an example would be atypical anorexia nervosa, all of the criteria are met, but the individual is normal weight for example; bulimia nervosa of low frequency or duration, and there are other presentations. The final presentation is unspecified feeding or eating disorder, an individual presents with feeding or eating disorder symptoms that don’t meet criteria but the clinician does not specify how the individual does not meet the criteria. And this can be used for example, I think Dr. Frank referred to it in emergency rooms or other places where there isn’t time to get adequate information.

Okay, I’m out of time pretty much. Jack, I’m totally out of time? I’m going to stop. All right, I had some cases I was going to make you guess. Thank you.