DSM V Diagnostic Criteria for Anorexia Nervosa

Diagnostic Criteria 307.1

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify subtype:

Restricting type (F50.01): During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging type (F50.02): During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify remission state:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behaviour that interferes with weight gain) or Criterion C (disturbance in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, the criteria have not been met for a sustained period of time.

Specify severity:

The minimum severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from the World Health Organisation categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17kg/m^2

Moderate: BMI 16-16.99 kg/m^2

Severe: BMI 15-15.99 kg/m^2

Extreme: BMI <15 kg/m^2

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Anorexia Nervosa - Characterisation

When a person has anorexia, the outward visible symptom is that they become underweight through persistent restriction of food. However, there is more to it than this. Clients with anorexia struggle with an intense fear of weight gain, and feel genuine anxiety and fear around eating as a result. This is hard for family, carers and even professionals to understand, but it is critical as a professional that we know how they feel – the underlying energy is that of intense fear or anxiety around weight gain.

Clients with anorexia universally experience a voice in their head, and they feel compelled to do what the voice tells them to do – so we may hear about compulsive behaviours such as over-exercising, or cutting food into the tiniest possible units but not eating them. Clients describe it as a battle in their heads – and they often characterise their eating disorder as an 'it' or separate entity to themselves, sometimes calling the voice 'Ed' or by another name.

Anorexia sufferers also become obsessive about weight and body image, it can become all important to them, over and above normal activities like eating or spending time with friends. Anorexia therefore can be very isolating as the person withdraws more and more. Along with compulsive over exercise, weight control strategies may be used such as self-induced vomiting, use of laxatives or diuretics – correct diagnosis of anorexia vs bulimia is important but normally relatively obvious as the anorexia sufferer will be significantly underweight.

Anorexia sufferers cannot understand or accept that their low weight is medically dangerous, and this is very difficult for non-sufferers to understand. The person is literally not seeing what we see, their distorted vision of themselves is not what is physically true in the mirror, it is a mental representation of themselves.

In essence, this means that when a person develops anorexia, the fear of losing control of eating, the fear of putting on weight, the fear of not living by the eating disorder's rules, is so overwhelming that they cannot imagine trying to let these thoughts, behaviours, and feelings go. Similar to when someone has a phobia, they will avoid the object that frightens them at all cost, even if this requires them to be or do irrational things.

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However, although the outward expressed behaviours and beliefs are all about food and weight, Anorexia is not about food and weight, it is how the person feels about themselves. It is often linked to needing to control something, because they do not feel in control in other areas of their life. But there can be myriad other emotional and experiential factors that contribute to the manifestation of Anorexia, every client is different. If offering support to a client with Anorexia, a family based therapy model is often recommended, as the carers around the client also need to understand that focusing on food/weight/eating is not helpful or constructive. Collaboratively finding the root of the issue and addressing that, in parallel with expert support in working towards weight restoration is essential.

Health Consequences of Anorexia

In order to deal with the effects of starvation, the body is forced to slow down all its processes and to find ways of conserving energy. The physical effects of starvation include:

- Dehydration -> risk of kidney failure.
- Muscle weakness -> risk of muscle loss.
- Tiredness and overall weakness -> risk of fainting.
- Abnormally slow heart rate and low blood pressure produces changes in the heart muscle -> risk of heart failure.
- Loss of bone density resulting in dry, brittle bones (osteoporosis) -> risk of postural problems and risk of fracture.

Critically, as a professional it is important to understand the impact of starvation on a client's ability to think clearly. Persistent lack of nutrition combined with dehydration results in changes in the brain and causes significant cognitive distortion.

These brain changes are one of the reasons why the client has persistent distorted thinking, a factually incorrect mental representation of their body shape/size, and the obsessive/compulsive behaviours around food/eating and exercise. They literally cannot think straight.

Clients will also experience 'brain fog', poor concentration and memory, difficulties in planning and decision making, difficulty with abstract thinking and problem solving. This can manifest itself in clients literally not remembering information or session content/discussion from week to week.

Clients with anorexia are at high risk of depression and/or anxiety due to their elevated cortisol and reduced serotonin. In extreme cases this can lead to suicidal ideation and risk of suicide.

Broadly, speaking, treatment ideally should be multi-disciplinary and this can be difficult for a practitioner in private practice. Other professionals who should ideally be involved include:

– A GP/physician – for physical health and to sign off that their patient is medically stable enough to attend a community/outpatient/private practice based therapist;

– A dietitian or registered nutritional therapist with experience of Anorexia;

– A psychotherapist, counsellor or psychologist with experience in Anorexia;

Support for both the person **and** their family/carers is crucial.

It is therefore vital as a mental health professional that you also have the support of the client's GP at a minimum to ensure you are working safely with your client and have medical oversight. Generally it would not be recommended for a private practice based practitioner to work alone with a client with anorexia who is significantly underweight.

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DSM V Diagnostic Criteria for Bulimia Nervosa

Diagnostic Criteria 307.51 (F50.2)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
    2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify if:

In partial remission: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have not been met for a sustained period of time.

In full remission: After full criteria for bulimia nervosa were previously met, the criteria have not been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviours (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: An average of 1-3 episodes of inappropriate compensatory behaviours per week.

Moderate: An average of 4-7 episodes of inappropriate compensatory behaviours per week.

Severe: An average of 8-13 episodes of inappropriate compensatory behaviours per week.

Extreme: An average of 14 or more episodes of inappropriate compensatory behaviours per week.

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Bulimia Nervosa Characteristics

Adults with Bulimia become trapped in a loop of dieting/restriction, binge eating and then purging, in a similar mindset to that of an anorexia client – they have a significant fear of gaining weight and are obsessed about their weight and body image.

Bulimia can be triggered by one of two things:

1. A traumatic event/experience where the person (usually as a child/young person), learns to self-soothe with food, then adopts purging as a way of compensating for binge eating, or:
2. Often an experience of being teased, bullied or commented about in the context of weight or food prompts the person to go on a diet, which quickly becomes obsessive. The compulsive pattern of restricting/bingeing/purging is all consuming, and it is usually very difficult for the person to break free of the cycle.

Clients with bulimia (or indeed any eating disorder) can often be very successful in their career, high functioning, the 'go to' problem solver for others, etc, but struggle hugely with imposter syndrome, feelings of worthlessness, guilt, shame and self-hatred.

It can be difficult to spot Bulimia as sufferers are often either normal weight or just slightly over/under normal weight, so it can go undetected for years. But the very fact of keeping it a secret from everyone in their lives is itself a cause of significant distress to sufferers – resulting in an internalised belief that 'if anybody knew the real me, they would instantly reject me'. There is significant psychological distress attached to Bulimia.

Health Consequences

The combination of vomiting and laxative abuse (or either on their own in frequent enough episodes) can result in serious dehydration. This also results in electrolyte imbalance. Our three critical electrolytes are potassium, magnesium and calcium. If we are dehydrated our electrolytes are unbalanced, and this has implication for all of our organs which need these essential body salts to function. The heart is particularly at risk, as electrolyte imbalance can ultimately induce a heart attack.

As with anorexia, it is advised that the client's GP be included in any treatment plan. Given the serious health consequences of purging, a client should see their GP as part of their recovery plan. At a minimum a blood test to rule in/out electrolyte depletion would be advisable, and nutritional guidance on changing eating patterns and challenging food rules is also advised.

Due to a lack of serotonin and high cortisol levels as a result of the body being under significant stress, it is common for clients to experience anxiety and/or depression.

Clients may also need to attend their dentist as over time, sustained vomiting will result in enamel and tooth decay.

Finally, laxative abuse can be addictive, and have serious implications of it's own. Ironically taking laxatives has no impact at all on weight, but a psychological dependence on them can develop in clients. Damage can be caused to certain valves and vessels in the excretory system due to persistent pressure, and surgery may be required to repair damage. This surgery is high risk, with the potential side effects of infertility, incontinence or both.

It is therefore vital as a mental health professional that you also have the support of the client's GP at a minimum to ensure you are working safely with your client and have medical oversight.

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DSM V Diagnostic Criteria for Binge Eating Disorder

Diagnostic Criteria 307.51 (F50.8)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

    1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
    2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:

    1. Eating much more rapidly than normal.
    2. Eating until feeling uncomfortably full.
    3. Eating large amounts of food when not feeling physically hungry.
    4. Eating alone because of feeling embarrassed by how much one is eating.
    5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:

- **In partial remission:** After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
- **In full remission:** After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- **Mild:** 1–3 binge-eating episodes per week.
- **Moderate:** 4–7 binge-eating episodes per week.
- **Severe:** 8–13 binge-eating episodes per week.
- **Extreme:** 14 or more binge-eating episodes per week.

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Binge Eating Disorder Characteristics

Clients with Binge Eating Disorder (BED) may not self-identify as having binge eating disorder, they are far more likely to identify with the idea of being an 'emotional eater' or a 'serial / yo-yo dieter' or both.

Clients frequently diet and have often been trapped in a cycle of Diet/Crash/Binge/Guilt/Diet for many years, but they do not purge. They are therefore more likely to be overweight and have spent significant periods of time in various diet programs. The average age of a client presenting with Binge Eating Disorder is usually older, and you may find they present either seeking support for their food/eating/weight, or they may present with a different issue initially, such as anxiety or low mood, and then disclose emotional / binge eating.

Clients have rarely disclosed their binge eating to others in their lives, and others may be unaware of the behaviours – sufferers work hard to maintain an appearance of 'normal' eating. There is usually a clear line between 'normal' – ie 3-5 times a day food – eating, and binge eating. Often a food diary will show a relatively healthy meal plan, but with binge eating episodes that involve high fat, high sugar processed foods that is high in calories. Food is eaten quickly and seldom savoured or enjoyed. Binge Eating episodes are followed by feelings of shame, disgust, despair, anxiety and self-hatred.

The only form of 'purging' or compensatory behaviour is to 'be on a diet' or trying to 'eat healthily'.

Binge Eating Disorder is by far the most common form of disordered eating, and is the most equal across genders, with 60% of sufferers being female and 40% male. Statistics suggest that up to 30% of adults seeking weight loss support meet the criteria for Binge Eating Disorder.

Health Consequences of Binge Eating Disorder

Many clients will present with co-occurring physical health conditions either as a direct result of their long-standing disordered eating – including but not limited to IBS, colitis, reflux, nausea, constipation, diarrhea, leaky gut.

Clients who are significantly overweight can also have high cholesterol, high blood pressure, heart disease, be pre-diabetic or already have type 2 diabetes, clients may have already had their gall bladder removed (gall bladder disease), and clients can be malnourished due to poor quality food choices over a prolonged period.

"Binge eating disorder is a serious mental health condition. Obesity is a weight classification – a symptom – which may occur as a result of binge eating disorder. While many of the health consequences associated with binge eating disorder are directly related to obesity, it is important to maintain a distinction between this symptom and the disorder itself". (www.bodywhys.ie)

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DSM V Diagnostic Criteria for Other Specified Feeding or Eating Disorders (OSFED)

Diagnostic Criteria 307.59 (F50.8)

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording "other specified feeding or eating disorder" followed by the specific reason (e.g., "bulimia nervosa of low frequency").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Atypical anorexia nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
2. **Bulimia nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
3. **Binge-eating disorder (of low frequency and/or limited duration):** All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging disorder:** Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
5. **Night eating syndrome:** Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

Unspecified Feeding or Eating Disorders (UFED)

Diagnostic Criteria 307.50 (F50.9)

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The unspecified feeding and eating disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific feeding and eating disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

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DSM V - Other Feeding and Eating Disorder Diagnoses

Pica

A. Persistent eating of non-nutritive, non-food substances over a period of at least 1 month.
B. The eating of non-nutritive, non-food substances in inappropriate to the developmental level of the individual.
C. The eating behaviour is not part of a culturally supported or socially normative practice.
D. If the eating behaviour occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Specify if: In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.

Rumination Disorder Diagnostic Criteria 307.53 (F98.21)

A. Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed or spit out.
B. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g, gastroesophageal reflux, pyloric stenosis).
C. The eating disturbance does not exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
D. If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify if: In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Avoidant/Restrictive Food Intake Disorder Diagnostic Criteria 307.59 (F50.8)

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

   1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
   2. Significant nutritional deficiency.
   3. Dependence on enteral feeding or oral nutritional supplements.
   4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Specify if: In remission: After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

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