National Eating Disorders Collaboration

NEDC e-Bulletin

Issue Thirteen | July 2013

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Editor's Note:

Welcome to the July edition of the NEDC e-Bulletin. This month we have put together a special edition focusing on the changes made to eating disorders diagnostic criteria in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

We hope you enjoy this month's special edition and if you would like to suggest topics or events to be featured in future editions of the e-bulletin, please contact us at info@nedc.com.au.

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1. Background to DSM-5

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), is the manual used by many clinicians and researchers to diagnose and classify mental disorders.

Since it was first published in 1952, the DSM has been the diagnostic benchmark for many psychiatrists and psychologists. Each time the manual is updated, new conditions are introduced and some are removed, often amid controversy.

The previous version of the DSM was completed nearly two decades ago and since that time there has been a wealth of new research and knowledge about mental health. The publication of the fifth edition of the DSM (DSM-5) has been a much anticipated event for mental health professionals and marks the end of more than a decade's journey in revising the criteria for the diagnosis and classification of mental health disorders.

The revision process, coordinated by the APA, brought together over 500 clinicians and researchers in designated Task Forces and Working Groups. The DSM-5 Eating Disorders Work Group was charged with improving the diagnostic categories and classification of the eating disorders based on the best available empirical data. A Scientific Review Committee of mental health experts reviewed and provided guidance on the strength of the evidence of proposed changes.

This most recent revision of the DSM was formally launched in May 2013.

2. Overview of Changes

During debates on the Diagnostic and Statistical Manual of Mental Disorders (DSM) revision there were various proposals for eating disorders. The American Psychiatric Association (APA) has indicated that one of the primary goals in the changes made in this version of the DSM is for more people experiencing eating disorders to have a diagnosis that accurately describes their symptoms and behaviours.

The DSM-5 approach to eating disorders has ultimately been relatively conservative: to retain anorexia nervosa and bulimia nervosa with more inclusive criteria and to introduce binge-eating disorder as a distinct diagnosis. The manual has also organised feeding and eating disorders together.

Below, we overview the changes in this latest version of the DSM.

What diagnostic categories are included in the DSM-5?

The DSM-5 includes the following diagnostic categories:

- Anorexia nervosa (AN)
- Bulimia nervosa (BN)
- Binge-eating disorder (BED)
- Avoidant/restrictive food intake disorder (ARFID)
- Pica
- Rumination disorder.

For each specific eating disorder diagnostic category a clinician is now required to specify state of remission if applicable:

- A person may be considered in partial remission where after full criteria were previously met, some but not all criteria have been met for a sustained period of time

- A person may be considered in full remission if full criteria were previously met but no criteria have been met for a sustained period of time.

Two new categories have also been included to capture clinically significant feeding and eating behaviours which do not meet the criteria for the disorders above.

Other Specified Feeding or Eating Disorder (OSFED) refers to situations where a person has clinically significant feeding and eating disorder symptoms but does not meet the full criteria for another diagnostic category. Examples of this category include;

1. Atypical anorexia nervosa (e.g. weight is within normal range)
2. Bulimia nervosa (e.g. low frequency and/or limited duration)
3. Binge-eating disorder (e.g. low frequency and/or limited duration)
4. Purging disorder (e.g. purging in the absence of binging)
5. Night-eating syndrome
6. Bulimia nervosa (e.g. low frequency and/or limited duration of inappropriate compensatory behaviours)
7. Binge-eating disorder (e.g. low frequency and/or limited duration of binge eating episodes)

Unspecified Feeding and Eating Disorders (UFED) are clinically significant feeding or eating disorders that do not meet the criteria for another eating or feeding disorder.

What are the changes to anorexia nervosa (AN)?

Several minor but important changes have been made to the physical and cognitive criteria for AN:

- Criteria no longer require the patient's weight for height to be less than 85% of that expected
- Cognitive criteria, such as fear of weight gain and shape and weight overvaluation, no longer need to be self-reported and can be inferred by behaviour or by parent report for young people
- The DSM-IV Criterion D requiring amenorrhea or the absence of at least three menstrual cycles has been deleted.
- Body Mass Index (BMI) has been used to specify the level of severity; based on BMI for adults and BMI percentile for children and adolescents. In adults, severity is indicated by:

- Mild; BMI less than or equal to 17

- Moderate; BMI between 16 and 16.99
- Severe; BMI between 15 and 15.99
- Extreme; BMI less than 15

What are the changes to bulimia nervosa (BN)?

DSM-5 criteria have reduced the frequency of binge eating and compensatory behaviours that people with bulimia nervosa must exhibit from twice a week to once a week. In addition, the purging and non-purging subtypes have been removed.

Frequency of inappropriate compensatory behaviours has been used to specify the level of severity for BN. Severity is indicated by:

- Mild; An average of 1-3 episodes per week
- Moderate; An average of 4 – 7 episodes per week
- Severe; An average of 8-13 episodes per week
- Extreme; An average of 14 or more episodes per week

What are the changes for binge eating disorder?

Binge Eating Disorder has been included in DSM-5 as its own category of eating disorder. In DSM-IV, binge-eating disorder previously fell under the general category of Eating Disorder Not Otherwise Specified (EDNOS).

Binge eating disorder is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. A person will be distressed and may have feelings of guilt, embarrassment, or disgust. This disordered binge-eating behaviour occurs, on average, at least once a week over three months.

Frequency of binge eating episodes has been used to specify the level of severity for Binge Eating Disorder. Severity is indicated by:

- Mild; An average of 1-3 episodes per week
- Moderate; An average of 4 – 7 episodes per week
- Severe; An average of 8-13 episodes per week
- Extreme; An average of 14 or more episodes per week

Where has EDNOS gone?

DSM-5 has replaced the 'not otherwise specified' (NOS) designation throughout the entire manual.

People who have previously been diagnosed with EDNOS may now meet the full criteria for one of the other DSM-5 eating disorders. Alternatively, they will be assessed as having either OSFED or UFED as detailed above.

What is avoidant/restrictive food intake disorder (ARFID)?

ARFID is characterised by restrictive or inadequate eating that is not due to medical or psychiatric co-morbidity and cannot be attributed to disturbances in the perception of shape and weight. There are three common clinical presentations to ARFID;

- individuals appear to lack interest in food or to have a blunted response to physiological hunger
- individuals avoid eating because they do not like the smell, taste, texture, temperature, or appearance of food and will only eat a narrow range of foods
- individuals restrict intake as a reaction to a previous upsetting event, usually a gastrointestinal experience such as choking.

ARFID occurs predominantly in children but can also occur in adults.

3. What does this mean?

Many of the changes in DSM-5 attempt to better characterise symptoms and behaviours of groups of people currently seeking clinical help who did not meet definitions in DSM-IV.

Although the DSM-5 criteria appear to capture clinical variance better than DSM-IV, an important question remains concerning the prognostic validity of the DSM-5 categories. Moving forward, there is a call to adhere to an open and transparent process so that feedback can enhance the validity and clinical utility of the DSM-5.

Should I start using DSM-5 for diagnosis?

DSM-5 can be used immediately for diagnosis. It contains the most up-to-date criteria for diagnosing mental health disorders. It is recommended that clinicians learn about diagnostic and coding changes and transition to the new manual. This may mean that clinical, research, and administrative forms require updating too.

How does DSM-5 relate to ICD-10?

The International Classification of Diseases (ICD) is the World Health Organisation's (WHO) standard diagnostic tool for epidemiology, health management and clinical purposes. It is used to monitor the incidence and prevalence of diseases and other health problems. ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. The 11th revision of the classification has already started and will continue until 2015.

The DSM and ICD have much in common, but they are not identical. They should be thought of as companion publications.

The DSM-5 includes coding for ICD-9-CM and ICD-10-CM, to allow 'cross-walking' to the corresponding code in ICD. Government-funded health settings in Australia use ICD-10-AM, the Australian modification.

Are there diagnostic and assessment tools for DSM-5?

The Eating Disorder Examination has been validated as a diagnostic instrument for some DSM-5 eating disorders. At present, no comprehensive diagnostic or assessment measures for DSM-5 exist. Until these become available, clinicians are advised to continue using previous validated diagnostic interviews, such as the EDE, Structured Clinical Interview for DSM (SCID), and the Structured Interview for Anorexic and Bulimic Disorders (SIAB-EX), and assessment instruments, such as the Eating Disorder Examination-Questionnaire (EDE-Q), Eating Disorder Inventory (EDI), and Eating Attitudes Test (EAT).

How will this affect different sectors?

We have asked individuals from a few different affected health sectors how they anticipate these changes will impact on their professional practice.

Gabriella Heruc, Accredited Practicing Dietician
"The changes in DSM-5 will likely result in more individuals meeting diagnostic criteria for feeding and eating disorders. In dietetic practice, this highlights the importance of early identification and appropriate management of these conditions, with particular focus on ARFID, binge eating disorder and anorexia nervosa. The ARFID diagnosis is significant for dietetic practice, with 'fussy eating' and food avoidance being common concerns in both paediatric and adult settings, often resulting in growth and weight concerns, as well as nutritional deficiencies. Dietitians also see many overweight individuals struggling to lose weight, often due to binging and comfort eating. In anorexia nervosa, the removal of the amenorrhoea criteria and clarification of the low body weight criterion are also significant in nutritional management. Improved education around identification and treatment of feeding and eating disorders is now even more important for both specialist and non-specialist dietitians."

Kirsty Greenwood, National Manager, Support, Education and Collaboration, The Butterfly Foundation
"For consumers and their loved ones, while the changes to the DSM V criteria for eating disorders might in the longer term assist with more accurate diagnosis and treatment of new cases, in the short term they are likely to bring up a degree of confusion and stress. Consumers with current eating disorders may now be unsure of what category their disorder is now in, and how this impacts on their diagnosis, services and supports they may have been accessing. For many consumers there is an identity factor in the diagnosis they hold, and so they may find it difficult to make the transition into whatever new diagnosis now best reflects their presentation. There may also be an impact on how they explain their illness to

others, both to clinicians who may not specialise in eating disorders, and family and friends for whom this relabelling might cause further confusion in understanding an already complex and very misunderstood set of disorders."

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4. Where to find out more

We are interested in your thoughts and questions about the DSM-5 and what these changes might mean to you. If you have any questions, comments or thoughts about the DSM, or would like more information please contact us at info@nedc.com.au. Your feedback will help us develop more relevant resources about diagnosis and treatment of eating disorders. We will also endeavour to help you find the information you need about eating disorders diagnosis.

You can find out more about diagnostic tools online. The ICD-10 diagnostic tool is freely available from the World Health Organisation and the American Psychiatric Association (APA) has a dedicated website for the DSM-5, including a form to provide feedback. You can also purchase the DSM from the APA, online book stores and professional associations such as the Australian Psychological Society.

If you're interested in further reading on the DSM-5 and its implications for eating disorders, you can access the following articles in our online Knowledge Hub:

- Birgegård, A., Clinton, D., & Norring, C. (2013). Diagnostic Issues of Binge Eating in Eating Disorders. European Eating Disorders Review, 21(3), 175-183.
- Birgegard, A., GroSZ, G., de Man Lapidoth, J., & Norring, C. (2013). DSM-5: problems and suggestions. Journal of Eating Disorders, 1(1), 8.
- Birgegård, A., Norring, C., & Clinton, D. (2012). DSM-IV versus DSM-5: Implementation of proposed DSM-5 criteria in a large naturalistic database. International Journal of Eating Disorders, 45(3), 353-361.
- Machado, P. P. P., Gonçalves, S., & Hoek, H. W. (2013). DSM-5 reduces the proportion of EDNOS cases: Evidence from community samples. International Journal of Eating Disorders, 46(1), 60-65.
- Ornstein, R. M., Rosen, D. S., Mammel, K. A., Callahan, S. T., Forman, S., Jay, M. S., Fisher, M., Rome, E., & Walsh, B. T. (2013). Distribution of Eating Disorders in Children and Adolescents Using the Proposed DSM-5 Criteria for Feeding and Eating Disorders. The Journal of adolescent health: official publication of the Society for Adolescent Medicine.
- Stice, E., Marti, C., & Rohde, P. (2013). Prevalence, incidence, impairment, and course of the proposed DSM-5 eating disorder diagnoses in an 8-year prospective community study of young women. Journal of Abnormal Psychology, 122(2), 445-457.

Coming up in August

In the next edition of the e-Bulletin we will be exploring issues relating to the treatment of eating disorders. The next e-Bulletin is out 30th August.