

*(Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – DSM-5)
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FEEDING AND EATING DISORDERS

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder.

The diagnostic criteria for rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder result in a classification scheme that is mutually exclusive, so that during a single episode, only one of these diagnoses can be assigned. The rationale for this approach is that, despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs. A diagnosis of pica, however, may be assigned in the presence of any other feeding and eating disorder.

Some individuals with disorders described in this chapter report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. This resemblance may reflect the involvement of the same neural systems, including those implicated in regulatory self-control and reward, in both groups of disorders. However, the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood.

Finally, obesity is not included in the DSM-5 as a mental disorder. Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic, physiological, behavioral, and environmental factors that vary across individuals contributes to the development of obesity; thus, obesity is not considered a mental disorder. However, there are robust associations between obesity and a number of mental disorders (e.g. binge-eating disorder, depressive and bipolar disorders, schizophrenia). The side effects of some psychotropic medications contribute importantly to the development of some mental disorders (e.g. depressive disorders).

PICA

Diagnostic Criteria

- A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
- B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.

- C. The eating behavior is not part of a culturally supported or socially normative practice.
- D. If the eating behavior occurs in the context of another mental disorder (e.g. intellectual disability [intellectual development disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Coding note: The ICD-9-CM code for pica is **307.52** and is used for children or adults. The ICD-10-CM codes for pica are (**F98.3**) in children and (**F50.8**) in adults.

Specify if:

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

DIAGNOSTIC FEATURES

The essential feature of pica is the eating of one or more nonnutritive, nonfood substances on a persistent basis over a period of at least 1 month (Criterion A) that is severe enough to warrant clinical attention. Typical substances ingested tend to vary with age and availability and might include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal or coal, ash, clay, starch, or ice. The term *nonfood* is included because the diagnosis of pica does not apply to ingestion of diet products that have minimal nutritional content. There is typically no aversion to food in general. The eating of nonnutritive, nonfood substances must be developmentally inappropriate (Criterion B) and not part of a culturally supported or socially normative practice (Criterion C). A minimum age of 2 years is suggested for a pica diagnosis to exclude developmentally normal mouthing of objects by infants that results in ingestion. The eating of nonnutritive, nonfood substances can be an associated feature of other mental disorders (e.g. intellectual disability [intellectual development disorder], autism spectrum disorder, schizophrenia). If the eating behavior occurs exclusively in the context of another mental disorder, a separate diagnosis of pica should be made only if the eating behavior is sufficiently severe to warrant additional clinical attention (Criterion D).

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

Although deficiencies in vitamins or minerals (e.g. zinc, iron) have been reported in some instances, often no specific biological abnormalities are found. In some cases, pica comes to clinical attention only following general medical complications (e.g. mechanical bowel problems; intestinal obstruction, such as that resulting from a bezoar; intestinal perforation; infections such as toxoplasmosis and toxocariasis as a result of ingesting feces or dirt; poisoning, such as by ingestion of lead-based paint).

PREVALENCE

The prevalence of pica is unclear. Among individuals with intellectual disability, the prevalence of pica appears to increase with the severity of the condition.

DEVELOPMENT AND COURSE

Onset of pica can occur in childhood, adolescence, or adulthood, although childhood onset is most commonly reported. Pica can occur in otherwise normally developing children, whereas in adults, it appears more likely to occur in the context of intellectual disability or other mental disorders. The eating of nonnutritive, nonfood substances may also manifest in pregnancy, when specific cravings (e.g. chalk or ice) might occur. The diagnosis of pica during pregnancy is only appropriate if such cravings lead to the ingestion of nonnutritive, nonfood substances to the extent that the eating of these substances poses potential medical risks. The course of the disorder can be protracted and can result in medical emergencies (e.g. intestinal obstruction, acute weight loss, poisoning). The disorder can potentially be fatal depending on substances ingested.

RISK AND PROGNOSTIC FACTORS

Environmental. Neglect, lack of supervision, and developmental delay can increase the risk for this condition.

CULTURE-RELATED DIAGNOSTIC ISSUES

In some populations, the eating of earth or other seemingly nonnutritive substances is believed to be of spiritual, medicinal, or other social value, or may be a culturally supported or socially normative practice. Such behavior does not warrant a diagnosis of pica (Criterion C).

GENDER-RELATED DIAGNOSTIC ISSUES

Pica occurs in both males and females. It can occur in females during pregnancy; however, little is known about the course of pica in the postpartum period.

DIAGNOSTIC MARKERS

Abdominal flat plate radiography, ultrasound, and other scanning methods may reveal obstructions related to pica. Blood tests and other laboratory tests can be used to ascertain levels of poisoning or the nature of infection.

FUNCTIONAL CONSEQUENCES OF PICA

Pica can significantly impair physical functioning, but it is rarely the sole cause of impairment in social functioning. Pica often occurs with other disorders associated with impaired social functioning.

DIFFERENTIAL DIAGNOSIS

Eating of nonnutritive, nonfood substances may occur during the course of other mental disorders (e.g. autism spectrum disorder, schizophrenia) and in Kleine-Levin syndrome. In any such instance, an additional diagnosis of pica should be given only if the eating behavior is sufficiently persistent and severe to warrant additional clinical attention.

Anorexia nervosa. Pica can usually be distinguished from other feeding and eating disorders by the consumption of nonnutritive, nonfood substances. It is important to note, however, that some presentations of anorexia nervosa include ingestion of nonnutritive, nonfood substances, such as paper tissues, as a means of attempting to control appetite. In such cases, when the eating of nonnutritive, nonfood substances is primarily used as a means of weight control, anorexia nervosa should be the primary diagnosis.

Factitious disorder. Some individuals with factitious disorder may intentionally ingest foreign objects as part of the pattern of falsification of physical symptoms. In such instances, there is an element of deception that is consistent with deliberate induction of injury or disease.

Nonsuicidal self-injury and nonsuicidal self-injury behaviors in personality disorders. Some individuals may swallow potentially harmful items (e.g. pins, needles, knives) in the context of maladaptive behavior patterns associated with personality disorders or nonsuicidal self-injury.

COMORBIDITY

Disorders most commonly comorbid with pica are autism spectrum disorder and intellectual disability (intellectual development disorder), and, to a lesser degree, schizophrenia and obsessive-compulsive disorder. Pica can be associated with trichotillomania (hair-pulling disorder) and excoriation (skin-picking) disorder. In comorbid presentations, the hair or skin is typically ingested. Pica can also be associated with avoidant/restrictive food intake disorder, particularly in individuals with a strong sensory component to their presentation. When an individual is known to have pica, assessment should include consideration of the possibility of gastrointestinal complications, poisoning, infection, and nutritional deficiency.

RUMINATION DISORDER

307.53 (F98.21)

Diagnostic Criteria

- 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 occur 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 other neurodevelopmental disorders), 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.

DIAGNOSTIC FEATURES

The essential feature of rumination disorder is the repeated regurgitation of food occurring after feeding or eating over a period of at least 1 month (Criterion A). Previously swallowed food that may be partially digested is brought up into the mouth without apparent nausea, involuntary retching, or disgust. The food may be re-chewed and then ejected from the mouth or re-swallowed. Regurgitation in rumination disorder should be frequent, occurring at least several times per week, typically daily. The behavior is not better explained by an associated gastrointestinal or other medical condition (e.g. gastroesophageal reflux, pyloric stenosis) (Criterion B) and does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant-restrictive food intake disorder (Criterion C). If the symptoms occur in the context of another mental disorder (e.g. intellectual disability [intellectual developmental disorder], neurodevelopmental disorder), they must be sufficiently severe to warrant additional clinical attention (Criterion D) and should represent a primary aspect of the individual's presentation requiring intervention. The disorder may be diagnosed across the life span, particularly in individuals who also have intellectual disability. Many individuals with rumination disorder can be directly observed engaging in the behavior by the clinician. In other instances diagnosis can be made on the basis of self-report or corroborative information from parents or caregivers. Individuals may describe the behavior as habitual or outside of their control.

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

Infants with rumination disorder display a characteristic position of straining and arching the back with the head held back, making sucking movements with their tongue. They may give the impression of gaining satisfaction from the activity. They may be irritable and hungry between episodes of regurgitation. Weight loss and failure to make expected weight gains are common features in infants with rumination disorder. Malnutrition may occur despite the infant's apparent hunger and the ingestion of relatively large amounts of food, particularly in severe cases, when regurgitation immediately follows each feeding episode and regurgitated food is expelled. Malnutrition might also occur in older children and adults, particularly when the regurgitation is accompanied by restriction of intake. Adolescents and adults may attempt to disguise the regurgitation behavior by placing a hand over the mouth or coughing. Some will avoid eating with others because of the acknowledged social undesirability of the behavior. This may extend

to an avoidance of eating prior to social situations, such as work or school (e.g. avoiding breakfast because it may be followed by regurgitation).

PREVALENCE

Prevalence data for rumination disorder are inconclusive, but the disorder is commonly reported to be higher in certain groups, such as individuals with intellectual disability.

DEVELOPMENT AND COURSE

Onset of rumination disorder can occur in infancy, childhood, adolescence, or adulthood. The age of onset in infants is usually between ages 3 and 12 months. In infants, the disorder frequently remits spontaneously, but its course can be protracted and can result in medical emergencies (e.g. severe malnutrition). It can potentially be fatal, particularly in infancy. Rumination disorder can have an episodic course or occur continuously until treated. In infants, as well as older individuals with intellectual disability (intellectual developmental disorder) or other neurodevelopmental disorders, the regurgitation and rumination behavior appears to have a self-soothing or self-stimulating function, similar to that of other repetitive motor behaviors such as head banging.

RISK AND PROGNOSTIC FACTORS

Environmental. Psychosocial problems such as lack of stimulation, neglect, stressful life situations, and problems in the parent-child relationship may be predisposing factors in infants and young children.

FUNCTIONAL CONSEQUENCES OF RUMINATION DISORDER

Malnutrition secondary to repeated regurgitation may be associated with growth delay and have a negative effect on developmental and learning potential. Some older individuals with rumination disorder deliberately restrict their food intake because of the social undesirability of regurgitation. They may therefore present with weight loss or low weight. In older children, adolescents, and adults, social functioning is more likely to be adversely affected.

DIFFERENTIAL DIAGNOSIS

Gastrointestinal conditions. It is important to differentiate regurgitation in rumination disorder from other conditions characterized by gastroesophageal reflux or vomiting. Conditions such as gastroparesis, pyloric stenosis, hiatal hernia, and Sandifer syndrome in infants should be ruled out by appropriate physical examinations and laboratory tests.

Anorexia nervosa and bulimia nervosa. Individuals with anorexia nervosa and bulimia nervosa may also engage in regurgitation with subsequent spitting out of food as a means of disposing of ingested calories because of concerns about weight gain.

COMORBIDITY

Regurgitation with associated rumination can occur in the context of a concurrent medical condition or another mental disorder (e.g. generalized anxiety disorder). When the regurgitation occurs in this context, a diagnosis of rumination disorder is appropriate only when the severity of the disturbance exceeds that routinely associated with such conditions or disorders and warrants additional clinical attention.

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER 307.59 (F50.8)

Diagnostic Criteria

- A. An eating or feeding disturbance (e.g. apparent lack of interest in eating or food; avoidance based on the 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 a 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.

DIAGNOSTIC FEATURES

Avoidant/restrictive food intake disorder replaces and extends the DSM-IV diagnosis of feeding disorder of infancy or early childhood. The main diagnostic feature of avoidant/restrictive food intake disorder is avoidance or restriction of food intake (Criterion A) manifested by clinically significant failure to meet requirements for nutrition or insufficient energy intake through oral intake of food. One or more of the following key features must be present: significant weight loss, significant nutritional deficiency (or related health impact), dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning. The determination of whether weight loss is significant (Criterion A1) is a clinical judgment; instead of losing weight, children and adolescence who have not completed growth may not maintain weight or height increases along their developmental trajectory.

Determination of significant nutritional deficiency (Criterion A2) is also based on clinical assessment (e.g. assessment of dietary intake, physical examination, and laboratory testing), and related impact on physical health can be of a similar severity to that seen in anorexia nervosa (e.g. hypothermia, bradycardia, anemia). In severe cases, particularly in infants, malnutrition can be life threatening. “Dependence” on enteral feeding or oral nutritional supplements (Criterion A3) means that supplementary feeding is required to sustain adequate intake. Examples of individuals requiring supplementary feeding include infants with failure to thrive who require nasogastric tube feeding, children with neurodevelopmental disorders who are dependent on nutritionally complete supplements, and individuals who rely on gastrostomy tube feeding or complete oral nutrition supplements in the absence of an underlying medical condition. Inability to participate in normal social activities, such as eating with others, or to sustain relationships as a result of the disturbance would indicate marked interference with psychosocial functioning (Criterion A4).

Avoidant/restrictive food intake disorder does not include avoidance or restriction of food intake related to lack of availability of food or to cultural practices (e.g. religious fasting or normal dieting) (Criterion B), nor does it include developmentally normal behaviors (e.g. picky eating in toddlers, reduced intake in older adults). The disturbance is not better explained by excessive concern about body weight or shape (Criterion C) or by concurrent medical factors or mental disorders (Criterion D).

In some individuals, food avoidance or restriction may be based on the sensory characteristics or qualities of food, such as extreme sensitivity to appearance, color, smell, texture, temperature, or taste. Such behavior has been described as “restrictive eating,” “selective eating,” “choosy eating,” “perseverant eating,” “chronic food refusal,” and “food neophobia” and

may manifest as refusal to eat particular brands of food or to tolerate the smell of food being eaten by others. Individuals with heightened sensory sensitivity associated with autism may show similar behaviors.

Food avoidance or restriction may also represent a conditioned negative response associate with food intake following, or in anticipation of, and aversive experience, such as choking; a traumatic investigation, usually involving the gastrointestinal tract (e.g. esophagoscopy); or repeated vomiting. The terms *functional dysphagia* and *globus hystericus* have also been used for such conditions.

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

Several features may be associated with food avoidance or reduced food intake, including a lack of interest in eating or food, leading to weight loss or faltering growth. Very young infants may present as being too sleepy, distressed, or agitated to feed. Infants and young children may not engage with the primary caregiver during feeding or communicate hunger in favor of other activities. In older children and adolescents, food avoidance or restriction may be associated with more generalized emotional difficulties that do not meet diagnostic criteria for anxiety, depressive, or bipolar disorder, sometimes called “food avoidance emotional disorder.”

DEVELOPMENT AND COURSE

Food avoidance or restriction associated with insufficient intake or a lack of interest in eating most commonly develops in infancy or early childhood and may persist in adulthood. Likewise, avoidance based on sensory characteristics of food tends to arise in the first decade of life but may persist into adulthood. Avoidance related to aversive consequences can arise at any age. The scant literature regarding long-term outcomes suggest that food avoidance or restriction based on sensory aspects is relatively stable and long-standing, but when persisting into adulthood, such avoidance/restriction can be associated with relatively normal functioning. There is currently insufficient evidence directly linking avoidant/restrictive food intake disorder and subsequent onset of an eating disorder.

Infants with avoidant/restrictive food intake disorder may be irritable and difficult to console during feeding, or may appear apathetic and withdrawn. In some instances, parent-child interaction may contribute to the infant’s feeding problem (e.g. presenting food inappropriately, or interpreting the infant’s behavior as an act of aggression or rejection). Inadequate nutritional intake may exacerbate the associated features (e.g. irritability, developmental lags) and further contribute to feeding difficulties. Associated factors include infant temperament or developmental impairments that reduce an infant’s responsiveness to feeding. Coexisting parental psychopathology, or child abuse or neglect, is suggested if feeding and weight improve in response to changing caregivers. In infants, children, and prepubertal adolescents, avoidant/restrictive food intake disorder may be associated with growth delay, and the resulting malnutrition negatively affects developmental and learning potential. In older children, adolescents, and adults, social functioning tends to be adversely affected. Regardless of the age,

family function may be affected, with heightened stress at mealtimes and in other feeding or eating contexts involving friends and relatives.

Avoidant/restrictive food intake disorder manifests more commonly in children than in adults, and there may be a long delay between onset and clinical presentation. Triggers for presentation vary considerably and include physical, social, and emotional difficulties.

RISK AND PROGNOSTIC FACTORS

Temperamental. Anxiety disorders, autism spectrum disorder, obsessive-compulsive disorder, and attention-deficit/hyperactivity disorder may increase risk for avoidant or restrictive feeding or eating behavior characteristics of the disorder.

Environmental. Environmental risk factors for avoidant/restrictive food intake disorder include familial anxiety. Higher rates of feeding disturbances may occur in children of mothers with eating disorders.

Genetic and physiological. History of gastrointestinal conditions, gastroesophageal reflux disease, vomiting, and a range of other medical problems has been associated with feeding and eating behaviors characteristic of avoidant/restrictive food intake disorder.

CULTURE-RELATED DIAGNOSTIC ISSUES

Presentations similar to avoidant/restrictive food intake disorder occur in various populations, including in the United States, Canada, Australia, and Europe. Avoidant/restrictive food intake disorder should not be diagnosed when avoidance of food intake is solely related to specific religious or cultural practices.

GENDER-RELATED DIAGNOSTIC ISSUES

Avoidant/restrictive food intake disorder is equally common in males and females in infancy and early childhood, but avoidant/restrictive food intake disorder comorbid with autism spectrum disorder has a male predominance. Food avoidance or restriction related to altered sensory sensitivities can occur in some physiological conditions, most notably pregnancy, but is not usually extreme and does not meet full criteria for the disorder.

DIAGNOSTIC MARKERS

Diagnostic markers include malnutrition, low weight, growth delay, and the need for artificial nutrition in the absence of any clear medical condition other than poor intake.

FUNCTIONAL CONSEQUENCES OF AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

Associated developmental and functional limitations include impairment of physical development and social difficulties that can have a significant negative impact on family function.

DIFFERENTIAL DIAGNOSIS

Appetite loss preceding restricted intake is a nonspecific symptom that can accompany a number of mental diagnosis. Avoidant/restrictive food intake disorder can be diagnosed concurrently with the disorders below if all criteria are met, and the eating disturbance requires specific clinical attention.

Other medical conditions (e.g. gastrointestinal disease, food allergies and intolerances, occult malignancies). Restriction of food intake may occur in other medical conditions, especially those with ongoing symptoms such as vomiting, loss of appetite, nausea, abdominal pain, or diarrhea. A diagnosis of avoidant/restrictive food intake disorder requires that the disturbance of intake is beyond that directly accounted for by physical symptoms consistent with a medical condition and following resolution of the medical condition.

Underlying medical or comorbid medical conditions may complicate feeding and eating. Because older individuals, postsurgical patients, and individuals receiving chemotherapy often lose their appetite, an additional diagnosis of avoidant/restrictive food intake disorder requires that the eating disturbance is a primary focus for intervention.

Specific neurological/neuromuscular, structural, or congenital disorders and conditions associated with feeding difficulties. Feeding difficulties are common in a number of congenital and neurological conditions often related to problems with oral/esophageal/pharyngeal structure and function, such as hypotonia of musculature, tongue protrusion, and unsafe swallowing. Avoidant/restrictive food intake disorder can be diagnosed in individuals with such presentations as long as all diagnostic criteria are met.

Reactive attachment disorder. Some degree of withdrawal is characteristic of reactive attachment disorder and can lead to a disturbance in the caregiver-child relationship that can affect feeding and the child's intake. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and the feeding disturbance is a primary focus for intervention.

Autism spectrum disorder. Individuals with autism spectrum disorder often present with rigid eating behaviors and heightened sensory sensitivities. However, these features do not always result in the level of impairment that would be required for a diagnosis of avoidant/restrictive food intake disorder. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and when the eating disturbance requires specific treatment.

Specific phobia, social anxiety disorder (social phobia), and other anxiety disorders. Specific phobia, other type, specifies, "situations that may lead to choking or vomiting" and can represent the primary trigger for the fear, anxiety, or avoidance required for diagnosis. Distinguishing specific phobia from avoidant/restrictive food intake disorder can be difficult when a fear of choking or vomiting has resulting in food avoidance. Although avoidance or restriction of food intake secondary to a pronounced fear of choking or vomiting can be conceptualized as specific phobia, in situations when the eating problem becomes the primary focus of clinical attention, avoidant/restrictive food intake disorder becomes the appropriate

diagnosis. In social anxiety disorder, the individual may present with a fear of being observed by others while eating, which can also occur in avoidant/restrictive food intake disorder.

Anorexia nervosa. Restriction of energy intake relative to requirements leading to significantly low body weight is a core feature of anorexia nervosa. However, individuals with anorexia nervosa also display a fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, as well as specific disturbances in relation to perception and experience of their own body weight and shape. These features are not present in avoidant/restrictive food intake disorder, and the two disorders should not be diagnosed concurrently. Differential diagnosis between avoidant/restrictive food intake disorder and anorexia nervosa may be difficult, especially in late childhood and early adolescence, because these disorders may share a number of common symptoms (e.g. food avoidance, low weight). Differential diagnosis is also potentially difficult in individuals with anorexia nervosa who deny any fear of fatness but nonetheless engage in persistent behaviors that prevent weight gain and who do not recognize the medical seriousness of their low weight—a presentation sometimes termed “non-fat phobic anorexia nervosa.” Full consideration of symptoms, course, and family history is advised, and diagnosis may be made in the context of a clinical relationship over time. In some individuals, avoidant/restrictive food intake disorder might precede the onset of anorexia nervosa.

Obsessive-compulsive disorder. Individuals with obsessive-compulsive disorder may present with avoidance or restriction of intake in relation to preoccupations with food or ritualized eating behavior. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and when the aberrant eating is a major aspect of the clinical presentation requiring specific intervention.

Major depressive disorder. In major depressive disorder, appetite might be affected to such an extent that individuals present with significantly restricted food intake, usually in relation to overall energy intake and often associated with weight loss. Usually appetite loss and related reduction of intake abate with resolution of mood problems. Avoidant/restrictive food intake disorder should only be used concurrently if full criteria are met for both disorders and when the eating disturbance requires specific treatment.

Schizophrenia spectrum disorders. Individuals with schizophrenia, delusional disorder, or other psychotic disorders may exhibit odd eating behaviors, avoidance of specific foods because of delusional beliefs, or other manifestations of avoidant or restrictive intake. In some cases, delusional beliefs may contribute to a concern about negative consequences of ingesting certain foods. Avoidant/restrictive food intake disorder should be used concurrently only if all criteria are met for both disorders and when the eating disturbance requires specific treatment.

Factitious disorder or factitious disorder imposed on another. Avoidant/restrictive food intake disorder should be differentiated from factitious disorder or factitious disorder imposed on another. In order to assume the sick role, some individuals with factitious disorder may intentionally describe diets that are much more restrictive than those they are actually able to consume, as well as complications of such behavior, such as a need for enteral feedings or

nutritional supplements, an inability to tolerate a normal range of foods, and/or an inability to participate normally in age-appropriate situations involving food. The presentation may be impressively dramatic and engaging, and the symptoms reported inconsistently. In factitious disorder imposed on another, the caregiver describes symptoms consistent with avoidant/restrictive food intake disorder and may induce physical symptoms such as failure to gain weight. As with any diagnosis of factitious disorder imposed upon another, the caregiver receives the diagnosis rather than the affected individual, and diagnosis should be made only on the basis of careful, comprehensive assessment of the affected individual, the caregiver, and their interaction.

COMORBIDITY

The most commonly observed disorders comorbid with avoidant/restrictive food intake disorder are anxiety disorders, obsessive-compulsive disorder, and neurodevelopmental disorders (specifically autism spectrum disorder, attention-deficit/hyperactivity disorder, and intellectual disability [intellectual developmental disorder]).

ANOREXIA NERVOSA

Diagnostic Criteria

- 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 behavior 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.

Coding note: The ICD-9-CM code for anorexia nervosa is **307.1**, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).

Specify whether:

(F50.01) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (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.

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

Specify if:

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 behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa 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, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization 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 ≥ 17 kg/m²

Moderate: BMI 16-16.99 kg/m²

Severe: BMI 15-15.99 kg/m²

Extreme: BMI < 15 kg/m²

SUBTYPES

Most individuals with the binge-eating/purging type of anorexia nervosa who binge eat also purge through self-induced vomiting or the misuse of diuretics, laxatives, or enemas. Some individuals with this subtype of anorexia nervosa do not binge eat but do regularly purge after the consumption of small amounts of food.

Crossover between the subtypes over the course of the disorder is not uncommon; therefore, subtype description should be used to describe current symptoms rather than longitudinal course.

DIAGNOSTIC FEATURES

There are three essential features of anorexia nervosa: persistent energy intake restriction; intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape. The individual maintains a body weight that is below a minimally normal level for age, sex, developmental trajectory, and physical health (Criterion A). Individuals' body weights frequently meets this criterion following a significant weight loss, but among children and adolescents, there may alternatively be failure to make expected weight gain or to maintain a normal developmental trajectory (i.e. while growing in height) instead of weight loss.

Criterion A requires that the individual's weight be significantly low (i.e. less than minimally normal or, for children and adolescents, less than minimally expected). Weight assessment can be challenging because normal weight range differs among individuals, and

different thresholds have been published defining thinness or underweight status. Body mass index (BMI; calculated as weight in kilograms / height in meters²) is a useful measure to assess body weight for height. In adults, a BMI of 18.5 kg/m² has been employed by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) as the lower limit of normal body weight. Therefore, most adults with a BMI greater than or equal to 18.5 kg/m² would not be considered to have a significantly low body weight. On the other hand, a BMI of lower than 17.0 kg/m² has been considered by the WHO to indicate moderate or severe thinness; therefore, an individual with a BMI of less than 17.0 kg/m² would likely be considered to have a significantly low body weight. An adult with a BMI between 17.0 and 18.5 kg/m², or even above 18.5 kg/m², might be considered to have a significantly low weight if clinical history or other physiological information supports this judgment.

For children and adolescents, determining a BMI-for-age percentile is useful (see, e.g. the CDC BMI percentile calculator for children and teenagers). As for adults, it is not possible to provide definitive standards for judging whether a child's or an adolescent's weight is significantly low, and variations in developmental trajectories among youth limit the utility of simple numerical guidelines. The CDC has used a BMI-for-age below the 5th percentile as suggesting underweight; however, children and adolescents with a BMI above this benchmark may be judged to be significantly underweight in light of failure to maintain their expected growth trajectory. In summary, in determining whether Criterion A is met, the clinician should consider available numerical guidelines, as well as the individual's body build, weight history, and any physiological disturbances.

Individuals with this disorder typically display an intense fear of gaining weight or of becoming fat (Criterion B). This intense fear of becoming fat is usually not alleviated by weight loss. In fact, concern about weight gain may increase even as weight falls. Younger individuals with anorexia nervosa, as well as some adults, may not recognize or acknowledge a fear of weight gain. In the absence of another explanation for the significantly low weight, clinician inference drawn from collateral history, observational data, physical and laboratory findings, or longitudinal course either indicating a fear of weight gain or supporting persistent behaviors that prevent it may be used to establish Criterion B.

The experience and significance of body weight and shape are distorted in these individuals (Criterion C). Some individuals feel globally overweight. Others realize that they are thin but are still concerned that certain body parts, particularly the abdomen, buttocks, and thighs, are "too fat." They may employ a variety of techniques to evaluate their body size or weight, including frequent weighing, obsessive measuring of body parts, and persistent use of a mirror to check for perceived areas of "fat." The self-esteem of individuals with anorexia nervosa is highly dependent on their perceptions of body shape and weight. Weight loss is often viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control. Although some individuals with this disorder may acknowledge being thin, they often do not realize the serious medical implications of their malnourished state.

Often, the individual is brought to professional attention by family members after marked weight loss (or failure to make expected weight gains) has occurred. If individuals seek help on their own, it is usually because of distress over the somatic and psychological sequelae of starvation. It is rare for an individual with anorexia nervosa to complain of weight loss per se. In fact, individuals with anorexia nervosa frequently either lack insight to or deny the problem. It is therefore often important to obtain information from family members or other sources to evaluate the history of weight loss and other features of the illness.

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

The semi-starvation of anorexia nervosa, and the purging behaviors sometimes associated with it, can result in significant and potentially life-threatening medical conditions. The nutritional compromise associated with this disorder affects most major organ systems and can produce a variety of disturbances. Physiological disturbances, including amenorrhea and vital sign abnormalities, are common. While most of the physiological disturbances associated with malnutrition are reversible with nutritional rehabilitation, some, including loss of bone mineral density, are often not completely reversible. Behaviors such as self-induced vomiting and misuse of laxatives, diuretics, and enemas may cause a number of disturbances that lead to abnormal laboratory findings; however, some individuals with anorexia nervosa exhibit no laboratory abnormalities.

When seriously underweight, many individuals with anorexia nervosa have depressive signs and symptoms such as depressed mood, social withdrawal, irritability, insomnia, and diminished interest in sex. Because these features are also observed in individuals without anorexia nervosa who are severely undernourished, many of the depressive features may be secondary to the physiological sequelae of semi-starvation, although they may also be sufficiently severe to warrant an additional diagnosis of major depressive disorder.

Obsessive-compulsive features, both related and unrelated to food, are often prominent. Most individuals with anorexia nervosa are preoccupied with thoughts of food. Some collect recipes or hoard food. Observations of behaviors associated with other forms of starvation suggest that obsessions and compulsions related to food may be exacerbated by undernutrition. When individuals with anorexia nervosa exhibit obsessions and compulsions that are not related to food, body shape, or weight, an additional diagnosis of obsessive-compulsive disorder (OCD) may be warranted.

Other features sometimes associated with anorexia nervosa include concerns about eating in public, feelings of ineffectiveness, a strong desire to control one's environment, inflexible thinking, limited social spontaneity, and overly restrained emotional expression. Compared with individuals with anorexia nervosa, restricting type, those with binge-eating/purging type have higher rates of impulsivity and are more likely to abuse alcohol and other drugs.

A subgroup of individuals with anorexia nervosa show excessive levels of physical activity. Increases in physical activity often precede onset of the disorder, and over the course of

the disorder increased activity accelerates weight loss. During treatment, excessive activity may be difficult to control, thereby jeopardizing weight recovery.

Individuals with anorexia nervosa may misuse medications, such as by manipulating dosage, in order to achieve weight loss or avoid weight gain. Individuals with diabetes mellitus may omit or reduce insulin doses in order to minimize carbohydrate metabolism.

PREVALENCE

The 12-month prevalence of anorexia nervosa among young females is approximately 0.4%. Less is known about prevalence among males, but anorexia nervosa is far less common in males than in females, with clinical populations generally reflecting approximately a 10:1 female-to-male ratio.

DEVELOPMENT AND COURSE

Anorexia nervosa commonly begins during adolescence or young adulthood. It rarely begins before puberty or after age 40, but cases of both early and late onset have been described. The onset for this disorder is often associated with a stressful life event, such as leaving home for college. The course and outcome of anorexia nervosa are highly variable. Younger individuals often manifest atypical features, including denying “fear of fat.” Older individuals more likely have a longer duration of illness, and their clinical presentation may include more signs and symptoms of long-standing disorder. Clinicians should not exclude anorexia nervosa from the differential diagnosis solely on the basis of older age.

Many individuals have a period of changed eating behavior prior to full criteria for the disorder being met. Some individuals with anorexia nervosa recover fully after a single episode, with some exhibiting a fluctuating pattern of weight gain followed by relapse, and others experiencing a chronic course over many years. Hospitalization may be required to restore weight and to address medical complications. Most individuals with anorexia nervosa experience remission within 5 years of presentation. Among individuals admitted to hospitals, overall remission rates may be lower. The crude mortality rate (CMR) for anorexia nervosa is approximately 5% per decade. Death most commonly results from medical complications associated with the disorder itself or from suicide.

RISK AND PROGNOSTIC FEATURES

Temperamental. Individuals who develop anxiety disorders or display obsessional traits in childhood are at increased risk of developing anorexia nervosa.

Environmental. Historical and cross-cultural variability in the prevalence of anorexia nervosa supports its association with cultures and settings in which thinness is valued. Occupations and avocations that encourage thinness, such as modeling and elite athletics, are also associated with increased risk.

Genetic and physiological. There is an increased risk of anorexia nervosa among first-degree biological relatives of individuals with the disorder. An increased risk in bipolar and depressive

disorders has also been found among first-degree relatives of individuals with anorexia nervosa, particularly relatives of individuals with the binge-eating/purging type. Concordance rates for anorexia nervosa in monozygotic twins are significantly higher than those for dizygotic twins. A range of brain abnormalities has been described in anorexia nervosa using functional imaging technologies (functional magnetic resonance imaging, positron emission tomography). The degree to which these findings reflect changes associated with malnutrition versus primary abnormalities associated with the disorder is unclear.

CULTURE-RELATED DIAGNOSTIC ISSUES

Anorexia nervosa occurs across culturally and socially diverse populations, although available evidence suggests cross-cultural variation in its occurrence and presentation. Anorexia nervosa is probably most prevalent in post-industrialized, high-income countries such as in the United States, many European countries, Australia, New Zealand, and Japan, but its incidence in most low- and middle-income countries is uncertain. Whereas the prevalence of anorexia nervosa appears comparatively low among Latinos, African Americans, and Asians in the United States, clinicians should be aware that mental health service utilization among individuals with an eating disorder is significantly lower in these ethnic groups and that the low rates may reflect an ascertainment bias. The presentation of weight concerns among individuals with eating and feeding disorders varies substantially across cultural contexts. The absence of an expressed intense fear of weight gain, sometimes referred to as “fat phobia,” appears to be relatively more common in populations in Asia, where the rationale for dietary restriction is commonly related to a more culturally sanctioned complaint such as gastrointestinal discomfort. Within the United States, presentations without a stated intense fear of weight gain may be comparatively more common among Latino groups.

DIAGNOSTIC MARKERS

The following laboratory abnormalities may be observed in anorexia nervosa; their presence may serve to increase diagnostic confidence.

Hematology. Leukopenia is common, with the loss of all cell types but usually with apparent lymphocytosis. Mild anemia can occur, as well as thrombocytopenia and, rarely, bleeding problems.

Serum chemistry. Dehydration may be reflected by an elevated blood urea nitrogen level. Hypercholesterolemia is common. Hepatic enzyme levels may be elevated. Hypomagnesemia, hypozincemia, hypophosphatemia, and hyperamylasemia are occasionally observed. Self-induced vomiting may lead to metabolic alkalosis (elevated serum bicarbonate), hypochloremia, and hypokalemia; laxative abuse may cause a mild metabolic acidosis.

Endocrine. Serum thyroxine levels are usually in the low-normal range; triiodothyronine levels are decreased, while reverse thyroxine levels are elevated. Females have low serum estrogen levels, whereas males have low levels of serum testosterone.

Electrocardiography. Sinus bradycardia is common, and, rarely, arrhythmias are noted. Significant prolongation of the QTc interval is observed in some individuals.

Bone mass. Low bone mineral density, with specific areas of osteopenia or osteoporosis, is often seen. The risk of fracture is significantly elevated.

Electroencephalography. Diffuse abnormalities, reflecting a metabolic encephalopathy, may result from significant fluid and electrolyte disturbances.

Resting energy expenditure. There is often a significant reduction in resting energy expenditure.

Physical signs and symptoms. Many of the physical signs and symptoms of anorexia nervosa are attributable to starvation. Amenorrhea is commonly present and appears to be an indicator of physiological dysfunction. If present, amenorrhea is usually a consequence of the weight loss, but in a minority of individuals it may actually precede the weight loss. In prepubertal females, menarche may be delayed. In addition to amenorrhea, there may be complaints of constipation, abdominal pain, cold intolerance, lethargy, and excess energy.

The most remarkable finding on physical examination is emaciation. Commonly, there is also significant hypotension, hypothermia, and bradycardia. Some individuals develop lanugo, a fine downy body hair. Some develop peripheral edema, especially during weight restoration or upon cessation of laxative and diuretic abuse. Rarely, petechiae or ecchymoses, usually on the extremities, may indicate a bleeding diathesis. Some individuals evidence a yellowing of the skin associated with hypercarotenemia. As may be seen in individuals with bulimia nervosa, individuals with anorexia nervosa who self-induce vomiting may have hypertrophy of the salivary glands, particularly the parotid glands, as well as dental enamel erosion. Some individuals may have scars or calluses on the dorsal surface of the hand from repeated contact with the teeth while inducing vomiting.

SUICIDE RISK

Suicide risk is elevated in anorexia nervosa, with rates reported as 12 per 100,000 per year. Comprehensive evaluation of individuals with anorexia nervosa should include assessment of suicide-related ideation and behaviors as well as other risk factors for suicide, including a history of suicide attempt(s).

FUNCTIONAL CONSEQUENCES OF ANOREXIA NERVOSA

Individuals with anorexia nervosa may exhibit a range of functional limitations associated with the disorder. While some individuals remain active in social and professional functioning, others demonstrate significant social isolation and/or failure to fulfill academic or career potential.

DIFFERENTIAL DIAGNOSIS

Other possible causes of either significantly low body weight or significant weight loss should be considered in the differential diagnosis of anorexia nervosa, especially when the presenting features are atypical (e.g. onset after age 40 years).

Medical conditions (e.g. gastrointestinal disease, hyperthyroidism, occult malignancies, and acquired immunodeficiency syndrome [AIDS]). Serious weight loss may occur in medical conditions, but individuals with these disorders do not also manifest a disturbance in the way their body weight or shape is experienced or an intense fear of weight gain or persists in behaviors that interfere with appropriate weight gain. Acute weight loss associated with a medical condition can occasionally be followed by the onset or recurrence of anorexia nervosa, which can initially be masked by the comorbid medical condition. Rarely, anorexia nervosa develops after bariatric surgery for obesity.

Major depressive disorder. In major depressive disorder, severe weight loss may occur, but most individuals with major depressive disorder do not have either a desire for excessive weight loss or an intense fear of gaining weight.

Schizophrenia. Individuals with schizophrenia may exhibit odd eating behavior and occasionally experience significant weight loss, but they rarely show the fear of gaining weight and the body image disturbance required for a diagnosis of anorexia nervosa.

Substance use disorder. Individuals with substance use disorder may experience low weight due to poor nutritional intake but generally do not fear gaining weight and do not manifest body image disturbance. Individuals who abuse substances that reduce appetite (e.g. cocaine, stimulants) and who also endorse fear of weight gain should be carefully evaluated for the possibility of comorbid anorexia nervosa, given that the substance use may represent a persistent behavior that interferes with weight gain (Criterion B).

Social anxiety disorder (social phobia), obsessive-compulsive disorder, and body dysmorphic disorder. Some of the features of anorexia nervosa overlap with the criteria for social phobia, OCD, and body dysmorphic disorder. Specifically, individuals may feel humiliated or embarrassed to be seen eating in public, as in social phobia; may exhibit obsessions and compulsions related to food, as in OCD; or may be preoccupied with an imagined defect in body appearance, as in body dysmorphic disorder. If the individual with anorexia nervosa has social fears that are limited to eating behavior alone, the diagnosis of social phobia should not be made, but social fears unrelated to eating behavior (e.g. excessive fear of speaking in public) may warrant an additional diagnosis of social phobia. Similarly, an additional diagnosis of OCD should be considered only if the individual exhibits obsessions and compulsions unrelated to food (e.g. an excessive fear of contamination), and an additional diagnosis of body dysmorphic disorder should be considered only if the distortion is unrelated to body shape and size (e.g. preoccupation that one's nose is too big).

Bulimia nervosa. Individuals with bulimia nervosa exhibit recurrent episodes of binge eating, engage in inappropriate behavior to avoid weight gain (e.g. self-induced vomiting), and are overly concerned with body shape and weight. However, unlike individuals with anorexia nervosa, binge-eating/purging type, individuals with bulimia nervosa maintain body weight at or above a minimally normal level.

Avoidant/restrictive food intake disorder. Individuals with this disorder may exhibit significant weight loss or significant nutritional deficiency, but they do not have a fear of gaining

weight or becoming fat, nor do they have a disturbance in the way they experience their body shape and weight.

COMORBIDITY

Bipolar, depressive, and anxiety disorders commonly co-occur with anorexia nervosa. Many individuals with anorexia nervosa report the presence of either an anxiety disorder or symptoms prior to onset of their eating disorder. OCD is described in some individuals with anorexia nervosa, especially those with the restricting type. Alcohol use disorder and other substance use disorders may also be comorbid with anorexia nervosa, especially among those with the binge-eating/purging type.

BULIMIA NERVOSA

307.51 (F50.2)

Diagnostic Criteria

- 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 behaviors 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 behaviors 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 been met for a sustained period of time.

In full remission: After full criteria for bulimia nervosa 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 inappropriate compensatory behaviors (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 behaviors per week.

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

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

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

DIAGNOSTIC FEATURES

There are three essential features of bulimia nervosa: recurrent episodes of binge eating (Criterion A), recurrent inappropriate compensatory behaviors to prevent weight gain (Criterion B), and self-evaluation that is unduly influenced by body shape and weight (Criterion D). To qualify for the diagnosis, the binge eating and inappropriate compensatory behaviors must occur, on average, at least once per week for 3 months (Criterion C).

An “episode of binge eating” is defined as eating, in a discrete period of time, an amount of food that is definitely larger than most individuals would eat in a similar period of time under similar circumstances (Criterion A1). The context in which the eating occurs may affect the clinician’s estimation of whether the intake is excessive. For example, a quantity of food that might be regarded as excessive for a typical meal might be considered normal during a celebration or holiday meal. A “discrete period of time” refers to a limited period, usually less than 2 hours. A single episode of binge eating need not be restricted to one setting. For example, an individual may begin to binge in a restaurant and then continue to eat on returning home. Continual snacking on small amounts of food throughout the day would not be considered a binge.

An occurrence of excessive food consumption must be accompanied by a sense of lack of control (Criterion A2) to be considered an episode of binge eating. An indicator of loss of control is the inability to refrain from eating or to stop eating once started. Some individuals describe a dissociative quality during, or following, the binge-eating episodes. The impairment in control associated with binge eating may not be absolute; for example, an individual may continue binge eating while the telephone is ringing but will cease if a roommate or spouse unexpectedly enters the room. Some individuals report that their binge-eating episodes are no longer characterized by an acute feeling of loss of control but rather by a more generalized pattern of uncontrolled eating. If individuals report that they have abandoned efforts to control their eating, loss of control should be considered as present. Binge eating can also be planned in some instances.

The type of food consumed during binges varies both across individuals and for a given individual. Binge eating appears to be characterized more by an abnormality in the amount of food consumed than by a craving for a specific nutrient. However, during binges, individuals tend to eat foods that they would otherwise avoid.

Individuals with bulimia nervosa are typically ashamed of their eating problems and attempt to conceal their symptoms. Binge eating usually occurs in secrecy or as inconspicuously as possible. The binge eating often continues until the individual is uncomfortably, or even

painfully, full. The most common antecedent of binge eating is negative affect. Other triggers include interpersonal stressors; dietary restraint; negative feelings related to body weight, shape, and food; and boredom. Binge eating may minimize or mitigate factors that precipitated the episode in the short-term, but negative self-evaluation and dysphoria often are the delayed consequences.

Another essential factor of bulimia nervosa is the recurrent use of inappropriate compensatory behaviors to prevent weight gain, collectively referred to as *purge behaviors* or *purging* (Criterion B). Many individuals with bulimia nervosa employ several methods to compensate for binge eating. Vomiting is the most common inappropriate compensatory behavior. The immediate effects of vomiting include relief from physical discomfort and reduction of fear of gaining weight. In some cases, vomiting becomes a goal itself, and the individuals will binge eat in order to vomit or will vomit after eating a small amount of food. Individuals with bulimia nervosa may use a variety of methods to induce vomiting, including the use of fingers or instruments to stimulate the gag reflex. Individuals generally become adept at inducing vomiting and are eventually able to vomit at will. Rarely, individuals consume syrup of ipecac to induce vomiting. Other purging methods include the misuse of laxatives and diuretics. A number of other compensatory methods may also be used in rare cases. Individuals with bulimia nervosa may misuse enemas following episodes of binge eating, but this is seldom the sole compensatory method employed. Individuals with this disorder may take thyroid hormone in an attempt to avoid weight gain. Individuals with diabetes mellitus and bulimia nervosa may omit or reduce insulin doses in order to reduce the metabolism of food consumed during eating binges. Individuals with bulimia nervosa may fast for a day or more or exercise excessively in an attempt to prevent weight gain. Exercise may be considered excessive when it significantly interferes with important activities, when it occurs at inappropriate times or in inappropriate settings, or when the individual continues to exercise despite injury or other medical complications.

Individuals with bulimia nervosa place an excessive emphasis on body shape or weight in their self-evaluation, and these factors are typically extremely important in determining self-esteem (Criterion D). Individuals with this disorder may closely resemble those with anorexia nervosa in their fear of gaining weight, in their desire to lose weight, and in the level of dissatisfaction with their bodies. However, a diagnosis of bulimia nervosa should not be given when the disturbance occurs only during episodes of anorexia nervosa (Criterion E).

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

Individuals with bulimia nervosa typically are within the normal or overweight range (body mass index [BMI] ≥ 18.5 and < 30 in adults). The disorder occurs but is uncommon among obese individuals. Between eating binges, individuals with bulimia nervosa typically restrict their total caloric consumption and preferentially select low-calorie (“diet”) foods while avoiding foods that they perceive to be fattening or likely to trigger a binge.

Menstrual irregularity or amenorrhea often occurs among females with bulimia nervosa; it is uncertain whether such disturbances are related to weight fluctuations, to nutritional deficiencies, or to emotional distress. The fluid and electrolyte disturbances resulting from the purging behavior are sometimes sufficiently severe to constitute medically serious problems. Rare but potentially fatal complications include esophageal tears, gastric rupture, and cardiac arrhythmias. Serious cardiac and skeletal myopathies have been reported among individuals following repeated use of syrup of ipecac to induce vomiting. Individuals who chronically abuse laxatives may become dependent on their use to stimulate bowel movements. Gastrointestinal symptoms are commonly associated with bulimia nervosa, and rectal prolapse has also been reported among individuals with this disorder.

PREVALENCE

Twelve-month prevalence of bulimia nervosa among young females is 1%-1.5%. Point prevalence is highest among young adults since this disorder peaks in older adolescence and young adulthood. Less is known about the point prevalence of bulimia nervosa in males, but bulimia nervosa is far less common in males than it is in females, with an approximately 10:1 female-to-male ratio.

DEVELOPMENT AND COURSE

Bulimia nervosa commonly begins in adolescence or young adulthood. Onset before puberty or after age 40 is uncommon. The binge eating frequently begins during or after an episode of dieting to lose weight. Experiencing multiple stressful life events can also precipitate onset of bulimia nervosa.

Disturbed eating behavior persists for at least several years in a high percentage of clinic samples. The course may be chronic or intermittent, with periods of remission alternating with recurrence of binge eating. However, over longer-term follow-up, the symptoms of many individuals appear to diminish with or without treatment, although treatment clearly impacts outcome. Periods of remission longer than 1 year are associated with better long-term outcome.

Significantly elevated risk for mortality (all-cause and suicide) has been reported for individuals with bulimia nervosa. The CMR (crude mortality rate) for bulimia nervosa is nearly 2% per decade.

Diagnostic cross-over from initial bulimia nervosa to anorexia nervosa occurs in a minority of cases (10%-15%). Individuals who do experience cross-over to anorexia nervosa commonly will revert back to bulimia nervosa or have multiple occurrences of cross-overs between these disorders. A subset of individuals with bulimia nervosa continue to binge eat but no longer engage in inappropriate compensatory behaviors, and therefore their symptoms meet criteria for binge-eating disorder or other specified eating disorder. Diagnosis should be based on the current (i.e. past 3 months) clinical presentation.

RISK AND PROGNOSTIC FACTORS

Temperamental. Weight concerns, low self-esteem, depressive symptoms, social anxiety disorder, and overanxious disorder of childhood are associated with increased risk for the development of bulimia nervosa.

Environmental. Internalization of a thin body ideal has been found to increase risk for developing weight concerns, which in turn increase risk for development of bulimia nervosa. Individuals who experienced childhood sexual or physical abuse are at increased risk for developing bulimia nervosa.

Genetic and physiological. Childhood obesity and early pubertal maturation increases risk for bulimia nervosa. Familial transmission of bulimia nervosa may be present, as well as genetic vulnerabilities for the disorder.

Course modifiers. Severity of psychiatric comorbidity predicts worse long-term outcome of bulimia nervosa.

CULTURE-RELATED DIAGNOSTIC ISSUES

Bulimia nervosa has been reported to occur with roughly similar frequencies in most industrialized countries, including the United States, Canada, many European countries, Australia, Japan, New Zealand, and South Africa. In clinical studies of bulimia nervosa in the United States, individuals presenting with this disorder are primarily white. However, the disorder also occurs in other ethnic groups and with prevalence comparable to estimated prevalences observed in white samples.

GENDER-RELATED DIAGNOSTIC ISSUES

Bulimia nervosa is far more common in females than in males. Males are especially under-represented in treatment-seeking samples, for reasons that have not yet been systematically examined.

DIAGNOSTIC MARKERS

No specific diagnostic test for bulimia nervosa currently exists. However, several laboratory abnormalities may occur as a consequence of purging and may increase diagnostic certainty. These include fluid and electrolyte abnormalities, such as hypokalemia (which can provoke cardiac arrhythmias), hypochloremia, and hyponatremia. The loss of gastric acid through vomiting may produce a metabolic alkalosis (elevated serum bicarbonate), and the frequent induction of diarrhea or dehydration through laxative and diuretic abuse can cause metabolic acidosis. Some individuals with bulimia nervosa exhibit mildly elevated levels of serum amylase, probably reflecting an increase in the salivary isoenzyme.

Physical examination usually yields no physical findings. However, inspection of the mouth may reveal significant and prominent loss of dental enamel, especially from lingual surfaces of the front teeth due to recurrent vomiting. These teeth may become chipped and appear ragged and “moth-eaten.” There may also be an increased frequency of dental caries. In some individuals, the salivary glands, particularly the parotid glands, may become notably

enlarged. Individuals who induce vomiting by manually stimulating the gag reflex may develop calluses or scars on the dorsal surface of the hand from repeated contact with the teeth. Serious cardiac and skeletal myopathies have been reported among individuals following repeated use of syrup of ipecac to induce vomiting.

SUICIDE RISK

Suicide risk is elevated in bulimia nervosa. Comprehensive evaluation of individuals with this disorder should include assessment of suicide-related ideation and behaviors as well as other risk factors for suicide, including a history of suicide attempts.

FUNCTIONAL CONSEQUENCES OF BULIMIA NERVOSA

Individuals with bulimia nervosa may exhibit a range of functional limitations associated with the disorder. A minority of individuals report severe role impairment, with the social-life domain most likely to be adversely affected by bulimia nervosa.

DIFFERENTIAL DIAGNOSIS

Anorexia nervosa, binge-eating/purging type. Individuals whose binge-eating behavior occurs only during episodes of anorexia nervosa are given the diagnosis anorexia nervosa binge-eating/purging type, and should not be given the additional diagnosis of bulimia nervosa. For individuals with an initial diagnosis of anorexia nervosa who binge and purge but whose presentations no longer meet the full criteria for anorexia nervosa, binge-eating/purging type (e.g. when weight is normal), a diagnosis of bulimia nervosa should be given only when all criteria for bulimia nervosa have been met for at least 3 months.

Binge-eating disorder. Some individuals binge eat but do not engage in regular inappropriate compensatory behaviors. In these cases, the diagnosis of binge-eating disorder should be considered.

Kleine-Levin syndrome. In certain neurological or other medical conditions, such as Kleine-Levin syndrome, there is a disturbed eating behavior, but the characteristic psychological features of bulimia nervosa, such as overconcern with body shape and weight, are not present.

Major depressive disorder, with atypical features. Overeating is common in major depressive disorder, with a typical features, but individuals with this disorder do not engage in inappropriate compensatory behaviors and do not exhibit the excessive concern with body shape and weight characteristic of bulimia nervosa. If criteria for both disorders are met, both diagnoses should be given.

Borderline personality disorder. Binge-eating behavior is included in the impulsive behavior criterion that is part of the definition of borderline personality disorder. If the criteria for both borderline personality disorder and bulimia nervosa are met, both diagnoses should be given.

COMORBIDITY

Comorbidity with mental disorders is common in individuals with bulimia nervosa, with most experiencing at least one other mental disorder and many experiencing multiple comorbidities. Comorbidity is not limited to any particular subset but rather occurs across a wide range of mental disorders. There is an increased frequency of depressive symptoms (e.g. low self-esteem) and bipolar and depressive disorders (particularly depressive disorders) in individuals with bulimia nervosa. In many individuals, the mood disturbance begins at the same time as or following the development of bulimia nervosa, and individuals often ascribe their mood disturbances to the bulimia nervosa. However, in some individuals, the mood disturbance clearly precedes the development of bulimia nervosa. There may also be an increased frequency of anxiety symptoms (e.g. fear of social situations) or anxiety disorders. These mood and anxiety disturbances frequently remit following effective treatment of the bulimia nervosa. The lifetime prevalence of substance use, particularly alcohol or stimulant use, is at least 30% among individuals with bulimia nervosa. Stimulant use often begins in an attempt to control appetite and weight. A substantial percentage of individuals with bulimia nervosa also have personality features that meet criteria for one or more personality disorders, most frequently borderline personality disorder.

BINGE-EATING DISORDER

307.51 (F50.8)

Diagnostic Criteria

- 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.

DIAGNOSTIC FEATURES

The essential feature of binge-eating disorder is recurrent episodes of binge eating that must occur, on average, at least once per week for 3 months (Criterion D). An “episode of binge eating” is defined as eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances (Criterion A1). The context in which the eating occurs may affect the clinician’s estimation of whether the intake is excessive. For example, a quantity of food that might be regarded as excessive for a typical meal might be considered normal during a celebration or holiday meal. A “discrete period of time” refers to a limited period, usually less than 2 hours. A single episode of binge eating need not be restricted to one setting. For example, an individual may begin a binge in a restaurant and then continue to eat on returning home. Continual snacking on small amounts of food throughout the day would not be considered an eating binge.

An occurrence of excessive food consumption must be accompanied by a sense of lack of control (Criterion A2) to be considered an episode of binge eating. An indicator of loss of control is the inability to refrain from eating or to stop eating once started. Some individuals describe a dissociative quality during, or following, the binge-eating episodes. The impairment of control associated with binge eating may not be absolute; for example, an individual may continue binge eating while the telephone is ringing but will cease if a roommate or spouse unexpectedly enters the room. Some individuals report that their binge-eating episodes are no longer characterized by an acute feeling of loss of control but rather by a more generalized pattern of uncontrolled eating. If individuals report that they have abandoned efforts to control their eating, loss of control may still be considered as present. Binge eating can also be planned in some instances.

The type of food consumed during binges varies both across individuals and for a given individual. Binge eating appears to be characterized more by an abnormality in the amount of food consumed than by a craving for a specific nutrient.

Binge eating must be characterized by a marked distress (Criterion C) and at least three of the following features: eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterwards (Criterion B).

Individuals with binge-eating disorder are typically ashamed of their eating problems and attempt to conceal their symptoms. Binge eating usually occurs in secrecy or as inconspicuously as possible. The most common antecedent of binge eating is negative affect. Other triggers include interpersonal stressors; dietary restraint; negative feelings related to body weight, body shape, and food; and boredom. Binge eating may minimize or mitigate factors that precipitated the episode in the short-term, but negative self-evaluation and dysphoria are often the delayed consequences.

ASSOCIATED FEATURES SUPPORTING DIAGNOSIS

Binge-eating disorder occurs in normal-weight/overweight and obese individuals. It is reliably associated with overweight and obesity in treatment-seeking individuals. Nevertheless, binge-eating disorder is distinct from obesity. Most obese individuals do not engage in recurrent binge eating. In addition, compared with weight-matched obese individuals without binge-eating disorder, those with the disorder consume more calories in laboratory studies of eating behavior and have greater functional impairment, lower quality of life, more subjective distress, and greater psychiatric comorbidity.

PREVALENCE

Twelve-month prevalence of binge-eating disorder among U.S. adult (age 18 or older) females and males is 1.6% and 0.8%, respectively. The gender ratio is far less skewed in binge-eating disorder than in bulimia nervosa. Binge-eating disorder is as prevalent among females from racial or ethnic minority groups as has been reported for white females. The disorder is more prevalent among individuals seeking weight-loss treatment than in the general population.

DEVELOPMENT AND COURSE

Little is known about the development of binge-eating disorder. Both binge eating and loss-of-control eating without objectively excessive consumption occur in children and are associated with increased body fat, weight gain, and increases in psychological symptoms. Binge eating is common in adolescent and college-age samples. Loss-of-control eating or episodic binge eating may represent a prodromal phase of eating disorders for some individuals.

Dieting follows the development of binge eating in many individuals with binge-eating disorder. (This is in contrast to bulimia nervosa, in which dysfunctional dieting usually precedes

the onset of binge eating.) Binge-eating disorder typically begins in adolescence or young adulthood but can begin in later adulthood. Individuals with binge-eating disorder who seek treatment usually are older than individuals with either bulimia nervosa or anorexia nervosa who seek treatment.

Remission rates in both natural course and treatment outcome studies are higher for binge-eating disorder than for bulimia nervosa or anorexia nervosa. Binge-eating disorder appears to be relatively persistent, and the course is comparable to that of bulimia nervosa in terms of severity and duration. Crossover from binge-eating disorder to other eating disorders is uncommon.

RISK AND PROGNOSTIC FACTORS

Genetic and physiological. Binge-eating disorder appears to run in families, which may reflect additive genetic influences.

CULTURE-RELATED DIAGNOSTIC ISSUES

Binge-eating disorder occurs with roughly similar frequencies in most industrialized countries, including the United States, Canada, many European countries, Australia, and New Zealand. In the United States, the prevalence of binge-eating disorder appears comparable among non-Latino whites, Latinos, Asians, and African Americans.

FUNCTIONAL CONSEQUENCES OF BINGE-EATING DISORDER

Binge-eating disorder is associated with a range of functional consequences, including social role adjustment problems, impaired health-related quality of life and life satisfaction, increased medical morbidity and mortality, and associated increased health care utilization compared with body mass index (BMI)-matched control subjects. It may also be associated with an increased risk for weight gain and the development of obesity.

DIFFERENTIAL DIAGNOSIS

Bulimia nervosa. Binge-eating disorder has recurrent binge eating in common with bulimia nervosa but differs from the latter disorder in some fundamental respects. In terms of clinical presentation, the recurrent inappropriate compensatory behavior (e.g. purging, driven exercise) seen in bulimia nervosa is absent in binge-eating disorder. Unlike individuals with bulimia nervosa, individuals with binge-eating disorder typically do not show marked or sustained dietary restriction designed to influence body weight and shape between binge-eating episodes. They may, however, report frequent attempts at dieting. Binge-eating disorder also differs from bulimia nervosa in terms of response to treatment. Rates of improvement are considerably higher among individuals with binge-eating disorder than among those with bulimia nervosa.

Obesity. Binge-eating disorder is associated with overweight and obesity but has several key features that are distinct from obesity. First, levels of overvaluation of body weight and shape are higher in obese individuals with the disorder than in those without the disorder. Second, rates of

psychiatric comorbidity are significantly higher among obese individuals with the disorder compared with those without the disorder. Third, the long-term successful outcome of evidence-based psychological treatment for binge-eating disorder can be contrasted with the absence of effective long-term treatments for obesity.

Bipolar and depressive disorders. Increases in appetite and weight gain are included in the criteria for major depressive episode and in the atypical features specifiers for depressive and bipolar disorders. Increased eating in the context of a major depressive episode may or may not be associated with loss of control. If the full criteria for both disorders are met, both diagnoses can be given. Binge eating and other symptoms of disordered eating are seen in association with bipolar disorder. If the full criteria for both disorders are met, both diagnoses should be given.

Borderline personality disorder. Binge eating is included in the impulsive behavior criterion that is part of the definition of borderline personality disorder. If the full criteria for both disorders are met, both diagnoses should be given.

COMORBIDITY

Binge-eating disorder is associated with significant psychiatric comorbidity that is comparable to that of bulimia nervosa or anorexia nervosa. The most common comorbid disorders are bipolar disorders, depressive disorders, anxiety disorders, and, to a lesser degree, substance use disorders. The psychiatric comorbidity is linked to the severity of binge eating and not to the degree of obesity.

OTHER SPECIFIED FEEDING OR EATING DISORDER

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 medical disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

UNSPECIFIED FEEDING OR EATING DISORDER

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 or 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).