

Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of feeding, eating and elimination disorders

In an interview with *Psychiatric News* in 2013, Timothy Walsh, chair of the American Psychiatric Association's Eating Disorders Work Group, said, "An enormous amount of research in the last several decades — more than 1,000 published papers — justifies the inclusion of binge eating disorder" in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). He added that its inclusion would "help to significantly decrease the use of eating disorder—not otherwise specified."

With this in mind, I would like to discuss the DSM-5's new conceptualization of feeding, eating and elimination disorders that places greater emphasis on observable, recurrent, quantifiable and persistent client behaviors.

Obesity

I begin with a discussion of obesity, the condition of being grossly fat or overweight that is calculated as a ratio of a person's height and weight wherein the body mass index is greater than 30.

As I travel the country providing DSM-5 trainings, a common question posed by attendees is "Why was obesity not included in the manual?" I assume some of you reading this article may share similar sentiments, especially considering that the DSM-5 defines a mental disorder as a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities" (p. 20).

Multiple mechanisms contribute to individuals' vulnerability to obesity, including genetic, developmental and environmental factors that are likely to interact in diverse ways to produce the behavioral phenotype of overeating. A growing body of evidence from epidemiologic and community samples has documented a relationship between obesity and psychiatric disorders, including mood and anxiety disorders, as well as personality disorders.

Moreover, developing evidence suggests a relationship between obesity and attention-deficit/hyperactivity disorder and posttraumatic stress disorder. Obesity also has a number of correlates in common with eating disorders and substance use disorders, including hypothalamic-pituitary-adrenal axis dysregulation and environmental precipitants such as childhood trauma. It further shares a number of symptomatic features with mood disorders, including increased appetite, decreased activity levels and sleep disturbance.

Even though obesity is linked to hypothalamic dysregulation, according to the DSM-5 obesity “results from 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” (p. 329).

It is important to understand that obesity’s pathophysiology (functional changes resulting in abnormal states) is not limited to the brain, the main body organ considered for mental disorders. The stomach, intestines, pancreas, liver, muscles and adipose tissues are involved in the etiology and maintenance of obesity. Most important, many hormonal mechanisms participate in the regulation of appetite and food intake, storage patterns of adipose tissue, rates of metabolism and development of insulin resistance.

Hence, by definition, obesity is a medical condition, not a psychological condition. For counselors working with clients whose overweight or obesity is a focus of clinical attention and who display nonadherence to medical treatment for this condition, you can use the code *278.00 Overweight or Obesity* found on page 725 of the DSM-5 under Other Conditions That May Be a Focus of Clinical Attention.

Pica and rumination disorder

Changes to phrasing of diagnostic criteria in the DSM-5 guide counselors in distinguishing eating behaviors that warrant a diagnosis of pica from behaviors that are developmentally normal, culturally supported or socially normative, or that support a diagnosis of a different mental disorder. Criterion A and B now include the words “nonfood substances,” and the DSM-IV-TR phrase “culturally sanctioned practice” was changed to “culturally supported or socially normative practice” in Criterion C.

Pica eating may be comorbid with a number of mental disorders, including intellectual development disorder (formerly called “mental retardation” in the DSM-IV-TR), autism spectrum disorder, schizophrenia and obsessive-compulsive disorder. In addition, pica eating can co-occur with trichotillomania (hair pulling) disorder and excoriation (skin picking) disorder when hair or skin is ingested. When nonnutritive substances are ingested to suppress appetite in the setting of anorexia nervosa, a pica diagnosis is not warranted.

Relatively minor changes occurred in the DSM-5’s phrasing of diagnostic criteria for rumination disorder. The word “re-chewing” was replaced with the phrase “regurgitated food may be re-chewed, re-swallowed or spit out.” In addition, Criterion B is new: “The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).”

Regurgitation and associated rumination may occur in the context of another mental disorder such as intellectual developmental disorder or generalized anxiety disorder. Rumination disorder is now mutually exclusive to binge eating disorder and avoidant/restrictive food intake disorder.

These changes are intended to improve clinical case formulation and comprehensive treatment planning by ensuring applicability across the age range and removing some ambiguity inherent in the prior phrasing. A diagnosis of rumination disorder is made only if the regurgitation and associated behaviors have features or consequences that warrant additional clinical attention.

Counselors should be aware that pica eating and rumination can occur in both children and adults. The disorders appear to be more prevalent in some populations yet frequently are not disclosed or detected. Clinical assessment to evaluate the presence of pica is advised when physical symptoms or abnormalities suggest that consumption of nonfood substances may be a contributing factor or when other clinical factors raise concern.

The structured Diagnostic Interview Schedule for Children can be used to assess pica in children. No validated assessments are available for adults. I suggest counselors use an empathic, nonjudgmental tone with child clients to avoid exacerbating their sense of shame or their unwillingness to disclose rumination or pica eating. Counselors should provide psychoeducation to parents that includes information about the potential medical consequences of these disorders.

Avoidant/restrictive food intake disorder

This disorder was previously titled “feeding disorder of infancy or early childhood” in DSM-IV-TR. It received a name change in the DSM-5 because avoidant or restrictive food intake symptoms manifest in children and adults. This disorder requires broad clinical assessment that includes dietary intake, a physical examination and laboratory testing to detect and measure significant weight loss, significant nutritional deficiency, dependence on enteral feeding or oral nutritional supplements, and marked interference with psychosocial functioning.

Unlike clients with anorexia nervosa, clients with avoidant/restrictive food intake disorder do not display a fear of gaining weight or becoming fat and do not manifest specific disturbances related to the perception and experience of their own body weight and shape.

Instead, this disorder may represent a conditioned negative response associated with food intake following, or in anticipation of, an aversive experience — for example, choking, traumatic ingestion or repeated vomiting. It may also be based on the sensory characteristics of food, such as appearance, color, smell, texture, temperature or taste.

The diagnosis should not be applied if the client’s inadequate food intake is related to the insufficient availability of food or to specific cultural practices involving food. Thus, parental underfeeding of infants should be excluded, as should normal dieting and fasting in relation to religious observances.

A 2010 article written by Rachel Bryant-Waugh and colleagues for the *International Journal of Eating Disorders* provides counselors with nine questions to assess and diagnose avoidant/restrictive food intake disorder:

- 1) What is current food intake? This ascertains whether the current intake represents an adequate, age-appropriate amount or range (is the diet sufficient in terms of energy, and does it include major food groups and essential micronutrients?).
- 2) Is diet supplemented by oral nutritional supplements or enteral feeding? This helps ascertain whether the individual is dependent on these other means of feeding.
- 3) Is the avoidance or restriction persistent? This helps determine whether the condition is an established rather than transient problem.
- 4) What are the individual's weight and height? This allows calculation of body mass index or body mass index percentile, comparison of the individual's previous weight and height percentiles, assessment of whether growth is faltering and whether weight has been lost or is static when it should be increasing.
- 5) Does the individual present with clinical or laboratory signs and symptoms of nutritional deficiency or malnutrition? For example, is there lethargy secondary to iron deficiency anemia or delayed bone age as a consequence of chronic restricted intake?
- 6) Is there evidence of any significant distress or impairment to the individual's social and emotional development or functioning associated with the eating disturbance?
- 7) Is the avoidance or restriction associated with a lack of interest in food or eating, or a failure to recognize hunger?
- 8) Is the avoidance or restriction based on sensory aspects of food such as appearance (including color), taste, texture, smell or temperature?
- 9) Does the avoidance or restriction follow an aversive experience associated with intense distress, such as a choking incident, an episode of vomiting or diarrhea, or complications from a medical procedure such as an esophagoscopy?

Anorexia nervosa

In the DSM-5, Criterion A focuses on behaviors, such as restricting calorie intake, and no longer includes the word "refusal" in terms of weight maintenance because that implies intention on the part of the client and can be difficult to assess.

Removed from the DSM-5 is a previous criterion that made amenorrhea (the absence of at least three menstrual cycles) core to diagnosing anorexia nervosa. Amenorrhea has proved difficult or impossible to apply to several groups that are nonetheless susceptible to anorexia nervosa, including premenarcheal girls, women taking exogenous hormones, postmenopausal women and males.

Additionally, although amenorrhea is commonly described in adolescents and young women who are low in weight, studies have not identified consistent differences in the

percentage of expected weight or percentage of body fat among those menstruating regularly and those manifesting amenorrhea. Furthermore, while amenorrhea often occurs following a reduction in body weight and body fat, it precedes weight loss in approximately 20 percent of individuals with anorexia nervosa.

Additional changes to anorexia nervosa in the DSM-5 include wording clarity; guidance for diagnosing children, adolescents and adults; and the inclusion of new remission specifiers and severity specifiers (i.e., mild, moderate, severe, extreme) based on the World Health Organization's body mass index for adults and body mass index percentile for children and adolescents (see DSM-5 page 339). The restricting type and binge eating/purging type descriptive specifiers are retained in the DSM-5.

Bulimia nervosa and binge eating disorder

In the DSM-IV-TR, binge eating — defined as uncontrolled binge eating without emesis or laxative abuse — was not recognized as a disorder. Instead, it was described in Appendix B: Criteria Sets and Axes Provided for Further Study and was diagnosable using only the catch-all category “eating disorder not otherwise specified” (EDNOS).

To reduce the excessive use of EDNOS, the required frequency and duration of disordered eating and compensatory behaviors in bulimia nervosa and binge eating disorder are reduced from twice weekly to once per week and from six months to three months, respectively, in the DSM-5. Both disorders share partial and full remission specifiers and new severity specifiers based on the number of disordered eating episodes, ranging from one episode per week (mild) to 14-plus episodes per week (extreme).

Many factors justify the “upgrading” of binge eating disorder in the DSM-5. Epidemiological findings indicate that binge eating disorder is the most common eating disorder, previously accounting for two-thirds of EDNOS prevalence rates.

The disorder is also associated with clinically significant impairments in life satisfaction, health-related quality of life and overall functioning, as well as specific conditions such as insomnia, early menarche, neck/shoulder and lower back pain, chronic muscle pain and metabolic disorders.

Finally, regardless of weight status, individuals with binge eating disorder are more likely than individuals without the disorder to exhibit psychiatric comorbidities, including major depressive disorder, generalized anxiety disorder and panic attacks.

Importantly, the binge eating disorder diagnosis also conveys information about response to treatment. For instance, a number of studies indicate that individuals with the disorder benefit more from specialized psychological treatments than from generic behavioral weight-loss interventions.

Enuresis and encopresis

These disorders are unchanged in the DSM-5. For counselors working with encopresis, I strongly recommend Bettina Shapira and Penny Dahlen's article on a treatment protocol for enuresis using an alarm published in the Spring 2010 Journal of Counseling & Development.

Latest research

This past year in the Journal of Abnormal Psychology, Karina Allen and colleagues published an article on the prevalence, stability and psychosocial correlates of eating disorders in a population-based sample of male and female adolescents. They discovered that eating disorder prevalence rates were significantly greater when using DSM-5 criteria versus DSM-IV-TR criteria at all time points for females and at age 17 only for males.

"Unspecified/other" eating disorder diagnoses were significantly less common when applying DSM-5 criteria, but they still formed 15-30 percent of the DSM-5 cases.

Also in a 2013 issue of the Journal of Abnormal Psychology, Eric Stice and colleagues reported results from an eight-year prospective community study of young women. They found that the new DSM-5 eating disorder criteria capture clinically significant psychopathology and usefully assign individuals with eating disorders to homogeneous diagnostic categories.

Case study

Lawanda, a 52-year-old single woman with morbid obesity presents with complaints of fatigue, difficulty losing weight, and no motivation. She notes a marked decrease in her energy level, particularly in the afternoons. She is tearful and states that she was diagnosed with depression (multiple episodes since age 13, with no suicide ideation) and prescribed an antidepressant that she chose not to take.

Lawanda reported gaining an enormous amount of weight during the past six years, and she is presently at the highest weight she has ever been – 243 pounds with a BMI of 41. She states that every time she tries to cut down on her eating she has symptoms of shakiness and increased hunger. She does not follow any specific diet, refuse medical treatment, and has been so fearful of hypoglycemia that she often eats extra snacks.

Lawanda's health care practitioners have repeatedly advised weight loss and exercise to improve her health status. She complains that the pain in her knees and ankles makes it difficult to do any exercise. Lawanda further annotated that neighborhood children verbally taunt and tease her when she goes outside to get the mail – resulting in elevated depressive mood states, feeling keyed up or tense, and feeling unusually restless.

At intake, Lawanda completed the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), the 36-item version, self-administered World Health Organization Disability Assessment Schedule 2.0, and the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult.

Putting together all relevant information obtained from psychological testing, mental status examination, and a biopsychosocial, the following DSM-5 diagnosis is warranted:

- 296.32 Moderate Major Depressive Disorder, Recurrent, With Anxious Distress
- Mild-moderate disability (score of 87 per self-administered WHODAS 2.0)
- 278.00 Overweight of Obesity (nonadherence to medical treatment)
- V62.4 Social Exclusion or Rejection (per teasing and intimidation by others regarding obesity)
- Emerging Avoidant Personality Disorder features (per results from MMPI-2)

Until next month, be well!

Bio

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