The Expansion and Clarification of Feeding and Eating Disorders in the *DSM-5*

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) introduced a chapter titled "Feeding and Eating Disorders," which takes a life-span approach to diagnosing eating disorders and contains all related diagnoses. Rather than appearing throughout the text, all eating disorders are now contained within their own chapter for ease of review and comparison. Changes to the feeding and eating disorders include diagnostic revisions and the addition of several new disorders, including avoidant/restrictive food intake disorder and binge-eating disorder. While pica and rumination disorder remain unchanged, anorexia nervosa and bulimia nervosa experience some criteria changes. There is now a system for classifying the severity of several eating disorders (mild, moderate and severe) and an emphasis on body mass index for the diagnosis of anorexia nervosa. The *DSM-5* also attempted to address the number of cases of eating disorders that did not meet criteria in any one category (e.g., eating disorder not otherwise specified), and the authors discuss the result of this attempt in examining two new disorders. This paper examines these changes and addresses clinical implications, while alerting counselors to important diagnostic information.

Keywords: **eating disorders, *DSM-5*, pica, anorexia nervosa, bulimia nervosa, binge eating**

With the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013a) in May 2013 came structural changes to the categorization of disorders as well as criteria changes to a variety of disorders. One diagnostic category that experienced multiple changes is eating disorders. As stated in the *DSM-5*, "feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (APA, 2013a, p. 329). Previously spread throughout several chapters in the *DSM*, these disorders are now self-contained in a single, more comprehensive chapter titled "Feeding and Eating Disorders." This revised diagnostic category includes several new disorders and reflects changes to the criteria and wording of some existing diagnoses. While some of the changes are minor, all are noteworthy (Hartmann, Becker, Hampton, & Bryant-Waugh, 2012) and warrant examination. This article seeks to highlight the changes to this category and assist counselors in a greater understanding of these updated diagnoses.

Prevalence of Eating Disorders

One study by Hudson, Hiripi, Pope, and Kessler (2007) used data from the National Comorbidity Survey Replication to generate estimates of the prevalence of anorexia nervosa (AN), bulimia nervosa (BN) and binge-eating disorder (BED) among adults in the United States. The researchers based these estimates on the criteria found in the *DSM-IV* (Hudson et al., 2007). The authors report the following lifetime prevalence rates for

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AN, BN and BED, respectively: 0.9% among females and 0.3% among males, 1.5% among females and 0.5% among males, and 3.5% among females and 2.0% among males (Hudson et al., 2007). Of note is that BED, a new diagnosis in the *DSM-5* (but one for which criteria appeared in the appendices of *DSM-IV-TR*), is by far the most prevalent of these three eating disorders. Also worth noting is the fact that the statistics for women, specifically for women under age 20, indicate that eating disorders are common among this subset of the population; young women appear to be afflicted at dramatically higher rates than the population at large. Using the *DSM-5* criteria, Stice, Marti, and Rohde (2013) found a lifetime prevalence of 13.1% among this population, concluding that "one in eight young women" (p. 455) will have some form of diagnosable eating disorder.

Not represented in the figures above is the fact that in the past, the most common eating disorder diagnosis has been the *DSM-IV* and the *DSM-IV-TR* category *eating disorder not otherwise specified* (EDNOS; Fairburn & Cooper, 2011; Machado, Gonçalves, & Hoek, 2013). EDNOS cases may represent as many as 60% of eating disorder diagnoses (Fairburn et al., 2007). As Smink, van Hoeken, and Hoek (2012) pointed out, a "major goal" (p. 407) of the revisions reflected among eating disorders in *DSM-5* was to decrease significantly the number of EDNOS or unspecified diagnoses. The addition of BED and the changes to AN and BN (which resulted in generally less stringent criteria) reflect this aim (Smink et al., 2012). Studies concluded that the *DSM-5* criteria will, in fact, reduce the number of EDNOS diagnoses considerably (Allen, Byrne, Oddy, & Crosby, 2013; Fairburn & Cooper, 2011; Machado et al., 2013). The authors in all three studies determined, however, that the number of cases that will not meet the revised *DSM-5* criteria for AN, BN or BED is still sizable (Allen et al., 2013; Fairburn & Cooper, 2011; Machado et al., 2013).

While the prevalence of AN and BN are reasonably well established, the *DSM-5* cites the prevalence of pica as unclear (APA, 2013a). It is predominantly recognized among children, most notably those with intellectual disabilities (Mash & Wolfe, 2013); pregnant women (Geissler, Mwaniki, Thiong'o, & Friis, 1998; Khan et al., 2009); adults with iron deficiency (Moore & Sears, 1994); and institutionalized persons (McAlpine & Singh, 1986). The prevalence of rumination disorder is also inconclusive, but believed to be higher in individuals with intellectual disabilities than the general population (APA, 2013a). Similarly, there are no reported prevalence rates for avoidant/restrictive food intake disorder (APA, 2013a).

Overview of Changes in *DSM-5*

Before the current edition of the *DSM*, feeding and eating disorders were in two main sections of the manual: (1) Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence and (2) Eating Disorders (APA, 2013a). The former no longer appears in the *DSM-5*. With the removal of a separate section describing disorders that were most likely to occur in childhood or adolescence, the *DSM-5* now contains chapters for each diagnostic category, which include both disorders that may first manifest during youth and others that may not surface until adulthood. In line with one objective of the *DSM-5*, the placement of eating and feeding disorders in their own chapter ensures that diagnoses are applicable across the life span (Bryant-Waugh & Kreipe, 2012), and helps bring attention to the development and presentation of symptoms at various points in the life span; this reflects what some refer to as the *age and stage approach* (Bryant-Waugh, 2013). The childhood section that was removed had previously contained several eating disorders (e.g., pica and rumination). The new chapter in the *DSM-5* now contains eight eating disorders (APA, 2013a), including several new disorders, among which are avoidant/restrictive food intake disorder (which replaces, but significantly expands on, feeding disorder of infancy or early childhood) and BED. The diagnoses of *other specified feeding or eating disorders* and *unspecified feeding or eating disorders* are new and replace the diagnosis of EDNOS. The already existing disorders of pica, rumination disorder, AN and BN reflect some minor changes as well. While many feeding and eating disorders share symptoms or behaviors, it is important to note that an individual can receive only

one diagnosis (Dailey et al., 2014). The feeding and eating disorders diagnostic criteria are mutually exclusive, meaning that if a client is diagnosed with one disorder in this chapter, the client cannot be diagnosed with another (with pica as the only exception). The *DSM-5* wants to ensure differentiation of each disorder and help counselors plan treatment that targets the unique features of a disorder (APA, 2013a). See Table 1 for a review of *DSM-IV-TR* and *DSM-5* classification of eating disorders.

Table 1

Past and Current Feeding and Eating Disorder Diagnoses

DSM- IV-TR	*DSM-5*
Pica	Pica
Rumination Disorder	Rumination Disorder
Feeding Disorder of Infancy or Early Childhood	Avoidant/Restrictive Food Intake Disorder
Anorexia Nervosa	Anorexia Nervosa
Bulimia Nervosa	Bulimia Nervosa
	Binge-Eating Disorder
Eating Disorder Not Otherwise Specified (EDNOS)	Other Specified Feeding or Eating Disorder
	Unspecified Feeding or Eating Disorder

Specific Changes to Eating Disorder Diagnoses

Pica and Rumination Disorder

Pica and rumination disorder are two eating disorders that often receive less clinical attention from counselors than other eating disorders. This is probably due to the fact that these disorders are likely to be observed in institutionalized settings, and that treatment may necessitate the expertise of behavioral analysts or therapists highly trained in working with developmental disabilities (Williams & McAdam, 2012). Only the locations of pica and rumination have changed in the *DSM-5*: These disorders now appear in the chapter on feeding and eating disorders. With this change, these diagnoses are now applicable to individuals across the life span. The criteria for these disorders did not change.

Pica is the ingestion of non-nutritive substances (e.g., hair, chalk, paint chips) over at least a one-month period. Availability and the age of the affected individual often determine what substances a person will consume (Hartmann et al., 2012). Some reports have included individuals eating paper, tissues, wood, metal, small rocks, carpet and soap (Matson, Belva, Hattier, & Matson, 2011). The eating of these non-food substances is deemed to be inappropriate to the developmental level of the individual and is not part of a cultural or socially accepted practice (APA, 2013a). Generally, clinicians see this disorder in children with intellectual disabilities (Mash & Wolfe, 2013). However, the fourth criterion of the diagnosis notes that if this condition does occur within the context of a developmental or intellectual disability, it should be sufficiently severe to warrant clinical attention.

Children with pica eat normal foods as well as non-nutritive foods. In most cases, the disorder remits on its own, or will cease with improved environmental conditions or added infant stimulation (Mash & Wolfe, 2013). One common thought is that this disorder presents in children who do not have sufficiently stimulating environments. Hartmann et al. (2012) reported that some clinicians regard pica as a form of self-soothing behavior, employed when one's arousal reaches a certain level. However, for children with intellectual

disabilities, it may be life-threatening (Matson et al., 2011). Ingestion of metal or other items with high toxicity pose a threat to the developing child (Hartmann et al., 2012). There are multiple treatments available for such individuals including punishment, overcorrection, restraint, positive reinforcement, psychopharmacology and time out (Matson et al., 2013). There is some literature that discusses the presence of pica in pregnant women, which may cause lead poisoning or other health issues for the developing fetus (Thihalolipavan, Candalla, & Ehrlich, 2013).

There were no major changes to the diagnosis of rumination disorder in the *DSM-5*. Rumination disorder is repeated regurgitation (e.g., spewing up or spitting up of food) for a period of at least one month (APA, 2013a). This regurgitation of food is not attributable to any related medical or gastrointestinal condition. Thus, the regurgitation is voluntary and distinguished from vomiting or gastroesophageal reflux. Similar to pica, the fourth criterion of this diagnosis notes that if this condition does occur within the context of a developmental or intellectual disability, it is sufficiently severe to warrant clinical attention. Some individuals with rumination disorder appear to engage in the behavior for self-soothing effects, while for others it is habitual and a difficult behavior to reduce (Hartmann et al., 2012). Certainly, this disorder reduces the social functioning of an individual, as it is a socially undesirable behavior.

The *DSM-5* reports that both pica and rumination disorder are generally first observable in infancy, but onset can occur in childhood, adolescence or adulthood. Another commonality of these diagnoses in *DSM-5* is that they both now have a specifier of *in remission*. This is reserved for individuals who may have previously met the criteria of the disorder, but have not "for a sustained period of time" (APA, 2013a, p. 330). Additionally, pica and rumination disorder are concurrently diagnosable. Another commonality of these disorders is that they often occur in secret and are difficult to detect (Hartmann et al., 2012). Individuals are not likely to disclose their engagement in these behaviors. For young children, parental report is critical in assessment.

Avoidant Restrictive Food Intake Disorder

An interesting addition to the *DSM-5* is the diagnosis of avoidant restrictive food intake disorder (ARFID). The essence of this disorder is a disturbance in eating or feeding characterized by inadequate food intake (Bryant-Waugh & Kreipe, 2012). This inadequacy may mean that the individual does not meet necessary energy intake needs for the day (i.e., by consuming too few calories from food), or has an insufficient nutritional diet, or both. This disorder replaces feeding disorder of infancy or early childhood, but also adds significant new criteria. As Kreipe and Palomaki (2012) stated, "Although it has somewhat awkward phrasing, the name captures the key clinical features of non-eating disorder eating disturbances: avoiding (not necessarily 'refusing') foods for a variety of reasons, and restricting intake in the amount and/or range of foods eaten" (p. 428). In the *DSM-IV-TR* (APA, 2000), feeding disorder of infancy or early childhood primarily emphasized the child's persistent failure to eat adequately, with significant failure to gain weight or significant loss of weight over at least one month. The primary symptom was a disturbance in eating or feeding not attributable to an associated medical or gastrointestinal condition, and the disorder was required to have an onset before six years of age. With the addition of ARFID, those criteria remain the same, but there is the additive criterion of significant nutritional deficiency, and dependence on enteral feeding (i.e., tube feeding) or oral nutritional supplements. The diagnosis is more specific in stating that the eating or feeding disturbance may be related to the sensory characteristics of food or a concern about aversive consequences of eating (e.g., nausea). The second criterion (a new addition) also mentions that a lack of available food or an associated, culturally sanctioned practice cannot account for the disturbance. The other criteria remain the same (e.g., ARFID cannot occur during the course of AN or BN; the condition cannot be related to a medical condition). It is, however, likely to co-occur with autism spectrum disorder or other neurodevelopmental disorders. Similar to other disorders in the *DSM-5*, one can apply *in remission* here if the individual previously met the full criteria for the disorder, but now has not met these criteria for a sustained period.

Sometimes the individual with ARFID restricts certain foods, and at other times, there is an inadequate intake of vitamins and minerals. The inadequacy of energy intake may result in a child's poor growth, weight loss or low weight. In their study on picky eating among children, Jacobi, Schmitz, and Agras (2008) pointed out that the longer the duration of the pickiness, the more avoidant the child becomes to trying new foods. However, children with ARFID are more than just picky eaters, as they suffer from failure to meet nutritional and/or energy needs that may result in weight loss. As the criteria imply, some of these individuals must rely on enteral feeding.

The clinical presentation of ARFID is quite variable (Bryant-Waugh & Kreipe, 2012). Over time, there may be evidence that subgroups of the disorder are present, requiring further classification. Bryant-Waugh and Kreipe (2012) describe several presentations that include some of the ARFID symptoms. For example, some children (and some adults) eat only certain-colored foods or foods with a particular texture, thus ingesting only a narrow range of foods. Others may avoid certain foods based on past negative experiences with them, usually gastrointestinal problems. While there is no specific assessment for ARFID, careful clinical interviewing, including parental observations and a medical evaluation, are necessary for diagnosis. Because ARFID and AN share many common symptoms in childhood and young adulthood (e.g., low weight, food avoidance), differential diagnosis may be difficult (APA, 2013a). The *DSM-5* reminds counselors that in AN, the individual has a persistent fear of becoming fat and/or gaining weight, which is not present in ARFID. We refer readers to Bryant-Waugh (2013) for a case study of a child with ARFID, including assessment questions and treatment.

Anorexia Nervosa

The *DSM-5* diagnostic criteria for AN reflect several significant changes from the criteria outlined in *DSM-IV-TR*. There are two particularly noteworthy changes to the first criterion for an AN diagnosis in *DSM-5*. The first of these is that what was described as "refusal to maintain body weight" in the *DSM-IV-TR* (APA, 2000, p. 589) has been reframed as "restriction of energy intake relative to requirements" in the *DSM-5* (APA, 2013a, p. 338). The removal of the word *refusal*, which has negative connotations, results in a more neutrally worded criterion. Moreover, the new phrasing of this criterion in *DSM-5* focuses specifically on the central behavioral component of AN (i.e., restriction of intake), rather than upon the results of this behavior (i.e., body weight).

The second key change to this first criterion is that the specific guideline provided in *DSM-IV-TR* as a definition of a less than "minimally normal" body weight (i.e., below "85% of that expected"; APA, 2000, p. 589) no longer appears in the *DSM-5*. The new criterion instead highlights the essential role of context (e.g., age, sex, developmental status) in determining whether a particular individual is at a "significantly low weight" for his or her own body (APA, 2013a, p. 338). This change is particularly important because, while the *DSM-IV-TR* clarifies that 85% is intended as a guideline, once incorporated into the criteria, it became in many cases a requirement for insurance reimbursement (Hebebrand & Bulik, 2011).

The second criterion for AN previously included only the cognitive symptom of "intense fear of gaining weight or becoming fat" (APA, 2000, p. 589). That same language appears in the *DSM-5*, but the new criterion includes a behavioral component as well. Moreover, because the word *or* is used rather than *and*, the behavioral manifestation of this criterion can actually stand in for other, more overt expressions of the cognitive component. In other words, according to the *DSM-5*, an individual engaging in "persistent behavior that interferes with weight gain" (APA, 2013a, p. 338) can now meet this second criterion even if he or she does not explicitly communicate anxiety around weight gain. This change may have particular relevance in pediatric cases, because some children with AN have not yet developed the cognitive abilities required either to have or to express this intense fear (Bravender et al., 2010; Reierson & Houlihan, 2008; Workgroup for Classification of Eating Disorders in Children and Adolescents, 2007).

The third criterion in the *DSM-5* is very similar to that of the previous edition, aside from one notable distinction. In the new *DSM*, the phrase "persistent lack of recognition" (APA, 2013a, p. 339) replaces "denial" (APA, 2000, p. 589) in describing the anorexic individual's perspective on the risks posed by his or her underweight status. As with the change to criterion one, the result of this rewording is more value-neutral (like *refusal*, the word *denial* has negative connotations). The resulting criterion may also be more accurate, in that the focus is on an inability of the anorexic individual to recognize the inherent dangers of his or her condition, rather than a conscious repudiation of the truth.

Although these small linguistic changes may not seem especially significant, the outcome is a set of criteria that is, on the whole, less stigmatizing. This is important because research indicates that many clinicians have negative biases toward individuals with eating disorders. This may be especially true in the case of those with AN, and the stigma appears to impact the availability of quality treatment for the disorder (Thompson-Brenner, Satir, Franko, & Herzog, 2012).

The fourth criterion for AN, which appears in the previous edition, was removed altogether from the *DSM-5*, so that there are now only three criteria for a diagnosis of AN. This previous criterion, amenorrhea (the cessation of menstruation), applied only to females who had achieved menarche (APA, 2000). By definition, then, this criterion inherently excluded all males, as well as pre-pubertal and post-menopausal females. Also excluded were females taking hormonal contraceptives (APA, 2013b). The removal of amenorrhea therefore results in a more inclusive set of criteria, reflective of the APA's (2013a) stated goal of avoiding "overly narrow" diagnostic categories (p. 12), which in the past have contributed to an excess of EDNOS diagnoses (Fairburn & Cooper, 2011; Machado et al., 2013).

As in the *DSM-IV-TR*, the criteria for AN in the *DSM-5* include specifiers of *restricting* or *binge-eating/purging* types (APA, 2000, 2013a). The language in the new edition is similar to that of the previous edition, but clarifies that the specifier applies to the last 3 months (APA, 2013a), rather than the *DSM-IV-TR*'s more vaguely stated "current episode" (APA, 2000, p. 589). This change is relevant because the empirical evidence indicates that crossover between subtypes is frequent (Eddy et al., 2008). The *DSM-5* reflects this research, and the text in the manual cautions that because such crossover occurs, "subtype description should be used to describe current symptoms rather than longitudinal course" (APA, 2013a, p. 339). It may be worth noting that some in the field have concluded that these diagnostic subtypes of AN are not actually clinically relevant (e.g., Eddy et al., 2008), although clearly the *DSM-5* does not reflect this thinking.

Like other disorders in the *DSM-5*, the diagnostic criteria for AN now include additional specifiers regarding remission status (*partial* or *full*) and severity (APA, 2013a). The remission specifier may be especially useful for clinicians working with individuals with eating disorders, AN in particular. For example, with regard to the weight criterion, an individual who reaches "normal" weight will no longer meet the full criteria for an AN diagnosis, but may still be struggling with other key components of the disorder (e.g., intense fear of weight gain). Such a scenario may be particularly likely with this disorder, especially because a change in weight status can be the result of outside intervention rather than internal motivation (Nicholls, Lynn, & Viner, 2011).

Finally, the *DSM-5* includes a severity specifier that uses the individual's body mass index (BMI). There are three levels of severity: extreme (BMI < 15 kg/m^2), severe (BMI 15–15.99 kg/m^2), moderate (BMI 16–16.99 kg/m^2) and mild (BMI ≥ 17 kg/m^2). As the manual states, the ranges are from the World Health Organization categories for thinness in adults. For children and adolescents, clinicians are encouraged to use the BMI percentiles. These levels of severity help indicate the clinical symptoms, the potential need for supervision and the degree of functional disability (APA, 2013a).

Bulimia Nervosa

The diagnosis of BN remains largely the same in the *DSM-5*, although there are some modifications to the criteria. BN is characterized by repeated, uncontrollable binge-eating episodes (criterion A) accompanied by ongoing compensatory behaviors to avoid weight gain (criterion B). These behaviors to avoid weight gain include "self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise" (APA, 2013a, p. 345). The *DSM-5* brings no changes to these first two criteria from the *DSM-IV-TR*. Also unchanged in the new edition is the fourth criterion, the following key cognitive symptom: "self-evaluation is unduly influenced by body shape and weight" (APA, 2013a, p. 345).

The major change to BN in the *DSM-5* is in criterion C, the frequency of the compensatory behaviors required for diagnosis. In the *DSM-5*, this frequency has been reduced from an average of twice weekly to an average of only once per week. The required duration of these behaviors, however, remains the same in *DSM-5*: three months. Research indicates that individuals who display these behaviors at this new, lower threshold of once per week experience similar levels of pathology and distress (Wilson & Sysko, 2009). This decrease in frequency is likely to result in more diagnoses of BN; as stated, "increased prevalence rates are the result of a general lowering of diagnostic thresholds for eating disorders" (Dailey et al., 2014, p. 180).

A secondary change to the BN criteria is the removal of the specifier regarding *purging* and *nonpurging* types of BN (APA, 2000). In the past, these specifiers described the type of compensatory behavior used by the individual. In the *DSM-5*, the criterion for compensatory behavior includes both types, so no further specifier is necessary. This change reflects the research indicating that many individuals with BN regularly engage in both purging and nonpurging compensatory behaviors, making this specifier insignificant (Ekeroth, Clinton, Norring, & Birgegård, 2013; Vaz, Peñas, Ramos, López-Ibor, & Guisado, 2001).

BN, like the other disorders in the *DSM-5*, now has severity specifiers. For this diagnosis, the assessment of severity depends upon the frequency of inappropriate compensatory behaviors (e.g., the average number of times an individual purges in a given week). Depending on the frequency of compensatory behaviors per week, a case may be categorized as one the following: *mild* (1–3 episodes), *moderate* (4–7 episodes), *severe* (8–13 episodes) or *extreme* (14 or more episodes) (APA, 2013a). Finally, as with other disorders in the *DSM-5*, clinicians can apply the specifiers of *partial* or *full remission* to BN.

Binge-Eating Disorder

The diagnosis of BED is new to the *DSM-5*. First mentioned in the *DSM-IV* (Striegel-Moore & Franko, 2008), the disorder appeared in that edition and the subsequent text revision under EDNOS, with research criteria outlined in the appendices (APA, 2000). With the publication of the *DSM-5*, BED was promoted from "criteria sets . . . for further study" (APA, 2000, p. 759) to being a full-fledged diagnosis. This addition is highly significant because BED is likely to be the most prevalent eating disorder (Striegel-Moore & Franko, 2008).

BED shares the binge-eating criterion of BN (i.e., consuming an objectively large quantity of food in a relatively short time while experiencing a loss of control). The disorder differs from BN, however, in that individuals with BED do not engage in compensatory behaviors (e.g., vomiting or laxative use) after binge eating. An additional distinction is that BED does not include a key cognitive criterion necessary for a diagnosis of BN—the undue influence of weight and shape on self-concept (APA, 2013a).

The second criterion for BED describes behaviors, emotions and cognitions associated with binge eating. The criterion includes five items and specifies that individuals must display a minimum of three to qualify for diagnosis. Examples are eating in the absence of physical hunger, eating unusually quickly and experiencing

feelings of guilt and disgust around eating. Although a diagnosis of BN does require the presence of binge eating, that diagnosis does not include these additional criteria.

As is the case with other eating disorders, the diagnostic criteria for BED in the *DSM-5* reflect reduced requirements for duration and frequency. Whereas the research criteria in the *DSM-IV-TR* specified that bingeing must take place at least two days a week for six months (APA, 2000), the *DSM-5* diagnostic criterion is that binge eating must occur an average of once per week, for a minimum of three months (APA, 2013a). In the *DSM-5*, frequency is measured in times—rather than days—per week (for discussion, see *DSM-IV-TR* Appendix B, APA, 2000). In keeping with the other eating disorders, *DSM-5* includes a severity specifier for BED, with, for example, between one and three episodes per week constituting *mild* BED, and 14 or more episodes per week qualifying as *extreme* (APA, 2013a). The addition of this severity rating is very helpful, as it will allow clinicians to determine the seriousness of the individual's disorder in order to assist in treatment planning. Clinicians should also now specify whether an individual is in partial or full remission from BED.

Obesity

The introduction to the chapter on feeding and eating disorders explicitly addresses the decision not to include obesity as a diagnosis in the *DSM-5*. This statement outlines the reasons that obesity itself does not constitute 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" (APA, 2013a, p. 329). In other words, obesity is a physical condition caused by a number of contributing factors and is not, therefore, simply the embodiment of a psychological state. The introduction goes on to clarify, however, that there exist complex relationships between obesity and several psychiatric conditions. This section also refers to the connection between obesity and medications used to treat mental disorders (APA, 2013a).

One of the disorders described by the *DSM-5* as having a "robust association" with obesity is BED (APA, 2013a, p. 329). The relationship between obesity and BED is complicated. The manual specifies, on the one hand, that while some obese individuals suffer from BED, the majority do not. Moreover, individuals with BED are not necessarily obese; they may be overweight, or their weight may fall in the normal range (Striegel-Moore & Franko, 2008). On the other hand, obesity is a risk factor for BED (Decaluwé & Braet, 2003), and "the risk of presenting with BED increases with increasing obesity" (Hill, 2007, p. 151). One might assume that binge eating would precede obesity, but the relationship appears to move in the opposite direction (Decaluwé & Braet, 2003). Obesity also is a risk factor for the development of BN (Decaluwé & Braet, 2003; Hill, 2007).

Other Specified Feeding or Eating Disorder and Unspecified Feeding or Eating Disorder

Whereas the *DSM-IV-TR* contained the catchall diagnostic category of EDNOS, this category no longer appears in the *DSM-5*. The EDNOS category previously was reserved for individuals who did not meet the full criteria for an eating disorder (e.g., a woman who meets all criteria for AN except that she has regular menses). It has been reported that this diagnosis was overly used by practitioners (Bryant-Waugh & Kreipe, 2012), so the changes in the *DSM-5* attempt to address this problem. The literature indicates that many individuals who were being treated for an eating disorder received this diagnosis because they did not meet the stringent criteria for AN or BN (e.g., Sysko & Walsh, 2011). As mentioned previously, researchers have reported that EDNOS represented as many as 60% of all eating disorder diagnoses (Fairburn et al., 2007).

In the *DSM-5*, two new diagnostic categories replace EDNOS: other specified feeding or eating disorder and unspecified feeding or eating disorder. Other specified feeding or eating disorder refers to individuals who present symptoms characteristic of a feeding or eating disorder that causes clinically significant impairment, but

does not meet the full criteria for any of the disorders in this section. However, when applying this diagnosis, the clinician is able to specify or state the specific reason that the presentation does not meet the full criteria. Thus, the specific reason should follow the diagnosis. An example of this diagnosis would be BN (of low frequency and/or limited duration). In this example, the individual meets all of the criteria of BN except that the inappropriate compensatory behavior and binge eating occur at a frequency less than once a week and/or for less than 3 months.

This diagnosis presents a contrast with another new diagnosis, unspecified feeding or eating disorder. In using this designation, the clinician is unable to provide the specific reason why the clinical presentation does not meet full criteria. This may be because of insufficient information from the client, such as may occur when a client obtains treatment in an emergency setting or a clinician fails to gather enough information during intake. In these cases, the client displays symptoms of an eating or feeding disorder that is causing clinically significant impairment, but does not meet the full criteria for any disorder.

Implications for Counselors

Given the prevalence of some eating disorders, as well as their presence across the life span, counselors will likely encounter individuals suffering from a diagnosable eating disorder at some point in their career. In fact, research suggests that *DSM-5* criteria will result in a rise in the prevalence of diagnosable eating disorders (Allen et al., 2013). This prediction underscores the importance of those in the counseling profession becoming well-informed regarding these revised criteria. New, broader criteria, when implemented by well-informed professionals, will likely increase the chances that a greater portion of the individuals suffering from these disorders will receive the help they need.

Feeding and eating disorders appear to exist on a continuum, with some related behaviors frequently occurring in the population at large. The skilled counselor will be able to differentiate between behaviors that would not be considered pathological (e.g., overeating or typical "dieting"), or are developmentally appropriate (e.g., picky eating), and those that are indicative of greater dysfunction (e.g., binge eating, dramatically restricting calories). Counselors should be aware, however, that clients with eating disorders may not be forthcoming about their symptoms, hide their behaviors and display resistance to seeking help (Abbate-Daga, Amianto, Delsedime, De-Bacco, & Fassino, 2013). Also, many individuals who are at risk for developing eating disorders or who have them may never seek help (Dailey et al., 2014). In addition, full recovery from eating disorders is the outcome in only about 50% of cases, while 20% of individuals make no improvement (Schlozman, 2002). Thus, many individuals have a lifelong battle with eating disorders and relapse is common. It is critical, therefore, that counselors screen all clients for potential eating disorders. Careful assessment of the client's underlying thoughts, symptom presentation and impairment will help counselors make a correct diagnosis.

Eating disorders can be damaging to one's physical well-being, emotional health and interpersonal relationships (Dailey et al., 2014). These factors, coupled with the possible medical consequences and potential fatality of some eating disorders, highlight the need for counselors who work with these clients to have specialized training. If a counselor does not have the appropriate background in eating disorders, it is vital that he or she refer the client to an eating disorders specialist. Moreover, individuals with eating disorders must consult a physician for a comprehensive physical assessment and intervention (Piran, 2013). Given the complexity of the symptom presentation, treatment is likely to involve a multidisciplinary team approach for treatment of eating disorders (Dailey et al., 2014) and counselors would be wise to familiarize themselves with treatment resources in their community.

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