A long with changes to the formally recognized eating disorders, the Diagnostic and Statistical Manual, Fifth Edition Eating Disorder Work Group has recommended that the DSM-IV eating disorder not otherwise specified category be renamed: Feeding and eating conditions not elsewhere classified.

This change reflects the inclusion of childhood feeding disorders within the eating disorder classification scheme, as well as the focus on reducing the ambiguous and “catch-all” nature of eating disorder not otherwise specified (EDNOS). While there is not currently enough rigorous sci-

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cientific evidence to categorize the proposed conditions as disorders, a diagnosis of not elsewhere classified (NEC) is warranted if the individual has an eating disturbance that is clinically significant, but does not meet criteria for any other feeding or eating disorder. Thus, the NEC category is not meant to capture disordered eating, which can be present among the general population, but rather, eating conditions that may cause significant distress, interference with daily life, and/or increased risk of death or disability.

From a practitioner’s standpoint, individuals seeking treatment for eating problems are likely either experiencing distress and/or impairment that are clinically significant. Proposed conditions included in NEC are: atypical anorexia nervosa (atypical AN); subthreshold bulimia nervosa (subthreshold BN); subthreshold binge eating disorder (subthreshold BED); purging disorder (PD); and night eating syndrome (NES). Treatment-seeking samples of bulimic-related EDNOS syndromes, which would include many, if not most, of the conditions proposed for NEC, are at increased risk of death by suicide, supporting the severity of illness among patients who will fall within the NEC category.

Unlike the clear hierarchy proposed for diagnoses of AN, BN, and BED, there is currently no specified diagnostic hierarchy for NEC conditions. With this understood, practitioners should only diagnose an individual with a single NEC condition, based on the best match between the description of NEC conditions and that individual’s specific constellation of symptoms.

**CLINICAL UTILITY OF NEC**

A large emphasis for revisions of DSM-5 was to reduce the preponderance of DSM-IV EDNOS diagnoses without reducing diagnostic validity of recognized categories, such as AN and BN. Perhaps the largest revision is the recommendation that BED be “promoted” from a form of EDNOS to a formal diagnostic category. The inclusion of BED as a formally recognized disorder, along with the expansion of the AN and BN categories, has helped reduce what conditions remain in the “residual” diagnostic group by re-allocating what were formerly several atypical or subthreshold presentations (eg, AN without amenorrhea or BN with once per week binge/purge episodes).

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Indeed, several studies have shown that with these revisions, the proportion of NEC diagnoses will decrease dramatically. In a community-based sample, the use of DSM-IV vs. DSM-5 criteria resulted in 63% EDNOS versus 53% NEC, respectively (P < .001). Similarly, among a treatment-seeking sample, estimates of EDNOS decreased from 53% to 25% for NEC (P < .001). As evident from these studies, while proposed revisions will reduce the “catch-all” nature of the EDNOS category somewhat, DSM-5 NEC is still likely to represent a sizeable minority of patients in clinical settings and the majority of clinically significant eating disorders in community settings.

In addition to the need to reduce the profusion of EDNOS diagnoses, the un-specified nature of the residual DSM-IV EDNOS category itself has been a major roadblock to initiating research and providing useful guidelines for clinical practice. With this issue in mind, further reorganization and specification was needed within this category to facilitate greater understanding regarding some of the alternative syndromes that have been identified in research and clinical practice.

Consistent with the broader change in the nomenclature from “not otherwise specified” to “not elsewhere classified,” the DSM-5 work group has focused on specifying and defining subgroups within EDNOS. While DSM-IV EDNOS included several examples of unnamed syndromes, DSM-5 will include several named syndromes with brief descriptions (but without formal diagnostic criteria) within three categories: (1) atypical, mixed, or subthreshold syndromes; (2) other specific syndromes; and (3) conditions with insufficient information. Notably, for all NEC conditions, no minimum frequency or duration requirements are designated. This decision was made, in large part, because there is no available research that would have guided more specific frequency or duration thresholds. Thus, it is left to clinical judgment to distinguish a clinically significant eating disorder from disordered eating.

**Atypical and Subthreshold Presentations**

Regarding the first category of NEC (atypical AN, subthreshold BN, subthreshold BED), descriptive changes were warranted based on revisions to diagnostic criteria for full threshold disorders. Given that the changes to diagnostic criteria for AN and BN and the inclusion of BED as a formal diagnosis reallocated a substantial proportion of patients from DSM-IV EDNOS to DSM-5 full-threshold diagnoses, the definitions of what constitute atypical or subthreshold presentations were in need of modification.
Purging Disorder

Regarding other specific syndromes, purging disorder (PD), which reflects the most commonly used specific name for this symptom configuration across recent studies, was first introduced as a potential description of an atypical eating disorder in 1986. An unnamed version of PD was added as an example descriptor of EDNOS in DSM-III-R, and as Example 4 in DSM-IV (“the regular use of inappropriate compensatory behavior by individuals with normal body weight after eating small amounts of food”). More detailed and rigorous studies of the condition have produced a clearer description and name for purging disorder.

Several studies have demonstrated the clinical significance of PD and its distinction from non-eating disordered individuals. A lesser number of studies have demonstrated physiological and psychological differences between PD and BN, however, these differences have been less consistently studied and found. Finally, studies examining the distinctiveness of PD from AN, and evidence of a distinctive course or treatment outcome for PD have not yet emerged in the literature.

Given the growing body of research on this syndrome, the DSM-5 Eating Disorder Work Group believed that discussion of the status of PD in DSM-5 was warranted. Ultimately, it was decided that PD should remain as NEC, as opposed to being included as a diagnosis on par with AN or BN. However, the inclusion of a name and clinical description will make it possible for clinicians to more easily access literature on this condition and may facilitate more uniform research efforts to examine treatment response, course, and outcome in PD.

NIGHT EATING SYNDROME

The next of these specific syndromes not elsewhere classified, night eating syndrome (NES), was first introduced in 1955 as a pattern of eating that potentially contributed to the chronicity of obesity among a case series of 23 obese individuals. While NES has not been mentioned in any iteration of the DSM, advocacy from researchers led to a rigorous scientific evaluation of NES to determine how it may be addressed within DSM-5.

The largest limitation within the NES research literature has been lack of agreement on a definitive syndromal definition and some debate regarding whether the condition described as NES best represents a syndrome or a set of symptoms. Several studies have found support for increased pathology on a number of psychological correlates for NES as compared to healthy controls; however, the variables examined have differed across research studies (eg, depressive symptoms, anxiety symptoms, substance-use problems, psychiatric diagnoses) making it difficult to draw definitive conclusions overall.

Further, several other methodological issues exist within the NES research literature, including lack of data regarding the prevalence and course of NES, and lack of data supporting the distinctiveness of NES from other eating disorders. Thus, to provide a brief definition of this syndrome to stimulate further research, the DSM-5 Eating Disorder Work Group decided to introduce NES as a named example of a NEC condition.

SUGGESTED NEC CHANGES FOR DSM-5

Regarding atypical, mixed, or subthreshold conditions, given changes made to full-threshold diagnoses, certain syndromes previously described in DSM-IV EDNOS (Example 1: AN without amenorrhea) will be diagnosed with AN in the DSM-5. Example 2 in DSM-IV has been retained as a descriptor and named “atypical” AN. The description for atypical AN remains consistent with that in DSM-IV, with the exception of the expansion of the weight specifier to include individuals both within and above normal weight.

Given that increased freedom has been designated to the practitioner to define what qualifies as “low weight” when diagnosing AN, diagnoses of AN among those who are underweight will largely exclude them from being assigned to NEC. Because a central feature of AN is low weight, the descriptor of “atypical” appears appropriate for this NEC condition.

The other two conditions in this subcategory of NEC include subthreshold conditions. Example 3 from DSM-IV EDNOS has been aptly named subthreshold BN, which accurately reflects a syndrome identical to DSM-5 BN, albeit with a frequency of less than once per week or less than 3 months in duration. Since the designation of BED as a full-threshold eating disorder, subthreshold BED also will be included within the NEC conditions (with identical frequency criteria as for subthreshold BN).

Reflecting the definition used in research on PD in recent years, PD will be described by recurrent purging behaviors (eg, self-induced vomiting, laxative, diuretic, or enema misuse) for the purpose of influencing shape or weight, in the absence of objective binge episodes. The label of compensatory behaviors was narrowed to include only purging behaviors, based on evidence that including fasting and excessive exercise in definitions of PD significantly reduced distinctions from normality.

Further specification regarding the purpose of purging for weight or shape reasons was included to clarify that this syndrome should be limited to a pathological eating condition and should not include culturally sanctioned purification rituals or purging due to anxiety. DSM-5 criteria also do not make an explicit statement regarding body weight, but as per rules regarding NEC conditions broadly, criteria for AN cannot be met.

While substantial literature on NES has evolved, definitions used have largely varied from study to study. As such, the relatively longer description of NES

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compared with other NEC syndromes was designed to provide a uniform working definition for the field. NES tentatively encompasses recurrent episodes of night eating, which are defined as either including evening hyperphagia (consuming a substantial portion of one’s calories after the evening meal) or nocturnal eating (“awakening during the night and consuming food before returning to sleep”15).

Several specifications were added to help guide the definition of NES, including noting that the individual must be aware of his/her behavior, to differentiate this syndrome from sleep disorders that include eating without awareness. Further, these behaviors cannot be solely the consequence of local norms or as a secondary consequence of a disrupted sleep cycle, as the first would preclude a diagnosis of a mental disorder and the second would be better accounted for by a sleep, rather than an eating, disturbance.

NES must also be associated with distress and/or impairment, which is similar to the criteria employed for BED, to limit overpathologizing behaviors that do not disrupt an individual’s functioning. Several exclusion criteria are also noted to ensure that this syndrome is not best characterized by another existing disorder (eg, BED, substance-use disorders, and other medical or psychiatric disorders).

Also of note, DSM-IV EDNOS Example 5, which referred to repeatedly chewing and spitting out large amounts of food without swallowing, has been removed from DSM-5 NEC, due to insufficient data on this clinical presentation.

The third category of NEC conditions serves as a residual category for any feeding or eating condition that is clinically significant, but does not meet criteria for any other feeding or eating disorder or condition. Although discussion of this section has been primarily focused on eating conditions, this category also includes feeding conditions in children who do not meet criteria for pica, rumination disorder, or avoidant/restrictive food intake disorder.

APPLICATION TO CLINICAL PRACTICE

One of the benefits of the DSM-5 NEC for clinical practice is the utility of having specifically named syndromes, which can help patients with these conditions by providing a label to identify and legitimize their symptoms. This, in turn, can help instill a sense of mutual understanding between patient and practitioner and facilitate hope for symptom improvement on the part of both individuals.17 Further, the more specific syndrome names can help streamline communication between practitioners compared with the broad category of EDNOS, which provided no indication regarding the configuration of symptoms.

While named NEC conditions have several general benefits for clinical practice, currently, there is limited data on treatment outcome and recommendations.

While named NEC conditions have included “expanded” diagnostic groups within their studies,19-22 and these studies have found efficacy for these treatments among both the stringently defined and “expanded” diagnostic groups. To our knowledge, only one study, at a tertiary treatment center, has examined treatment outcome in PD. The authors found no difference in remission and completion rate for PD patients as compared with AN and BN patients, suggesting that treatments that have promise for patients with AN and BN may be adapted to those with PD.23

While these results are encouraging, this study was not a RCT and did not focus on a specific form of intervention; thus, no direct recommendations for treatment can be made for PD from this study. While no studies have specifically examined treatments for atypical/subthreshold conditions or PD, there has been research conducted on transdiagnostic treatments, most notably Fairburn’s transdiagnostic cognitive-behavioral therapy (CBT) and its “enhanced” counterpart (CBT-E).24

In an RCT of 57 patients with BN, 92 patients with EDNOS, and seven patients with BED, the authors found that CBT and CBT-E outperformed a waitlist control group both at end-of-treatment and 60-week follow-up.24 Importantly, treatment outcome did not differ by diagnosis, with 52.7% of patients with BN and 53.3% of patients with EDNOS having a global Eating Disorder Examination score less than one standard deviation above community norms at end-of-treatment. Although the specific forms of EDNOS included in the sample were not specified, this study demonstrates a theoretically sound approach to treating the function of eating disorder behaviors and demonstrates the utility of CBT and CBT-E for BN and related EDNOS who were not underweight.

Thus, such an approach serves as a sound starting point for practitioners treating these conditions. As with treat-
ment for any disorder, clinicians should conduct carefu...news and symptoms. To achieve this goal, researchers will need to examine the clinical utility of these newly proposed conditions, and clinicians will need to actively seek out the newest information available on how to best treat their patients.

Following introduction of BED as a named EDNOS in the DSM-IV, there was an explosion of research on its clinical correlates, treatment, course, and outcome, making it possible for clinicians to better assist their own patients with BED. The inclusion of named NEC in the DSM-5 may presage a similar expansion of information on these prevalent but understudied conditions.

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