Eating Disorders: Comprehensive Psychoeducation (DSM-5-TR–Aligned, 2019–2025 Evidence)

Introduction & Scope

Eating disorders (EDs) are serious psychiatric conditions characterized by disturbances in eating behavior, cognition, and perception of body weight/shape. They are associated with high morbidity and mortality, often co-occurring with mood, anxiety, and substance use disorders. DSM-5-TR recognizes several eating disorders, including Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, Avoidant/Restrictive Food Intake Disorder (ARFID), Pica, and Rumination Disorder. This document synthesizes diagnostic features, epidemiology, etiology, clinical presentations, treatment, and prognosis with updated evidence (2019–2025).

DSM-5-TR Eating Disorder Diagnoses

Anorexia Nervosa (AN)

- Restriction of energy intake leading to significantly low body weight.
- Intense fear of gaining weight or persistent behavior interfering with weight gain.
- Disturbance in self-perceived weight/shape, undue influence on self-evaluation, or lack of recognition of seriousness.
- Subtypes: Restricting type; Binge-eating/purging type.

Bulimia Nervosa (BN)

- Recurrent binge eating (large amount + loss of control).
- Inappropriate compensatory behaviors (vomiting, laxatives, diuretics, excessive exercise).
- Occurs at least once/week for 3 months.
- Self-evaluation unduly influenced by body shape/weight.
- Not occurring exclusively during episodes of Anorexia Nervosa.

Binge-Eating Disorder (BED)

- Recurrent binge-eating episodes associated with ≥3 of: rapid eating, eating until uncomfortably full, eating large amounts when not hungry, eating alone due to embarrassment, guilt/disgust afterward.
- Marked distress present.
- Occurs at least once/week for 3 months.
- No compensatory behaviors (distinguishes from BN).

Avoidant/Restrictive Food Intake Disorder (ARFID)

- Avoidance/restriction of food intake leading to significant weight loss, nutritional deficiency, dependence on supplements/tube feeding, or psychosocial impairment.
- Not due to lack of available food or culturally sanctioned practice.
- Not explained by body image disturbance.
- Common in children; may persist into adulthood.

Pica

- Persistent eating of non-nutritive, non-food substances for ≥1 month.
- Inappropriate to developmental level; not culturally supported.
- May occur in children, pregnant women, or individuals with developmental disorders.

Rumination Disorder

- Repeated regurgitation of food (re-chewed, re-swallowed, or spit out) for ≥1 month.
- Not due to GI condition or other ED.
- Can occur in infants, children, or adults; often associated with neglect or developmental delay.

Epidemiology

Lifetime prevalence: AN ~0.5–1%, BN ~1–2%, BED ~3–4%. ARFID, Pica, Rumination less common but clinically significant. Onset: adolescence to early adulthood for AN/BN; BED often later (20s–30s). Higher prevalence in females, though BED shows smaller gender gap. EDs are increasing globally, with rising incidence in males and diverse ethnic/racial groups.

Etiology & Risk Factors

- Genetic heritability (~50–60% for AN, BN, BED).
- Neurobiology: dysregulation of serotonin/dopamine reward and appetite pathways; abnormalities in insula, striatum, prefrontal circuits.
- Psychological: perfectionism, harm avoidance, impulsivity, emotion dysregulation, trauma history.
- Sociocultural: thin-ideal internalization, weight stigma, social media exposure.
- Medical/Developmental: GI disorders, picky eating/feeding problems in childhood, neurodevelopmental disorders (ARFID, Pica).

Assessment & Differential

Assessment: detailed psychiatric and nutritional history, collateral, labs (CBC, CMP, electrolytes, thyroid, vitamins), ECG if malnourished. Structured tools: Eating Disorder Examination (EDE), SCOFF, EDE-Q. Differentials: GI disease, depression, anxiety, OCD, body dysmorphic disorder, psychosis, medical causes of weight loss.

Treatment Approaches

Psychotherapy

- First-line: Family-Based Treatment (FBT) for adolescents with AN; enhanced CBT (CBT-E) for BN, BED, and adults with AN.
- DBT and interpersonal therapy (IPT) effective adjuncts for BN/BED.
- Exposure and response prevention for ARFID; habit reversal for rumination.

Pharmacotherapy

- AN: Limited evidence; antipsychotics (olanzapine) may aid weight gain and reduce obsessive thoughts.
- BN: SSRIs (fluoxetine 60mg) FDA-approved; others may reduce binge/purge.
- BED: Lisdexamfetamine FDA-approved; SSRIs and topiramate also studied.
- ARFID, Pica, Rumination: No specific meds; treat comorbidities.

Medical/Nutritional Management

- Nutritional rehabilitation, weight restoration, and medical stabilization are critical, particularly in AN.
- Multidisciplinary care (physician, dietitian, therapist) is standard.
- Hospitalization for severe malnutrition, electrolyte imbalance, suicidality, or medical instability.

Prognosis & Course

AN has highest mortality (~5–10%, suicide and medical complications). Early intervention improves outcomes. BN and BED show better response to therapy; remission rates ~50–70% with treatment. ARFID, Pica, Rumination vary; prognosis depends on underlying factors and early management.

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