SPEED PROJECT

Sport & Prevention of Emerging Eating Disorders

CLASSIFICATION OF EDs according to DSM-5 (DSM-5-TR)

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Eating and Feeding Disorders (EDs) are **complex pathologies** characterized by:

- **dysfunctional eating behavior**
- **excessive concern about weight and body shape**
- **distorted perception of body image**
- **low levels of self-esteem.**

EDs may co-occur **with other psychic problems** such as anxiety disorders and mood disorders.

Physical health is almost always affected due to disordered eating behaviors that lead to nutritional imbalances. **Low body weight**, however, contrary to a common misconception, **is not the sole and specific marker for EDs**, as conditions such as **normal weight** and **overweight**, and even **obesity**, can also be associated with eating and feeding disorders.

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- If not treated in **due time** and with **appropriate methods** EDs can become a permanent condition and seriously compromise the health of all body systems (cardiovascular, gastrointestinal, endocrine, hematological, skeletal, central nervous system, dermatological, etc.) and, in severe cases, lead to death. **Anorexia nervosa**is associated with a **mortality rate 5–10 times higher than the general population**

- These disorders currently represent a significant public health concern, as for **anorexia** and **bulimia**, there has been a progressive **lowering of the age of onset in recent decades**, with diagnoses increasingly common in pre-adolescence and childhood. Early onset, by interfering with healthy biological and psychological development, is associated with far more severe consequences for both body and mind.

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The delay with which the diagnosis is often made can have **serious repercussions** on the disorder, since the earlier treatment begins, the greater the chances of success. Unfortunately, early diagnosis represents a challenge that is not always easy, as the very nature of the psychopathology of these disorders — characterized by **denial**, **ambivalence**, **secrecy**, and **shame** — makes it difficult for the person suffering from them to speak openly about the eating problem with their primary care physician, leading them to minimize or deny the issue.

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Often the **initial symptoms are mistaken for health and fitness cultural trends**, which can exploit individual vulnerability by serving as a justification to reduce food intake — a boundary that is not always easy to define.

It is therefore essential to be prepared to implement **early interventions**, using age-appropriate nutritional assessment tools and therapeutic techniques effective for adolescent patients, in order to start treatment as early as possible for a better disease prognosis.

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- It is also essential to maintain **therapeutic continuity** and plan activities with multidisciplinary teams.
- The levels of care, universally established, are organized along a gradient of clinical complexity and severity **from the general practitioner (GP) and primary care pediatrician, through outpatient clinics, Day Hospitals, and residential centers**, up to **hospitalization** during acute episodes. The roles and responsibilities of each level of care are outlined in national documents.

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In 2018 was established the **National Purple Ribbon Day dedicated to eating disorders** was established. It is celebrated every year on March 15th.

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Epidemiology

- It is estimated that today in Italy more than **three million people** soffrano di **EDs** and tens of millions of young people and adults worldwide develop them every year. The pandemic further worsened the situation, with an estimated increase of at least 30–35% and a **lowering of the age of onset.** EDs are increasingly spreading among the pediatric population, with children aged 8–9 presenting symptoms typical of adolescent and adult EDs, particularly of the anorexic type, rather than childhood-specific eating disturbances.
- 2020 data (Ministry of Health, pandemic period) confirm a **nearly 40% increase in cases compared to 2019**. In the first half of 2020, various reporting streams recorded **230,458 new cases compared to 163,547 in the first half of 2019**. The total care burden of new and existing cases in 2020 amounted to 2,398,749 patients — a figure likely underestimated, as many patients never reach treatment.

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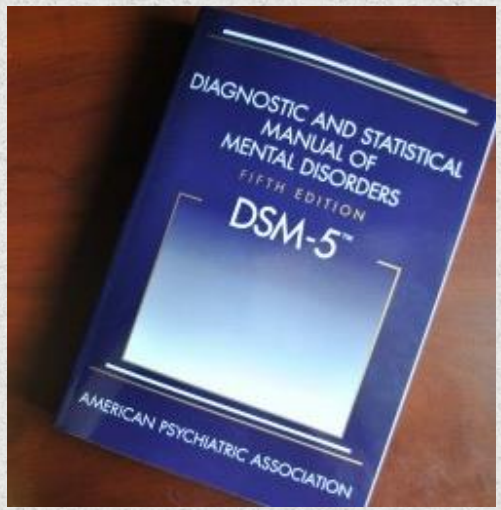
Classification of EDs

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder (ARFID)
- **Anorexia nervosa**
- **Bulimia Nervosa**
- **Binge-Eating DisorderBinge-Eating**
- Other Specified Feeding or Eating Disorder (OSFED)
- Unspecified Feeding or Eating Disorder (UFED)



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Pica

- **Persistent eating of non-nutritive, non-food substances over a period of at least one month.**
- The ingestion of non-nutritive and non-edible substances is **inappropriate for the individual's developmental level**.
- The eating behavior **is not part of culturally or socially normative practices**.
- If the behavior occurs exclusively during the course of another mental disorder (intellectual disability, autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is **sufficiently severe** to warrant independent clinical attention.

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Rumination Disorder

- **Repeated regurgitation of food over a period of at least one month**. The regurgitated food may be re-chewed, re-swallowed, or spat out.
- The repeated regurgitation **is not due to an associated gastrointestinal condition** o a un'altra condizione medica (es. reflusso gastroesofageo, stenosi pilorica).
- The disorder **does not occur exclusively during the course of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, or Avoidant/Restrictive Food Intake Disorder**.
- If symptoms occur during the course of another mental disorder (intellectual disability or other neurodevelopmental disorders), they are **sufficiently severe** to warrant independent clinical attention.
- In remission: Following full satisfaction of the criteria, the criteria are no longer met for a sustained period of time.

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Avoidant/Restrictive Food Intake Disorder ARFID

"It is not uncommon for some children to be labeled as 'picky' or 'selective' because they appear uninterested in food or because they **restrict their food intake to a very limited range of foods**.

When this form of selective eating has a negative influence on psycho-physical development and growth, the diagnosis of ARFID may be applicable. Typical onset in childhood or early adolescence.

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Avoidant/Restrictive Food Intake Disorder ARFID

- Significant **weight loss** (or failure to achieve expected weight gain or faltering growth in children)
- Significant **nutritional deficiency**
- **Dependence on enteral feeding or oral nutritional supplements**
- Marked **interference with psychosocial functioning.**

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- The disorder is not better explained by lack of available food or by an associated cultural practice.
- The feeding disturbance does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa, and **there is no evident disturbance in how one's body weight or shape is experienced.**
- The disturbance is not attributable to a medical condition or not better explained by another mental disorder.
- If symptoms occur in the context of another disorder or medical condition, they are sufficiently severe to warrant independent clinical attention beyond what is typically associated with that condition.

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Profiles:

- Apparent lack of interest in food
- Avoidance based on the sensory characteristics of food
- Concern about aversive consequences of eating (e.g., vomiting, stomachache)

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Comorbidities

- Obsessive-Compulsive Disorder (OCD)
- Autism
  - Do not fully meet the diagnostic criteria
  - Rigid behavioral patterns and difficulty adapting to new situations (common autism spectrum symptoms)
- Anxiety disorders (generalized anxiety disorder, panic disorder, social phobia).

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Neophobia

- Food neophobia is the refusal by children, typically between 2 and 6 years of age, to taste new or unfamiliar foods, often fruits and vegetables. It is a normal developmental phase, defined as a “fear of the new,” affecting approximately 30% of children. It can be overcome with patience, repeated exposure (even 10–15 times), parental role modeling, and involving children in food preparation.
- **Definition:** A natural wariness toward unfamiliar foods, often rooted in a primitive protective reflex.
- **Age:** Predominantly manifests in the preschool years, between ages 2 and 6, peaking during this stage.
- **Commonly Refused Foods:** Usually fruit, vegetables, and meat.
- **Factors:** Influence of parental diet, limited flavor variety introduced during weaning, and aversion to new textures.

It does not represent a psychopathological disorder!

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Other Specified Feeding or Eating Disorder (OSFED)

According to the DSM-5, this category applies to presentations in which characteristic symptoms of a feeding and eating disorder - causing 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.

Atypical Anorexia Nervosa: All the criteria for anorexia nervosa are met, except that, despite significant weight loss, the individual's weight remains within or above the normal range.

Bulimia Nervosa (of low frequency and/or limited duration): All the criteria for bulimia nervosa are met, except that binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.

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- **Binge-Eating Disorder (at low frequency and/or of limited duration)**: all criteria for Disorder are met, except that binge eating occurs, on average, less than once a week and/or for less than 3 months.
- **Purging Disorder**: Recurrent purging behaviors to influence body weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
- **Night Eating Syndrome**: Recurrent episodes of night eating, 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. Night eating causes significant distress and/or impairment in functioning. The pattern of disordered eating is not better explained by binge-eating disorder or another mental disorder, and is not attributable to another medical condition or to the effects of substances or medications.

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Unspecified Feeding or Eating Disorder (UFED)

- This category applies to presentations in which symptoms characteristic of a feeding or eating disorder—causing clinically significant distress or impairment in social, occupational, or other important areas of functioning - predominate, **but the full criteria are not met 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 why 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 an emergency setting or during initial evaluations).

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	With other specification (OSFED)	Without specification (UFED)
Disorder present	✅	✅
Clear clinical picture	✅	❌
Known reason	✅	❌
Detailed diagnosis	✅	❌
Often used in ER	❌	✅
Severity	❗ Can be high	❗ Can be high

- OSFED and UFED are NOT "minor" disorders
- They are NOT "residual"
- They do NOT indicate lesser severity
- **They only indicate a different degree of diagnostic definition**

In disorders with other specification, the clinician knows the nature of the disorder and the reason why DSM criteria are not fully met; in unspecified disorders, information is insufficient or not specified.

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