

Chapter 20

Classification and Diagnosis of the Eating Disorders

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In the field of medicine the value of classification and diagnosis of diseases is generally unquestioned. Classification is the process whereby complex clinical phenomena are reduced to defined categories for the purpose of treatment and prevention, while diagnosis is the assignment of the patient's clinical features (eg, constrictive chest pain occurring on exertion in a 50-year-old man with exercise ECG changes and coronary atherosclerosis) to a particular category (eg, angina pectoris) for the purpose of treatment (eg, nitrates and beta-blockers) and secondary prevention (eg, weight reduction). However, in psychiatry, classification and diagnosis are often deemed irrelevant to the nature of the problem. Thus, for instance, a diagnosis of anorexia nervosa does not convey vital information such as why the patient needs to strive for control, who brought her to treatment, or how she relates to her family. Furthermore, in other branches of medicine treatment is usually directly related to diagnosis, whereas in psychiatry specific treatments are rare. Thus, classification and diagnosis are of less value for treatment planning in psychiatry. Finally, some psychiatrists feel that it is dehumanizing and harmful to fit a patient's symptoms into a classification scheme; they insist that a patient should be understood as an individual and treated as a person.

Why then are we concerned about classification and diagnostic criteria? Classification is based on the assumption that there are certain shared features between disorders that distinguish this particular category of disorder from others. A related assumption is that patients

with this category of disorder can be distinguished from those without. Classification is therefore essential for delineating and defining the condition that we propose to treat. It is also essential for the purpose of communication, so that we can all know what particular mental disorder we are describing. A third reason is that it is essential for learning, for comparing with each other our experience of treating patients with the same disorder. The fourth is for developing specific prevention and treatments. While these are still rare in psychiatry, it is nevertheless essential that we should set the stage for the evaluation of such efforts by clearly defining the conditions.

However, to argue for the value of diagnosis in psychiatry is not to overlook its shortcomings. Thus, in clinical practice, the assignment of a diagnosis should always be accompanied by a detailed formulation of the patient's clinical features, personality features, personal and social history, family history and relationships, and previous treatments.

DIAGNOSES OF ANOREXIA NERVOSA AND BULIMIA NERVOSA

The emergence of the eating disorders as diagnostic categories have been hampered by two major difficulties. The first is a lack of agreement on how diagnostic criteria should be established. The traditional approach to establishing diagnostic categories is to provide brief descriptions of the characteristic features of each con-

Table 20.1 Comparison of Anorexia Nervosa and Bulimia Nervosa

	Anorexia Nervosa		Bulimia Nervosa	
	Restrictor Subgroup (60%)	Bulimic Subgroup (40%)		
Cardinal Features		Emaciation Drive for Thinness Behavior Directed to Weight Loss		Normal or Overweight Fear of Fatness Bulimic Episodes
Weight		Low		Normal or Overweight
Amenorrhea (female)		Present		Variable
Binge-eating	Absent		Present	Present
Vomiting/Purging	Usually Absent		Usually Present	Usually Present

dion. The problem related to this approach is a lack of precision, which severely limits the usefulness of classification schemes thus defined. A more recent approach is to provide adequate working (ie, operational) definitions of the various diagnostic categories. Examples of this approach are the Feighner et al criteria [1] and the American Psychiatric Association's DSM III [2]. The correct use of such operational criteria allows a clinician to make a fairly precise description of the patient sample.

A second hurdle is a lack of agreement and understanding among researchers as to the etiology, cardinal features, course, and outcome of the eating disorders. Thus, some clinicians still regard anorexia nervosa as an appetite disorder, when in fact many researchers have shown that the anorectic's refusal to eat is certainly not related to a loss of appetite. Despite these difficulties, the American Psychiatric Association [2] has produced succinct and useful descriptions of the disorders, which are contrasted in table 1.

DIAGNOSIS OF ANOREXIA NERVOSA

A list of diagnostic criteria for anorexia nervosa is described in table 2; it retains most of what is present in the DSM III. The cardinal feature of anorexia nervosa is the relentless pursuit of thinness [3], most commonly expressed by willful starvation and excessive exercising, less often by vomiting and laxative/diuretic abuse. Strictly speaking, anorexia nervosa is therefore not really an eating disorder, since the refusal to eat is related to the fear of weight gain. Amenorrhea is a recognized feature of the disorder and should be included. For operational purposes the degree of weight loss necessary to qualify for a diagnosis of anorexia nervosa should be specified. Furthermore, simply relying on weight loss as a criterion may inadvertently classify normal or overweight subjects into the syndrome (eg, if a premorbidly obese subject weighing 100 kg loses weight to 60 kg and

displays all the other symptoms of anorexia nervosa, she could technically qualify for the diagnosis even though she is not emaciated) and thus destroy the classical image of the emaciated patient. A low body weight as an additional criterion is thus proposed. An attempt is also made to include the less severe cases and to this end a staging of body weight is suggested. The distinction between the restrictor (or abstainer) and the bulimic (or vomiting) subgroups has been the subject of much recent research and should therefore be drawn. The presence of concurrent or previous Axis I and II diagnoses should be specified, since recent research has demonstrated that anorexia nervosa patients may also develop other psychiatric disorders such as a major depression or a schizophreniform disorder. Finally, disturbance of body image as a diagnostic criteria has been deleted, in part because the concept is difficult to define [4], and in part because all the recent studies suggest that overestimation of body width is not a characteristic feature of the illness [4,5,6]. The DSM-III-R has incorporated some but not all of these proposed changes.

Table 20.2 Diagnostic Criteria for Anorexia Nervosa

- A. Intense fear of becoming obese, which does not diminish as weight loss progresses.
- B. Emaciation as a result of weight loss of at least 15% of original body weight:
 1. Grade 1: Body weight less than 85% of average weight for height
 2. Grade 2: Body weight less than 75% of average weight for height
- C. Behavior directed towards weight loss.
- D. Amenorrhea in the female
- E. Subgroup:
 1. Bulimic: Presence of bulimic episodes
 2. Restrictor: Absence of bulimic episodes
- F. No known physical illness that could account for the weight loss and emaciation.

Table 20.3 Diagnostic Criteria for Bulimia Nervosa

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- A. Recurrent episodes of binge-eating (rapid consumption of a large amount of food in a discrete period of time, usually less than 2 hours), frequency of at least once a week over the previous four weeks.
 - B. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily once the binge-eating begins.
 - C. Intense fear of fatness, depressed mood, and self-deprecatory thoughts following eating binges.
 - D. Termination of binge-eating episodes by abdominal pain, sleep, social interruption, self-induced vomiting, or use of cathartics or diuretics.
 - E. Repeated attempts to lose weight by severe dieting, self-induced vomiting, or use of cathartics or diuretics.
 - F. The bulimic episodes are not related to a concurrent anorexia nervosa of any known physical disorder.
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DIAGNOSIS OF BULIMIA NERVOSA

The cardinal feature of bulimia (Greek for "ox appetite") is the presence of recurrent episodes of binge eating occurring with varying duration (from minutes to hours) and frequency (up to many times a day) (table 3). Initially the binge eating is almost always described as pleasurable and soothing, but depression and guilt soon follow, and the patient experiences a fear of loss of control. No clear demarcation exists between bulimia thus defined and eating binges or great variations in dietary intake [7,8]. Binge eating [9] occurs in nearly half of all anorexia nervosa patients [7,10,11] and in 30% of obese subjects who seek treatment [12]. Binges also occur sporadically in many normal-weight subjects, particularly in those dieting to control weight [13,14]. Thus in order to define bulimia nervosa as a syndrome, the frequency criterion has been included. In addition, the criterion for normal body weight is specified so that obese or anorectic subjects are excluded from the diagnosis. In the bulimic a relatively normal body weight is maintained by self-induced vomiting, laxative/diuretic abuse, prolonged fasting, or excessive exercising. A fear of fatness is always present, particularly after a binge, but bulimic patients do not seem to be striving for an unrealistically low weight. The term bulimia nervosa has been proposed for a diagnosable, severe form of the disorder [15] and will also be used in this chapter. The DSM-III-R has incorporated some but not all of these proposed changes.

Debate continues on whether the two eating disorders are separate, dichotomous syndromes [15-18]. Existing evidence suggests that the consistency of the association of the cardinal features, and the course and outcome of the two disorders, form relatively distinct

aggregates. The treatment focus of the two disorders is also distinct: for anorexia nervosa the emphasis is on weight restoration, while for bulimia nervosa the emphasis is on the control of abnormal eating. Thus, from an operational and treatment point of view, it is best at this stage to regard them as separate conditions.

This proposed classification used body weight as the distinguishing feature between the two disorders. More recently researchers have suggested that bulimic behavior, rather than low body weight, may have greater diagnostic, prognostic, and etiological significance. For example, the bulimic patients, whether of normal or low body weight, more often are emotionally labile and impulsive, and are more likely to be premorbidly obese [11,19,20-24]. They are also more likely to have a family history of obesity, alcoholism and depression [20,23,25]. However, at this stage it seems premature to abandon the previous classification, because many issues remain unresolved (such as the fact that some normal-weight bulimics resemble closely the classic restricting anorectic in psychopathology [22]. It is to be expected, however, that as our understanding of the patients increases, the classification scheme will change.

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