

EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS)

What is Eating Disorder Not Otherwise Specified (EDNOS)?

The Diagnostic and Statistical Manual – 4th Edition (DSM-IV) recognizes two distinct eating disorder types, anorexia nervosa and bulimia nervosa. If a person is struggling with eating disorder thoughts, feelings or behaviors, but does not have all the symptoms of anorexia or bulimia, that person may be diagnosed with eating disorder not otherwise specified (EDNOS). The following section lists examples of how an individual may have a profound eating problem and not have anorexia nervosa or bulimia nervosa.

- A female patient could meet all of the diagnostic criteria for anorexia nervosa except she is still having her periods
- A person could meet all of the diagnostic criteria for anorexia nervosa are met except that, despite significant weight loss the individual's current weight is in the normal range.
- A person could meet all of the diagnostic criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for duration of less than 3 months.
- The person could use inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies). This variant is often called purging disorder.
- The person could repeatedly chewing and spitting out, but not swallowing, large amounts of food.
- Binge-eating disorder is also officially an EDNOS category (see separate fact sheet for BED): recurrent episodes of binge eating in the absence if the regular use of inappropriate compensatory behaviors characteristic of bulimia nervosa.

The examples provided above illustrate the variety of ways in which disordered eating can look when a person has EDNOS, but this list of examples does not provide a complete picture of the many different ways that eating disorder symptoms can occur.

The “not otherwise specified” label often suggests to people that these disorders are not as important, as serious, or as common as anorexia or bulimia nervosa. This is not true. Far more individuals suffer from EDNOS than from bulimia and anorexia combined, and the risks associated with having EDNOS are often just as profound as with anorexia or bulimia because many people with EDNOS engage in the same risky, damaging behaviors seen in other eating disorders.

Individuals with EDNOS who are losing weight and restricting their caloric intake often report the same fears and obsessions as patients with anorexia. They may be overly driven to be thin, have very disturbed body image, restrict their caloric intake to unnatural and unhealthy limits, and may eventually suffer the same psychological, physiological and social consequences of anorexic people. Those who binge, purge, or binge and purge typically report the same concerns as people with bulimia, namely, that they feel they need to purge to control their weight, that they are afraid of getting out of control with their eating, and that bingeing and/or purging often turn into a very addictive, yet ineffective coping strategy that they feel they can not do without. In all meaningful ways, people with EDNOS are very similar to those with anorexia or bulimia, and are just as likely to require extensive, specialized, multidisciplinary treatment.

How common is EDNOS?

Eating Disorder NOS typically begin in adolescence or early adulthood although they can occur at any time throughout the lifespan. Like anorexia nervosa and bulimia, EDNOS is far more common in females; however, among those individuals whose primary symptom is binge eating, the number of males and females is more even. Because EDNOS has not been studied as extensively as anorexia and bulimia, it is harder to gauge an exact prevalence, but estimates suggest that EDNOS accounts for almost three quarters of all community treated eating disorder cases.

What are the symptoms of EDNOS?

Signs of EDNOS are the same signs you would look for in anorexia and bulimia nervosa. Constant concern about food and weight is a primary sign, as are behaviors designed to restrict eating or compensate for eating (such as exercise or purging). For individuals who binge, most notable is the disappearance of large amounts of food, long periods of eating, or noticeable blocks of time when the individual is alone. Individuals who restrict often find the need to eat by the end of the day and the urge is so strong that it results in a binge. This binge can lead to guilt and shame the leads to purging, which may prompt the individual to promise to “do better tomorrow” by restricting. Cycles like this are consistent with EDNOS and bulimia, and can become very intractable if not addressed. Characteristically, these individuals have many rules about food -- e.g. good foods, bad foods -- and can be entrenched in these rules and particular thinking patterns. This preoccupation and these behaviors allow the person to shift their focus from painful feelings and reduce tension and anxiety perpetuating the need for these behaviors appropriately.

What are the causes of EDNOS?

As with other eating disorders that have been more widely studied, the cause of EDNOS is most likely a combination of environmental and biological factors that contribute to the development and expression of these disorders. While each individual may feel that they developed these behaviors “on their own” they are often amazed to find that other people have the same obsessions, irrational fears, and self-loathing. They are not alone, and they are not to blame for having this problem.

Is treatment available for persons with EDNOS?

Unfortunately, treatment studies specifically for EDNOS are rare.

Cognitive-behavioral therapy, both in a group setting or individual therapy session, has been shown to benefit many people with bulimia and would logically be applicable to those with EDNOS who binge or purge. It focuses on self-monitoring of eating and purging behaviors as well as changing the distorted thinking patterns associated with the disorder. Cognitive-behavioral therapy is often combined with nutritional counseling and/or antidepressant medications such as fluoxetine (Prozac).

Treatment plans should be adjusted to meet the needs of the individual concerned, but usually a comprehensive treatment plan involving a variety of experts and approaches is best. It is important to take an approach that involves developing support for the person with an eating disorder from the family environment or within the patient’s community environment (support groups or other socially supportive environments).