FEEDING AND EATING DISORDERS

Other Specified Feeding or Eating Disorder

OSFED

DSM-5-TR 307.59 | ICD-10-CM F50.89

Clinically significant eating pathology that falls short of one threshold for a named disorder, and is not therefore a milder illness.

SHARE OF ED CASES	PREVALENCE	TYPICAL ONSET	COURSE
~30-60% of clinical samples	~2-3% lifetime (US adults)	Ages 15-25	Frequent crossover between ED

CLINICAL PICTURE

- Atypical anorexia nervosa presents at or above a normal weight after substantial loss, with the same starvation physiology and often greater absolute weight loss.
- Purging disorder involves recurrent vomiting, laxative, diuretic, or exercise purging to control shape and weight without any objective binge episodes.
- Night eating syndrome features repeated eating after waking from sleep or heavy intake after the evening meal, with full awareness and recall of eating.
- Subthreshold bulimia nervosa and binge-eating disorder meet every criterion except frequency below weekly or duration shorter than 3 months.
- Patients are routinely told they are not sick enough, which delays care by years and reinforces the belief that deterioration is the price of being believed.
- Medical instability tracks the rate and magnitude of weight loss and the intensity of purging, not body mass index, so normal-weight patients still collapse.

DIAGNOSTIC CRITERIA AT A GLANCE

- Symptoms characteristic of a feeding or eating disorder cause clinically significant distress or impairment but fall short of full criteria for any named disorder.
- The clinician records the specific reason in the diagnosis itself, for example atypical anorexia nervosa or purging disorder, rather than stopping at the label.
- Atypical anorexia requires all anorexia features including restriction and shape or weight overvaluation, with weight remaining within or above the normal range.
- Bulimia nervosa and binge-eating disorder of low frequency or limited duration cover presentations under once weekly or shorter than 3 months.
- Unspecified feeding or eating disorder is used instead when the clinician does not specify a reason, typically in emergency or information-limited settings.

NEUROBIOLOGY & PHYSIOLOGY

- Starvation physiology is weight-independent: bradycardia, orthostasis, hypothermia, hypoglycemia, low triiodothyronine, and amenorrhea all occur at normal BMI.
- Refeeding syndrome risk follows the size of the caloric deficit and the speed of loss, so hypophosphatemia and thiamine depletion must be anticipated at any weight.
- Purging produces hypokalemia, hypochloremic metabolic alkalosis, QT prolongation, parotid hypertrophy, dental erosion, and Russell sign on the dorsum of the hand.
- Night eating syndrome reflects a phase delay of food intake relative to the sleep cycle, with a blunted nocturnal melatonin and leptin rise and elevated cortisol.
- Twin studies place heritability of eating-disorder phenotypes near 40-60%, and the genetic loading is shared across the diagnostic boundaries rather than specific.
- Chronic weight suppression, defined as the gap between highest past and current weight, predicts binge frequency and treatment resistance independent of BMI.

PSYCHOLOGICAL MECHANISMS

- Overvaluation of shape and weight in self-evaluation is the transdiagnostic maintaining mechanism, and it is identical in threshold and subthreshold presentations.
- Dietary restraint drives the binge and compensation cycle regardless of whether episode counts reach the arbitrary weekly threshold set by the manual.
- Clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties are the additional maintainers targeted by broad-form CBT-E.
- Being told they look fine invalidates the illness and can escalate restriction, since the patient learns that visible deterioration produces access to care.
- In night eating syndrome the belief that eating is required to return to sleep conditions nocturnal intake and turns each awakening into a feeding cue.

DIFFERENTIAL & COMORBIDITY

- The line from anorexia, bulimia, and binge-eating disorder is a single unmet threshold, and patients migrate across these categories over the course of illness.
- ARFID involves restriction without any shape or weight motivation, which separates it from atypical anorexia even when weight loss is severe.
- Consider medical causes of weight loss such as celiac disease, inflammatory bowel disease, hyperthyroidism, and malignancy before attributing loss to restriction.
- Insulin omission in type 1 diabetes for weight control is classified here and carries very high risk of ketoacidosis, retinopathy, and premature death.
- Depression, anxiety, OCD, PTSD, substance use, and self-harm are common, and mortality in atypical anorexia approaches that of full anorexia nervosa.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No agent is FDA-approved for OSFED, so pharmacotherapy targets the specific presentation and any comorbid mood, anxiety, or obsessional symptoms.
- **Fluoxetine 60 mg/day** is the best-supported option for bulimic-spectrum presentations including purging disorder, and reduces purging frequency.
- **Sertraline 50-200 mg/day** has randomized evidence in night eating syndrome, reducing nocturnal ingestions and awakenings over roughly 8 weeks.
- Avoid bupropion in any purging presentation because of seizure risk, and check potassium and QTc before starting agents with cardiac liability.
- **Lisdexamfetamine** is approved only for full binge-eating disorder; using it below threshold is off-label and does not replace nutritional work.

PSYCHOTHERAPY

- **CBT-E** is the transdiagnostic first-line for adults across all OSFED presentations, delivered in 20 sessions over 20 weeks, or 40 sessions if underweight.
- **Family-based treatment** is first-line for adolescents including atypical anorexia, with about 15-20 sessions over 6-12 months and parent-led refeeding.
- Weight targets are set from the individual's own historical growth trajectory and premorbid weight, never from a population BMI cutoff.
- **DBT** skills help emotion-driven binge and purge episodes, and interpersonal psychotherapy is a reasonable alternative with a slower response curve.
- Night eating syndrome responds to a dedicated **CBT** protocol combining sleep scheduling, meal timing shifts, and occasionally bright light therapy.

ADJUNCT & SUPPORTIVE

- Order orthostatic vitals, ECG with QTc, electrolytes, magnesium, and phosphate on presentation regardless of body weight or apparent nutritional status.
- A dietitian-led meal plan with structured regular eating restores intake and interrupts restraint faster than any cognitive intervention alone.
- Screen and monitor with the **EDE-Q**, SCOFF, or Eating Disorder Diagnostic Scale, and use the Night Eating Questionnaire for nocturnal presentations.
- Match level of care to medical and psychiatric risk using the practice guideline, since subthreshold status never justifies a lower level of care.
- Name weight stigma explicitly with the team and family, and correct the assumption that a higher-weight patient cannot be medically compromised.

CLINICAL PEARLS

- Atypical anorexia is anorexia at a higher weight: same physiology, same risk, same treatment.
- Not sick enough is a treatment failure, not a triage finding. OSFED mortality matches AN and BN.
- Ask directly about purging without bingeing and about eating after waking; both get missed.

References

Allison, K. C., Lundgren, J. D., O'Reardon, J. P., Geliebter, A., Gluck, M. E., Vinai, P., Mitchell, J. E., Schenck, C. H., Howell, M. J., Crow, S. J., Engel, S., Latzer, Y., Tzischinsky, O., Mahowald, M. W., & Stunkard, A. J. (2010). Proposed diagnostic criteria for night eating syndrome. *International Journal of Eating Disorders, 43*(3), 241-247. https://doi.org/10.1002/eat.20693

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychiatric Association. (2023). *The American Psychiatric Association practice guideline for the treatment of patients with eating disorders* (4th ed.). https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines/eating-disorders

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Bohn, K., Hawker, D. M., Wales, J. A., & Palmer, R. L. (2009). Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: A two-site trial with 60-week follow-up. *American Journal of Psychiatry, 166*(3), 311-319. https://doi.org/10.1176/appi.ajp.2008.08040608

National Institute for Health and Care Excellence. (2017). *Eating disorders: Recognition and treatment* (NICE Guideline NG69). https://www.nice.org.uk/guidance/ng69

National Institute of Mental Health. (n.d.). *Eating disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/eating-disorders

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

NOTE

References are formatted in APA 7th edition style with hanging indents. Diagnostic terminology, criteria structure, and coding follow the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; APA, 2022); criteria are paraphrased for instructional use and are not reproduced verbatim. Verify all citations against the original sources before use in academic work, and confirm medication dosing against current prescribing information.