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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders General cultural considerations for feeding and eating disorders • Weight and shape concerns are prevalent in many societies, and dieting to lose weight is common. Cultural preoccupation with body weight and shape – for example, due to global dissemination of body ideals through mass media (typically low weight in women and muscular physique in men) – has contributed to increased rates of eating disorders in many parts of the world. The global obesity epidemic has also contributed to social concerns about eating and weight. • The prevalence of feeding and eating disorders varies by region, including differences by gender. For example, weight concerns and eating disturbances are more prevalent among men in some Asian and eastern Mediterranean societies than in the Americas. Anorexia nervosa Essential (required) features • Significantly low body weight for the individual's height, age, developmental stage or weight history is required for diagnosis. A commonly used threshold is body mass index (BMI) of less than 18.5 kg/m2 in adults and BMI for age under the 5th percentile in children and adolescents. Rapid weight loss (e.g. more than 20% of total body weight within 6 months) may replace the essential feature of low body weight, as long as other diagnostic requirements are met. Children and adolescents may exhibit failure to gain weight as expected based on the individual developmental trajectory rather than weight loss. • Low body weight is not better accounted for by another medical condition or the unavailability of food. • The presentation is characterized by a persistent pattern of restrictive eating or other behaviours aimed at establishing or maintaining abnormally low body weight, typically associated with extreme fear of weight gain. Behaviours may be aimed at reducing energy intake by fasting, choosing low-calorie food, excessively slow eating of small amounts of food, and hiding or spitting out food, as well as by purging behaviours such as selfinduced vomiting and use of laxatives, diuretics or enemas, or omission of insulin doses in individuals with diabetes. Behaviours may also be aimed at increasing energy expenditure through excessive exercise, motor hyperactivity, deliberate exposure to cold and use of medication that increases energy expenditure (e.g. stimulants, weight-loss medication, herbal products for reducing weight, thyroid hormones). • Excessive preoccupation with body weight or shape is apparent. Low body weight is overvalued and central to the person's self-evaluation, or the person's body weight or shape is inaccurately perceived to be normal or even excessive. Preoccupation with weight or shape, when not explicitly reported, may be manifested in behaviours such as repeatedly checking body weight using scales; repeatedly checking body shape using tape measures or reflection in mirrors; constantly monitoring the calorie content of food or searching for 6B80 Feeding and eating disorders | Anorexia nervosa

399 Feeding and eating disorders information on how to lose weight; or exhibiting extreme avoidant behaviours, such as refusal to have mirrors at home, avoidance of tight-fitting clothes, or refusal to know one’s weight or to purchase clothing with specified sizing. Specifiers for underweight status In the context of anorexia nervosa, severe underweight status is an important prognostic factor that is associated with a high risk of physical complications and substantially increased mortality. In adults, very low BMI has been found to be associated with poorer long-term prognosis among individuals with anorexia nervosa, although it is not the sole determinant of medical risk. Anorexia nervosa with significantly low body weight • Anorexia nervosa with significantly low body weight meets all diagnostic requirements for anorexia nervosa, with BMI between 18.5 kg/m2 and 14.0 kg/m2 in adults or BMI for age between the 5th and 0.3rd percentile in children and adolescents. Anorexia nervosa with dangerously low body weight • Anorexia nervosa with dangerously low body weight meets all diagnostic requirements for anorexia nervosa, with BMI of under 14.0 kg/m2 in adults or BMI for age under the 0.3rd percentile (fewer than three in one thousand) in children and adolescents. In the context of anorexia nervosa, dangerously low body weight is an important prognostic factor that is associated with a high risk of physical complications and substantially increased mortality. Anorexia nervosa in recovery with normal body weight • Among individuals who are recovering from anorexia nervosa who have achieved a healthy body weight, the diagnosis should be retained until a full and lasting recovery is achieved. A full and lasting recovery includes maintenance of a healthy weight and the cessation of behaviours aimed at reducing body weight for a sustained period (e.g. at least 1 year) following the termination of treatment. Other specified anorexia nervosa Anorexia nervosa, unspecified 6B80.0 6B80.1 6B80.2 6B80.Y 6B80.Z Feeding and eating disorders | Anorexia nervosa

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Specifiers for the pattern of weight-related behaviours Different patterns of weight-related behaviours among individuals with anorexia nervosa may be related to treatment selection and clinical management, as well as the course and outcome of the disorder. The following specifiers may be applied to 6B80.0 Anorexia nervosa with significantly low body weight and 6B80.1 Anorexia nervosa with dangerously low body weight. (The x below corresponds to the fifth-character code 0 or 1, indicating the individual’s underweight status.) 6B80.x0 restricting pattern The restricting pattern specifier should be assigned to individuals with anorexia nervosa who induce weight loss and maintain low body weight through restricted food intake or fasting, alone or in combination with increased energy expenditure (e.g. through excessive exercise), but who do not engage in binge-eating or purging behaviours. 6B80.x1 binge-purge pattern The binge-purge pattern specifier should be assigned to individuals with anorexia nervosa who present with episodes of binge-eating or purging behaviours aimed at getting rid of ingested food (e.g. self-induced vomiting, laxative abuse or enemas). This type of anorexia nervosa also includes individuals who exhibit binge-eating episodes but do not purge. 6B80.xZ unspecified Additional clinical features • Signs of low body weight may include visible or measurable signs of starvation, such as emaciation (lack of fat and muscle mass), extremities that feel cold to the touch or appear blue, hair loss, growth of fine “lanugo” hair, oedema, proximal muscle weakness, amenorrhea, osteopenia or osteoporosis, slow heart rate and low blood pressure. • An explicitly stated fear of weight gain is not an absolute requirement for the diagnosis of anorexia nervosa, as long as the behaviours maintaining underweight status appear to be intentional, and there are other behavioural indicators of preoccupation with body weight or shape (e.g. repeated checking or monitoring, or extreme avoidance behaviours). • Individuals with anorexia nervosa often show a

persistent lack of recognition that they are underweight or excessively thin, and dismiss objective evidence regarding their actual weight or shape and the seriousness of their condition. • Medical risk among individuals with anorexia nervosa is not solely dependent on weight status. Medical assessment should take into account other important medical risk factors as part of a comprehensive physical examination. Other risk factors include, but are not limited to, rapid weight loss (especially in children), orthostatic hypotension, bradycardia or postural tachycardia, hypothermia, cardiac arrhythmia and biochemical disturbance. Feeding and eating disorders | Anorexia nervosa

401 Feeding and eating disorders Boundary with normality (threshold) • Anorexia nervosa must be associated with significantly low body weight for the individual's height, age, developmental stage or weight history, and with extreme attitudes and behaviours that distinguish it from normal dieting and "normative discontent" with one's body shape and weight. Course features • Anorexia nervosa often has its onset during adolescence or early adulthood (i.e. between the ages of 10 and 24 years), typically following a stressful life event. Early-onset anorexia nervosa (prior to puberty) and late-onset anorexia nervosa (after the age of 40 years) are relatively rare. • Many individuals display a period of altered eating behaviours prior to meeting the full diagnostic requirements for anorexia nervosa. • Although some individuals recover fully after a single episode of anorexia nervosa, many experience a chronic course of illness over many years. • Individuals with severe symptoms of anorexia nervosa may require hospitalization to restore weight and address medical complications. These individuals are less likely to experience remission of symptoms. • Most individuals diagnosed with anorexia nervosa experience remission within 5 years of onset. However, even after an individual no longer meets the diagnostic requirements for anorexia nervosa, they are more likely to have a lower body weight and increased psychological features associated with anorexia nervosa (e.g. perfectionism) compared to the general population. • Anorexia nervosa is associated with premature death, often due to medical complications of starvation or to suicide. Developmental presentations • Children with anorexia nervosa may not be able to articulate body-image concerns and emotions related to restrictive eating. Presenting features among children may include avoidance of food intake with denial of the severity of malnutrition for reasons other than body-image concerns (e.g. reporting they are "not hungry" or have abdominal pain), as well as nonverbal forms of food refusal. • Children with anorexia nervosa are less likely to engage in binge eating and purging, or to engage in other compensatory behaviours. • The prognosis for adolescents diagnosed with anorexia nervosa is better than the prognosis for adults with anorexia nervosa. Feeding and eating disorders | Anorexia nervosa

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • Older individuals with anorexia nervosa who have had a longer duration of illness often exhibit chronic medical complications. Culture-related features • Symptom presentation of anorexia nervosa varies across cultural groups. For example, in Asia, a subset of individuals with anorexia nervosa may not express fear of weight gain (sometimes referred to as "fat phobia") as a rationale for reducing energy intake. Instead, dietary restriction may be attributed to gastrointestinal discomfort or to cultural or religious motives (fasting or dietary rules). Such cases should still be regarded as meeting the excessive preoccupation with body weight or shape essential feature if clinical observation or collateral history supports the conclusion that they are motivated by an intention to lose weight or to prevent weight gain. • Anorexia nervosa occurs in all cultures, but cross-cultural variations exist in prevalence and presentation. For example, the

incidence of anorexia nervosa is greater in high-income countries and in populations with higher levels of globalization and related transformations in sociocultural values, gender roles, work, food supply and lifestyle. The prevalence of anorexia nervosa is very low in Africa and Latin America, and among African Americans and Latin Americans in the United States compared to the prevalence found in Europe and some Asian countries, such as China and Japan. • The prevalence of anorexia nervosa among men is increasing globally, and more men are presenting for treatment of the disorder. Sex- and/or gender-related features • Globally, anorexia nervosa is up to 10 times more commonly diagnosed among females. Lifetime prevalence among women has been reported to be between 0.8% and 6.3% in Western settings. Emerging studies from eastern Europe, Asia and Latin America show a similar range of prevalence. • Less is known about the true prevalence of anorexia nervosa in males. However, there is evidence that incidence and detection of anorexia nervosa in males is increasing. • The onset of anorexia nervosa is earlier in females. • Laxative abuse is more common among females; excessive exercise is more common among males. • Males with anorexia nervosa are more likely to be preoccupied with being insufficiently muscular or lean – in response, they may exhibit unusual eating behaviours (e.g. excessive protein consumption along with caloric restriction) or engage in excessive exercise for the purpose of attaining and maintaining low body weight or a low percentage of body fat. If low body weight and low body weight idealization are not part of the clinical presentation, a diagnosis of body dysmorphic disorder should be considered (see the section on boundaries with other disorders and conditions (differential diagnosis) below). Feeding and eating disorders | Anorexia nervosa

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Such beliefs are consistent with a diagnosis of anorexia nervosa, and an additional diagnosis of delusional disorder or other psychotic disorder is not warranted in such cases. However, if other delusional beliefs are present (e.g. persecutory delusions that are unrelated to weight, shape or food intake) or there are other psychotic symptoms (e.g. thought disorder, hallucinations), a separate diagnosis of a primary psychotic disorder may be warranted. Boundary with obsessive-compulsive disorder Individuals with anorexia nervosa often experience repetitive and persistent thoughts about their weight or shape or about food, which can resemble obsessions. They may also engage in repetitive behaviours in response to these thoughts (e.g. exercise, purging). If repetitive thoughts and behaviours are limited to concerns about weight or shape or about food, an additional diagnosis of obsessive-compulsive disorder should not be assigned. Boundary with body dysmorphic disorder Body dysmorphic disorder is distinguished from anorexia nervosa in that preoccupations and body-image disturbance in body dysmorphic disorder are focused on features other than overall Feeding and eating disorders | Anorexia nervosa

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