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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders weight, shape and size (e.g. preoccupation with the nose or skin), and are not accompanied by disturbance in eating behaviour or marked weight loss. Some individuals (primarily males) with body dysmorphic disorder exhibit muscle dysmorphia such that they are preoccupied about being insufficiently muscular or lean and, in response, may exhibit unusual eating behaviours (e.g. excessive protein consumption) or engage in excessive exercise (e.g. weightlifting). In these cases, behaviours related to diet and exercise are motivated by a desire to be more muscular rather than to attain or maintain a low body weight. However, if low body weight idealization is central to the clinical presentation, and body weight is sufficiently low, a diagnosis of anorexia nervosa instead of body dysmorphic disorder should be assigned. Bulimia nervosa Essential (required) features • Frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of at least 1 month) are required for diagnosis. Binge eating is defined as a discrete period of time (e.g. 2 hours) during which the individual experiences a loss of control over their eating behaviour, and eats notably more or differently than usual. Loss of control over eating may be described by the individual as feeling like they cannot stop or limit the amount or type of food eaten; having difficulty stopping eating once they have started; or giving up even trying to control their eating because they know they will end up overeating. • The presentation is characterized by repeated inappropriate compensatory behaviours to prevent weight gain (e.g. once a week or more over a period of at least 1 month). The most common compensatory behaviour is self-induced vomiting, which typically occurs within an hour of binge eating. Other inappropriate compensatory behaviours include fasting or using diuretics to induce weight loss, using laxatives or enemas to reduce the absorption of food, omission of insulin doses in individuals with diabetes, and strenuous exercise to greatly increase energy expenditure. • Excessive preoccupation with body weight or shape is apparent. 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 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. • There is marked distress about the pattern of binge eating and inappropriate compensatory behaviour, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. During the early phases of the disorder, symptoms may be concealed and functioning maintained through significant additional effort. • The symptoms do not meet the diagnostic requirements for anorexia nervosa. 6B81 Feeding and

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders • Individuals with bulimia nervosa are at a significantly increased risk of substance use, suicidality and health complications (e.g. gastrointestinal problems) that can lead to premature death. • Some individuals may cease purging or compensatory behaviours but continue to engage in binge eating. In this case, the diagnosis may be changed to binge-eating disorder if all diagnostic requirements are met. • Stressful life events or a history of anorexia nervosa increase the likelihood of the onset of bulimia nervosa. A restricting pattern in anorexia nervosa may evolve over time into a pattern of binging and purging in bulimia nervosa. In such cases, the diagnosis may be changed to bulimia nervosa after 1 year during which body weight has not been sufficiently low to meet the diagnostic requirements of anorexia nervosa. Developmental presentations • Onset of bulimia nervosa typically occurs during or shortly after puberty. Young children do not commonly engage in binge eating due to a lack of access and control of food availability. Culture-related features • The prevalence of bulimia nervosa is higher in cultures characterized by an idealized thin body ideal. In addition, the prevalence of bulimia nervosa is increasing in countries that are industrializing and transitioning to more global and urbanized societies. • The distribution of bulimia nervosa across cultural groups within a society can change over time. For example, in the United States, the incidence of the disorder appears to be decreasing among Euro-American females and increasing among ethnic minority groups –

particularly Latin Americans and African Americans. • Purging methods may be locally specific, such as the use of herbal purgatives in Asia and the Pacific region (e.g. seaweed and herbal teas in Japan; indigenous tea in Fiji), and justified with medicinal or other rationales that may obscure their pathological significance. Sex- and/or gender-related features • Bulimia nervosa is more prevalent among females. • Males are less likely than females to engage in purging behaviours, and have a greater tendency to use excessive exercise or steroids as compensatory behaviours in response to binges. Males are also less likely to seek treatment. Feeding and eating disorders | Bulimia nervosa

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