

Assessment of the individual with an eating disorder and their family

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Abstract

This article highlights the critical importance of assessing eating disorders, addressing both physical and mental health impacts. The proposed framework combines medical history, physical assessment and family influences. The emphasis is on achieving early recognition and effective intervention using a multidimensional approach.

Keywords: mental health, physical health, eating disorders, anorexia nervosa, assessment, family dynamics

1. Introduction

Eating disorders are intricate mental health conditions with profound impacts on both physical and psychological wellbeing (1, 2). This paper covers the assessment process for these disorders, focusing on the interplay of medical, psychiatric and sociocultural factors that influence their development and persistence (3, 4).

The International Classification of Diseases, 11th Revision (ICD-11), categorises conditions such as anorexia nervosa, bulimia nervosa and binge eating disorder as severe mental health issues that disrupt eating behaviours, body weight and shape. Understanding these classifications is important for developing effective, tailored interventions (5, 6). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), reinforces the importance of precise assessment in diagnosing these disorders.

Effective treatment hinges on a comprehensive assessment encompassing medical, psychiatric and sociocultural dimensions (7, 8). The evolution of eating disorder assessment methodologies reflects a shift toward multidimensional and integrative approaches, with a growing emphasis on the critical interplay of medical, psychiatric and sociocultural dimensions. Mitchell and Peterson (9) laid the groundwork by emphasising standardised diagnostic tools, such as the Eating Disorder Examination (EDE), to evaluate disordered eating behaviours and associated psychological conditions, noting the importance of assessing patient readiness for change. Building on this, Rienecke, Nance and Wallis (10) expanded the scope by advocating for developmental, cultural and familial considerations, emphasising the use of validated instruments to assess symptom severity and functional impairment. More recently, Mehler and Andersen (7) reinforced the necessity of thorough assessments that include rigorous medical evaluations to identify complications such as electrolyte imbalances and cardiovascular issues, which are common in this population. These reviews collectively highlight that effective treatment depends on holistic assessments that address the severe physical, psychological and sociocultural risks, including heightened suicide rates, associated with eating disorders (1, 8, 11, 12). This integrated approach enhances diagnostic precision and informs tailored interventions, emphasising the urgency of timely and detailed care.

The evolution from the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines to the Medical Emergencies in Eating Disorders (MEED) framework signified a significant advance in assessment protocols. While MARSIPAN focused on immediate medical stabilisation, MEED integrates comprehensive medical and psychological evaluations, emphasising the interconnectedness of physical and mental health (13-18). Timely evaluations are essential for detecting changes in eating habits and ensuring effective intervention.

The assessment of eating disorders differs between adolescents and adults. For adolescents, family dynamics, school pressures and developmental changes are typically key factors (17, 19, 20). In contrast, adult assessments address broader psychosocial factors and long-term health consequences, including chronic medical conditions and entrenched behavioural patterns (21-23).

Assessing eating disorders is particularly challenging due to factors such as patient denial or minimisation of symptoms, which can obstruct accurate diagnosis and treatment. This difficulty is compounded for under-recognised groups, including males, older adults, ethnic minorities and those of average weight (24-26). Stigma and the complex interplay of physical, psychological and social factors often hinder effective communication (27, 28), while patients may downplay their symptoms due to embarrassment or lack of insight, further complicating diagnosis (29). While structured questionnaires can provide valuable data, they may overlook individual nuances; in contrast, clinical interviews allow for deeper insights but rely heavily on patient disclosure. The broad spectrum of eating disorder sub-

types, including those at normal weight, and the dynamic nature of these conditions necessitate comprehensive and adaptable assessments (6, 20, 23). For adolescents, developmental factors add complexity to the assessment process, making corroborating information from caregivers essential, especially when comorbidities such as anxiety or depression are involved (21, 22, 30).

2. Assessment of eating disorders

A comprehensive eating disorder assessment by a multidisciplinary team (MDT) – including a psychiatrist, dietician and therapist – is essential for diagnosis, severity evaluation and treatment planning. This approach integrates history, clinical assessment, diagnostic tools and family dynamics within a biopsychosocial framework.

3. Biopsychosocial formulation

Eating disorders are complex conditions influenced by biological, psychological and social factors, including predisposing, precipitating, perpetuating and protective elements.

Biologically, genetic predispositions contribute significantly, with heritability estimates for anorexia and bulimia ranging from 50% to 80% (31). Neurobiological factors like serotonin and dopamine imbalances, and hormones such as leptin and ghrelin, increase vulnerability (32). Autism spectrum disorder (ASD) also influences eating disorder development, particularly anorexia, emphasising the need for tailored treatments addressing ASD-related behaviours (33).

Psychologically, predisposing factors include perfectionism and negative self-evaluation, which can lead to rigid dietary rules and compulsive behaviours (34). Precipitating factors, such as trauma or weight-related teasing, often trigger disordered eating (35). Maladaptive cognitions and societal pressures perpetuate the disorder through persistent negative beliefs and internalisation of thin ideals (36).

Jacobi et al. (35) highlight the critical roles of social, familial and cultural factors in perpetuating eating disorders. Socially, individuals often face isolation and stigma, fostering shame and reinforcing disordered behaviours. Within families, dynamics such as overinvolvement, criticism or lack of emotional support exacerbate the disorder, alongside parental modelling of dieting or imposing unrealistic expectations. Culturally, the glorification of thinness, particularly in Western societies, perpetuates body dissatisfaction and restrictive eating, as individuals strive to meet unattainable ideals. These interconnected influences create a complex backdrop that sustains eating disorders and emphasises the need for holistic, context-aware interventions.

4. Mental health assessment

4.1 History

Good history-taking is essential in eating disorder assessments; it can offer vital insights into the individual's experiences and the onset and progression of the disorder.

Onset and duration

Understanding the progression of an eating disorder involves examining changes in eating habits over time to discern patterns and trajectories. Exploring personal history may reveal links between stressful or traumatic events and the individual's relationship with food, facilitating comprehensive interventions aimed at addressing underlying factors contributing to the disorder.

4.2 Psychological assessment

Eating habits

During assessment, exploring changes in eating patterns and recent habits is essential. Questions on specific dietary preferences or restrictions, such as vegetarianism, must be asked. Exploring family eating patterns provides insight into familial influences on dietary choices. These inquiries gather information about nutritional habits and family dynamics, facilitating a holistic understanding of eating patterns.

Eating attitude

During assessment, it is essential to ask individuals about their preoccupation with thoughts about food, eating or body image, including the intensity and frequency of these concerns. Inquiries should cover feelings of guilt after meals, changes in mood, anxiety levels, or concentration, fears related to body fat or weight gain and preferences for food textures or sensory aspects.

Eating behaviours

Individuals are asked about any binge eating episodes and prompted to detail the circumstances. Enquiries should also explore behaviours like separating or smearing food to reveal the underlying emotions and thoughts linked to these actions.

Weight-controlling strategies

As part of the assessment, individuals are asked to detail their weight control strategies, including restrictive eating, exercise frequency and methods such as laxatives, purging or self-induced vomiting. They are also questioned about any episodes of diarrhoea related to their eating habits.

Body image and shape

Individuals are prompted to share changes in their perception of body shape over time. Additionally, questions are posed regarding behaviours such as body checking or measuring. By sensitively exploring these aspects, clinicians gain deeper insights into body image concerns and potential preoccupations.

4.3 Psychiatric history

Evaluating past treatments and their outcomes is essential in assessing individuals with eating disorders. Reviewing previous interventions helps clinicians to understand their effectiveness and to identify areas for adjustment. Additionally, examining coexisting mental health conditions is important, as these can influence and aggravate the eating disorder.

4.4 Risk assessment for self-harm and suicide

Individuals with eating disorders face a significantly higher risk of self-harm and suicide compared to the general population. Research, such as the meta-analysis by Preti et al. (12), shows a 27.2% rate of suicide attempts among those with eating disorders, highlighting the need for thorough risk assessment and appropriate intervention. This evaluation should consider current and historical factors contributing to vulnerability, including access to harmful online content and substance use.

4.5 Insight and motivation

Assessing insight and motivation, particularly gaining an understanding of the factors influencing the patient's perception of their condition, can provide valuable information for effective treatment. Patients often minimise or deny their symptoms (37). Understanding their perception of the condition and factors influencing their motivation provides critical insights into their readiness and commitment to recovery.

4.6 Temperament and personality

In the assessment process, individuals are asked to describe their temperament and overall personality traits. It is essential to ask about tendencies toward perfectionism in various aspects of their lives, including attitudes towards food and body image. By exploring these aspects sensitively, clinicians can gain deeper insight into the individual's psychological makeup and potential contributing factors to their eating disorder.

4.7 Social and environmental factors

The influence of support systems from friends, family and others, as well as societal and cultural factors, is important in the development and management of eating disorders. Individuals are asked to describe the support they receive from friends, family or others in managing their overall wellbeing. Additionally, consideration is given to societal or cultural factors that may contribute to the eating disorder.

5. Medical assessment

A key aspect of eating disorder assessments is a detailed evaluation of medical history and current physical health, given the extensive impact that eating disorders can have on organ systems, the risk of potentially life-threatening complications and the necessity to exclude organic causes of weight loss (13).

5.1 Medical history

Inquiry should be made about potential physical health issues associated with eating habits, including dizziness, chest pain or fatigue. The history-taking should also explore whether the individual has pre-existing medical conditions or takes medications that might impact their condition. Any history suggestive of organic causes of weight loss must be elicited. This should include identifying any pre-existing conditions that could influence or be affected by the eating disorder, such as diabetes, metabolic disorders, gastrointestinal issues, psychiatric conditions, autoimmune disorders or thyroid problems.

Recent or recurrent illnesses should be recorded, particularly those that have led to significant weight loss or nutritional deficiencies. Additionally, past hospitalisations related to physical or psychiatric conditions, including complications linked to the eating disorder, should be noted. The use of weight-loss aids, such as laxatives, diuretics, appetite suppressants or other supplements, should also be documented, detailing their duration, frequency and effects. It is important to document all medications the patient takes, including prescriptions, over-the-counter drugs and supplements, focusing on those that impact appetite, weight, metabolism or mental health.

5.2 Weight history and weight change

Individuals are asked to provide a detailed history of their weight throughout adolescence and adulthood, including their highest and lowest weights, current weight and any notable trends. Enquiries are made regarding the frequency of self-weighing and how this practice impacts their emotions or behaviours.

5.3 Pubertal development

Assessing the onset of puberty and related physical changes is essential for understanding the developmental stage of adolescents who may have an eating disorder. Inquiring about the onset of menstruation in females offers vital insights into their reproductive health. It can help identify any potential issues related to menstrual irregularities or conditions such as amenorrhea. For males, exploring the development of secondary sexual characteristics, such as increased muscle mass, voice changes and body hair, can provide important information about pubertal progression and overall hormonal health. These assessments can not only identify any concerns about normal development but can also assist in the early detection of potential health concerns related to malnutrition, allowing for timely interventions to support optimal growth and wellbeing during this critical period.

5.4 Anthropometry

Height

Sequential height measurement, conducted using a calibrated, wall-mounted stadiometer, is a good indicator of nutritional status and overall health. It is recommended that height be measured every three months, except in post-menarche patients with minimal potential for further growth. Regular height assessments are essential for identifying complications such as growth stunting or osteoporosis, and informing targeted management strategies tailored to the patient's needs.

Weight

Accurate weight assessment is essential in evaluating eating disorders. Standard protocols are followed, including voiding before measurement and wearing minimal clothing to prevent inflated readings. Calibrated digital or balance-beam scales are used to ensure reliable weight tracking. Body mass index (BMI) is the primary metric for adults, calculated by dividing weight in kilograms by height in meters squared. BMI categories are underweight ($<18.5 \text{ kg/m}^2$), normal weight ($18.5\text{--}24.9 \text{ kg/m}^2$) and obese ($>30 \text{ kg/m}^2$) (38).

Growth and development changes must be considered for children and adolescents. The percentage of median BMI (%mBMI) compares an adolescent's BMI to sex-specific medians, offering a more accurate reflection of nutritional status. Adult BMI criteria are unsuitable for adolescents, and %mBMI does not apply to adults due to differences in growth patterns. In children, weight-for-height percentiles between the 5th and 95th percentiles are normal.

BMI should be interpreted cautiously because it can be affected by factors such as muscle mass, pregnancy and fluid retention. Accurate assessment and treatment of eating disorders require nuanced clinical judgment, with values individualised to reflect unique physiological factors, for example, post-menarche changes in women.

5.5 Physical health examination

A thorough physical examination is essential for evaluating suspected eating disorders. It can distinguish between organic and eating-disorder-related features, detect physical complications and guide tailored treatment plans, enabling early intervention and comprehensive care (39).

Skin

The skin can reveal physiological and nutritional imbalances in individuals with eating disorders. Pale or yellowish skin may indicate anaemia due to iron or vitamin B12 deficiency, or liver dysfunction from malnutrition. Russell's sign, calluses on the back of the hand, may result from self-induced vomiting. Bruising and petechiae suggest increased skin fragility or impaired blood clotting. Lanugo, fine hair covering the body, is an adaptive response to conserve heat during malnutrition. Dehydration manifests as dry skin, sunken eyes and poor skin turgor. Poor wound healing often indicates inadequate protein or vitamin C intake; further signs of vitamin C deficiency include petechiae or ecchymosis. Brittle nails may result from insufficient biotin, zinc or magnesium. Self-harm lesions reflect emotional distress and body image concerns, often present in eating disorders. Vitamin B deficiency can manifest as seborrheic dermatitis, angular stomatitis and glossitis; it can also lead to skin redness, scaling and inflammation.

Ear, nose and throat

Repeated vomiting can cause dental erosion, gingivitis and periodontal disease due to prolonged stomach acid exposure; chronic irritation may lead to parotid enlargement and pharyngeal redness from throat irritation. Dry, brittle hair or hair loss indicates poor nutrient intake, reflecting the body's prioritisation of essential nutrients during malnutrition. Swollen lymph nodes (lymphadenopathy) may arise from infections or inflammation linked to a compromised immune system. Thyroid gland examination can assess the impact of hypo/hyperthyroidism on weight loss, a

common issue in eating disorders. Facial puffiness, resulting from fluid imbalance, may be seen in severe malnutrition. Halitosis (bad breath) can be caused by reduced saliva from dehydration. Restrictive eating habits can also cause an acetone smell, signalling ketosis.

Cardiovascular system

Bradycardia, defined as a pulse below 60 bpm, often indicates reduced metabolic rate due to low energy intake and electrolyte disturbances, including deficient potassium levels. If accompanied by dizziness, fainting or chest pain, it requires urgent medical attention, especially if the pulse falls below 50 bpm. Hypotension, often resulting from dehydration caused by purging behaviours, leads to low blood pressure and decreased blood volume. Monitoring blood pressure while lying and standing helps to assess orthostatic changes that indicate dehydration or electrolyte imbalance. Orthostatic hypotension, a drop in blood pressure upon standing, reflects low blood volume. Oedema, caused by fluid imbalances and nutrient deficiencies, increases cardiovascular strain. Cyanosis, a bluish tint in the skin, particularly in the extremities, may indicate severe malnutrition and poor oxygenation. Mitral valve regurgitation, caused by cardiac muscle thinning due to starvation, highlights structural changes in the heart. Cardiac arrhythmias, often due to electrolyte imbalances such as low potassium, interfere with the heart's electrical conduction and pose additional cardiovascular risks. Cardiomegaly, an enlarged heart, resulting from chronic malnutrition and loss of cardiac muscle mass, can further compromise cardiac function.

Musculoskeletal system

Inadequate nutrition can cause reduced bone density and compromise bone health, making individuals more susceptible to fractures and stress fractures. Additionally, proximal muscle atrophy or wasting, resulting primarily from insufficient protein intake, can manifest as muscle weakness and loss of muscle mass.

Gastrointestinal system

Abdominal discomfort and the presence of a mass may stem from inadequate fibre intake and dehydration, exacerbating constipation, a common gastrointestinal complaint in this population. Delayed bowel sounds, reflecting disrupted gastrointestinal motility, may be observed due to irregular eating patterns characteristic of eating disorders. Additionally, gastroparesis, a condition where the stomach empties slowly, may further complicate gastrointestinal motility and contribute to symptoms such as bloating, nausea and early satiety. Ascites, characterised by abdominal swelling from abnormal fluid collection, may indicate severe malnutrition or liver dysfunction.

Neurological system

Diminished deep tendon reflexes may be observed due to malnutrition and electrolyte imbalances disrupting nerve function. Peripheral neuropathy, stemming from malnutrition-related vitamin deficiencies, can cause symptoms like numbness and tingling in the extremities. Malnutrition can impair cognitive function, leading to difficulties in concentration, memory and thinking ability. Additionally, individuals with eating disorders may exhibit symptoms of specific neurological conditions related to nutritional deficiencies, such as beriberi or Wernicke's encephalopathy, which may present with various neurological manifestations, including peripheral neuropathy; in the case of beriberi, cardiac abnormalities, and in Wernicke's encephalopathy, confusion, ataxia and ophthalmoplegia can occur.

Endocrine system

Hypothermia, characterised by a body temperature below 35.5°C can result from decreased metabolic activity and loss of subcutaneous fat due to inadequate calorie intake.

Pubertal assessment

Pubertal assessment using Tanner stages is typically deferred to a later stage or if there are concerns about delayed puberty. This evaluation enables developmental progress and abnormalities in sexual maturation to be tracked.

6. Medical investigations

6.1 Blood tests

Blood tests in eating disorder assessment can help to distinguish between eating disorders and organic causes of symptoms, assess consequences of malnutrition, evaluate weight-controlling strategies and identify the risk of re-feeding syndrome.

Blood tests to rule out organic causes of symptoms

Blood tests are essential for ruling out organic causes of symptoms. A full blood count identifies anaemia, infections or bone marrow issues. Thyroid function tests diagnose thyroid disorders affecting weight regulation, including euthyroid syndrome, where results are abnormal despite normal thyroid function. HbA1c tests help detect diabetes, alongside baseline blood glucose measurements to assess hypoglycaemia concerns. Liver function tests assess liver health, which can be affected by malnutrition, while renal function tests evaluate kidney function, particularly if acute

kidney injury or dehydration is suspected. Anti-tTG antibodies are used for coeliac disease screening. Urinary pregnancy testing and measuring luteinising hormone, follicle-stimulating hormone and oestradiol may be relevant for amenorrhoeic girls.

Blood tests to assess the consequences of malnutrition

The comprehensive metabolic panel evaluates electrolyte imbalances, bone profiles and magnesium levels. Iron studies assess anaemia and iron deficiency resulting from inadequate nutrient intake. Vitamin D, folate and B12 levels are often compromised. The levels of these vitamins should be determined; they are important for both bone and neurological health. Lipid profiles offer insights into cardiovascular risk, particularly in cases of extreme weight loss. Zinc levels should not be routinely assessed via blood tests due to inaccuracies; instead, hair specimens provide more reliable results. A micronutrient assessment by a dietitian, coupled with clinical evaluation, may be a more suitable approach.

Other blood tests to consider in specific scenarios

There are various other circumstances in which blood tests may be considered, including those in which there is known or suspected self-induced vomiting, laxative overuse or over-exercise. Blood tests should be used as part of the assessment of refeeding syndrome. These are discussed in the following sections.

Self-induced vomiting

This practice can result in significant electrolyte changes, including low potassium, chloride and magnesium levels. The loss of hydrochloric acid during vomiting disrupts the acid-base balance and affects renal tubules, leading to potassium loss. Self-induced vomiting can induce metabolic alkalosis, characterised by elevated serum bicarbonate levels due to the loss of hydrogen ions, resulting in an increased blood pH.

Laxative misuse

Laxative misuse can result in electrolyte imbalance, dehydration, metabolic alkalosis and impaired kidney function, as evidenced by blood test abnormalities, including low potassium, elevated (BUN) and creatinine, metabolic alkalosis and hypomagnesemia. These complications can lead to cardiac arrhythmias, muscle weakness, seizures and kidney problems. Monitoring electrolyte levels, kidney function and markers of organ damage through blood tests is essential for comprehensive care and early intervention. Additionally, vigilance for complications such as anaemia and bone changes is paramount in managing the consequences of laxative misuse.

Over-exercise

Elevated creatine kinase and lactate dehydrogenase levels indicate muscle damage, suggesting potential strain or injury incurred during physical exertion. Electrolyte disturbance, such as hypokalaemia, hyponatraemia and hypochloreaemia, can result from prolonged physical activity accompanied by excessive sweating, disrupting the body's delicate balance of essential ions. Elevated BUN and creatinine levels are indicators of dehydration induced by significant fluid loss through sweat, highlighting the physiological toll of extended periods of strenuous exercise.

Blood tests to identify the risk of refeeding syndrome

Refeeding syndrome, a potential complication in nutritional rehabilitation, arises from electrolyte imbalance. Rapid carbohydrate reintroduction prompts insulin release, causing low phosphorus levels and possible hypophosphataemia. Decreased potassium and magnesium levels can occur, posing risks to cardiac, respiratory and neuromuscular function. A complete set of urea and electrolyte tests, including additional magnesium, calcium and phosphate, is required.

6.2 Electrocardiography (ECG)

ECG findings in severe malnutrition reveal cardiac abnormalities linked to conduction issues, electrolyte imbalance or structural changes. Key markers include QTc prolongation (corrected QT interval over 460 ms in males and 470 ms in females), T-wave abnormalities (flattening or inversion) and heart rate irregularities such as sinus bradycardia (below 60 bpm) and sinus tachycardia (above 100 bpm). Other signs include atrial fibrillation (irregular rhythm without discernible P waves) and ventricular arrhythmias, such as premature ventricular contractions or ventricular tachycardia. These ECG findings are important for assessing cardiac health in individuals with severe malnutrition and guiding appropriate management strategies.

6.3 Dual-energy x-ray absorptiometry (DEXA) scan

The DEXA scan is valuable for assessing bone health, especially in those with anorexia nervosa, who often have low bone mineral density (BMD). It provides baseline BMD measurements and assists in monitoring the impact of malnutrition on bone health. This is particularly important for females with persistent amenorrhea, as they are at an increased risk of osteoporosis and fractures due to hormonal imbalance affecting bone density. According to NICE guidelines, children and young people should have a DEXA scan after one year of being underweight, or sooner if bone pain or fractures occur. Adults should undergo a scan after two years of being malnourished or earlier. DEXA

scans should not be repeated more than once per year, unless bone pain or fractures develop, to limit unnecessary radiation exposure while ensuring effective monitoring.

7. Risk assessment of comorbid physical and mental health conditions

Research shows that 20% of cases involve additional mental health risks (1), while 80% present medical risks (40). The UK MEED guidance provides a structured approach to evaluate the risks comprehensively. For details, see Table 1.

Checklist of "Lightbulb" signs

The MEED guidance includes a Checklist of "Lightbulb" signs to identify indicators of increased severity in eating disorders.

Realm of inquiry	Finding	Notes
History	Rapid weight loss	>1 kg per week for two weeks
	Acute food refusal	>24 hours seek advice
	Frequent vomiting	Risk of hypokalaemic alkalosis
	Faints, chest pain	Cardiorespiratory malfunction
	Little urine output	Renal shutdown
	Intractable constipation	Colonic atony
	Suicidal thoughts	Suicidal behaviour
Examination	BMI <13	Depends on rate of weight loss
	Pulse <40 bpm, postural hypotension with recurrent syncope	Red on risk assessment
	Core temperature 35.5°C	Red on risk assessment
	Muscle weakness (SUSS)	SUSS score 0-1, red on risk assessment
Investigations	Any significant ECG abnormality	Red on risk assessment
	Hypokalaemia	<2.5 mmol/L red on risk assessment
	Hyponatraemia	Water loading
	Low phosphate	From being refed or recent binge
	Raised transaminases	Usually due to malnutrition
	Urine SG <1.010	Water loading
	Hypoglycaemia, glucose <3 mmol/L	Can occur in extreme starvation, often with ketosis
	HbA1C > 10%	The patient has type 1 diabetes and an eating disorder

Table 1. MEED (reproduced with permission from the Royal College of Psychiatrists)

Abbreviations: ECG = electrocardiogram; SG = specific gravity; SUSS = Sit up, Squat, Stand Test

8. Family assessment

Understanding family dynamics is important for treating eating disorders and ensuring long-term recovery (40, 41). While an initial overview of the family system provides a foundation, a thorough assessment is essential at the beginning of therapy. This assessment includes gathering detailed information about family composition, such as each member's name, age and role. It also involves reviewing the medical and psychiatric history of family members, particularly any previous occurrences of eating disorders or mental health conditions. Understanding the family's attitudes toward food, dietary practices, restrictions and cultural influences is essential.

Additionally, the assessment explores family dynamics, including communication patterns and support systems. Evaluating how family roles and relationships affect the individual with an eating disorder helps identify sources of conflict and support (42, 43).

Recognising the impact of the eating disorder on the family's psychosocial context is vital for developing a targeted treatment plan. By addressing these dynamics through family therapy, clinicians can facilitate realignment and support sustained recovery, ensuring that the family's specific needs and challenges are effectively discussed (40, 41).

9. Differential diagnosis

A comprehensive differential diagnosis requires evaluation of a range of medical and psychiatric conditions that may present with symptoms or signs similar to those of eating disorders. This includes assessing gastrointestinal, endocrine, neurological and autoimmune disorders and malnutrition-related complications, as well as psychiatric conditions such as major depressive disorder, anxiety disorders, neurodiversity, personality disorders and obsessive-compulsive disorder.

10. Collateral history

Gathering collateral history from family or close contacts is essential in eating disorder assessments, as patients may under-report or minimise symptoms. External perspectives can uncover hidden behaviours and provide insight into early triggers, family dynamics and overall functioning. This additional information helps clinicians to make accurate diagnoses and tailor individual interventions appropriately.

11. Diagnostic tools and screening

Screening and assessment tools

Screening tools identify potential eating disorders, but they differ from comprehensive clinical assessments, which are essential for accurate diagnosis and personalised treatment planning. Brief screening tools like the SCOFF questionnaire are helpful for initial identification of individuals in primary care or school settings who are likely to require specialist referral. In contrast, detailed diagnostic questionnaires, like the EDE, are more suitable in specialised clinical settings as they facilitate thorough evaluations and tailored treatment strategies.

Screening tools

SCOFF questionnaire: according to Morgan, Reid and Lacey (44), this is used in clinical settings and comprises five questions assessing eating disorder risk factors. A score of two or more suggests a likely diagnosis, prompting further evaluation for eating disorders in individuals aged 13 and older. This test has a sensitivity of 81.5% and a specificity of 89.0% (44).

S – Do you make yourself **S**ick because you feel uncomfortably full?

C – Do you worry you have lost **C**ontrol over how much you eat?

O – Have you recently lost more than **O**ne stone (6.35 kg) in three months?

F – Do you believe yourself to be **F**at when others say you are too thin?

F – Would you say **F**ood dominates your life?

The **Eating Disorder Examination for Adolescents (EDE-A)** is an assessment tool specifically designed to evaluate eating disorder symptoms and behaviours in adolescents aged 12 to 18. It is adapted from the original EDE to suit adolescents' developmental and psychological characteristics (45).

Eating Disorder Examination Questionnaire (EDE-Q): adapted from the EDE interview, a self-reported instrument assessing eating disorder psychopathology. It is tailored for age groups including adults 18 years and older (46). It has a sensitivity of 84% and a specificity of 79% (47).

The **Eating Attitudes Test (EAT-26)** is a widely employed self-report questionnaire for individuals aged 13 years and older. It evaluates attitudes and behaviours concerning eating habits and body image through 26 items, effectively identifying those at risk of developing eating disorders. (48). A score of 20 or higher indicates a high level of concern about dieting, body weight or problematic eating behaviours.

The **Binge Eating Scale (BES)** is a self-reported questionnaire suitable for adolescents and adults. It explores behaviours and emotions linked to binge eating to provide valuable insights into the presence and severity of binge eating behaviours (49). This test has a sensitivity of 81.8% and a specificity of 97.8% (50).

The **Nine Item Avoidant/Restrictive Food Intake Disorder (NIAS)** is a brief assessment tool designed to identify individuals exhibiting symptoms of avoidant/restrictive food intake disorder (ARFID) quickly, prompting further evaluation and intervention by healthcare professionals (51).

Clinically useful questionnaires

The **PARDI-AR-Q** is a self-report measure of the symptoms of ARFID, based on the Pica, ARFID and Rumination Disorder Interview (52).

The **Body Shape Questionnaire (BSQ)** is a self-report tool used in clinical and research contexts to assess concerns and preoccupations regarding body shape. It evaluates body dissatisfaction and weight-and-shape-related distress to provide insights into body-image-related distress (53).

The **Dutch Overeating Questionnaire (DEBQ)** is a self-report tool designed to assess different aspects of eating behaviour. Focused on emotional eating, external eating and restrained eating, it helps identify patterns related to overeating in response to emotions, external cues and conscious control efforts (54). It is typically used for individuals aged 18 years and older.

Diagnostic tools

The **Eating Disorder Examination for Children (ChEDE)** is a structured interview designed to assess eating disorder

ders in youth. It evaluates eating behaviours, body image concerns and related psychological issues, offering essential insights for diagnosis and treatment (55, 56).

The **Eating Disorder Examination (EDE)** is a structured clinical interview widely considered the gold standard for assessing adult (>18 years) eating disorders (57). It has four subscales: restraint, eating concern, shape concern and weight concern.

The **Pica, ARFID and Rumination Disorder Interview (PARDI)** is a semi-structured, multi-informant clinical assessment designed to assess and diagnose pica, ARFID and rumination disorder according to DSM-5 criteria.

Assessment of clinical impact tools

The Clinical Impairment Assessment (CIA) evaluates the effects of eating disorders on diverse life domains, including relationships, work and overall wellbeing, offering clinicians valuable insights into the broader consequences of these disorders (58). The CIA is typically used for individuals aged 14 years and older. This test carries a sensitivity of 76% and a specificity of 86% (58).

12. Diagnosis

Table 2 provides a comparative overview of the diagnostic criteria for various eating disorders defined by the ICD-11 and DSM-5-TR. It highlights similarities and critical differences between the two diagnostic systems, illustrating each system's unique approach to categorising and defining eating disorders based on symptomatology, severity, duration and contextual factors.

13. Conclusion

Evaluating eating disorders transcends mere diagnosis; it is a critical blueprint for bespoke treatment and comprehensive recovery. By taking into account medical history, clinical evaluation and family dynamics within the biopsychosocial model, it can facilitate early detection and effective therapy. Thorough assessment can clarify severity and guide personalised interventions, with the aim of achieving effective recovery and enduring health.

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ED diagnosis	ICD-11	DSM-5-TR	Key differences
Pica	Pica is characterised by regular consumption of non-nutritive substances or raw food ingredients. Substances may include non-food objects like clay, soil, chalk, or raw food ingredients such as salt or corn flour. The behaviour is persistent or severe enough to require clinical attention. Typically occurs in individuals who have reached a developmental age of approximately two years. Consumption of non-food items causes damage to health, impairment in functioning, or significant risk due to the frequency, amount, or nature of ingested substances.	A. Persistent eating of nonnutritive, non-food substances over at least one month. B. Eating nonnutritive, non-food substances is inappropriate for the individual's developmental level. C. The eating behaviour is not part of a culturally supported or socially normative practice. D. If the eating behaviour occurs in the context of another mental disorder (e.g., intellectual developmental disorder [intellectual disability], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.	ICD-11 comprehensively describes substances consumed and behaviour severity, emphasising developmental aspects. In contrast, DSM-5-TR considers cultural and social norms alongside the presence of other mental disorders or medical conditions and requires a minimum duration of one month.
Rumination-regurgitation disorder/rumination disorder	Characterised by intentional and repeated regurgitation of previously swallowed food. Regurgitation may involve re-chewing, re-swallowing, or deliberately spitting out. Behaviour occurs frequently (several times per week) over several weeks. Not fully explained by other medical conditions causing regurgitation or nausea/vomiting. Diagnosis limited to individuals at least two years old.	A. Repeated regurgitation of food over at least one month. Regurgitated food may be re-chewed, re-swallowed, or spat. B. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis). C. The eating disturbance does not occur exclusively during anorexia nervosa, bulimia nervosa, binge eating disorder, or avoidant/restrictive food intake disorder. D. If the symptoms occur in the context of another mental disorder (e.g., intellectual developmental disorder [intellectual disability] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.	ICD-11 criteria provide comprehensive descriptions of behaviour and specify frequency/duration requirements for diagnosis, emphasising minimum age for diagnosis. In contrast, DSM-5-TR criteria consider comorbid medical conditions and exclude diagnosis if the eating disturbance occurs exclusively within other specified eating disorders.
Avoidant/restrictive food intake disorder (ARFID)	ARFID characterised by: -Insufficient quantity or variety of food intake results in weight loss, nutritional deficiencies, or adverse physical health effects. -Significant impairment in various areas of functioning. -Eating behaviour not driven by a preoccupation with body weight or shape. -Not due to food unavailability, other medical conditions, mental disorders, or substance/medication effects.	A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) associated with one or more of the following: 1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children). 2. Significant nutritional deficiency. 3. Dependence on enteral feeding or oral nutritional supplements. 4. Marked interference with psychosocial functioning. B. The disturbance is not better explained by a lack of available food or by an associated culturally sanctioned practice. C. The eating disturbance does not occur exclusively during anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced. D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.	ICD-11 highlights the physical health impact of food restriction, while DSM-5-TR also considers psychosocial functioning. DSM-5-TR includes exclusion criteria for cultural practices and other disorders, offering a comprehensive framework. It also assesses the severity of eating disturbances relative to concurrent medical or mental conditions, prompting additional clinical attention if needed.
Anorexia nervosa	-Anorexia Nervosa characterised by: -Significantly low body weight for height, age, and developmental stage. -Commonly defined by BMI less than 18.5 kg/m ² in adults or BMI-for-age under 5th percentile in children/adolescents. -Rapid weight loss (>20% of total body weight within six months) may replace low body weight guidelines if other criteria are met. -Children/adolescents may fail to gain weight as expected. -Persistent behaviours to prevent weight restoration include restricted eating, purging, and excessive exercise. -Central role of low body weight or shape in self-evaluation.	A. Restricting energy intake relative to requirements leads to a significantly low body weight regarding age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than usual or, for children and adolescents, less than minimally expected. B. Intense fear of gaining weight or becoming fat or persistent behaviour that interferes with weight gain, even at a significantly low weight. C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent recognition of the seriousness of the current low body weight.	ICD-11 focuses on specific BMI thresholds to define low body weight, while DSM-5-TR emphasises weight relative to developmental trajectory and physical health without specifying BMI. Additionally, DSM-5-TR incorporates criteria concerning fear of weight gain and disturbance in body weight or shape perception, aspects not explicitly outlined in the ICD-11 criteria. Notably, ICD-11 allows for rapid weight loss as an alternative diagnostic criterion, while DSM-5-TR does not expressly mention this criterion.

ED diagnosis	ICD-11	DSM-5-TR	Key differences
Bulimia nervosa	Bulimia Nervosa is characterised by: Frequent, recurrent binge eating episodes (once a week or more over at least one month). Binge eating involves subjective loss of control, eating significantly more or differently than usual. Compensatory behaviours like self-induced vomiting, laxative misuse, or excessive exercise. Preoccupation with body shape or weight influencing self-evaluation. Marked by distress or impairment in various areas of functioning. Does not meet diagnostic requirements of Anorexia Nervosa.	A. Recurrent episodes of binge eating. Both of the following characterise an episode of binge eating: 1. Eating, in a discrete period (e.g., within any 2 hours), an amount of food that is larger than what most individuals would eat in a similar period under similar circumstances. 2. A lack of control of overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating). B. Recurrent inappropriate compensatory behaviours to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise. C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months. D. Self-evaluation is unduly influenced by body shape and weight. E. The disturbance does not occur exclusively during episodes of anorexia nervosa.	ICD-11 defines binge eating episodes as occurring at least once weekly over one month, while DSM-5-TR requires this frequency for three months. ICD-11 emphasises impairment in various areas of functioning, whereas DSM-5-TR focuses on body shape and weight influence on self-evaluation. ICD-11 excludes individuals meeting anorexia nervosa criteria, while DSM-5-TR does not specify this criterion.
Binge eating disorder	Binge eating disorder is characterised by: Frequent, recurrent episodes of binge eating (once a week or more over several months). Binge eating episodes involve subjective loss of control, eating significantly more or differently than usual. Accompanied by distressing emotions like guilt or disgust. They are not followed by inappropriate compensatory behaviours seen in Bulimia Nervosa. Marked by distress or impairment in various areas of functioning.	A. Recurrent episodes of binge eating. Both of the following characterise an episode of binge eating: 1. Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is larger than what most people would eat in a similar period under similar circumstances. 2. A lack of control overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating). B. The binge eating episodes are associated with three (or more) of the following: 1. Eating much more rapidly than usual. 2. Eating until feeling uncomfortably full. 3. Eating large amounts of food when not feeling physically hungry. 4. Eating alone because of feeling embarrassed by how much one is eating. 5. Feeling disgusted with oneself, depressed, or very guilty afterwards. C. Marked distress regarding binge eating is present. D. Binge eating occurs, on average, at least once a week for three months. E. Binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during bulimia nervosa or anorexia nervosa.	The ICD-11 emphasises the absence of compensatory behaviours post-binge eating, while the DSM-5-TR excludes their presence and includes additional associated features. Both criteria highlight marked distress or impairment related to binge eating behaviour. The ICD-11 specifies the absence of binge eating during episodes of bulimia nervosa or anorexia nervosa, while the DSM-5-TR adds this criterion and specifies the absence of associated compensatory behaviours.
Other specified feeding or eating disorder	Involve atypical or subthreshold presentations of feeding or eating disorders, which may include variations in the frequency, duration, or severity of symptoms or the presence of symptoms that do not fully meet the criteria for a specific disorder.	This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. Sub-classes include atypical anorexia nervosa/purge disorder.	ICD-11 acknowledges variations in symptomatology that deviate from established criteria, while DSM-5-TR categorises presentations causing distress but not meeting full disorder criteria. DSM-5-TR introduces sub-classes like atypical anorexia nervosa/purging disorder for specificity.
Feeding or eating disorders unspecified/unspecified feeding or eating disorder	This is a broad category used when the symptoms do not fit into specific diagnostic criteria or when there is insufficient information available for a more specific diagnosis.	The unspecified feeding or eating disorder category is used when the clinician chooses not to specify why the criteria are not met for a specific feeding or eating disorder. It also includes presentations with insufficient information to make a more specific diagnosis.	ICD-11 employs a "broader category" for cases not fitting specific diagnostic criteria or lacking sufficient information without specifying reasons. In contrast, DSM-5-TR introduces an "unspecified feeding or eating disorder category," explicitly addressing situations where criteria are not met for a specific disorder, including insufficient information. Furthermore, DSM-5-TR offers detailed guidance on clinician discretion in specifying reasons for not meeting criteria.

Table 2. Comparison of diagnostic criteria for eating disorders between the ICD-11 and DSM-5-TR