Revision of ICD – status update on feeding and eating disorders†

Samir Al-Adawi⁎, Brigita Bax⁎, Rachel Bryant-Waugh⁎, Angélica M. Claudino⁎⁎, Phillipa Hay⁎, Palmiero Monteleone⁎, Claes Norring⁎⁎, Kathleen M. Pike⁎, David J. Pilon⁎, Cecile Rausch Herscovici⁎, Geoffrey M. Reed⁎, Per-Anders Rydelius⁎, Pratap Sharan⁎⁎, Cornelia Thiels⁎, Janet Treasure⁎ and Rudolf Uher⁎

⁎Department of Behavioral Medicine, College of Medicine and Health Sciences, Sultan Qaboos University, Muscat, Sultanate of Oman; ⁎Eating Disorders Center, University of Vilnius, Vilnius, Lithuania; ⁎Feeding and Eating Disorders Service, Department of Child and Adolescent Mental Health, Great Ormond Street Hospital for Children NHS Foundation Trust, London, UK; ⁎⁎Eating Disorders Program, Federal University of São Paulo, São Paulo, SP, Brazil; ⁎⁎⁎James Cook University & Foundation Chair of Mental Health, School of Medicine, University of Western Sydney, Australia; ⁎Department of Psychiatry, University of Naples SUN, Naples, Italy; ⁎⁎Centre for Psychiatry Research, Department of Clinical Neuroscience, Karolinska Institutet & Stockholm Centre for Eating Disorders, Stockholm, Sweden; ⁎Department of Psychiatry, Columbia University, New York, USA; ⁎⁎⁎Capital Health, Halifax, Nova Scotia, Canada; ⁎⁎⁎⁎TESIS Center for Systems Therapies, Buenos Aires, Argentina; ⁎⁎Department of Mental Health and Substance Abuse (MSD/MER), World Health Organization, Geneva, Switzerland; ⁎Department of Child and Adolescent Psychiatry, Karolinska Institutet, Stockholm, Sweden; ⁎⁎Department of Psychiatry, All India Institute of Medical Sciences, Ansari Nagar, New Delhi, India; ⁎⁎⁎Department of Social Studies, University of Applied Sciences Bielefeld, Bielefeld, Germany; ⁎⁎⁎⁎Eating Disorders Unit, Institute of Psychiatry, King’s College London, London, UK; ⁎⁎⁎⁎Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia, Canada B3H 2E2

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The World Health Organization is currently revising the International Classification of Diseases and Related Health Problems (ICD-10). A central goal for the revision of the ICD classification of mental and behavioural disorders is to improve its clinical utility. Global representation and cultural sensitivity and relevance are important across all mental disorders, but are especially critical to advancing our understanding, diagnosis and treatment of feeding and eating disorders (FED). This paper summarises the current status of the Eating Disorders Consultation Group (EDCG) considerations regarding diagnostic categories for FEDs in ICD-11 and represents work in progress. The recommendations of the EDCG are informed by relevant research evidence, and the consultation group is striving to find a balance between clinical utility and diagnostic purity. Provisional recommendations of the EDCG include: (1) merger of previous FEDs categories in one group; (2) inclusion of six main FED categories that include anorexia nervosa (AN), bulimia nervosa (BN), pica, regurgitation disorder, binge-eating disorder (BED) and avoidant/restrictive food intake disorder, the last two representing new categories; (3) broadening of categories with the aim of reducing the use of the unspecified ED category (e.g. dropping the amenorrhea requirement, increasing the body mass index cut-off for low weight and rewording the

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⁎Corresponding author. Email: angelica.claudino@uol.com.br

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cognitive and behavioural features of AN to be more culturally-sensitive). In line with this last recommendation, one point that require further analysis pertain to frequency and severity of the binge-eating and purging behaviours in BN and BED, as the EDCG is considering reducing or eliminating the frequency criterion and broadening the binge-eating criterion to include ‘subjective’ binge episodes.

**Keywords:** mental disorders; classification; diagnosis; International Classification of Diseases (ICD); Diagnostic and Statistical Manual of Mental Disorders (DSM); clinical utility; cross-cultural applicability; eating disorders; feeding disorders

**Introduction**

The World Health Organization (WHO) is currently developing the 11th version of the International Classification of Diseases and Related Health Problems (ICD-11). The ICD-10 was approved in 1990 (WHO, 1992), making the current period the longest in the history of the ICD without a major revision. By international treaty, WHO’s 194 Member States of the WHO have assigned responsibility for the development and maintenance of international classifications for health to WHO (WHO, 2007), and to use the ICD as the basis for global health reporting. Countries and health systems also use the ICD as a basic unit of clinical information for a wide range of other purposes, including health-care eligibility determination, treatment selection, reimbursement, outcomes evaluation, health policy, and resource allocation.

Within the context of the overall ICD revision process, the WHO Department of Mental Health and Substance Abuse has been assigned responsibility for managing the technical work of developing the chapter on mental and behavioural disorders. To assist the Department in all phases of the mental and behavioural disorders revision process, the WHO has appointed an International Advisory Group for the revision of ICD-10 Mental and Behavioural Disorders, which has in turn appointed a series of Working Groups in specific areas (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011).

The Consultation Group on the Classification of Eating Disorders was appointed to: (1) review available scientific evidence and clinical information on use, clinical utility, and experience with ICD-10 diagnostic categories related to eating disorders in various countries around the world and within various health-care settings; (2) review proposals for eating disorders diagnoses in the American Psychiatric Association’s forthcoming Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5); DSM-5 and consider how these may or may not be suited for global applications; (3) assemble proposals for the ICD-11 classification; and (4) advise WHO on global field trials in this area. A comprehensive international review that served as a partial foundation for the group’s work has recently been published elsewhere (Uher & Rutter, 2012).

From the WHO’s perspective, a central goal of the current revision process is to improve the clinical utility of the ICD-11 classification of mental and behavioural disorders. As the International Advisory Group has indicated, ‘People are only likely to have access to the most appropriate mental health services when the conditions that define identification, eligibility and treatment selection are supported by a precise, valid, and clinically useful classification system’ (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011, p. 90). In order for the ICD-11 classification of mental and behavioural disorders to be a more effective tool for meeting international public health goals, the new system needs to be usable for implementation throughout the world at the point where people with mental health concerns are most likely to come into contact with the health system. That is, the ICD-11 will constitute a key interface between health information and clinical practice, and its clinical utility will influence the extent to which it can support global practice improvement as well as the validity of data aggregated from health encounters.
Although the ICD and DSM revision processes overlap and have been in substantial communication with one another, the two classifications differ in their purpose, organisational context, and constituencies (Reed, Dua, & Saxena, 2011). They also differ in time frame. The ICD-11 is scheduled for presentation to the World Health Assembly, the WHO’s governing body, in 2015. Consistent with this schedule, the EDCG is still in the process of finalising its proposals, which have not yet been approved by the Advisory Group. Nonetheless, several significant changes from ICD-10 in the classification of eating disorders can be foreseen, which are described in general terms below. We intend to follow this brief article with a longer one that describes the Consultation Group’s proposals in much more specific detail, once the proposals are finalised.

The initial proposals for categories, structure or architecture, definitions and diagnostic guidelines on Mental and Behavioural Disorders will be published on the Internet for public review and discussion, together with the revision proposals for all other chapters of the ICD-11. The proposals will be revised in response to public comment and expert peer review, under the guidance of the WHO Advisory Group, as well as in response to the results of international field trials.

Guiding principles for the ICD revision

Global representation and cultural diversity

The WHO, as a specialised agency of the United Nations, is global by definition. Given the unique position of the WHO, the ICD provides a common classification system that facilitates communication and information exchange across the multitude of countries and health-care systems globally. The WHO’s primary constituency is the governments of the WHO member countries; the second constituency group is health-care providers; and the third core constituency group is the users of mental health services and their families (International Advisory Group for the Revision of the ICD-10 Mental and Behavioural Disorders, 2011).

In the revision of the ICD, WHO has intensified its commitment to expanding and ensuring substantive engagement of the diverse constituency groups and representation of the wide range of cultures across the globe. WHO has engaged a wide range of mental health providers, not just psychiatrists, to provide professional contributions to the process and thus, members of the International Advisory Group for the Revision of the ICD-10 and the Expert Consultation Groups for each diagnostic category represent multiple disciplines and global regions, and field trials will engage an even broader professional community. WHO is committed to creating opportunities for input from users and their families to meaningfully contribute to the revision process, with input to the proposed criteria open to all.

In an attempt to maximise cultural sensitivity and relevance, one of the first steps of the ICD revision was the preparation of international and multilingual literature reviews of mental disorders. Importantly, these reviews focused especially on the clinical utility of the ICD in low- and middle-income countries. In addition, the WHO conducted in-depth analyses of the ICD system at the country and regional levels to determine which elements of the system are clinically valued and useful, where the gaps lie, and gather recommendations for alternative disorder descriptions. A third initiative consisted of surveys of global psychiatrists (Reed et al., 2011) and psychologists (Evans et al., 2012), conducted in collaboration with the World Psychiatric Association and the International Union of Psychological Science, respectively.

Global representation and cultural sensitivity and relevance are important across all mental disorders, but are especially critical to advancing our understanding of eating disorders. The field of eating disorders was highly culture bound in its origins and largely dominated by a focus on Western and industrialised countries (Al-Adawi, Dorvlo, Viernes, Alexander, & Al-Zakwani, 2012; Becker, 2007; Becker, Thomas, & Pike, 2009; Lai, 2000).
However, data are emerging from around the globe that make it evident that eating disorders are global and that understanding societal and cultural factors is essential to provide the best clinical care and to advance our understanding of eating disorders generally.

**Expansion of the diagnostic category to feeding and eating disorders**

The field of eating disorders has grown in many respects since the establishment of the ICD-10, and the revision of the ICD to expand the category name to ‘feeding and eating disorders (FEDs)’ reflects the current recognition that eating pathology occurs across a much wider developmental spectrum than was previously captured by the more narrow category name (Uher & Rutter, 2012). The integration of FEDs allows for greater continuity of care across the developmental lifespan and reflects the recognition that feeding disorders in childhood may precede eating disorders in adolescence and adulthood. Also, the separation of FEDs in the past created developmental biases in that the diagnostic criteria for feeding disorders were framed as problems of infancy and childhood and those for eating disorders were framed for adolescents and adults. Although this distinction is often accurate, there are many cases where this developmental divide failed to capture the eating disturbances of individuals across the lifespan. For example, increasingly younger children are presenting with what have traditionally been described as ‘adult’ eating disorders such as anorexia nervosa (AN), and adults present with feeding disorders that have been traditionally described as disorders of infancy and childhood such as ‘selective eating’ (Wildes, Zucker, & Marcus, 2012). By combining FEDs into one larger grouping, the ICD-11 aims to ensure that the diagnostic criteria for FEDs capture the range of developmental manifestations of eating disturbances and thereby improve diagnostic accuracy and delivery of care.

**Prioritisation of clinical utility of the ICD-11**

There are five main uses of the ICD: clinical, research, teaching and training, health statistics, and public health (International Advisory Group, 2011). One of the most important shifts in this ICD revision process is the prioritisation of the utility of the ICD in clinical settings, particularly primary-care settings. The reality is that in much of the world, highly trained mental health professionals are scarce or non-existent. In fact, around the globe, even in high-income countries, people are more likely to receive mental health services in primary health-care settings as compared to specialised mental health services (Wang et al., 2007). Thus, WHO is committed to revising the ICD to maximise its clinical utility for individuals working in the broadest range of health services, particularly non-specialist care settings.

The anticipated implication for FEDs is that feeding and eating pathology across the developmental spectrum will more accurately be identified and assessed around the globe. The challenge for the field is that the incidence and expression of pathology is culturally sensitive. This is particularly true for eating disorders. Cultural variations in terms of eating disorder phenotype present significant tension between sufficiently specifying diagnostic criteria so that each syndrome represents ‘true’ cases (rather than a comingling of related but distinct disorders) and allowing for sufficient latitude in clinical presentation so that cultural variations of the same disorder do not result in failure to meet diagnostic criteria.

**Provisional recommendations of the EDCG**

The sections below highlight key recommendations of the EDCG. A more detailed set of recommendations, including the full proposal for all the syndromes included in FEDs, will follow in a later paper. It should be noted that, in line with the general ICD-11 proposal for all mental disorders, symptoms should be present for at least one month for the diagnosis to be made unless otherwise noted.
**Anorexia nervosa**

It is anticipated that the core features of AN will remain largely the same in ICD-11 as compared to ICD-10. These core features include: significantly low body weight for height, age, and developmental stage due to restrictive eating alone or restrictive eating accompanied by binge eating and purging. The cognitive and behavioural features include fear of weight gain or persistent behavioural patterns that interfere with maintenance of normal weight and disturbances in the way that body weight and shape are perceived and/or overvaluation of body weight and shape.

The one major exception to the continuity of diagnostic criteria from ICD-10 to ICD-11 is that the EDCG recommends that amenorrhea be eliminated from the diagnosis of AN. Although commonly associated with AN, amenorrhea is now understood to be an epiphenomenon for many, but certainly not all, individuals with AN. Moreover, menstrual functioning is not relevant for males and young children, and the empirical data suggest that amenorrhea does not provide significant clinical value in terms of diagnosis or prognosis (Attia & Roberto, 2009).

The EDCG recommends that the ICD-11 provide a general guideline for low weight of a body mass index (BMI) 18.5 kg/m² or less in adults and BMI-for-age under the 5th percentile in children and adolescents. However, the EDCG also recommends that the guidelines accommodate other conditions and contexts where the low-weight threshold may vary. For example, for individuals who lose substantial weight, even if their current weight does not fall below a BMI of 18.5 kg/m², they may nonetheless present with all the core psychological and behavioural features of AN, and may be in a similarly compromised physiological state as someone at a much lower weight. Similarly, some cultures have lower mean population weights than global averages, and a BMI of 18.5 kg/m² may not represent an exceedingly low weight.

One further complication regarding weight status and the diagnosis of AN, is that as individuals achieve weight restoration, they no longer meet the diagnostic criterion of low-weight despite the fact that other symptoms of the disorder are still present. It is premature to drop the diagnosis of AN as soon as weight increases above the underweight threshold, especially if this occurs in the context of treatment. Thus, the EDCG recommends that the diagnosis of AN should be retained until a full and lasting recovery (e.g. at least a year) of healthy weight and cessation of behaviours aimed at reducing body weight is achieved and maintained without continuous treatment. The EDCG also recommends that those with AN who develop binge-eating and/or purging symptoms should retain the AN binge-purge-type diagnosis for the duration of one year, even if weight is restored to normal, and only change diagnosis to BN if, after one year at normal (or above normal) weight, the binge/purge symptoms are maintained.

A central topic of debate is the role of fat phobia in the diagnosis of AN. Cross-cultural data indicate that individuals with AN report a wide range of rationales for food refusal, and non-fat-phobic AN (NFP-AN) has wide geographic distribution (Becker et al., 2009). Except for the absence of ‘fat phobia’, many individuals with NFP-AN appear similar in terms of clinical presentation to individuals with AN, which raises the question of whether fat phobia is truly essential and intrinsic to the disorder (Al-Adawi et al., 2012; Becker et al., 2009). Some data indicate that individuals with NFP-AN tend to present with lower levels of eating pathology overall; however, we do not have sufficient data on NFP-AN to know the implications for course and outcome (Becker et al., 2009). Thus, the current recommendation of the EDCG is that the diagnosis of AN will subsume NFP-AN, and the diagnostic criteria will not require that fat phobia be the rationale for low weight status.

**Avoidant/restrictive food intake disorder**

This disorder is an expansion and renaming of the ICD-10 category Feeding Disorder of Infancy and Childhood, and is characterised by eating an insufficient quantity or variety of food. The
EDCG supports its proposed inclusion in ICD-11 in light of the main aims of the ICD-10 revision process to improve clinical utility across the lifespan, as well as maintaining consistency where appropriate with DSM-5 proposals. It is well recognised that there are a number of clinical presentations of eating disturbances that are currently not well categorised (Bryant-Waugh, Markham, Kreipe, & Walsh, 2010), and that a number of terms are in use that describe essentially similar presentations (e.g. ‘sensory food aversions’ (Chatoor, 2009) and ‘selective eating’ (Nicholls & Bryant-Waugh, 2008). The EDCG hopes that the inclusion of avoidant/restrictive food intake disorder (ARFID) in ICD-11 will contribute to better recognition of such disturbances and the development of targeted, effective clinical interventions.

The EDCG recognises that many children and adults are picky or faddy in their eating and recommends that ARFID should only be diagnosed if there is evidence that the insufficient quantity or variety of food eaten is of a severity that leads to adverse health consequences or functional impairments. This might include significant weight loss, clinically significant deficiency of specific nutrients or other adverse impact on the physical health of the individual, and an inability to eat with family members or peers. In some instances, the avoidance or restriction may lead to a dependence on enteral tube feeding.

Although there may be a superficial similarity between AN and ARFID in that both involve dietary restriction or food avoidance, individuals with ARFID do not share the core disturbance in the way in which one’s own body weight or shape is experienced in AN. Thus, the differentiation between the two diagnostic categories relies particularly on whether or not the individual exhibits a significant disturbance in the perception of the shape or size of his or her body, overvaluation of weight and shape, and avoids gaining weight, which if present would rule out the diagnosis of ARFID. The boundary between NFP-AN and ARFID requires further elucidation, as by definition a fear of fatness is absent in both. However, in NFP-AN there is a determined avoidance of weight gain, which is not present in ARFID.

The EDCG recommends that guidance be given to clinicians to clarify that there may be one or more of a number of factors contributing to the eating disturbance in ARFID. These include having little interest in eating and/or avoidance of multiple types of food. The avoidance of specific types of food may be based on specific sensory properties (e.g. colour, appearance, texture, taste, temperature or smell) or on perceived adverse consequences of eating such food (to include, e.g. feared health problems, vomiting, or choking). Avoidances of this nature typically result in acceptance of a diet that is not sufficient to provide the energy and nutrients for healthy development and functioning. Such presentations have been documented across infancy, childhood, adolescence, and into adulthood (Chatoo, 2009; Nicholls & Bryant-Waugh, 2008; Wildes, Zucker & Marcus, 2012).

At present there is only limited evidence regarding continuities between early feeding difficulties and later eating disorders. It seems likely that early feeding difficulties in childhood may resolve completely, persist into adulthood or may lead on to another type of eating disorder. The EDCG proposes that the diagnostic category of ARFID can apply to feeding and eating problems in children, adolescents or adults, and recognises that to date age-related variations in presentation have not yet been adequately documented.

**Bulimia nervosa**

In line with the recommendation of broadening categories in ICD-11, the EDCG proposes that the bulimia nervosa (BN) category will combine the ICD-10 BN and atypical BN categories, the latter used to classify partial or subclinical cases of BN.

Diagnosis of BN requires frequent binge-eating episodes and compensatory behaviours aimed at preventing weight gain, as well as self-evaluation excessively dependant on weight and/or shape, but weight should not be below the normal range (to be distinguished from AN binge-
purge type). Thus, binge eating and compensatory behaviours – either purgative (self-induced vomiting, laxatives/enemas, diuretic misuse and other substances) or non-purgative (prolonged fasting and strenuous exercise) ones – should be recurrent for the diagnosis of BN. In addition, loss of control over eating is an essential feature of both objectively large and subjective binge-eating.

One point that require further analysis by the EDCG pertain to frequency and severity of the binge-eating and purging behaviours. Compelling data suggest that the current ICD Research and DSM-IV binge frequency criterion and the threshold for the ‘objective binge-eating’ criterion are arbitrary and do not reflect clinical reality because they exclude a large percentage of individuals who subjectively report clinical levels of disturbance comparable to those who meet full criteria and show equal patterns of psychiatric comorbidity and service utilisation (Mond, Latner, Hay, Owen, & Rodgers, 2010; Wolfe, Baker, Smith, & Kelly-Weeder, 2009). Thus, the EDCG is considering introducing weekly frequency criteria for binge-eating and purging and broadening the binge-eating criterion to include ‘subjective’ binge episodes. If the ICD diagnosis of BN ultimately does not require objective binge-eating, substantial differences in the categorisation of BN cases may emerge between future editions of the ICD and DSM classification systems, but it is expected that it will also significantly help in reducing the unspecified ED category (Sysko & Walsh, 2011) while still maintaining a certain homogeneity in terms of main psychopathology of cases and treatment recommendation, besides simplifying the diagnosis for clinicians (potentially improving its clinical utility).

The EDCG is recommending that subtyping (purging and non-purging) be eliminated because empirical evidence to support this distinction is weak (van Hoeken, Veling, Sinke, Mitchell, & Hoek, 2009).

Binge-eating disorder

One of the greatest changes to the FEDs Category in ICD-11 will be the introduction of ‘binge-eating disorder’ (BED). This recommendation is consistent with DSM-5 and is based on extensive research that emerged in the last 20 years since the provisional criteria for its diagnosis were proposed in DSM-IV (APA, 1994) and which supports its validity and clinical utility as a new ED entity (Keel, Brown, Holland, & Bodell, 2012; Palavras, Kaio, Mari, & Claudino, 2011; Striegel-Moore & Franko, 2008; Wonderlich, Gordon, Mitchell, Crosby, & Engel, 2009). Data suggest that BED is the most prevalent diagnosis among people identified with an unspecified eating disorder both among adolescents and adults (Le Grange, Swanson, Crow, & Merikangas, 2012), so it is expected that the inclusion of BED category will reduce the number of people that receive an ‘atypical’ or unspecified diagnosis (Keel et al., 2012; Le Grange et al., 2012; Sysko & Walsh, 2011).

Diagnostic guidelines for BED require the presence of recurrent binge-eating episodes that are accompanied by loss of control over eating and significant distress, but are not regularly followed by inappropriate compensatory behaviour (as compared to BN which requires inappropriate compensatory behaviour). A binge-eating episode is considered present when the individual eats more and/or differently than his/her regular eating pattern (e.g. eating alone for fear of embarrassment, and/or eating types of food that are not usually part of the diet, such as high calorie foods) and feels unable to stop eating or limit the type or amount of food eaten, emphasising the loss of control as the core feature of the behaviour (Telch, Pratt, & Niego, 1998). Though binge-eating episodes in BED often involve large amounts of food, episodes that are not large but are considered large by the individual may pose similar impairment and be associated with same level of distress and psychopathology (Grilo & White, 2011; Wolfe et al., 2009). Thus, similar to BN, the EDCG is deliberating on whether and how to include subjective binges in
the diagnosis of BED. At this point, the EDCG is also considering a guideline of approximately once per week binge-eating (as in BN) for a minimum of one month without setting this as a strict minimum threshold. Again, the tension is between capturing the less severe cases (which may promote early identification) versus overdiagnosing BED.

The presence of behaviours that represent efforts to manage weight does not preclude the diagnosis of BED if the individual engages in the behaviour as a function of wanting to lose weight rather than in direct compensation for a binge-eating episode. The ECDG recognizes that in clinical practice the distinction between ‘wanting to lose weight’ and ‘direct compensation for binge-eating episode’ could be difficult and this will need to be addressed in refining the criteria.

Although overvaluation of body weight and shape, with increased body checking and avoidance, is commonly reported by individuals with BED (and may influence their self-evaluation), further research is needed to clarify the body image disturbance in this group (Ahrberg, Trojca, Nasrawi, & Vocks, 2011), and thus, at this point, the EDCG is not proposing that body image disturbance be required for the diagnosis of BED in ICD-11.

**Pica**

Pica is characterised by the eating of non-food substances, with a very wide range of substances having been described in the literature. In ICD-10 Pica is classified in disorders with onset in childhood, yet it is known to occur across the lifespan. Consistent with ICD-10, a diagnosis of Pica should only be made if the eating disturbance is associated with serious adverse consequences and is not better accounted for by another mental disorder (e.g. psychosis), general condition (such as pregnancy), or socially sanctioned practice (such as eating of soil or clay in parts of Africa). The main revision proposed by the EDCG is that there should be no age restrictions in relation to the diagnosis of Pica.

**Regurgitation disorder (RD)**

This disorder is characterised by repeated regurgitation of previously swallowed food, which may be re-chewed and spat out or re-swallowed. In ICD-10 it was termed ‘rumination disorder’ and classified in disorders with onset in childhood. The EDCG recognises that regurgitation of this nature can occur across the age range, and therefore proposes that there should be no age restrictions in relation to diagnosis. Additionally, in order to avoid confusion with the psychological process of repetitive thinking, also known as ‘rumination’, it has been suggested that the name should be changed to RD (Uher & Rutter, 2012).

**Invitation to provide input and conclusion**

The EDCG will continue to incorporate research findings and will encourage essential field trials to generate data that can better inform the final diagnostic criteria. The EDCG is committed to employing all relevant research evidence to guide the process of finding a balance between clinical utility and diagnostic purity.

Some key issues include articulating criteria for symptom frequency and severity in the case of BED and BN and ascertaining whether there is sufficient justification to include ARFID as a formal diagnosis. Concern also remains linked to the challenge of providing clear-cut differentiation between BN and BED due to overlap of symptoms and common cross-over between both diagnostic categories (Fichter, Quadflieg, & Hedlund, 2008; Striegel-Moore & Franko, 2008) as well as clear-cut differentiation between AN and ARFID.
This paper represents a summary of the current status of the EDCG’s considerations regarding diagnostic categories for FEDs in ICD-11 and represents work in progress. The group welcomes thoughts and responses from colleagues working in the field of FEDs, as well as from other interested clinicians and academics working in related fields of mental health. Comments can be communicated to the corresponding author of this paper, or to the Editors of Advances in Eating Disorders.

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Notes on contributor

Samir Al-Adawi is a professor of Behavioral Medicine at College of Medicine & Health Sciences, Sultan Qaboos University, Muscat, Oman. Previously he was Fulbright Scholar at the Department of Physical Medicine and Rehabilitation, Harvard Medical School, Boston, USA and a research scientist sponsored by Matsumae International Foundation at the Department of Psychosomatic Medicine, Graduate School of Medicine, the University of Tokyo, Tokyo, Japan. His doctorate training was at the Institute of Psychiatry, King’s College, UK.

Brigita Baks is Director Eating Disorders Center, University of Vilnius Lithuania. She did her psychodynamic psychoanalytical psychotherapy postgraduate studies at Kaunas Medical University (2000-2005) and at Oslo Psychoanalysis Institute, Norway (2007-2010).

Rachel Bryant-Waugh is Consultant Clinical Psychologist and Joint Head of the Feeding and Eating Disorders Service at Great Ormond Street Hospital and Honorary Senior Lecturer at the Institute of Child Health, University College London. She has a special interest and expertise in childhood onset eating disorders and feeding disorders and is Chair of the UK National Steering Group for Childhood Feeding Disorders.

Angélica M. Claudino is Director and Founder of the Eating Disorders Program (PROATA), and Supervisor of the Post-Graduation Course in Psychiatry at the Department of Psychiatry, Federal University of São Paulo, Brazil. She did her post-doctoral training at the Institute of Psychiatry, King’s College London, UK (2007-2008). Dr Claudino is Chair of the Eating Disorders Consultation Group for the revision of the ICD-10 Mental and Behavioral Disorders, World Health Organization.

Phillipa Hay is Foundation Chair of Mental Health at the Centre for Health Research University of Western Sydney, Adjunct Professor of Psychiatry James Cook University, Senior Consultant in Psychiatry Campbelltown Mental Health Service Sydney & South Western Sydney Local Health Districts and Co-Editor-in-Chief Journal of Eating Disorders. She is a graduate of the University of Otago and University of Oxford and Fellow of the Royal Australian and New Zealand College of Psychiatrists.

Cecile Rausch Herscovici is Professor of the Master’s Program in Family Studies at the Universidad del Salvador, in Buenos Aires, Argentina and Approved Supervisor and Clinical Member of the American Association for Marriage and Family Therapy (AAMFT) since 1982. Since 2008 is member of the Committee of Nutrition, Obesity and Physical Activity of the International Life Sciences Institute (ILSI, Argentina).

Palmiero Monteleone is Professor of Psychiatry at the Department of Medicine and Surgery of the University of Salerno, Italy. He is the Coordinator of Eating Disorders Center of the Department of Psychiatry at the Second University of Naples, Naples, Italy and Chair of the Eating Disorders Section of the World Psychiatric Association since 2008.

Claes Norring has been involved in eating disorder research and development for more than 30 years, and is presently Research Director at the Stockholm Center for Eating Disorders and Associate Professor at the Center for Psychiatry Research, Department of Clinical Neuroscience at Karolinska Institutet, Stockholm. Twenty years ago he was one of the founders of the Swedish Eating Disorders Society, whose president he has also been, and some years later he co-founded the Nordic Eating Disorders Society.
**Kathleen M. Pike** is Clinical Professor of Psychology in Psychiatry at Columbia University, Executive Director and Scientific Co-Director of the Global Mental Health Program at Columbia University. In her previous position, Dr. Pike served as Professor and Assistant Dean at Temple University Japan, where she conducted the first interview based study of eating disorders in Japan. Dr. Pike is a Fellow of the Academy for Eating Disorders and a founding member of the Eating Disorders Research Society.

**David J. Pilon** is Program Leader at Capital Health in Halifax, Nova Scotia, Canada where he oversees all of the tertiary mental health services including the adult Eating Disorder Clinic. He is the Founding Chair of the Nova Scotia Eating Disorder Treatment Network and the 2012 President of the Eating Disorders Association of Canada - Association des Troubles Alimentaire du Canada.

**Geoffrey Reed** joined the World Health Organization (WHO) in 2008 as Senior Project Officer for the Revision of ICD-10 Mental and Behavioural Disorders in the Department of Mental Health and Substance Abuse, and was previously Assistant Executive Director for Professional Development at the American Psychological Association in Washington, DC, where he collaborated closely with WHO on the development of the International Classification of Functioning, Disability and Health (ICF).

**Pratap Sharan** is a Professor of Psychiatry at the All India Institute of Medical Sciences, New Delhi, India. He had earlier served as a Medical Officer with the Department of Mental Health and Substance Abuse, World Health Organization (2002-2004). He is the President of the Indian Association for Child and Adolescent Mental Health and had earlier served as the Editor of the Journal of Indian Association for Child and Adolescent Mental Health.

**Cornelia Thiels** is a Professor of Social Medicine at the Department of Social Studies, University of Applied Sciences Bielefeld since 1988. She worked previously at the Maudsley Hospital/London and the Departments of Clinical Psychiatry, Child and Adolescent Neurology and Psychiatry, and Neurology of the Free University Berlin.

**Janet Treasure** is Director of Eating Disorders Unit, South London and Maudsley NHS Trust and Professor of Psychiatry, Kings College London.

**Rudolf Uher** is Canada Research Chair in Early Intervention in Psychiatry at the Dalhousie University, Halifax, NS, and Clinical Senior Lecturer in Affective Disorders at King's College London, UK. His primary interests are early interventions to prevent severe mental illness, classification of psychopathology, treatment of mood disorders, the use of clinical assessment and genomics to personalize treatment and the interplay of genes and environment in the causation of mental illness.

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