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BRIEF REPORT

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Comparing ICD-11 and DSM-5 eating disorder diagnoses with the Munich eating and feeding disorder questionnaire (ED-Quest)

Norbert Quadflieg Dr. rer. biol. hum., Dipl. -Psych.[1] | Ulrich Voderholzer MD[1,2,3] | Adrian Meule PhD[1,2] | Manfred Maximilian Fichter MD, Dipl.-Psych.[1,2]

[1]Department of Psychiatry and Psychotherapy, University Hospital, Ludwig-Maximilians-University (LMU), Munich, Munich, Germany

[2]Schoen Clinic Roseneck, Prien am Chiemsee, Germany

[3]Department of Psychiatry and Psychotherapy, University Hospital, Freiburg, Germany

Correspondence
Norbert Quadflieg, Department of Psychiatry and Psychotherapy, University Hospital, Ludwig-Maximilians-University Munich (LMU), Munich, Nussbaumstraße 7, 80336 München, Germany.
Email: norbert.quadflieg@med.uni-muenchen.de

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Abstract

Objective: The new ICD-11 eating disorders (ED) guidelines are similar to the DSM-5 criteria. One difference to the DSM-5 is the inclusion of subjective binges in the definition of bulimia nervosa (BN) and binge-eating disorder (BED). The aim of this study was to identify differences between the ICD-11 guidelines and DSM-5 ED criteria, which could impact access to medical care and early treatment.

Method: Data of 3863 ED inpatients who completed the Munich Eating and Feeding Disorder Questionnaire were analyzed using standardized diagnostic algorithms for DSM-5 and ICD-11.

Results: Agreement of diagnoses was high (Krippendorff's $\alpha = .88$, 95% CI [.86, .89]) for anorexia nervosa (AN; 98.9%), BN (97.2%) and BED (100%), and lower for other feeding and eating disorders (OFED; 75.2%). Of the 721 patients with a DSM-5 OFED, 19.8% were diagnosed with AN, BN or BED by the ICD-11 diagnostic algorithm, reducing the number of OFED diagnoses. One-hundred and twenty-one patients received an ICD-11 diagnosis of BN or BED because of subjective binges.

Discussion: For over 90% of patients, applying either DSM-5 or ICD-11 diagnostic criteria/guidelines resulted in the same full-threshold ED diagnosis. Sub-threshold and feeding disorders exhibited a discrepancy of 25%.

Public Significance Statement: For about 98% of inpatients, the ICD-11 and DSM-5 agree on the same specified eating disorder diagnosis. This is important when comparing diagnoses made by different diagnostic systems. Including subjective binges in the definition of bulimia nervosa and binge-eating disorder contributes to improved ED diagnoses. Clarifying the wording of diagnostic criteria at several places could further increase this agreement.

KEYWORDS

anorexia nervosa, avoidant/restrictive food intake disorder, binge-eating disorder, bulimia nervosa, diagnosis, DSM-5, eating disorders, feeding disorders, ICD-11, regurgitation, rumination

1 | INTRODUCTION

Two diagnostic systems with a long history of development (Regier et al., 2020) are presently used in clinical research and practice in the Western world. In 2019, the World Health Organization (WHO) adopted the latest version of diagnostic guidelines for the 11th revision of the International Classification of Diseases (ICD-11). Like the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), this revision introduced for the first time a category combining feeding and eating disorders (WHO, 2022).

Definitions of eating disorders (ED) are very similar in both diagnostic systems. The definition of anorexia nervosa (AN) focuses on low body weight (the hallmark feature according to Pike and Grilo [in Stein et al., 2020]) with essentially the same clinical features being required in both ICD-11 and DSM-5. Palavras et al. (2018) compared ED diagnoses in 107 treatment-seeking individuals with high body mass index (BMI) and found no significant differences in the characteristics of DSM-5 and ICD-11 diagnoses of bulimia nervosa (BN), binge-eating disorder (BED), and bulimic types of other specified feeding and eating disorders.

However, there are differences in the diagnostic criteria and guidelines with a potential for diverging ED diagnoses. These definitional aspects are important for the precise identification of subgroups with a specific or high risk for poor outcome, and for epidemiological studies. An important contribution of the ICD-11 to ED diagnoses is the inclusion of subjective binges for BN and BED. This deviates from the DSM-5 requirement of an objectively large amount of food eaten in a binge episode and focuses on the feeling of loss of control over eating as the central feature of eating binges. The present study compared ICD-11 and DSM-5 ED diagnoses aiming at identifying diagnostic differences with a potential for blurring the distinction of separate EDs and impacting access to medical care and treatment.

2 | METHOD

At the Schoen Clinic Roseneck, data (e.g., age, sex, diagnoses, body weight, questionnaire scores) are automatically transferred to a database from which they can be exported without any identifying information (e.g., name, date of birth, place of residence) by authorized employees. Thus, accessing individual patient charts is not necessary. According to the guidelines of the institutional review board of the LMU Munich, retrospective studies conducted on already available, anonymized data are exempt from requiring ethics approval.

2.1 | Sample

Data from the routine diagnostic assessment at admission of $N = 3863$ patients (mean age 24.22 years [SD = 10.83; range: 12–73], 4.5% male) treated on an inpatient service for an ED at the Schoen Clinic Roseneck (Prien am Chiemsee, Germany) between September 2014 and December 2020 were analyzed. Further details are listed in Table 1.

2.2 | Assessment

The Munich Eating and Feeding Disorder Questionnaire (ED-Quest; Fichter et al., 2015) provided DSM-5 and ICD-11 diagnoses AN, BN, BED, and other specified feeding and eating disorders. Atypical AN, BN and BED with shorter duration or low frequency, purging disorder, night-eating syndrome, avoidant/restrictive food intake disorder, and rumination/regurgitation disorder were combined into a study-specific category of other feeding and eating disorders (OFED). The residual category of unspecified feeding and eating disorder (UFED) included all ED patients who did not meet the criteria/guidelines for any of the EDs described above. Diagnoses were based on diagnostic criteria as listed in the DSM-5 and essential (required) features as described in ICD-11 (see Tables S1 and S2 in the online supplement). Subjective binges were included in the definition of ICD-11 BN and BED. Objective and subjective binge eating was differentiated by the number of kilocalories consumed during an eating binge. Consuming more than 1000 kilocalories during an eating binge defined objective binging while consuming less than 1000 kilocalories defined subjective binging (Forney et al., 2015). Both definitions included a feeling of loss of control over eating.

ICD-11 defines a BMI below 18.5 kg/m^2 as low body weight. The DSM-5 refers to a "less than minimally normal" body weight (page 338) which we defined as a BMI below 18.5 kg/m^2 (WHO, 2000). Therefore, this threshold was used for the definition of AN for both diagnostic systems. The frequency of binge eating and compensatory behavior was assessed for a three-month period only. This precluded a comparison of the diagnostic systems regarding their differences in minimum required period for BN, that is 3 months for DSM-5 and 1 month for ICD-11.

2.3 | Data analyses

Number of cases and percentages are presented for ED diagnoses. As an overall measure of the agreement between DSM-5 and ICD-11 diagnoses, Krippendorff's α (Hayes & Krippendorff, 2007) was computed.

3 | RESULTS

Table 2 presents a cross-tabulation of DSM-5 and ICD-11 diagnoses. Agreement between DSM-5 and ICD-11 was very high (Krippendorff's $\alpha = .88$, 95% CI: [.86, .89]). However, there were several discrepancies between the diagnostic systems.

3.1 | AN (DSM-5)

Twenty-three patients with DSM-5 AN did not receive an ICD-11 diagnosis of AN. While meeting all other diagnostic requirements for

TABLE 1 Description of the total sample and for eating disorder diagnoses according to DSM–5 at admission to inpatient treatment.

		DSM–5				
	Total group $n = 3863$ Mean (SD) [range]	Anorexia nervosa $n = 2124$ Mean (SD) [range]	Bulimia nervosa $n = 688$ Mean (SD) [range]	Binge-eating disorder $n = 95$ Mean (SD) [range]	Other feeding or eating disorder $n = 721$ Mean (SD) [range]	Unspecified feeding or eating disorder $n = 235$ Mean (SD) [range]
Age	24.22 (10.83) [12–73]	21.85 (8.99) [12–63]	26.06 (10.69) [13–69]	32.40 (13.30) [15–67]	27.36 (12.45) [13–73]	27.36 (13.84) [13–67]
Body mass index	18.84 (7.07) [8.55–62.42]	15.11 (1.88) [8.55–18.49]	24.65 (6.82) [12.19–61.47]	33.67 (10.98) [11.36–57.45]	22.17 (7.50) [8.96–62.42]	19.31 (9.27) [9.49–61.35]
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Males	172 (4.5%)	67 (3.2%)	34 (4.9%)	3 (3.2%)	42 (5.8%)	26 (11.1%)
Age at onset						
Until 14 years	1956 (50.6%)	1048 (49.4%)	348 (50.5%)	57 (60.0%)	384 (53.2%)	119 (50.6%)
15–17 years	1094 (28.3%)	663 (31.2%)	188 (27.3%)	15 (15.8%)	180 (25.0%)	48 (20.4%)
18 years or older	741 (19.2%)	389 (18.3%)	143 (20.8%)	22 (23.2%)	135 (18.8%)	52 (22.1%)
no information	72 (1.9%)	24 (1.1%)	9 (1.3%)	1 (1.1%)	22 (3.1%)	16 (6.8%)

Note: Sex is reported as assigned at birth. Race and ethnicity were not documented in the clinical database.

AN, this difference was due to not endorsing fear of gaining weight. These patients received ICD-11 diagnoses of BN ($n = 3$; one because of subjective binges), OFED ($n = 8$) and UFED ($n = 12$).

3.2 | BN and BED (DSM-5)

Seventeen patients with DSM-5 BN received an ICD-11 diagnosis of AN. These patients met guidelines for ICD-11 AN and BN and because of the priority of AN over BN received an AN diagnosis. They also did not endorse restricted eating, preventing a diagnosis of DSM-5 AN. An additional two patients with DSM-5 BN did not endorse restricted eating or distress/impairment caused by eating binges, resulting in an ICD-11 OFED diagnosis. All patients with DSM-5 BED also received an ICD-11 diagnosis of BED.

3.3 | OFED (DSM-5, study-specific definition)

Thirty-seven patients with DSM-5 OFED received an ICD-11 AN diagnosis. These patients met all criteria for DSM-5 AN except that they did not endorse restricted eating thus preventing a diagnosis of AN. An additional 90 patients with ICD-11 BN reported subjective but no objective binge eating episodes. Despite meeting all other criteria for DSM-5 BN, this put them into the DSM-5 OFED category. Similarly, of the 16 patients with DSM-5 OFED and ICD-11 BED, 12 had only subjective binges. The other four patients reported objective binges but did not endorse at least three of the five characteristics of binge episodes required by the DSM-5 for BED. These 16 patients met all other criteria for DSM-5 BED. A further 36 patients with DSM-5 OFED received an ICD-11 diagnosis of UFED. These patients reported no subjective or objective binges, and would have received an ICD-11 avoidant/restrictive food intake disorder diagnosis. Reporting preoccupation with body weight or shape, however, excluded this diagnosis.

3.4 | UFED (DSM-5)

Diagnosed with DSM-5 UFED, 24 patients with ICD-11 AN did not endorse restricted eating, which prevented them from receiving a DSM-5 diagnosis of AN. Seven patients with ICD-11 BN would have received a DSM-5 diagnosis of BN except that they reported only subjective but no objective binge episodes. Of the 18 patients with ICD-11 BED but DSM-5 UFED, 11 reported subjective and 7 patients reported objective binges. Six of the latter patients did not endorse at least three of the five characteristics of binge episodes required by the DSM-5 for BED, and one patient denied distress due to binge eating. Twenty-nine patients with ICD-11 OFED did not receive a diagnosis of DSM-5 OFED because they did not meet one or more OFED criteria, for example, reporting no restricted eating (28 cases) or subjective binges only (11 cases). Overall, 98 of the 769 patients with ICD-11 BN (12.7%) and 23 of

TABLE 2 Eating disorder diagnoses according to DSM–5 and the corresponding eating disorder diagnoses according to ICD–11.

	DSM–5		Diagnoses		
ICD–11 diagnoses	**Anorexia nervosa** $n = 2124$ **n (%)**	**Bulimia nervosa** $n = 688$ **n (%)**	**Binge-eating disorder** $n = 95$ **n (%)**	**Other feeding or eating disorder**[a] $n = 721$ **n (%)**	**Unspecified feeding or eating disorder** $n = 235$ **n (%)**
Anorexia nervosa $n = 2179$	2101 (98.9%)	17 (2.5%)	0	37 (5.1%)	24 (10.2%)
Bulimia nervosa $n = 769$	3 (0.1%)	669 (97.2%)	0	90 (12.5%)	7 (3.0%)
Binge-eating disorder $n = 129$	0	0	95 (100.0%)	16 (2.2%)	18 (7.7%)
Other feeding or eating disorder[a] $n = 581$	8 (0.4%)	2 (0.3%)	0	542 (75.2%)	29 (12.3%)
Unspecified feeding or eating disorder $n = 205$	12 (0.6%)	0	0	36 (5.0%)	157 (66.8%)

[a]Other feeding or eating disorders included atypical anorexia nervosa, bulimia nervosa, and binge-eating disorder with short duration or low frequency, purging disorder, night-eating syndrome, avoidant/restrictive food intake disorder, and rumination/regurgitation disorder.

the 129 patients with ICD-11 BED (17.8%) received the diagnosis because of subjective binges.

4 | DISCUSSION

Using questionnaire data, ED diagnoses according to DSM-5 and ICD-11 were compared in a large inpatient sample. Agreement was very high. The combination of the requirement of fear of gaining weight with other requirements for a diagnosis of AN resulted in a lower frequency of DSM-5 as compared to ICD-11 AN diagnoses. Including subjective binges in the definition of BN and BED by the ICD-11 increased the number of BN and BED diagnoses and reduced the number of ICD-11 OFED and UFED diagnoses compared to DSM-5.

Both DSM-5 and ICD-11 include fear of gaining weight as a diagnostic requirement for AN. However, the formulation of this requirement in the diagnostic criteria and guidelines is different, leading to different interpretations in a diagnostic algorithm. Criterion B of the DSM-5 reads "Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain…" ICD-11 formulates "A persistent pattern of restricted eating or other behaviors aimed at establishing or maintaining abnormally low body weight, typically associated with extreme fear of gaining weight." The crucial point is how to combine the emotional symptom of fear of gaining weight with behaviors that interfere with weight gain. The DSM-5 combines these symptoms with "or," indicating that one of these symptoms is sufficient for diagnosis. In our algorithm, this appears as (fear of gaining weight or fasting or purging or excessive exercise). Interpreting the term "typically associated with," the ICD-11 requires fear of gaining weight as a separate diagnostic criterion, putting more emphasis on this emotional symptom. In our algorithm, this appears as (fear of gaining weight *and* [fasting or purging *or* excessive exercise]). This is certainly a point open to a variety of interpretations and additional studies for clarification are necessary. New evidence could change the ED-Quest diagnostic algorithm and would lead to changes in the results.

A similar point refers to the role of restricted eating. Fifty-two patients did not receive a diagnosis of DSM-5 AN because they did not endorse restricted eating. DSM-5 requires "Restriction of energy intake relative to requirements, leading to a significantly low body weight…" A frequent approach is only requiring a low BMI to meet this criterion. Although we could not assess the causal relationship of restricted eating and low body weight implied in the DSM-5, we adhered very closely to the wording of this criterion and included restricted eating as a separate requirement for diagnosis. Pike and Grilo (in Stein et al., 2020) describe low body weight as the hallmark feature of AN, supporting the application of a low BMI as the only requirement for meeting the A-criterion of AN in DSM-5. This would further increase agreement between the diagnostic systems.

Compared to DSM-5, application of ICD-11 guidelines reduced the number of patients with OFED considerably. Almost 20% of the patients with DSM-5 OFED received a diagnosis of ICD-11 AN, BN or BED. Similarly, Claudino et al. (2019) found ICD-11 to improve the specificity of ED diagnoses compared to ICD-10 in a study involving a very large number of mental health professionals who assessed case vignettes. A major reason for this reduction is the inclusion of subjective binges for an ICD-11 diagnosis of BN or BED. This puts an emphasis on the feeling of loss of control and is a major step in stressing the greater importance of the patient's subjective experience compared to the amount of food consumed in a binge-eating episode (Pike & Grilo in Stein et al., 2020). EDs below the threshold of a full diagnosis are frequently considered mild cases, but studies show that their mortality is comparable to the mortality of full EDs (Crow et al., 2009; Fichter & Quadflieg, 2016). Including subjective binges in a full diagnosis of BN and BED reflects the patient's symptom burden much better and highlights the need for health care and access to early treatment.

The definition of a binge-eating episode includes an unusual amount of consumed food. To clarify what constitutes a usual amount of food, Forney et al. (2015) collected ratings of upper limits of normal food consumption by college and university students, and concluded that a threshold of 1000 kilocalories is suitable for identifying a large amount of food in an eating episode. We followed this recommendation

and included the requirement of consuming at least 1000 kilocalories in the definition of an objective binge-eating episode. This definition relies exclusively on the caloric content of food and does not consider eating unusual amounts of one food (e.g., eating a greater number of pieces of cream cake). Both approaches would probably lead to the same assessment of an unusual amount of food, and for a diagnostic questionnaire it is more economical to rely on caloric content. However, it is unclear if patients can reliably estimate the caloric content of the food consumed during a binge-eating episode. In one study patients with AN tended to overestimate the caloric content of food compared to controls (Milos et al., 2013), and in another study, students overestimated the caloric content of food (Horne et al., 2019). On the other hand, Fichter and Quadflieg (2000) compared the ratings of the caloric content of a binge-eating episode by patients with an ED and by clinical interviewers. The question was nearly identical to item 12c of the ED-Quest and the answer categories were identical. The difference between self- and expert rating was small, contradicting the assumption that patients usually overestimate caloric content.

Limitations of this study include: (1) For ICD-11 BN we included only cases with binges over a three-month period. This may have increased agreement between DSM-5 and ICD-11 diagnoses of BN; (2) We used a self-report questionnaire and do not know if a clinical interviewer would find more discrepancies; (3) Deriving a diagnostic algorithm from a standardized questionnaire implies some limitations which do not apply to a clinical interview and may have led to underestimating the number of AN cases. Both DSM-5 and ICD-11 provide weight thresholds for diagnosis of AN as guidance and not as strict cut-offs, while our diagnostic algorithm required a fixed BMI threshold. Similarly, evidence of fear of gaining weight, or restricting energy intake can be assessed by a clinical interviewer even if the patient does not report it. Additionally, our algorithm adhered closely to the listed criteria of DSM-5 and essential features of ICD-11 and did not include the general descriptions of ED, which may have led to an emphasis on minor differences. On the other hand, using self-report assessment is an economical way to collect data in a time of limited research funding, and standardized definitions of ED diagnoses contribute to comparability of results from different studies; (4) Pica was not included as an ED. Pica is rare in individuals with ED and is most often found in children, or individuals with an iron deficiency, or during and after pregnancy (Delaney et al., 2015); (5) Our sample included only patients with inpatient treatment and we do not know if our findings are valid for patients with outpatient or no treatment; (6) The ICD-11 includes a qualifier of AN "in recovery with normal body weight," offering the opportunity to consider cognitive symptoms even if the patient's body weight is within the normal range (Pike & Grilo in Stein et al., 2020). We were not able to include this specifier in our analysis, and this would be a relevant area for future research; (7) Our data base included only information on the sex assigned at birth, but no information on gender, race or ethnicity.

Strengths of this study are: (1) the large sample size resulted in percentage estimates with relatively narrow confidence intervals. (2) The sample consisted of patients with confirmed ED status who were treated at a unit specialized on ED. (3) ED diagnoses according to DSM-5 and ICD-11 were derived from the same questionnaire. Thus, the discrepancies are not attributable to the use of different assessments for DSM-5 and ICD-11.

5 | CONCLUSION

Essentially DSM-5 and ICD-11 describe the same patients with mostly the same ED diagnosis. Further research should address the impact of criterion wording on the prevalence of ED diagnoses and conduct an empirical examination of the scoring cut-points.

AUTHOR CONTRIBUTIONS

Norbert Quadflieg: Conceptualization; data curation; formal analysis; methodology; writing – original draft; writing – review and editing. **Ulrich Voderholzer:** Resources; writing – original draft; writing – review and editing. **Adrian Meule:** Data curation; writing – review and editing. **Manfred Maximilian Fichter:** Conceptualization; project administration; resources; writing – original draft; writing – review and editing.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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DATA AVAILABILITY STATEMENT

Data available from the authors on qualified request.

ORCID

Norbert Quadflieg https://orcid.org/0000-0001-6252-3315
Ulrich Voderholzer https://orcid.org/0000-0003-0261-3145
Adrian Meule https://orcid.org/0000-0002-6639-8977
Manfred Maximilian Fichter https://orcid.org/0000-0002-8788-4878

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