by Roger Clemens

ARFID: A New Eating Disorder Classification

Norris and Katzman (2015) describe Avoidant/Restrictive Food Intake Disorder (ARFID) as one of the most significant changes to the Feeding and Eating Disorders section of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders/DSM-5* (2013).

Those who struggle with ARFID generally declare themselves in childhood with symptoms often persisting into adulthood. Affected individuals restrict the range of their preferred foods, sometimes excluding and refusing entire food groups and/or avoiding food of various textures and even temperatures. The high rate of comorbid psychiatric and medical symptoms seems to be interpreted largely as effects and not causes of the disorder although *DSM-5* notes that gastroesophageal reflux disease or a history of choking may contribute to the disorder.

Prevalence and incidence are thought to be impressive but disparate, and relatively low numbers likely reflect underdiagnosis and poor reporting frequency. Between 25% and 35% of feeding disorders occur in children with normal developmental history and up to 60% in those with developmental disabilities. As one would expect, these children are also at high risk for structural gastrointestinal illness (Manikam et al. 2000; Sullivan 2008; Floch 2015).

Castro-Fornieles (2015) asserts that within ARFID, the precipitating factors are typically psychological, yet unlike other eating disorders, there is no impaired body image or fear of weight increase. Interestingly, there is no discussion of neuropsychological or consistent emotional abnormality or any evidence of thought disorder although *DSM-5* lists autism spectrum disorder, obsessive-compulsive disorder, and attention-deficit hyperactivity disorder as possible risk factors for ARFID. It is again important to note that individuals who present neurodevelopmental disorders are significantly at risk for structural gastrointestinal (GI) illness.

The recent literature is replete with rather sweeping statements about functional abnormalities in neuroimaging and about neuropeptide dysregulation, but it is difficult to distinguish causality from effects of this disorder. Similarly, possible genetic factors and epigenetic effects are hard to evaluate in etiologic terms except to propose that interaction with significant developmental stressors results in phenotypic expression of certain maladaptive traits that may constitute risks for an eating disorder.

Shaefer and Ornstein (2015) raise the question of whether some ARFID patients meet the *DSM-5* criteria for hyperselective eating because primary GI symptoms (e.g., *Helicobacter pylori* gastritis, pyloric strictures, or peptic ulcer) lead to anxiety and avoidance of eating specific kinds of foods with or without subsequent weight loss. The fact that absence of shape or body image distortion, family stressors around eating, or other explanatory comorbidity compose diagnostic criteria seems to suggest one of two possibilities: 1) a hitherto unrecognized psychopathology; 2) a behavioral response to (a possibly unrecognized) physiologic pathology.

Kenney and Walsh (2013) pointed out that distinguishing a medical condition from a psychogenic feeding disorder can be challenging. They assert that if a feeding disturbance itself leads to clinically significant changes in nutrition, weight, or social functioning, it should be classified as ARFID only when the feeding disturbances require treatment beyond that needed for any diagnosed GI problems.

The entire discussion seems full of qualification and begs for more careful multidisciplinary assessment of patients with feeding disturbances, both in psychosocial assessment and GI pathophysiology. In other words, we must not forget to apply the biopsychosocial approach in delineating and developing management strategies for complex syndromes.

Apart from biomedical and clinical issues, the diagnostic and management implications of ARFID have great potential import for food science. The development of medical foods or foods with textures, flavor profiles, and nutritional components that may be better tolerated by the large number of young patients who suffer from ARFID may represent an important and novel R&D frontier.

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Regardless of the specific etiology of the diagnosis, most of these patients are in critical phases of growth and development and require balanced oral nutrition—which they are not likely to readily receive. The larger context for food scientists and the food industry is the emerging mandate to creatively reexamine the needs of individuals who suffer from the spectrum of cancer, diabetes, GI tract impairment, neurodevelopmental disorders, allergies, and metabolic stress. **FT**

References cited in this column are available from the author.

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