

Conceptualizing Pediatric Feeding Disorder from an Anxiety Disorders Perspective

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The DSM-5 has reconceptualized pediatric feeding disorders. In DSM-IV-TR [1] there was a separate chapter for “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” which captured various forms of dysfunctional feeding behaviors. In DSM-5, such difficulties have been placed into the larger context of feeding and eating disorders. However, despite such a merger, there remain important developmental distinctions to keep in mind. As contrasted with anorexia nervosa, bulimia nervosa, and the newly added binge eating disorder, the diagnosis of a pediatric feeding disorder likely represents something qualitatively different.

With regard to the new diagnosis of ARFID, out of the 4 (A through D) diagnostic criteria, only criterion A specifically describes the actual pathology: “Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month” [2]; the other criteria simply have to do with ruling out other possible explanatory mechanisms. ARFID is etiologically different than “eating” disorders; while the latter contain behavioral diagnostic criteria regarding consumption of food, they include an emphasis on self-perception of body weight/shape and self-esteem in relation to the body shape [2]. The maladaptive behavior regarding the food is largely thought to be due to the individual’s self-perception and self-evaluation, whereas this is not the case for children who meet criteria for ARFID.

We believe the inclusion of ARFID in the DSM V to be a substantial improvement from DSM-IV-TR in which the same numerical diagnosis 307.59 was labeled as “Feeding Disorder of Infancy or early Childhood” [1] and thus was somewhat of a ‘catch-all’ diagnostic label (e.g., not PICA or Rumination Disorder). However, its grouping with eating disorders (anorexia, bulimia and binge eating) is somewhat misleading and we argue ARFID may better be thought of as belonging with other anxiety disorders such as we believe it is more akin to a specific phobia as the restriction of food appears to be related to fear of the food itself or the feeling of eating the food, rather than fear of the body image consequences to eating. Indeed the “avoidance” seen in Avoidant/Restrictive Food intake disorder is behaviorally similar to avoidance described by criterion A and C of a Specific Phobia [2]; marked fear or anxiety which in children may present as clinging, crying, tantrums,

or freezing. Furthermore the phobic situation (presentation of food) almost always provokes immediate fear or anxiety. We postulate that, in ARFID is in truth a subtype of a specific phobia, like Blood-Injection-Injury or Situational subtypes. It’s reclassification here would suggest that effective treatment strategies would include exposure, and desensitization, which indeed are the clinical approaches currently being utilized in the field [3].

An interesting note regarding the shift in classification from the DSM IV-TR to the DSM V diagnostic criteria of 307.59 is that in DSM IV-TR, it was categorized with disorders first diagnosed in Infancy or Early Childhood, whereas the new ARFID diagnosis does not specify age and could theoretically apply to an individual of any age, including adults. However, it is the authors’ experience that any such adult likely qualified for the diagnosis as a young child and never resolved or “out grew” their feeding difficulty as they transitioned to adulthood. With rare exception does ARFID show up later in childhood, adolescence, or adulthood for the first time.

There has been a paucity of research on ARFID in the years since the introduction of the diagnosis. While this diagnosis is relatively new in its current form, clinicians have recognized these problems in feeding and have been treating them for over 20 years. This discussion is intended to serve as a guidepost from clinicians who have been providing treatment for ARFID before it was a formal diagnosis to focus future research endeavors with regard to etiology and treatment. When a pediatric feeding disorder arises, it is the belief of this paper’s authors that an anxiety-focused intervention is called for and we encourage research to evaluate this conceptualization as well as treatments based on this premise.

References

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