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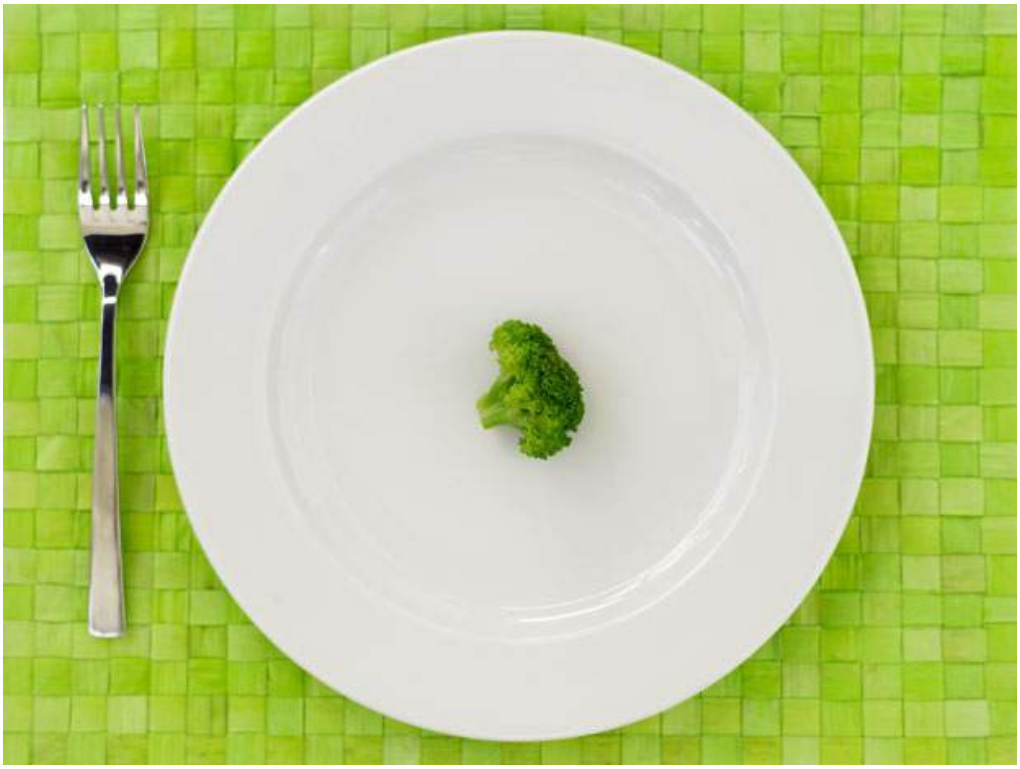

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Picky eaters could join ranks of mentally ill

By Sharon Kirkey

Could picky eaters actually be suffering from a mental illness?

That's the prospect some are raising over a proposed addition to psychiatry's official manual of mental illness.

"Avoidant/restrictive food intake disorder," or ARFID, is being recommended as a new eating disorder for the next edition of the Diagnostic and Statistical Manual of Mental Disorders, or DSM-5, an influential book used daily by doctors worldwide.

ARFID is being defined as an "eating or feeding disturbance" that includes avoiding foods of a particular taste, texture or colour.

The diagnosis is designed to capture children — as well as adults — with such peculiar and profound food preferences it's causing significant weight loss or serious nutritional deficiencies.

But some observers worry the new disorder would inevitably add large numbers of people to the “swelling ranks” of the mentally ill.

Field trials have just been completed. Whether ARFID makes it into the DSM-5 depends on whether the diagnosis can be reliably made by doctors in the “real world,” researchers says.

The psychiatric manual is in the midst of its first major revision since 1994. The next edition is due out in 2013.

The first volume, published in 1952, contained 28 disorders. The current one lists 357, and runs 886 pages long.

ARFID would replace and expand “feeding disorder of infancy or early childhood” to reflect the fact that the problem can occur across the age range, says Dr. Timothy Walsh, chair of the expert work group recommending ARFID be included in the DSM.

Walsh says the diagnosis would give a home to people with eating problems who don’t meet the diagnostic criteria for any other diagnosis and who end up lumped in a catch-all category called eating disorders “not otherwise specified.”

“And that’s unsatisfactory, for everybody,” says Walsh, a professor of psychiatry at Columbia University and New York State Psychiatric Institute.

“Patients don’t like it because they think they’ve got a real problem that at least deserves a name. And it really inhibits the study of problems, because there’s no common language.”

According to the criteria, a diagnosis of ARFID could be made in people who don’t eat enough, who show little interest in eating or who eat only a limited number of foods. Sometimes it’s the result of an “aversive” or unpleasant experience — for example, a child who gets sick with stomach flu or vomiting who becomes too scared to eat.

Other people avoid certain foods — green foods or foods with lumps, for example. Unlike anorexia nervosa, people with ARFID don’t have an intense fear of gaining weight or getting fat, but the behaviour can become so severe, people need tube feeding.

“This is not meant to characterize minor eating problems (in children) or minor food weirdnesses as an adult,” says Dr. Marsha Marcus, chief of the Centre for Overcoming Problem Eating at the University of Pittsburgh Medical Center and a member of the DSM-5 work group on feeding and eating disorders. “It really has to interfere with your functioning.”

People won’t eat in restaurants, “or they don’t want to travel because they can’t find their preferred foods,” she said. “Sometimes people say, ‘My partner just won’t put up with this. They want to eat at friends’ houses, they are tired of not being able to go out,’ ” she said.

“What many people don’t realize is the extent to which our social lives and our family lives and even our professional lives revolve around shared meals.”

Marcus, together with colleagues at Duke University, is conducting a study called the Food FAD study — or Finicky Eating in Adults, an online survey of adults 18 and older who describe themselves as “extremely picky or selective eaters.” People were asked questions, such as “Are there certain textures of food that you refuse to eat” and “Do you have certain rules about the foods you will or will not eat?”

“We got a huge number of hits,” Marcus said.

The researchers are preparing to publish the first paper based on 6,000 respondents.

Marcus said that it’s clear from the data that picky eating can interfere with work and “interpersonal functioning” for a significant sub-group of people. “There are people who are seriously affected.”

But psychiatrist Dr. Valerie Taylor says far more research is needed to confirm ARFID is a true illness and not just on the continuum of normal, albeit unusual, human behaviour. “We may be jumping the gun a bit,” said Taylor, chief of psychiatry at Women’s College Hospital in Toronto and head of the mental health section for the Canadian Obesity Network.

“We don’t want to stigmatize people who might be outside the bell curve in terms of what they like and what they don’t like to eat,” Taylor said.

“It’s really important that we do research to make sure this actually exists, that it’s actually impairing and that we have treatments for it that have been shown to work.”

Not enough resources exist to treat established eating disorders, she said. “The last thing we need to do is invent more.”

Christopher Lane, author of Shyness: How Normal Behavior Became a Sickness, says the American Psychiatric Association — publisher of the manual of mental disorders — seems “unhealthily obsessed with how much or how little we’re eating.”

The DSM-5 feeding and eating disorders work group is also proposing that binge-eating disorder be recognized as a free-standing diagnosis in the next manual. Binge eating is defined as eating, in two hours or less, an amount of food that is significantly larger than most people would consume in the same time, and feeling a lack of control over what, or how much one is eating.

According to Lane, ARFID “will be to picky eaters what ‘binge eating disorder’ will be for those who sometimes overeat.

“A substantial number of North Americans will be diagnosed as mentally ill because of the proposal,” he said, “and for no good reason.”

But Walsh says unpublished data suggest 10 to 15% of adolescents being treated for eating disorders meet criteria for ARFID.

“We don’t want to pathologize every idiosyncrasy that people develop” around food, he said. “We don’t want to make those into a disorder. The most obvious dividing line is problems that lead to significant impairment — and that’s embedded in the criteria. And that’s the best we can do.”

Walsh said researchers are caught between a rock and a hard place. “If you go too far in one direction you run the risk of labelling things that are just idiosyncrasies problems.

“On the other hand, we clinicians really feel a need to identify the problems that people present to us with, because they’re coming in because they think this needs treatment. And they’re probably right,” he said.

“Who can judge better than the person?”

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