
Food, taste and other aversions

INVITERT KOMMENTAR

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Eating and meals are challenging for many children and adolescents with autism spectrum disorders. Some need help from the specialist health service. For others, it is better not to focus too much on eating.

In a recently published review article in the Journal of the Norwegian Medical Association, Mørdre et al. draw attention to food selectivity in children and adolescents with autism spectrum disorders [\(1\)](#). They define food selectivity as 'refusing food intake, fear of new foods (neophobia), a strong preference for certain types of food and/or a severely restricted food repertoire'.

This is an important and relevant topic, and there is a stronger focus on food selectivity in the general child and adolescent population. Although there is also greater understanding of the fact that eating difficulties in connection with autism may be associated with food selectivity, knowledge of this is limited [\(2\)](#).

Food selectivity is not a diagnosis but a broad category without a clear definition. Thus its prevalence varies widely [\(1\)](#). Selective eating difficulties are more clearly defined and are a synonym of *avoidant/restrictive food intake disorder* (ARFID) in the DSM-5 diagnostic system. The term ARFID is established in clinical practice in Norway but will only become a formal diagnosis when the ICD-11 diagnostic system is introduced. Children with ARFID avoid food or some types of food to such a degree that it affects their nutritional status and somatic health and/or psychosocial functioning as they avoid social arenas as a result of eating difficulties. Some children with this condition are underweight and have nutritional deficiencies, others are overweight/obese due to an unbalanced, high-energy diet. While yet others

have good nutritional status, the condition is serious for them because of its psychosocial consequences. The clinical impression is that children with autism spectrum disorders are also included in this latter group.

The somatic consequences are mainly obstipation and overweight/obesity (1). As a group, children and adolescents with autism spectrum disorders present with an increased prevalence of overweight/obesity (3). For many, this reinforces social withdrawal and loneliness. Measures targeting food selectivity can therefore be important in preventing and treating overweight/obesity in this group.

The review article includes studies on selective eating as defined by the ARFID criteria as well as studies using the term 'food selectivity', and thus concern children with both severe and less severe eating difficulties (1). Clinically, it seems that children with autism spectrum disorders and selective eating patterns form a complex group, and this is significant for our approach and treatment.

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Several factors make these children vulnerable to developing selective eating patterns. The basic difficulties caused by autism such as limited flexibility, a preoccupation with routines and problems with change, are general traits that can also be expressed in eating patterns. Changed sensitivity to sense stimuli such as smell, taste, temperature, texture and sound occur frequently, and are now regarded as core symptoms of autism spectrum disorder (2, 4). Mørdre et al. found an association between repetitive, stereotyped behaviour and food selectivity – texture and taste in particular were of significance (1).

Meanwhile it is important to keep in mind that it is normal for children to be selective as regards food. A Norwegian study found that one out of four children of kindergarten age were selective to a moderate or considerable degree (5). Children are most receptive to new foods up to the age of two, and then become more sceptical. Scepticism to new foods may be an innate characteristic that protects the child from potentially dangerous food (6). Genetics may play a strong role in the development of selective eating patterns, and some children may find it more difficult to get used to new foods than others (7). In their early years, children encounter new foods in different social arenas. They see what other children eat, taste it and extend their food repertoire. This development can also be disrupted in children with autism spectrum disorders who struggle with social contact. It is therefore important to provide arenas where the child can eat together with others.

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Mapping of eating patterns should be included in the assessment of all children and adolescents with autism spectrum disorder (1). At present, this is not done systematically. Moreover, nutritional and somatic status should be evaluated. Children with autism spectrum disorders and severe food selectivity need treatment from the specialist health service, either in the child and adolescent mental health services or in a department of paediatric medicine.

It is important not to be over-concerned about exactly what the child eats or does not eat when they have good nutritional status despite food selectivity traits. We know that in general, paying too much attention and pressuring the child to eat exacerbates the difficulties (5). Parents and carers must be reassured and helped to cope with their frustration and concern. The child should be constantly encouraged to eat a wider variety of foods, but we must accept that this will take a long time, and they may always be fussy eaters.

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