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How do adult inpatients with ARFID or AN-R compare on self-report eating disorder assessments?

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ABSTRACT

The Pica, ARFID, and Rumination Disorder ARFID Questionnaire (PARDI-AR-Q) and the Eating Disorders in Youth Questionnaire (EDY-Q) were developed to assess avoidant/restrictive food intake disorder (ARFID), but research is ongoing regarding their discriminant validity. This study examined scores of adult inpatients with ARFID or anorexia nervosa, restricting type (AN-R) on the PARDI-AR-Q, EDY-Q, and Eating Disorder Examination Questionnaire (EDE-Q) at admission to a medical stabilization unit for severe eating disorders. Response differences between 78 adult inpatients with ARFID or AN-R were analyzed using a two-sample t-test or Fisher's exact test. Sensitivity and specificity of self-report measures were examined using receiver operating characteristic curves. Patients with AN-R had significantly higher severity of impact and lower concern about aversive consequences scores than patients with ARFID on the PARDI-AR-Q ($p < .001$), with no significant differences on sensory-based avoidance or lack of interest or EDY-Q total score. Patients with AN-R scored significantly higher on all domains of the EDE-Q (p 's $< .001$) and the EDE-Q subscales had better discrimination than ARFID measures. This study provides further evidence of the need for assessments that can distinguish ARFID from AN, and may also highlight the need for future research on the nosological accuracy of differentiating these disorders.

Clinical Implications

- Individuals with ARFID are assessed via questionnaires designed for their unique symptomatology, but validation studies have not used these questionnaires with a comparative eating disorder sample.
- Inpatient treatment-seeking adults with ARFID or anorexia nervosa, restricting type (AN-R) completed questionnaires designed to measure ARFID symptomatology, with both groups scoring similarly.

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- Given the poor discriminant validity found in this study, future research should examine symptom crossover between these diagnoses and identify ways to better differentiate the diagnoses.

Introduction

Avoidant/restrictive food intake disorder (ARFID) was first described in the Diagnostic and Statistical Manual, 5th edition (DSM-5; American Psychiatric Association [APA], 2013) and is characterized by one or more of the following: 1) significant weight loss or failure to achieve expected weight gain, 2) significant nutritional deficiency, 3) dependence on enteral feeding or oral nutritional supplements, and 4) marked interference with psychosocial functioning. According to the DSM-5, three clinical presentations of ARFID are suggested: 1) lack of interest in eating, 2) avoidance of eating due to sensory characteristics of food, such as taste, smell, or texture; and 3) avoiding eating due to concern about aversive consequences of eating, such as vomiting or choking. However, research has found that many patients with ARFID endorse symptoms of more than one presentation (Manwaring et al., 2023; Reilly et al., 2019).

ARFID is associated with significant psychiatric and medical comorbidities (Nitsch et al., 2023) and impaired quality of life (Hay et al., 2017), similar to eating disorders (EDs) such as anorexia nervosa (AN) (Chesney et al., 2014; Jenkins et al., 2011; Udo & Grilo, 2019). However, ARFID differs from AN in that patients with ARFID do not endorse fear of weight gain or disturbance in the way they experience their body shape or weight, hallmark characteristics of both types of AN (AN-restricting subtype [AN-R] and AN-binge/purge subtype) (APA, 2013). Currently, according to the DSM-5, an individual cannot receive diagnoses of both AN and ARFID; an AN diagnosis supersedes other ED diagnoses. However, it has been noted that a significant minority of patients seem to present with symptoms of both disorders, muddying the diagnostic waters (e.g., Becker et al., 2020). In addition to diagnostic uncertainty, this is also important because the respective treatments are uniquely different. Thus, the ability to accurately assess symptoms of each disorder is crucial for establishing accurate diagnoses to better focus treatment. The Pica, ARFID, and Rumination Disorder Interview (PARDI) was developed to assess the presence and severity of three feeding disorders: pica, ARFID, and rumination disorder (Bryant-Waugh et al., 2019). However, the administration time to complete the PARDI (> 40 min) can make it challenging for clinicians to use regularly. Thus, the questionnaire version of the interview was developed (the Pica, ARFID, and Rumination Disorder ARFID Questionnaire; PARDI-AR-Q), which assesses ARFID, but not pica or rumination disorder (Bryant-Waugh et al., 2022).

Development and validation studies of the PARDI and PARDI-AR-Q have compared patients with ARFID to healthy controls (Bryant-Waugh et al., 2022), but have not compared patients with ARFID to patients who have an ED diagnosis with symptoms and signs that overlap with ARFID, such as AN. To optimize the utility of an assessment of ARFID symptoms, the assessment must have good sensitivity and specificity; that is, it should be able to identify those with ARFID while simultaneously recognizing when a patient does not have ARFID, such as a patient with AN.

The purpose of the current study is to examine the scores of treatment-seeking adult patients with ARFID or AN-R on the PARDI-AR-Q at admission. Based on clinical observations, it is hypothesized that patients with AN-R will score similarly to patients with ARFID on the PARDI-AR-Q. A secondary exploratory aim is to conduct similar analyses on another ARFID measure (the Eating Disorders in Youth-Questionnaire; EDY-Q; Kurz et al., 2015, 2016) and a measure of ED symptoms (the Eating Disorder Examination-Questionnaire; EDE-Q; Fairburn & Beglin, 1994, 2008).

Method

Participants and procedure

Participants included 78 adult patients with ARFID or AN-R receiving treatment at ACUTE, a 30-bed medical stabilization unit dedicated to providing care for medically compromised patients with severe EDs. Typical criteria for admission to ACUTE include one or more of the following: weight less than 70% of the patient's expected body weight (EBW) or a body mass index (BMI) less than 15 kg/m²; a history of serious medical complications due to the ED (e.g., acid–base electrolyte aberrations, cardiac irregularities, or gastrointestinal complications); or previously experienced incidents of refeeding syndrome.

Patients provide informed consent to participate in research studies upon admission. Inclusion criteria for the current study were as follows: 1) age ≥ 18 years, 2) admission %EBW $\leq 75\%$, 3) DSM-5 diagnosis of ARFID or AN-R, and 4) completion of at least one of the measures of interest (PARDI-AR-Q, EDY-Q, and EDE-Q). All three questionnaires are provided to patients at admission by a licensed clinical psychologist as part of the standard of care, and patients complete them on their own. All patients in this study completed all three questionnaires other than 19 patients with AN-R and 1 patient with ARFID who did not complete questions 13–18 of the EDE-Q, which are not included in the scoring of this measure. Exclusion criteria were as follows: 1) adolescents < 18 years old, 2) DSM-5 diagnosis of an ED other than ARFID or AN-R, 3) the patient was ever on a mental health hold or short-term certification during treatment. ED diagnoses were determined via

clinical interview from a licensed clinical psychologist and psychiatrist. For patients with multiple admissions to ACUTE, information from their most recent admission was used. Charts were reviewed of admissions from January 2021 through July 2024 until a sufficient number of individuals meeting the inclusion criteria were identified. This study was approved by COMIRB.

Measures

Demographic information. Demographic information was collected at admission. The demographics used in the current study included age, sex, height (measured at admission), weight (gowned weight after voiding), %EBW, BMI, age of onset of the disorder, duration of illness, number of previous ACUTE hospitalizations, and comorbid psychiatric diagnoses.

The *Pica, ARFID and Rumination Disorder ARFID Questionnaire (PARDI-AR-Q)* (Bryant-Waugh et al., 2022) is a 32-item self-report measure of ARFID symptoms based on the PARDI interview (Bryant-Waugh et al., 2019). Most of the first 20 items on the PARDI-AR-Q are questions already known about the ACUTE population from their admission assessment (e.g., height, weight, presence of enteral nutrition) and are not used in the scoring. Due to this and to decrease participant burden, patients at ACUTE only complete items 21–32. The questionnaire assesses the severity of the disorder as well as the three clinical presentations of ARFID: lack of interest, sensory-based avoidance, and concern about aversive consequences. For each of these subscales, the total score ranges from 0 to 6, with a higher score indicating greater symptom severity. In the present study, the PARDI-AR-Q displayed acceptable to good internal consistency for all PARDI-AR-Q subscales (α .73–.85) and acceptable for the total scale (α .73).

The *Eating Disorders in Youth-Questionnaire (EDY-Q)* (Hilbert & van Dyck, 2016; Kurz et al., 2015, 2016) is a 14-item self-report measure assessing ARFID symptoms, developed for youth and validated in ages 8–13, although the items are also clinically relevant to adults with ARFID (e.g., “I am afraid of choking or vomiting while eating”), and have been subsequently validated in adults (Hilbert et al., 2020). Because of this validation in adults, the EDY-Q was chosen as another measure to examine discriminant validity with these populations. Two items also assess symptoms of pica and rumination disorder, and two items assess symptoms characteristic of AN, which are used as exclusion criteria for ARFID (i.e., “I feel fat, even if other people do not agree with me” and “As long as I do not look too fat or weigh too much, everything else does not matter”). Items are scored on a 7-point Likert scale from “0” (never) to “6” (always) and cover the three presentations of ARFID described above. In the present study, the EDY-Q displayed acceptable internal consistency (α = .64).

The *Eating Disorder Examination-Questionnaire (EDE-Q)* (Fairburn & Beglin, 1994, 2008) is a widely used 28-item questionnaire assessing the behavioral and cognitive psychopathology of EDs. The EDE-Q has four subscales—Restraint, Eating Concern, Shape Concern, and Weight Concern—as well as a Global Score. The EDE-Q does not provide diagnostic questions for ARFID. In the present study, the EDE-Q displayed acceptable to excellent internal consistency for all EDE-Q subscales (α .74–.96) and excellent for the total scale (α .94).

Statistical analysis

Demographic and clinical characteristics were summarized descriptively overall and by diagnostic group. Differences between groups were analyzed using a two-sample *t*-test or Fisher's exact test. A power analysis determined the study required 76 total patients, 28 ARFID and 48 AN-R, to achieve 80% power to detect a mean difference of 1.26 in PARDI severity subscale, assuming an alpha of 0.05 and a standard deviation (SD) of 1.9. The clinical questionnaires were compared at admission between diagnostic groups using a two-sample *t*-test and reported with Cohen's *d* as the standardized difference between diagnostic groups and 95% confidence intervals (CIs). Levene's tests were conducted to examine homogeneity of variance across groups. For subscales where the variance between groups was unequal, a Welch's *t*-test was conducted and reported with Cohen's *d*. Sensitivity and specificity of the individual subscales of the clinical questionnaires were analyzed using receiver operating characteristic (ROC) curves, using the pROC package (Robin et al., 2011). Statistical significance was assessed at the 0.05 level, and analysis was done using R version 4.4.2 (R Core Team, 2023).

Results

The sample consisted of 78 patients, 49 (63%) with AN-R and 29 (37%) with ARFID. The average age was 34 years (SD = 13.1) and approximately 95% of patients identified as White. Compared to patients with ARFID, patients with AN-R were more likely to be female (88% vs. 66%, $p = .039$), have a lower average BMI at admission, significantly more prior ACUTE hospitalizations, a younger age at onset of illness, and a longer duration of illness (Table 1).

Comparisons between diagnostic groups on the PARDI-AR-Q showed that patients with AN-R had significantly higher severity of impact scores compared to patients with ARFID ($p < .001$). Patients with AN-R scored significantly lower on concern about aversive consequences than patients with ARFID ($p < .001$). There were no significant differences between diagnostic groups on sensory-based avoidance or lack of interest (Table 2). The ROC

Table 1. Demographic and clinical characteristics.

	Total (N = 78)	AN-R (N = 49)	ARFID (N = 29)	<i>p</i> -value
Age (M, SD)	33.8 (13.1)	32.1 (12.5)	36.7 (14.0)	.150
Female (N,%)	62 (79%)	43 (88%)	19 (66%)	.039
Gender (N,%)				
Female	58 (74%)	42 (86%)	16 (55%)	.009
Male	12 (15%)	4 (8%)	8 (28%)	
Transgender Female	3 (4%)	1 (2%)	2 (7%)	
Transgender Male	3 (4%)	2 (4%)	1 (3%)	
Genderqueer/Non-Binary/Other	0 (0%)	0 (0%)	0 (0%)	
Chose Not to Disclose/Missing	2 (3%)	0 (0%)	2 (7%)	
Race (N, %)				
Asian	3 (4%)	2 (4%)	1 (3%)	.999
White	74 (95%)	46 (94%)	28 (97%)	
Black or African American	1 (1%)	1 (2%)	0 (0%)	
American Indian/Alaska Native	0 (0%)	0 (0%)	0 (0%)	
Other	0 (0%)	0 (0%)	0 (0%)	
Admission BMI (M, SD)	13.2 (2.0)	12.7 (1.8)	14.0 (2.1)	.012
Admission %EBW (M, SD)	61.9 (8.9)	60.3 (8.9)	64.5 (8.3)	.043
Age of Onset of Illness (M, SD)	22.3 (12.3)	18.3 (8.5)	29.2 (14.5)	< .001
Duration of Illness	10.9 (9.9)	11.1 (13.5)	6.6 (4.9)	< .001
Number of Prior ACUTE Hospitalizations*	1.7 (1.6)	2.1 (1.9)	1.2 (0.5)	.002

*Number of prior ACUTE hospitalizations was analyzed with a non-parametric Mann–Whitney U test.

Table 2. Clinical scores at admission and differences between diagnostic groups.

	AN-R (N = 49) <i>M (SD)</i>	ARFID (N = 29) <i>M (SD)</i>	<i>t</i> -value	<i>p</i> -value	Cohen's <i>d</i> (95% CI)
PARDI Severity of Impact	4.3 (1.4)	2.7 (2.0)	3.85	0.004	−1.00 (−1.48, −0.51)
PARDI Sensory-Based Avoidance	2.2 (1.8)	1.7 (1.9)	1.00	0.319	−0.25 (−0.71, 0.21)
PARDI Lack of Interest	3.6 (1.5)	3.3 (2.0)	0.82	0.414	−0.21 (−0.67, 0.25)
PARDI Concern about Aversive Consequences	1.7 (1.8)	3.5 (2.2)	−3.85	< .001	0.92 (0.43, 1.39)
EDE-Q Restraint	3.5 (2.1)	0.2 (0.7)	10.10	< .001	−1.95 (−2.50, −1.39)
EDE-Q Eating Concern	2.7 (1.4)	1.0 (1.1)	5.77	< .001	−1.34 (−1.84, −0.83)
EDE-Q Shape Concern	3.8 (1.6)	1.6 (1.2)	6.14	< .001	−1.46 (−1.97, −0.94)
EQE-Q Weight Concern	3.4 (1.5)	1.6 (1.1)	5.61	< .001	−1.31 (−1.82, −0.81)
EQE-Q Global	3.3 (1.5)	1.1 (0.9)	0.93	< .001	−1.76 (−2.30, −1.22)
EDY-Q Total Score	2.9 (0.9)	2.9 (1.2)	0.00	0.838	0.05 (−0.41, 0.51)

curves for both severity of impact (AUC = .73 [.62, .85]) and concern about aversive consequences (AUC = .73 [.61, .85]) demonstrated fair discrimination between patients with AN-R and ARFID (Figure 1, Table 3). Figure 1 displays the ROC curves, and Table 3 reports the associated statistics (e.g., AUC, specificity, and sensitivity). The ROC curves for sensory-based avoidance (AUC = .57 [.44, .71]) and lack of interest (AUC = .47 [.33, .62]) displayed poor discrimination. Sensitivity ranged from 37.93 to 71.43% and specificity ranged from 57.14 to 87.76% (Table 3).

Patients with AN-R scored significantly higher than patients with ARFID on all domains of the EDE-Q: Restraint, Eating Concern, Shape

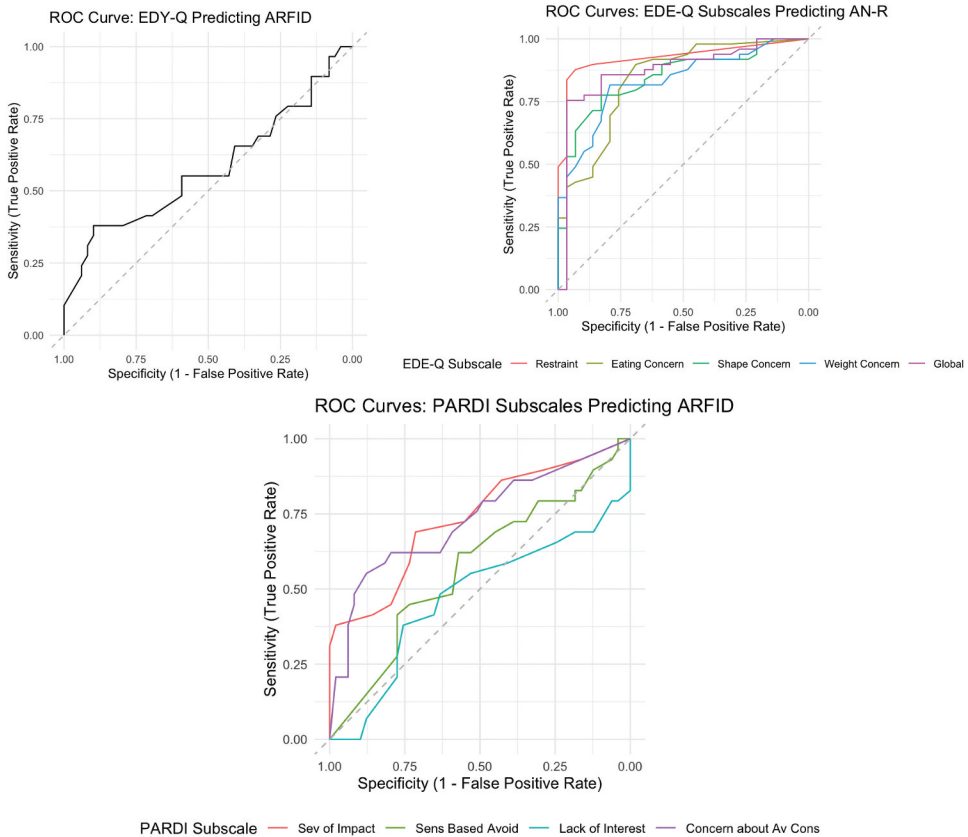


Figure 1. ROC curves identifying AN-R and ARFID patients. *Note.* PARDI = Pica, ARFID, and Rumination Disorder ARFID Questionnaire; EDE-Q = Eating Disorder Examination Questionnaire; EDY-Q = Eating Disorders in Youth-Questionnaire. Sev of Impact = severity of impact; Sens Based Avoidance = Sensory-based avoidance; Concern about Av Cons = Concern about aversive consequences. Measures used to examine ARFID (i.e., PARDI-AR-Q and EDY-Q) have ARFID as the “case” or positive group. Measures that are used to examine eating pathology (EDE-Q) have AN-R as the “case” or positive group.

Concern, Weight Concern, and Global Score (all p 's < .001). There was no significant difference in the EDY-Q total score between groups ($p = .838$; Table 2). The ROC curve for EDE-Q Restraint (AUC = .93 [.87, .98]) demonstrated excellent discrimination between patients with AN-R and ARFID (Figure 1, Table 3). The ROC curves for EDE-Q Eating concern (AUC = .84 [.75, .93]), Shape Concern (AUC = .85 [.76, .93]), Weight Concern (AUC = .83 [.74, .92]), and Global Score (AUC = .87 [.79, .97]) displayed good discrimination between diagnostic groups. The EDY-Q (AUC = .58, [.44, .72]) displayed poor discrimination. Of the EDE-Q subscales, sensitivity ranged from 75.51% to 89.80% and specificity 68.97% to 96.55% (Table 3). Finally, the EDY-Q displayed a sensitivity of 37.93% and specificity of 89.90%.

Table 3. ROC curve summaries.

Clinical Scale	AUC	95% Confidence Interval	Clinical Cutoff	Specificity	Sensitivity
PARDI Severity of Impact	0.73	[.62, .85]	3.75	68.97%	71.43%
PARDI Sensory-Based Avoidance	0.57	[.44, .71]	1.50	57.14%	62.07%
PARDI Lack of Interest	0.47	[.33, .62]	4.50	75.51%	37.93%
PARDI Concern about Aversive Consequences	0.73	[.61, .85]	3.84	87.76%	55.17%
EDE-Q Restraint	0.93	[.87, .98]	0.40	93.10%	87.76%
EDE-Q Eating Concern	0.84	[.75, .93]	1.10	68.97%	89.80%
EDE-Q Shape Concern	0.85	[.76, .93]	2.57	82.76%	77.55%
EDE-Q Weight Concern	0.83	[.74, .92]	2.30	79.31%	81.63%
EDE-Q Global	0.87	[.79, .97]	2.25	96.55%	75.51%
EDY-Q Total Score	0.58	[.44, .72]	1.75	89.80%	37.93%

Note. AUC = Area Under the Curve. Clinical Cutoff is Youden's value. PARDI = Pica, ARFID, and Rumination Disorder ARFID Questionnaire; EDE-Q = Eating Disorder Examination Questionnaire; EDY-Q = Eating Disorders in Youth-Questionnaire. Measures used to examine ARFID (i.e., PARDI-AR-Q and EDY-Q) have ARFID as the "case" or positive group. Measures that are used to examine eating pathology (EDE-Q) have AN-R as the "case" or positive group.

Discussion

The purpose of the current study was to examine the overall scores of adult patients with ARFID or AN-R on the PARDI-AR-Q. The hypothesis that patients with AN-R would score similarly to patients with ARFID on the PARDI-AR-Q was mostly supported, as patients with AN-R demonstrated similar scores to patients with ARFID on sensory-based avoidance and lack of interest, which both had poor AUCs, and higher scores on severity of impact, which displayed good discriminant ability, demonstrating more concerns of patients with AN-R than patients with ARFID regarding the negative impact of their eating habits on their relationships and social situations.

Patients with AN-R only scored significantly lower than patients with ARFID on the subscale regarding concern about aversive consequences, indicating that patients with AN-R endorse less restricting behavior due to, for example, fears of being sick or being in pain, consistent with the inherent features of AN-R. The similar endorsements of ARFID symptomatology for both patient groups may call into question the sensitivity of the PARDI questionnaire and inform attempts to further develop the measure. The similar symptomatology may also demonstrate the difficulty in differentiating between ARFID and non-fat-phobic AN (Becker et al., 2009; Izquierdo et al., 2019); highlight a period in which an individual is crossing over to another diagnosis (Bhattacharya et al., 2022; Norris et al., 2020); or provide further evidence for a class of "restrictive" EDs wherein avoidance of eating is the primary feature (Abber et al., 2025; Kambanis et al., 2024). Future research could further examine the clinical and research utility of a unifying restrictive ED diagnosis with specifiers for primary and potentially secondary motivations (Birgegård et al., 2023; Phillipou & Beilharz, 2019; Sharpe, 2024) or examine the recently proposed diagnostic criteria that allow for a diagnosis of ARFID with other EDs (Zickgraf et al., 2025).

A secondary exploratory aim of the study was to examine differences between the diagnostic groups on the ARFID measure EDY-Q. The lack of differences between the two diagnostic groups on the total EDY-Q score, as well as poor AUC and sensitivity, is somewhat surprising given that this measure was created to measure ARFID, not AN, symptoms. In the original validation paper of the EDY-Q (Kurz et al., 2015), the authors noted that the EDY-Q total mean score was positively (albeit weakly) correlated with items on the child version of the EDE-Q, a measure intended to measure ED symptoms outside of ARFID (Fairburn & Beglin, 1994; TODAY Study Group [TODAY], 2007). Similar to the PARDI-AR-Q, the validation of the EDY-Q examined children with features of ARFID but were not compared to children or adolescents with other EDs (Kurz et al., 2015). While the EDY-Q was initially validated with youth, it has also subsequently been validated in an adult population (Hilbert et al., 2020). However, the results from the current study's adult population raises some concern about using the EDY-Q solely as a measure of ARFID in adults, despite its clinical relevance, given the potential overlap observed in this study between the diagnostic groups.

For the exploratory aim of examining differences between the diagnostic groups on the EDE-Q, it is not surprising that patients with AN-R scored significantly higher on the EDE-Q subscales and Global Score than patients with ARFID given this measure was designed prior to the introduction of ARFID as a diagnostic entity in the DSM-5; indeed, these all displayed good to excellent discrimination between diagnostic groups. Other studies have also found similar discrepant scores between these populations (Abber et al., 2024; Becker et al., 2019). However, it does suggest that the EDE-Q is not an appropriate measure to assess ARFID symptoms and that validated ARFID-specific measures should be used instead (Willmott et al., 2024).

Collectively, the ROC analyses demonstrated that the PARDI-AR-Q and the EDY-Q—both questionnaires designed to identify and assess patients with ARFID—did a poor to fair job in this study, particularly in the areas of sensory-based avoidance and lack of interest. Conversely, the EDE-Q, designed without considering ARFID, did an excellent job of discriminating between these patient populations with its Restraint Subscale, and a good job of discriminating with its Global and other subscales. The Global Score of the EDE-Q also demonstrated excellent specificity. While the EDE-Q has come under scrutiny recently for its psychometric properties (Jenkins & Rienecke, 2022; Reilly et al., 2025), it performed better in this inpatient population in discriminating between AN-R and ARFID.

This is not the first study to recognize the problematic lack of discriminant validity in ARFID questionnaires. The Nine Item Avoidant/Restrictive Food Intake disorder screen (NIAS; Zickgraf & Ellis, 2018), the first questionnaire designed to assess symptoms of ARFID, has been demonstrated as

insufficient by itself in distinguishing between ARFID and other EDs, as individuals with other EDs also score highly on this measure (Billman Miller et al., 2024; Burton Murray et al., 2021). A large study of 9148 participants similarly found that participants with AN demonstrated the highest mean scores on the NIAS, with the authors suggesting using the PARDI interview to better explicate the subtleties between these diagnoses (Presseller et al., 2024).

Recent research demonstrates that relying on the currently available questionnaires to distinguish ARFID from other EDs—especially AN—is fraught with problems, and a careful clinical interview such as the PARDI may be most clinically accurate and informative, despite the drawback of its time burden. If clinicians wish to rely on questionnaires, a measure such as the EDE-Q, in addition to an ARFID questionnaire, may be helpful in distinguishing among the EDs, although future research would be helpful in confirming the ideal balance of participant and clinician burden with diagnostic accuracy, as well as determining whether these results can be replicated in other levels of care. For underserved populations, or with clinicians without ED expertise, relying on questionnaires to guide treatment could result in patients being misdiagnosed with ARFID due to demonstrating sensory-based avoidance or lack of interest in eating. While treatments for both ARFID and AN-R focus on weight restoration, having an erroneous impression of the motivations of weight loss could result in valuable time lost in treating AN-R. Further evaluating discriminant validity between AN-R and ARFID measures would allow for the establishment of clinical cutoff scores to provide less experienced clinicians a more clear and concise method to distinguish between these diagnoses.

Strengths of the current study include the relatively large sample of individuals with severe AN and ARFID, as well as the gender diversity in the sample. The strength of the unique severely ill population is also at the same time, a limitation, as the preponderance of the clinical presentation of fear of aversive consequences in the patients with ARFID is likely higher than individuals with ARFID at lower levels of care (Manwaring et al., 2023; Nitsch et al., 2023), limiting generalizability of findings. This preponderance of the fear of aversive consequences presentation may also explain why the AN-R sample had a younger age of onset compared to the ARFID group, which has not been found in previous research (e.g., D’Adamo et al., 2023; Norris et al., 2014). Further, given the prevalence of ARFID and other ED diagnoses in children and adolescents, and the older age of our ARFID study population, future research should replicate this study in a younger population. It is possible that adults with AN who have had more years to experience negative symptoms of their ED (mean of 11 years in this sample, with a large standard deviation) may appear more like ARFID, but that children and adolescents are more distinct in their presentation. For example, an adult with AN may—after years of malnutrition—suffer from gastroparesis that increases stomach

bloating, fullness, and discomfort, consequently reducing interest in eating (Gibson et al., 2021). Another area for future research is to discern how the clinical presentations of ARFID (fear of aversive consequences, lack of interest, and sensory issues) impact its assessment.

This study aligns with previous research on the lack of discriminant validity in questionnaires assessing ARFID, and provides further evidence that the field needs brief and accurate assessments that can distinguish ARFID from AN. In the interim, clinicians would be prudent not to rely solely on the results of ARFID questionnaires to distinguish AN-R from ARFID

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