

MONOPHAGISM

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1. Core Definition

The term **Monophagism**, often used clinically as a descriptor rather than a formal diagnosis in isolation, refers to a severe, pathological condition characterized by an extreme restriction in dietary intake. This restriction limits the individual to consuming only one specific type of food, or a very narrow category of food items, on a consistent basis, often described as "religiously" consuming the same meal day after day. Unlike general picky eating, monophagism signifies an obsessive and often distressing pattern of food selection that significantly impairs the individual's psychological, social, and physiological well-being. It is characterized by the inability or refusal to introduce variety into the diet, leading to a profound dependence on the single preferred food source. This pattern is distinguished from voluntary, short-term dietary restrictions, such as fasting or elimination diets, by its involuntary, compulsive nature and its duration, typically persisting over months or years.

In a clinical context, **monophagism** represents a severe form of selective eating. While the original definition sometimes implies eating only one type of food *per day*, modern interpretations broaden this to mean habitual, long-term dependence on a single or very limited range of foods, irrespective of the frequency within a 24-hour cycle. The underlying mechanisms are often rooted in psychological factors, such as extreme food neophobia (fear of new foods), sensory sensitivities (aversion to specific textures or smells), or anxiety surrounding eating and swallowing. Consequently, this highly constrained diet invariably results in significant nutritional inadequacy, posing serious risks to physical health and development, especially in children and adolescents.

It is crucial to differentiate **monophagism** from anorexia nervosa or bulimia nervosa, where the primary driver is typically body image distortion or fear of weight gain. In contrast, the restrictive behavior observed in monophagism is driven by avoidance, sensory issues, or fear related to the food itself, aligning more closely with the diagnostic criteria for Avoidant/Restrictive Food Intake Disorder (ARFID). The pathological nature of this behavior arises from the resulting functional impairment, nutritional deficiencies, and the high level of distress associated with deviating from the strictly defined dietary regimen.

2. Etymology, Taxonomy, and Biological Context

The term **monophagism** is derived from the Greek roots: *monos* (meaning 'single' or 'alone') and *phagein* (meaning 'to eat'). Etymologically, it directly signifies "eating one thing." The concept

originates in biological and zoological taxonomy, where the related term **monophagy** is used to classify organisms, predominantly insects, that feed exclusively on a single host species or a very narrow range of food sources. This biological distinction helps define feeding strategies across the animal kingdom, contrasting with polyphagy (eating many types of food) and oligophagy (eating a few types of food). While the biological term describes an evolutionary survival strategy, the application of **monophagism** to human behavior describes a dysfunctional, maladaptive pattern.

Historically, the term has been loosely applied in various early psychological texts describing highly idiosyncratic or abnormal eating patterns. Before the formalization of modern eating disorder classifications, particularly the introduction of ARFID in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition), severe selective eating patterns were often grouped under generalized diagnoses or labeled descriptively using terms like **monophagism** or selective eating disorder. The persistence of the term in clinical lexicon highlights the extreme degree of restriction involved, serving as a powerful descriptive label for the most severe end of the selective eating spectrum. Its use helps clinicians communicate the gravity of the dietary limitation when discussing patient histories.

Understanding the biological context of **monophagy** helps underscore the unnatural state of human monophagism. Humans, as omnivores, are biologically designed for polyphagy, requiring a diverse range of nutrients that cannot typically be supplied by a single food source (e.g., consuming only bread, or only a specific brand of chicken nuggets). This biological incongruity emphasizes why human **monophagism** is inherently pathological, as it contradicts fundamental nutritional requirements for growth, maintenance, and metabolic health. The severity of the resulting malnutrition is directly proportional to how narrow the restriction is and the nutritional completeness of the single item consumed.

3. Clinical Presentation and Psychological Manifestations

The presentation of **monophagism** is often stark and immediately noticeable to caregivers or clinicians. Patients typically exhibit an intense reliance on one specific food item, such as plain pasta, chicken strips, or a particular brand of cracker, often prepared in a highly specific manner. Deviation from this precise formula--such as a different brand, a slight change in cooking method, or the presence of a new seasoning--can provoke significant distress, anxiety, or outright refusal to eat. This rigidity defines the behavior and complicates intervention efforts. The individual often expends substantial mental energy managing their food supply and avoiding situations where their preferred food is unavailable, leading to social withdrawal and compromised quality of life.

Psychologically, **monophagism** is deeply intertwined with anxiety disorders and obsessive traits. The intense aversion to varied foods is frequently rooted in sensory hypersensitivity, where certain textures (e.g., sliminess, lumpiness), smells, or even the appearance of food are perceived as

intolerable or physically threatening. For others, the restriction is driven by a profound fear of adverse consequences, such as choking, vomiting, or an allergic reaction, even if these fears are irrational or generalized beyond foods that previously caused harm. The strict adherence to the limited diet acts as a coping mechanism, a way to exert control over overwhelming sensory or anxiety-provoking situations, thus reinforcing the restrictive cycle.

In social settings, **monophagism** creates significant barriers. Meals outside the home, school lunches, or social gatherings centered around food become sources of extreme stress. Individuals may refuse to eat in public, conceal their limited diet, or insist on bringing their own food, leading to isolation and misunderstandings from peers and family members who may perceive the behavior simply as stubbornness or extreme pickiness. This social impairment underscores the pathological nature of the condition, demonstrating that the restriction is not a lifestyle choice but a manifestation of underlying psychological distress and inability to cope with dietary variation.

4. Differential Diagnosis and Associated Conditions

While **monophagism** is a descriptive term, it is most often categorized clinically under the umbrella of Avoidant/Restrictive Food Intake Disorder (ARFID), as defined in the DSM-5. ARFID is characterized by disturbed eating that leads to persistent failure to meet appropriate nutritional and/or energy needs, associated with one or more of the following: significant weight loss, nutritional deficiency, dependence on enteral feeding/supplements, or marked interference with psychosocial functioning. Monophagism represents a severe subtype of ARFID rooted in sensory or avoidance concerns. However, clinicians must carefully differentiate it from other conditions that involve restricted eating.

Differential diagnoses include **Anorexia Nervosa (AN)**, where restricted intake is driven by body image disturbance and intense fear of gaining weight; this motivation is generally absent in monophagism. Similarly, obsessive-compulsive disorder (OCD) may co-occur, but if the food restriction is a secondary manifestation of broader, non-food related rituals, the primary diagnosis shifts. Pica, the craving and consumption of non-food items, is also distinct, although both conditions involve highly unusual eating patterns. Furthermore, medical conditions causing true dysphagia (difficulty swallowing) or gastrointestinal pain that necessitate dietary simplification must be ruled out before a purely behavioral diagnosis is established.

A significant proportion of individuals presenting with **monophagism** also display co-occurring psychiatric conditions. These frequently include generalized anxiety disorder, social anxiety, and conditions related to sensory processing difficulties, such as Autism Spectrum Disorder (ASD). Individuals with ASD often exhibit heightened sensory sensitivities, making them particularly vulnerable to developing restricted eating patterns based on texture or flavor aversion. The presence of these comorbidities complicates both diagnosis and treatment, necessitating an

integrated therapeutic approach that addresses both the underlying anxiety or sensory issues and the resulting eating behavior.

5. Nutritional and Physiological Consequences

The most immediate and severe consequence of **monophagism** is pervasive nutritional deficiency. Because the diet consists of only one or a few items, it is virtually impossible to meet the body's requirements for essential macro- and micronutrients. Common deficiencies include insufficient intake of fiber, key vitamins (especially B12, D, and C), minerals (like iron, calcium, and zinc), and essential fatty acids. Over time, these deficiencies can lead to severe health outcomes, impacting multiple physiological systems.

In children and adolescents, chronic nutritional deficiency resulting from **monophagism** can severely impede physical growth and cognitive development. Iron deficiency can lead to anemia and fatigue, while inadequate calcium and Vitamin D intake poses risks for osteopenia and osteoporosis later in life. Furthermore, a lack of dietary variety can negatively impact the gut microbiome, potentially contributing to chronic gastrointestinal issues. In extreme cases, severe vitamin deficiency can lead to neurological damage. For instance, documented case studies linked extreme selective eating to conditions like Wernicke-Korsakoff syndrome, although these are rare and typically involve years of extremely deprived intake.

Managing the physiological consequences requires immediate and often intensive intervention. Nutritional rehabilitation focuses not only on stabilizing weight but also on correcting specific deficiencies through targeted supplementation and gradual, structured dietary expansion. Without professional guidance, the long-term prognosis for individuals with unaddressed **monophagism** includes chronic poor health, decreased immune function, and significantly reduced life expectancy due to complications arising from malnutrition. The pathological insistence on eating only one type of food underscores the urgency of clinical intervention.

6. Therapeutic and Intervention Strategies

Treating **monophagism** requires a multidisciplinary team approach involving psychiatrists, clinical psychologists, and registered dietitians specializing in eating disorders. The core goal of therapy is gradual dietary expansion combined with addressing the underlying psychological drivers of restriction, whether they stem from anxiety, sensory sensitivities, or trauma related to food. Unlike treatment for AN, where weight restoration is often the primary initial focus, ARFID-related **monophagism** treatment centers on fear reduction and tolerance building.

One of the most effective psychological interventions utilized is Cognitive Behavioral Therapy (CBT), often adapted specifically for ARFID (CBT-AR). This therapy helps the individual identify and challenge the catastrophic thoughts associated with eating new foods (e.g., "If I eat this, I will

choke"). Exposure therapy, a critical component, involves systematic, graded exposure to non-preferred foods, starting with minimal contact (e.g., smelling, touching) and slowly progressing toward tasting and swallowing. This process is slow, patient-centered, and relies heavily on building trust and minimizing distress to prevent reinforcing avoidance behaviors.

Nutritional counseling plays an essential supportive role. Dietitians work to ensure immediate nutritional needs are met, often initially through liquid supplements or fortified foods, while simultaneously developing a plan for introducing new food groups strategically. Family-Based Treatment (FBT), particularly effective for adolescents, empowers parents to take an active role in food preparation and exposure, normalizing varied eating habits within the home environment. Effective intervention is highly individualized, recognizing that the emotional and sensory drivers behind **monophagism** vary greatly among patients.

7. Debates and Contemporary Understanding

Contemporary debate surrounding **monophagism** focuses primarily on its exact relationship with ARFID and the boundary between severe picky eating and true psychopathology. While ARFID successfully captured the clinical reality of non-body-image driven restrictive eating, some researchers argue that the level of extreme restriction inherent in **monophagism** warrants specific sub-classification due to the intensity of resulting nutritional risk and the unique challenges in treatment adherence. The debate centers on whether the term should remain purely descriptive or whether the pattern of reliance on a single food represents a distinct clinical phenotype within the ARFID spectrum.

Furthermore, there is ongoing research into the neurobiological underpinnings of extreme food selectivity. Studies utilizing neuroimaging are exploring differences in how individuals with **monophagism** or ARFID process sensory information related to taste, smell, and texture compared to control groups. Preliminary findings suggest altered activity in brain regions associated with fear processing (amygdala) and sensory integration, lending credibility to the hypothesis that these restrictive patterns are rooted in genuine perceptual differences rather than simply behavioral obstinance. This research may eventually lead to more targeted, biologically informed interventions.

Ultimately, the clinical understanding of **monophagism** has shifted significantly from a simple behavioral abnormality to a recognition of a complex, anxiety-driven condition often comorbid with neurodevelopmental differences. The emphasis in current practice is on early identification, aggressive nutritional support, and anxiety-reduction techniques, recognizing that untreated **monophagism** carries profound and life-threatening physiological risks far exceeding those associated with typical childhood picky eating.

Further Reading

[Avoidant Restrictive Food Intake Disorder \(ARFID\) - National Eating Disorders Association \(NEDA\)](#)

[Eating Disorder - Wikipedia](#)

[Cognitive Behavioral Therapy \(CBT\) - Psychology Today](#)

[Autism Spectrum Disorder - Wikipedia](#)

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