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Avoidant Restrictive Food Intake Disorder (ARFID)–what is it and what to do with them?

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Eating disorders are common in children. With the evolving time, the typical anorexia nervosa or bulimia are less common. These are identified earlier. In fact, other types of relatively less severe eating disorders are being identified more, which are subtle and more difficult to identify and manage.

"Avoidant Restrictive Food Intake Disorder" (ARFID) is one of such non-typical eating disorders. It used to be called "Selective Eating Disorder" in past, however there are more nuances to the disorder than just selective eating. ARFID patients are more likely than those diagnosed with Anorexia nervosa, to have a chronic rather than acute weight loss [1]. It has significant ramifications and people need to understand the spectrum of disorder and the differences from Anorexia Nervosa.

Avoidant Restrictive Food Intake Disorder (ARFID) is a relatively new diagnosis in the DSM-5, has characteristics defined and replaces "feeding disorder of infancy or early childhood [2]. It is similar to anorexia in a manner as both these disorders involve limits in the quantity and/or types of food consumed, however unlike anorexia, ARFID doesn't comprise any anguish about body shape or size, or any fears of becoming fat. Some authors say that Avoidant restrictive food intake disorder is a rearticulated eating disorder diagnosis in the DSM-5 [3].

DSM-5 defined Avoidant/Restrictive Food Intake Disorder (ARFID) as a failure to meet nutritional needs leading to low weight, nutritional deficiency, dependence on supplemental feedings, and/or psychosocial impairment [4,5]. There is persistent refusal to eat specific foods or refusal to eat any type of food due to an adverse response related to certain foods or textures, colours or smells of the food. Unlike the Selective Eating Disorder, ARFID is identified by a pattern of persistent failure to eat to meet the required nutritional and/or energy needs.

This may cause a static weight and height in children; and may result in weight loss in adults. ARFID can cause significant problems at school in children or at work in adults due to extended times needed to eat and the need for a different environment in view of difficulties eating with others. In addition, treating ARFID may be difficult because some individuals may refuse to eat out of fear of vomiting or the fear of choking on food.

Interestingly, ARFID doesn't have the obsession with body shape or weight but has somewhat problem due to the lack of interest in food and avoidance of foods. On the other hand, ARFID can result in unwarranted and excessive weight loss. At times to the extent that it needs feeding with nasogastric tube feeds to prevent nutritional impairment.

Fisher et al 2014 reported that patients with ARFID were demographically and clinically distinct from those with AN or BN. They were significantly underweight with a longer duration of illness and had a greater likelihood of comorbid medical and/or psychiatric symptoms [6]. Psychosocial problems are identified in a good proportion of cases of ARFID and are quite difficult to manage. Although ARFID is much more common in children and was at some time considered a disorder of childhood and infancy, it is now identified and recognised to affect all ages.

Although a decent proportion of children go through a picky eating stage, ARFID is much more than just a "picky eating habit." Furthermore, it's interesting to note that children do not grow out of it and many a times become under-nourished due to a limited variety of foods they eat. It is now well established that ARFID needs to addressed early and can potentially lead to serious health problems if it is not addressed early.

Although data suggest that ARFID may affect as much as 5% children, the true prevalence of ARFID is not well studied. A prevalence of 1.5% to 17.4% is however reported in various studies [6-9].

What causes ARFID?
It's hard to pin point to a singular cause, however, there is suggestion in the current scientific literature that the evolving pattern of ARFID and disordered eating develops from a complex interplay between, environmental, psychological, genetic, and sociocultural factors.

The risk factors for ARFID thus involve a range of biological, psychological, and sociocultural factors, some of which are common to many other eating disorders. A child with ARFID does not consume enough calories to grow and develop properly and, adults does not consume enough calories to maintain basic

body function.

It is now known that:

- Children and even adults with autism spectrum conditions are much more likely to develop ARFID. ADHD and intellectual disabilities also have higher prevalence of ARFID.
- Children whose picky eating is severe, or who don't outgrow the normal picky eating by school going age are more likely to develop ARFID.
- Children who have anxiety disorder, are also at high risk for ARFID and also other psychiatric disorders.

How to Diagnose?

ARFID is in fact a heterogeneous disorder that is associated with high levels of physical and psychological comorbidity and impact on physical health and psychosocial functioning [10].

It can be a subtle disorder initially, however according to the DSM-5, ARFID can be diagnosed when there is:

1. An eating or feeding disturbance (e.g. apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) is manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
   - Significant weight loss (or faltering growth in children or failure to achieve expected weight gain).
   - Significant nutritional deficiency.
   - Dependence on enteral feeding or oral nutritional supplements.
   - Marked interference with psychosocial functioning.
2. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
3. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
4. The eating disturbance is not attributable to a concurrent medical condition or is not better explained by another mental disorder.

If the eating disturbance happen in the context of another condition or disorder, the severity of the problem far exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Table: Warning signs and symptoms

Indicator	Manifestation
Behavioural	Will only eat certain textures of food
	Fears of choking or vomiting
	Lack of appetite or interest in food
	Limited range of preferred foods that become narrower over time
	consistent, vague gastrointestinal issues around mealtimes that have no known cause i.e. tummy upset , fully tummy etc
	Reports constipation, abdominal pain, cold intolerance, lethargy, and/or excess energy
	Dramatic restriction in types or amount of food eaten
Physical	Dizziness
	Cold, mottled hands and feet or swelling of feet
	Sleep problems
	Thinning of hair on the head, dry and brittle hair
	Dry skin
	Dry and brittle nails
	Poor wound healing
	Recurrent infections and impaired immune function
	Menstrual irregularities—missing periods or only having a period while on hormonal contraceptives
	Abnormal laboratory findings (anaemia, low thyroid and other hormone levels, low potassium, low blood cell counts, slow heart rate)

Both ARFID and Anorexia nervosa can manifest as people dressing in layers to hide weight loss or stay warm, or have dramatic weight loss, but there is no body image disturbance or fear of weight gain in ARFID.

Management /Treatment

Management of ARFID is quite complex and the comprehensive delivery of therapeutic care for children or adults suffering from ARFID like many other eating disorders is based on an integrated approach involving nursing, psychiatric and medical care. The evidence shows that the magic for improvement comes from setting of a multidisciplinary team that is dynamic, supportive of each other, considerate of the psychiatric and physical manifestations of eating disorders and is focused on the holistic care including mind and body.

Some of the approaches that work in ARFID are:

1. Cognitive-behavioural therapy
2. Dialectal behavioural therapy
3. Interpersonal therapy
4. Whole Family therapy
5. Exposure therapy

CBT-AR is an outpatient manualized psychosocial treatment for ARFID in older adolescents, and the findings of recent research provide evidence of feasibility, acceptability, and proof-of-concept for CBT-AR. More randomized controlled trials are needed to establish the role It is important to remember that in ARFID, the body is deprived of the essential nutrients, and thus the body is forced to slow down its processes to conserve energy[11]. Some of the essential nutrients are required for organs to function normally,

and if not attended in time, ARFID can result in possible serious medical complications. It is interesting to learn that although the body is generally resilient and is okay to cope with the stress of disordered eating behaviours, the underlying compensation may become strained. The laboratory tests can appear fine till late even if someone is at high risk of death. Sudden decompensation with electrolyte imbalances can kill without warning. It is thus, extremely important to be aware of the manifestations and monitor these patients on a regular basis. A dedicated multidisciplinary eating disorder team with a common understanding of referral pathway is paramount to prevent the complications associated with eating disorders that affect the body.

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