What is Avoidant/Restrictive Food Intake Disorder (ARFID)?

ARFID is a psychiatric disorder that was introduced into the DSM-5 in 2013 under the feeding and eating disorders category.

Individuals with ARFID have a persistent disturbance of eating resulting in the altered consumption of food, impairing physical health and/or psychosocial functioning. ARFID is more than being a 'picky or fussy eater'.

The main diagnostic feature of avoidant/restrictive food intake disorder is avoidance or restriction of food that results in one or more of the following consequences:

- significant weight loss
- significant nutritional deficiency
- dependency on enteral feeding or oral supplements
- marked interference with psychosocial functioning.

Individuals with ARFID restrict or avoid food intake due to one or more of the following:

- Sensory characteristics of food: concerns about the texture/taste/appearance/smell of food
- Aversive consequences of eating: concern of choking, gagging or vomiting
- Lack of interest or low appetite for food or eating

It is the presence of one, or more, of these factors that make the individual find food and eating unsafe, fearful or distressing, resulting in food restriction or avoidance.

Such underlying factors appear logical to the individual in the short-term, but soon become problematic in the long term.

ARFID is different to Anorexia and Bulimia Nervosa as individuals with ARFID do not typically fear weight gain or worry about how they look, although they often worry about being too thin or being underweight and unhealthy in their appearance.

What are the signs of ARFID?

- Limited accepted foods. Accepted foods often share similar sensory properties. May be underweight or malnourished as a result.
- Limited variety in accepted foods. One or more food groups are often missing from diet. Nutritional deficiency(s) as a result.
- Sensory sensitivities identified with some foods. Avoidance/distress of foods associated with similar feared sensory properties.
- Avoidance of food following a negative feeding experience. Fear of vomiting. Fear of choking. Fear of gagging.
- Unwilling or refusing or distress with trying new foods.
- Extreme fear or disgust of the smell, sight, taste, texture of some foods.
- Lack of appetite and difficulty identifying hunger and satiety cues.
- Periods of only eating one food or food group for extended periods of time, followed by refusal to eat the food again.
- Avoidance/ distress of social activities involving food and eating.
- History of medical conditions impacting feeding experience, appetite, growth and enjoyment of food/eating.

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There are many different origins of ARFID. It may be helpful to consider comments from people with ARFID across the lifespan to understand their experiences with food and eating.

- "I just don't feel hungry. Never have. I don't look forward to eating. If I did not set my alarm, I think I would forget to eat".
- "I don't like the way that some food smells. Smells disgust me. I seem to lose my appetite then"
- "When food is soggy in my mouth it makes me gag. I don't feel that way with crunchy dry foods".
- "I need to check expiry dates on chicken, and I force myself to eat white meat. I worry it will make me sick. I don't want to vomit. I had gastro once and I will do anything to avoid vomiting again".
- "After I nearly choked on sausage skin, I think all food will get stuck in my throat. I eat soft mashed food to prevent this from happening".

What are the causes of ARFID?

Most commonly ARFID develops in infancy and early childhood and can persist into adulthood. However, ARFID may develop after an aversive traumatic eating experience at any point across the lifespan, without any early childhood history of avoidance or restriction of food.

There is not one cause of ARFID and in fact, it can be unclear as to why some people develop ARFID. It does appear that a combination of temperamental, environmental, medical, and biological factors contributes to the development of ARFID, with all individual cases having a unique combination of factors.

People with ARFID often also have anxiety. People with Autism and Attention Deficit /Hyperactive Disorder (ADHD) are more likely to develop ARFID.

How is ARFID treated?

At present there is no one standardised evidence-based treatment for ARFID.

Emerging ARFID treatment research indicates preliminary findings for a positive outcome for the application of CBT-AR and FBT-Unified Protocols or modified FBT.

Treatment components of these emerging treatments include:

- parental supervision to ensure weight restoration utilising preferred high calorie foods
- correction of nutritional deficiencies
- reducing mealtime stress and anxiety
- anxiety management and techniques aimed at gradually expanding the variety and range of accepted food.

Treatment should target the factors that maintain ARFID and a treating team, including a combination of medical, dietetics, speech pathology, and psychology/social work may be helpful to address and manage both the physical health and psychosocial aspects of the condition.

Where do I go if I have concerns?

General Practitioners are often the first contact for those experiencing ARFID symptoms.

A GP can begin the collection of information about symptoms, including arranging blood tests if needed and providing medical monitoring of symptoms.

A GP may also refer to a dietitian for a nutritional assessment or a speech pathologist for a swallow or feeding safety assessment.

In addition, a referral to an Occupational Therapist for a Sensory Assessment or a Psychologist for assessment of anxiety or a traumatic event, may also be warranted. The information provided by such assessments will guide a diagnosis of ARFID and the development of a treating team.