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Avoidant/Restrictive Food Intake Disorder (ARFID): Information for Primary Care

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Summary: Avoidant/restrictive food intake disorder (ARFID) was first articulated in the DSM-5 and is characterized by persistent and sustained difficulties with eating or restriction of food intake. However, unlike eating disorders such as anorexia nervosa, there are no body image issues, nor a desire to lose weight. Primary care providers can play a key role in early identification (such as through noticing problems with growth at annual checkups) and management, which may include referral to specialized feeding and eating disorders resources.

Case 1, Part 1

J. is a 10-yo male previously well. Unfortunately, this has been a stressful year with multiple stresses including 1) Parental separation; 2) Bullying at school; 3) Gastrointestinal illness, which led to the use of medications. Unfortunately, these medications resulted in nausea, which persisted long after the prescription ended and has since resulted inseverely limited intake.
J. has been losing weight, to the point of requiring medical intervention...

Case 2, Part 1

D. is a 5-yo with longstanding difficulties with feeding. She has difficulties transitioning to textured solid foods and avoids new foods as a result. She has less than 10 foods that she will eat and is beginning to restrict her intake more with time. Her weight has dropped in the last six months from the 25th percentile to the 10th percentile and her health care provider is worried that she has not grown as much as she should have in the last year...

Epidemiology

Prevalence

- Little epidemiological data is known. To date, most studies on patients with ARFID have focused on pediatric samples, and the majority of reported incidence and prevalence rates have been drawn from eating disorder programs. A review of ARFID cases diagnosed f in tertiary care centres suggested that ARFID cases represented about 5-15% of patients assessed (Katzman, 2014)
- In an OT feeding group at a tertiary care centre (Ottawa), 70% of the children in the age 1-3 group met ARFID diagnosis, and 60% of the age 4-5 group, and 50% of age 6+ year olds (personal communication, Carrie Owen, 2017)

Age of onset:

- ARFID can present in children, adolescents and adults.

Identification and Screening

- **Have regular annual checkups** in order to build an appropriate and well-informed **growth chart**. The growth chart can show early indications of ARFID, which can be apparent even before there are obvious clinical symptoms.
- **Detailed feeding histories** are very important and necessary in order to fully understand the extent and impact of sustained feeding difficulties.

Clinical Presentation

Various presentations have been reported:

1. Type 1: Patients with acute stressful events leading to feeding problems and weight loss.
2. Type 2: Patients with sustained difficulties with appetite regulation, hunger cues, early satiety which directly or indirectly lead to weight loss.
3. Type 3: Children with sustained difficulties in the realm of sensory regulation which results in limited overall intake.

History

- Feeding history from birth
    - When did the issues start? Acute? Acute on chronic?
- Persistence of problem
    - Has the problem been a persistent problem? Or a transient one?
- Current food intake
    - Does the current intake represent an adequate age-appropriate amount
    - Is the diet sufficient in terms of overall energy intake?
    - Hunger/ Appetite signaling
        - Does the child get hungry?
- Structure at meal times
    - Is intake within an adequate age-appropriate range? Does it include major food groups and essential micronutrients?
- Oral supplement or tube feed dependency
- Social/emotional functioning
    - Is there evidence of any associated significant distress?
        - Any associated impairment to the individual’s social and emotional development or functioning?
        - In the case of children or younger adolescents, this can include disruptions to normal family function that negatively affect the child.
        - ◦ How stressful is this for the patient? For the family?
- Sensory profile
    - Any sensory sensitivities? To light? To touch, including texture? To sound? Etc.
- Fears/aversion
- Family history

Diagnosis

Avoidant/restrictive food intake disorder (ARFID) is a new diagnosis first described in the DSM-5.

DSM-5 Criteria

ARFID is an eating or feeding disturbance that manifests as a chronic failure to satisfy energy or nutritional needs associated with at least one of the following:

- A significant deficit in nutrition.
- Significant loss of weight, not achieving expected weight gain, or the absence of normal physical development.
- Disruption in psychosocial functioning.
- Reliance on enteral feeding (e.g., feeding tube) or oral nutritional supplements.

ARFID is not accompanied by a distortion of one's weight or body shape and is not concurrent with symptoms of anorexia or bulimia.
Exclusion criteria for ARFID

- ARFID is not due to
    - Unavailability of food such as from poverty or famine,
    - Culturally sanctioned food observance or practice
    - A medical condition,
    - A different psychiatric disorder.

Proposed Subtypes of ARFID

1. ARFID-avoidant

- Child who restricts intake based upon nutritional avoidance and fear of adverse consequences
- Occurs as a result of a specific anxiety, event or fear (e.g. fear of pain or nausea).

2. ARFID-limited variety

- Restriction based upon nutritional aversions/ sensory difficulties
- Patients with histories of longstanding feeding issues (e.g. food neophobia and/ or picky eating), sensory and/or texture issues, aversions related to food items, and/or profound rigidity involving the act of eating (e.g. food items on a plate cannot touch).

3. ARFID-limited intake

- Weight loss, medical compromise, and/ or impairment is due to insufficient caloric intake
- This may be due to
    - Low overall appetite (or lack of interest);
    - Factors related to the act of feeding;
        - Excessive energy demands.
    - Patients typically have a history of relative energy deficiency with:
        - Weight loss,
        - Inadequate weight gain for growth,
        - Growth stunting;
        - Feeding-specific issues (e.g. small bite sizes, prolonged duration to finish)

Differential Diagnosis

Consider other diagnoses in the differential such as:
Anorexia / Bulimia

- Unlike anorexia/bulimia, patients with ARFID are not preoccupied with body image concerns (i.e. feeling too big), and are not fearful of weight gain.

Emetophobia (Fear of vomiting)

- Individual is worried about vomiting and as a result, restricts intake to avoid the potential for vomiting

“Picky eating”

- ARFID is more than simply a child with “picky eating”
- Although the term “picky eating” is often used, note that there is no standardized definition, although typically it refers to a child who:
- Consumes an inadequate variety of foods
- Has limited variety of foods eaten
- Rejects foods that may either be familiar or unfamiliar
- Rejects foods of a particular texture, consistency, color, or smell
- Has aberrant eating behaviors
- Picky eating behaviours generally peak between age 2-6, and improves gradually over time
- Children with picky eating behaviors should have normal growth and development

Comorbid Conditions

Assess for comorbid symptoms such as:

- Depression
- Anxiety
- Obsessive compulsive disorder (OCD)
- Autism spectrum disorder (ASD)

Physical Exam

- Vitals
    - Weight, height, BMI percentile, pubertal status
- Look for signs of nutritional deficiency

Management / Treatment

In an ideal world, there would be multidisciplinary ARFID teams with:

- Paediatrician,
- Registered dietician,
- Behavioural therapist, which can be helpful if there are longstanding, entrenched negative behaviour patterns;
- Occupational therapist (OT), which can be helpful if there are self-regulation, sensory / motor issues;
- Social worker,
- Mental health professional(s) to screen for other mental health issues such as Psychiatrist, psychologist
- Depending on what treatments are available, approaches include:
    - Family-based therapy, to reduce family stress;
    - Behavioral training, to improve positive eating behaviours;
    - Cognitive based therapy, to help with coping with stress and anxiety.

Since there are probably no such services in your community, primary care providers can do the following:

Parent education

We don’t usually think of eating as a ‘skill’, but it is. It can be stressful when a child has difficulty eating. Eating problems usually begin because of physical differences that make learning to manage and enjoy food more

difficult. Parents don’t cause feeding problems. But there are many things parents can do to help their child learn eating skills. Tips for mealtimes

1. Stick to a routine for meals and snacks. This will encourage hunger in your child. Stay with this schedule, even if your child does not eat a meal.
2. Have your child sit at the table or in a highchair for all meals and snacks.
3. Eat with your child. If you’re not ready for your own meal, have a small snack like carrot sticks.
4. Notice positive mealtime behaviours, like:
5. Coming to the table;
6. Sitting at the table;
7. Taking tastes of food.
8. Don’t express any feelings of frustration or disappointment during a meal or snack if your child doesn’t eat.
9. Limit mealtime to 10-30 minutes. If your child is not cooperating at the table, thank him for coming to the table, and pleasantly take the meal away.
10. Start with small portions and slowly increase to help facilitate weight gain. Always offer a small serving of a food your child likes as you introduce new foods on her plate.
11. Schedule a time for drinks. Offer liquids during snack time or mealtime.
12. Keep meals simple. Too many choices can be confusing for your child.

Strategic adult attention
The stress of having a child who has difficulty eating can cause parents to focus a lot of attention on food refusal behaviour. Children may even increase this kind of behaviour, because it gets quite a bit of attention from parents. Parents’ attention and reactions to food refusal become a kind of ‘reward’ to the child. Children will do things more often when these actions are ‘rewarded’ by parents’ attention. 1. Pay positive attention to the behaviours you want, and don’t pay attention to food refusal behaviours. It is important to notice when your child is doing something positive at meal or snack time. This could be sitting calmly in the highchair, holding a spoon or picking up a piece of food. Just describe what you see in a positive tone (with a smile!).

- I see you’re holding your spoon already!
- You’ve got a piece of apple.
- I like it when you’re sitting in your chair.

2. Don’t respond to or ‘reward’ behaviours that get in the way of eating. This is hard. If your child says "yuck!", spits or throws food, take care that you don’t ‘accidentally’ reward him by expressing your frustration. Any expression of emotion from you (worry, irritation, disgust) may cause your child to repeat these unwanted behaviours. Instead, try to:

- Keep your face calm;
- Act as if the behaviour is of no interest to you;
- Continue your meal;
- Keep chatting with another family member.

3. Stay quiet when your child is not eating. It’s best not to say anything at all, because your voice carries emotion, and your words show interest. Do not coax your child to eat-this just gives attention to not eating. While your child sits staring at her plate, try to busy yourself with something else, but be ready to show interest in eating related behaviours. For example, if your child picks up a spoon, you could say, "We’re using our spoons and forks". 4. Keep calm and carry on if your child gags or coughs. This is difficult, but very important. Many children will gag or cough on new textures. Your child will be looking to you for emotional guidance. Have a few phrases ready that you can repeat with confidence:

- "It’s okay."
- "It’s going down."
- "You did it"
- "You swallowed!"

To help prevent choking, avoid round, smooth foods like hot dogs or whole grapes, as their diameter is a choking risk. If you do serve hot dogs or grapes, cut them so that their diameter is small enough to no longer pose a choking risk. 5. Be authoritative. When you talk to your child about food and eating, keep your attitude warm and

positive, but ‘in charge’. Say what needs to happen in a clear, confident voice. This will keep things simple, but convey your authority.

- "Time to eat"
- "Food first, then play"
- "Food first, then milk"

Set shared goals to work on with the patient

- Set goals that people can agree upon such as
    - Functional mealtime as opposed to weight gain.
        - The problem when clinicians emphasize weight gain, is that parents may be reluctant to follow through on implementing change as initially as the child is developing new functional feeding skills they will lose weight
    - Try to reach agreement with parents to work towards functional mealtimes
        - E.g. mealtime that is less stressful, with less nagging from parents
- Use hunger to motivate the patient to increase their range of foods
    - Patients have usually been sustaining themselves on a limited amount of preferred foods such as milk or pediasure, yogurt or peanut butter sandwiches.
    - The goal is to increase the number of foods that they will eat.
    - To do so, one strategy is to restrict their preferred foods at mealtimes, while providing alternatives, in the hope that hunger will motivate them to try new foods.
    - Change is difficult however, so note that in the short run, there may not necessarily be weight gain, but rather maintenance of weight or even slight weight loss.
- Mental health goals
    - E.g. treat depression or anxiety
    - E.g. Behavioral therapy, i.e. Gradual exposure to the avoided foods

Provide close and regular follow-up

- Close, regular follow-up is important to be able to monitor weight and for worsening.

Medications

A case series (Spettigue, 2018) of a highly specialized intensive feeding intervention provided by an adolescent medicine specialist and a child psychiatrist involved medications including:

- Olanzapine
- Fluoxetine
- Cyproheptadine

When and Where to Refer

Most communities do not have an ARFID program where you can refer to.
Nonetheless, you can:

- Contact the intake service of your local eating disorders program, and ask what they recommend
- Consider referral to
    - Paediatrician,
    - Registered dietician,
    - Behavioural therapist, which can be helpful if there are longstanding, entrenched negative behaviour patterns;
    - Occupational therapist (OT), which can be helpful if there are self-regulation, sensory / motor issues;
    - Social worker,

- Mental health professional(s) to screen for other mental health issues such as
- Psychiatrist, psychologist

Prognosis

Early intervention and treatment is important as left untreated, studies suggest ARFID behaviors do not necessarily remit.

Family Education Resources

“Helping Children with Feeding Challenges”, information on the CHEO website
http://www.cheo.on.ca/en/feeding-challenges

References

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Disclaimer

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