Title: Early Identification and Awareness of Avoidant Restrictive Food Intake Disorder (ARFID)

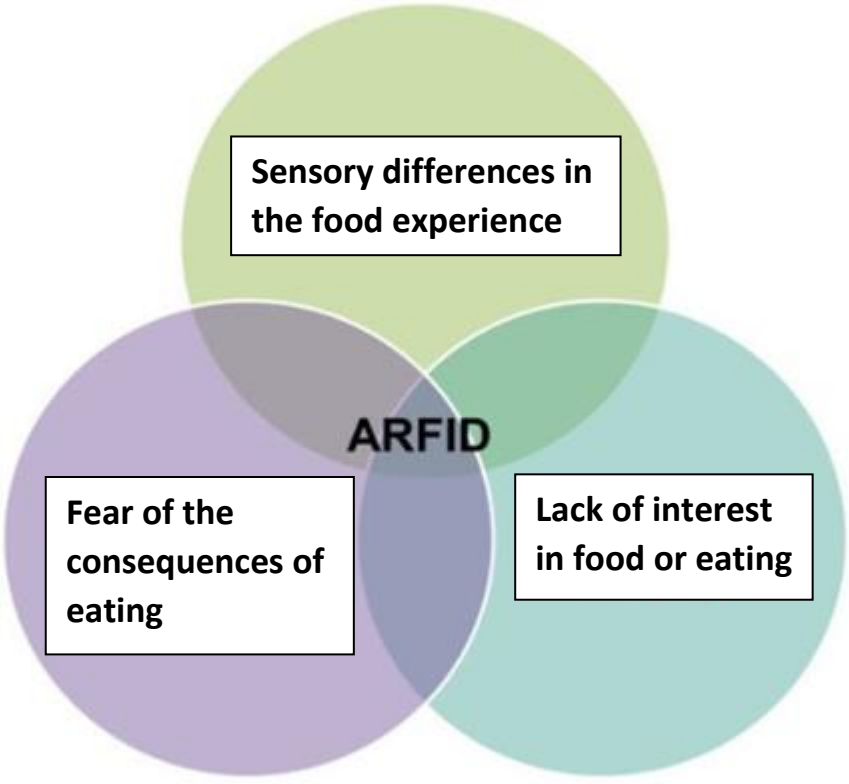
Declaration: This article has been written by committee members of the British Dietetic Association (BDA) ARFID Specialist Interest Group all of whom work clinically with ARFID in both public and private settings. It has been co-produced with a practicing GP who also has lived experience as a carer of a young person with ARFID. Our collective motivation is to raise awareness of ARFID and inform early identification in a primary care setting to improve patient care and experience. There are no other competing interests.

What is Avoidant Restrictive Food Intake Disorder (ARFID)?

ARFID is a classified eating disorder diagnosis with criterium outlined in both DSM-V (2013) and ICD-11 (2022) diagnostic manuals. A diagnosis of ARFID diagnosis should only be made by an adequately informed multi-disciplinary team.

ARFID is best understood as per the Venn Diagram (figure 1) below. Most of the time, a person struggling with ARFID will have more than one presentation.

Figure.1



The potential signs of ARFID that may present in clinic:

- Avoidance of whole food groups or avoidance of sensory-specific food categories
- Disgust response to foods/categories (e.g., gagging or retching)
- Having a diet that is extremely limited to (usually less than 10) 'preferred/safe foods'
- Lack of interest in eating or missing meals completely (not feeling hungry)
- Avoidance of social food settings or environments (e.g., unable to eat outside the family home)

- Negatively impacted physical health status including reported weight loss, lack of growth or symptoms consistent with nutritional deficiency
- Needing to take supplements to meet their nutritional needs
- Sudden phobia or anxiety impacting food intake

Understanding 'picky eating' vs. ARFID

'Picky eating' exists as a continuum from disliking a few foods to significant restriction and avoidance. ARFID is the clinically diagnosable and severe end of this spectrum. The eating restriction and resultant physical impact is such that it has a significant detrimental impact on the quality of life of those affected (and their families). ARFID does not occur exclusively in low-weight status, and it is important to recognise that significant nutritional deficiency can also occur in average, and above-average, weight individuals.

Common associations:

- ARFID is also commonly associated with co-morbid autism spectrum disorder (Kozak *et* al., 2023) where the avoidance of foods often stems from sensory specificity. However, not all individuals with ARFID have autism and not all autistic individuals have ARFID.
- Can present with a chronic history of food avoidance (such as long-term sensory specificity which has worsened over time)
- Can also present with an acute onset of food avoidance (e.g., a sudden restriction of foods secondary to phobia (such as vomiting, choking or contamination resulting from phobia/trauma) and may require access urgent care.

ARFID is not Anorexia Nervosa (AN)

ARFID differs from AN in that the avoidance is not driven by concerns regarding weight and shape. Any individuals presenting with suspected AN should be referred to the appropriate local eating disorder service.

Initial primary care assessment:

The initial assessment of a person presenting with suspected ARFID should focus on:

- A brief history of the presenting difficulties (including current range of foods eaten and psychosocial impact); chronicity; and their understanding of the food avoidance.
- Exploration to rule out differential diagnosis of anorexia nervosa, cultural sanction, or food availability.
- Brief medical history to understand if there is, or may be, a physical cause for the avoidance which may either explain the avoidance, or require further medical investigation
- Physical assessment assessed against MEED guidelines (see below) with historic measurements of weight/height to assess the impact on expected growth and development. For autistic individuals, compliance with physical investigations can present an additional challenge. You may therefore need to be more creative or offer subjective assessment based upon clinical experience.
- In younger children, an assessment of the characteristics which may indicate Paediatric Feeding Difficulty. Where this applies, referral for paediatric feeding assessment/support is likely most helpful.
- Where there is evidence of physical symptoms (such as gastrointestinal disturbance or abdominal discomfort), which may impact upon appetite, interest in eating or food aversion, these should be investigated first as part of important differential diagnostic exclusion.

Available assessment tools:

The South London and Maudsley NHS Trust also have short ARFID screen questionnaires which can help inform initial assessment available from: Featured resources - MCCAED (slam.nhs.uk)

Assessing physical risk:

All eating disorders, across all ages, share the same framework for assessing medical risk: the Medical Emergencies in Eating Disorders (MEED) Guideline (RCP, 2023) available from: www.rcpsych.ac.uk. MEED is essential in ARFID and helps to inform where referrals meet an urgent clinical risk or may require urgent medical attention.

First contact with families

Individuals and families presenting to primary care are likely to feel anxious and concerned and may have had previous experience of feeling unheard, judged and criticised or blamed. This is the most common negative complaint received of services. It is important that you offer an empathetic and validating response to their reported challenges.

Offering hope and treatment referral

ARFID is considered to be a treatable condition, though instances of relapse may occur. However, it is highly individual, heterogenous and can be complicated by factors such as autism, Sensory Processing Disorder, anxiety, visceral/Interoceptive difficulties, and other health needs. Therefore, an individualised formulation and care plan is needed for every patient. Evidence based therapies are still underdevelopment and a recent review of the current evidence base can be found here: A scoping review of psychological interventions and outcomes for avoidant and restrictive food intake disorder (ARFID) - PubMed (nih.gov).

In view of this, it can be difficult to outline the specifics of a care package. Furthermore, treatment pathways for ARFID vary nationally and can include community teams, acute teams, mental health teams and eating disorder teams depending on presentation and risk. Third sector organisations and other support agencies can also be included depending. It is important that you understand your local-area referral process including which service(s) support treatment and any associated age-related access and severity indices required to meet criteria.

Signposting and further CPD

- Self-help guidance for patients/carers, and further information for professionals, can be found from: www.bebodypositive.org.uk (ARFID section)
- A sensory play toolkit (especially for younger children) can be found from: SENSORY PLAY TOOLKIT - Home (weebly.com)
- Further support and information can be found from www.ARFIDawarenessuk.org and www.beateatingdisorders.org.uk.
- ARFID Avoidant Restrictive Food Intake Disorder: A guide for parents & carers by Rachel Bryant-Waugh and Helping Your Child with Extreme Picky Eating by Katja Rowell and Jenny McGlothlin are helpful and informative books available to purchase
- A 1-hour CPD module for ARFID aimed at primary care can be found via the Yorkshire and Humber Clinical Network on FutureNHS platform (www.future.nhs.uk) by using the tabs for: children and young peoples mental health → eating disorders → ARFID.
- You can also find an NHS-England ARFID awareness film and resource via NHS England ARFID Awareness Film (youtube.com)

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