AVOIDANT RESTRICITVE FOOD INTAKE DISORDER

Supporting Document for Health Professionals

Draft for Comment

Avoidant Restrictive Food Intake Disorder (ARFID)

Introduction

The BDA Mental Health Specialist Group and NDR-UK have developed the resource 'Dietary Advice for Avoidant Restrictive Food Intake Disorder' to support children, young people and adults with ARFID and their parents/carers to understand their condition and help them to work towards improving their diet so that it is nutritionally complete. (*Link to resource on website will be included here*).

This supporting document provides further information for health professionals on supporting people with ARFID.

ARFID

Avoidant Restrictive Food Intake Disorder is a mental health disorder, first recognised in 2013. It existed previously as a collection of diagnoses such as selective eating disorder, feeding disorder of infancy and early childhood, and picky eating. ARFID can occur in children and adults.

Individuals with ARFID restrict their intake, avoiding certain foods or food groups. They may also eat only small amounts and have little or no interest in food.

To meet the criteria for diagnosis, at least one of the following needs to be met:

- A significant nutritional deficiency (related to vitamins and minerals, calories or protein).
- Significant weight loss, failure to gain adequate weight or poor growth.
- Dependence on oral nutritional supplements or feeding via a tube.
- Interference with psychosocial functioning e.g. attendance at school or work, socialising, interactions with friends and family.

Unlike other eating disorders, concerns about weight and shape do not influence the foods that people with ARFID avoid or restrict.

Individuals with ARFID may not be underweight.

ARFID has a huge overlap with autism and ADHD and may need adaptations in treatment.

Nutritional consequences of ARFID

People with ARFID can be underweight or overweight and/or have a deficiency in specific vitamins or minerals.

Bodyweight and growth should be monitored.

Deficiencies in vitamins, minerals and essential fatty acids are more difficult to identify. For this reason, a full dietary assessment should be carried out by a registered dietitian with appropriate experience in treating ARFID.

Deficiencies can impact quality of life, energy levels, concentration and mental health. They can also result in damage to the body or diseases such as anaemia, scurvy, poor bone health and in very severe cases, blindness. Deficiencies in childhood also have the potential to impact growth and development, both physically and mentally.

A reliance on high fat, high sugar foods can impact oral health. This may be further impacted in children who experience sensory difficulties when using a toothbrush, toothpaste, or when a dentist inspects their teeth. However, continuing to eat their preferred foods is essential to ensure they are getting enough energy each day, even if this means a high fat/sugar diet.

ARFID presentations

There are many different ARFID presentations. Common presentations include:

- Food avoidance based on fear of consequences, for example fear of vomiting, choking or gagging. This can happen at any age and without experiencing any adverse effects directly – the fear may be triggered by seeing someone else vomiting, choking or gagging. This presentation usually leads to rapid weight loss as the individual will normally stop eating altogether or will only have liquid foods.

- A lack of interest in food – there is no pleasure in eating and it feels like a chore. This presentation is usually followed by a history of allergies, reflux, hospital admission or any other presentation where there was pain/discomfort when eating. They no longer find food enjoyable. It usually leads to a lower weight and they need prompted to eat every meal. This normally affects appetite – they may feel full quickly or not feel hungry and this can aggravate the presentation.

- Food avoidance based on sensory characteristics, for example appearance, temperature, texture, taste and/or smell. This presentation can lead to difficulties with eating away from home, more rules around eating and low tolerance to changes in how food is presented.

Nearly half of individuals with ARFID who are referred for psychological treatment exhibit eating difficulties in multiple ARFID domains.

A typical example would be a young person with long-standing selective eating (sensory sensitivity) and chronic low appetite (lack of interest in eating) who loses weight precipitously following an acute choking episode (thus developing fear of adverse consequences).

Interoception

Many individuals with ARFID struggle to understand and respond to their internal body signals (interoception). This can affect their mood, emotions, interest in social interaction, thinking and decision making.

Individuals may be **hyper**sensitive or **hypo**sensitive.

Hypersensitive characteristics	Hyposensitive characteristics
○ Heightened sensitivity to the body's internal sensations ○ Hunger may be extremely distracting and even painful ○ Extreme emotional responses e.g. fight, flight or freeze ○ Difficulty maintaining attention to tasks ○ Overactive food reward signals and more sensitive to hunger cues which can lead to overeating.	○ Less sensitivity to the body's internal sensations ○ Individuals may never feel full after eating, or may never feel hungry in the first place ○ Crave more intense input e.g. needing intense flavour or noise ○ Unable to recognise that they are full which can lead to overeating.

Strategies that may improve interoception include mindfulness, body scanning, yoga, meditation and breathing exercises. Using hunger and thirst charts can help individuals to understand their sensitivity around eating and drinking, and identify ways to help.

Vitamins and Minerals

It is important to take a holistic view when deciding on treatment – usually, a multi-modal approach is required. Ideally, this will involve a multidisciplinary team, taking into consideration nutritional deficiencies, growth, and weight concerns as primary and first-line treatment goals, and the family's worries about eating difficulties.

In most cases, a food diary is the suggested first step to identify any nutritional deficiencies – analyse using a nutritional analysis software programme to gain a detailed understanding of specific micronutrients deficiencies.

Ideally, this will always include an assessment of energy, protein, fat and key vitamins and minerals including:

- Calcium
- Iron
- Vitamin C
- Vitamin A
- Vitamin D
- Omega 3

Consideration should be given to any clinical signs of deficiency such as tiredness, scurvy, poor condition of hair, nails and skin, or other symptoms not otherwise explained by a clinical diagnosis.

If a clinical deficiency is suspected, blood tests should be requested. However, it is important to recognise that this is likely to be an unpleasant experience for children. If blood tests are carried out in the same location as other treatment for ARFID, individuals may form a negative association with the place and this may impact on their engagement with treatment. The need for these blood tests should always be balanced with the psychological impact. You may be able to request these at the same time as other blood tests so that they are not repeated. If there is a need for sedation or general anaesthetic at any point, tests could be requested as part of this. If available, use of play therapists and specialist learning disability advisors in hospital can be very helpful. In some cases, it may be appropriate to continue without testing.

Supplementation

If required, vitamin and mineral supplementation can be provided. A few different preparations may need to be trialled to find one that is acceptable. Consultation with a clinical psychologist may be necessary for individuals who are highly anxious and averse to new tastes and textures to help introduce this in an appropriate way.

Care needs to be taken not to exceed the recommended daily intake for any vitamin or mineral. This is particularly important in the case of fat-soluble vitamins.

Fortified foods

Fortified foods can be a useful source of vitamins and minerals. This can be achievable by changing brands or adding a similar product.

Nutritional Support

Prescribable nutritional supplements available in the style of milkshakes, juices and desserts can be used when it is not possible to meet nutritional requirements through food and drink. These are not always well accepted due to their flavour and texture. If required and appropriate ones are chosen, they can be used as a sole source of nutrition.

Occasionally, if individuals are not able to consume adequate food and fluid, then long- or short-term artificial feeding may need to be considered. This should always be considered with the multidisciplinary team and fully discussed and explained.

Medication

Medication is not a first line of treatment for ARFID and there is still limited research on the efficacy of this in ARFID patients. If medication is needed, it should be discussed with the doctor within the multidisciplinary team.

Diet and nutrition strategies for improving intake

In children where growth is a concern, or adults with a low weight, the priority is increasing energy intake. This can be done by increasing their preferred foods and how often they eat them by encouraging more time and opportunities to eat.

Meal and snack plan

A daily or weekly meal and snack plan can be helpful for individuals who forget to eat, lack structure when eating, or are anxious at mealtimes. The individual with ARFID should be involved in developing the meal and snack plan so that they have ownership of it. Depending on age, pictures rather than words may be more helpful for their preferred foods and drinks.

A meal and snack plan should include all the individual's preferred foods, including those not eaten recently and only if they are not too anxiety provoking. This can help to keep preferred foods in their diet and decrease food fatigue. In some cases, the range of food may be so limited that this is not possible. Having a comprehensive list of all their preferred foods is important.

Food exposure techniques

Once nutritional intake and growth have been optimised, other therapies to expand dietary intake can be considered. These should be considered with the individual in mind and explained in the most appropriate way.

Food exposure techniques include:

- Initial food exposure/food therapy
- Food chaining
- Fading in

The individual can stop at any time when doing food exposure. They are not expected to eat the food and it is okay to spit it out. If they do manage to eat it, small mouthfuls are fine and quantities can be increased over time. It can take up to an hour for an individual to do food exposure the first time, but once everyone knows what they are doing, it can take much less time.

If the individual would like to explore meals that have several layers such as pizza, you may want to think about deconstructing the food and starting with just plain pizza dough first.

Further information on food exposure techniques is included in the resource 'Dietary Advice for Avoidant Restrictive Intake Disorder' *(link to website)*.

Hiding or sneaking new foods is rarely acceptable and can lead to mistrust – this method is not recommended.

Other approaches

There are other approaches that can be taken using elements of the Sequential Oral Sensory (SOS) approach to feeding. This is when all the underlying causes of feeding difficulties are explored including the environment, the eight senses, muscles (including seating) and overall stage of development.

Cognitive behavioural therapy (CBT) for ARFID and family-based treatment for ARFID are options. These should be discussed with the wider multidisciplinary team and used with appropriate training and under supervision.

Eating away from home

Eating outside of the home can be difficult for individual's with ARFID and their friends and family. It is important to consider the eating environment. Further information to support individuals with ARFID when eating away from home (school, restaurant, workplace) is included in the resource 'Dietary Advice for Avoidant Restrictive Intake Disorder' *(link to website)*.

A letter from a healthcare professional explaining ARFID to schools, colleagues, family and friends, giving a brief overview of the impact of the condition and coping strategies can be helpful. It is important that the person with ARFID is not put into a situation where they feel judged or uncomfortable.

An individual with ARFID should never be put under pressure to eat or even 'try' a food as this can be overwhelming and upsetting. It may result in the individual not feeling comfortable with eating in that environment again. Schools can become involved in trying 'new foods' but this should be done as part of a structured programme.

Important points to remember

- It can be hard work and there is no quick fix to treating ARFID.
- Eating is one aspect of the individual's life, so understanding that treatment should not be focused on eating only, especially if other primary needs aren't met (e.g. sleep, safety), is essential.
- It is helpful to discuss expectations with parents, carers, partners and be very clear about goals in treatment and the importance of keeping regular reviews.
- There are no right, wrong or specific steps. Individuals work in different ways.
- Each step can take days, months and sometimes years. Individuals may change their mind during the process. Consistency is important.
- Depending on the individual's presentation, they can "jump" stages (i.e. from square bread to bread and cheese) or they may need more steps – always ask how they feel about it and explain what to expect.
- They should not be expected to eat the new food straight away, sometimes it is just about exposure.

What does success look like?

- Success is different for everyone, so it is important to discuss what success means to the individual, their family and their clinicians.
- Consider supporting parents or adults with ARFID to make notes of what success looks like to them.
- Every change is a progress – very often we forget how the 'baby steps' lead to 'big steps' in the long journey.

Importance of self-care for parents or partners

- Dealing with an eating disorder is very energy demanding and exhausting at times. Managing the parenting role effectively and their own emotions is important to allow time for themselves. Challenges can include:
    - trying to manage their child's behaviours
    - cooking different meals
    - dealing with family, extended family, clinicians
    - pressure from school
    - attending several appointments.
- We know that when parents/partners/family are anxious, the individual with ARFID will be even more anxious.
- Simple things can help them to relax and calm down when things are very difficult, even if they only have few minutes. Some examples of self-care include:
    - drinking tea
    - taking a bath
    - reading a book
    - going for a walk
    - talking to a friend
    - expressing feelings in a journal/diary.