Avoidant Restrictive Food Intake Disorder

An update on the role of dietitians in the treatment of avoidant restrictive food intake disorder (ARFID) since publication of the British Dietetic Association (BDA) Position Statement in 2022

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Avoidant/restrictive food intake disorder (ARFID) was introduced as a new mental health and behaviour disorder diagnosis in 2013. ARFID is characterised by a pattern of eating that avoids certain foods or food groups entirely and/or eating small amounts due to lack of interest in food, high sensitivity to sensory aspects of food (e.g. texture, colour, or taste), and/or fear of aversive consequences (e.g. being sick or choking). These restrictive eating patterns can result in significant health problems. It differs from other eating disorders in that people with ARFID do not restrict their food intake for the specific purpose of losing weight or managing feelings of fear and anxiety around their shape and size.

BDA Position Statement & Toolkit

The BDA Position Statement was written in 2021 by a group of 15 dietitians with experience in working with children and young people with ARFID.[1] The aim was to highlight the dietetic role in the management of ARFID and provide a resource for commissioning of services. At the time of publication, the group was operating as a Special Interest Group (SIG). In 2024 the group became a sub-group of the BDA; membership is free to all members of the paediatric and mental health group.

The BDA Toolkit is due to be published in Spring 2025 and will provide information and resources for dietitians working with people with ARFID in a variety of settings. It will be openly accessible on the BDA website.

Learning from the tragic death by malnutrition of 7-year-old Alfie Nicholls

The tragic death of Alfie was highlighted in a coroner's report (https://bit.ly/3EICk0f); it outlines recommendations for health, social and education professionals locally and nationally, and includes the role of the dietitian within assessment and treatment of ARFID with autism.[2] Alfie's mum, Lucy, is keen that health professionals are talking about Alfie and using his case to highlight service gaps and recognise the need for change.

How does ARFID differ from picky eating?

Unlike typical picky eating, which most children grow out of over time, ARFID can have long-lasting effects on physical health, emotional well-being and social functioning. Understanding how ARFID presents, how it differs from everyday picky eating, and how it is diagnosed can help clarify the severity of this condition and the critical role of the multidisciplinary team, including dietitians, in treatment.[3]

Anxiety and social isolation can arise if individuals with ARFID avoid eating in front of others or feel distressed in situations involving unfamiliar foods. This also extends to their ability to attend school or work.

Picky eating is an expected developmental stage, known as food neophobia, particularly in children, and usually resolves with time or with gentle encouragement from parents/caregivers. It often involves rejecting certain foods – mainly new ones – but does not typically cause significant distress or health issues.

ARFID is a serious and persistent condition. It is not a phase or a preference for certain foods. Picky eating may involve occasional refusal of certain foods, whereas ARFID is characterised by a deeply ingrained fear or aversion to eating, and is often accompanied by severe emotional distress.

How is ARFID diagnosed & next steps?

Diagnosing ARFID is a multifaceted process that typically involves a multidisciplinary team, including paediatricians/psychiatrists, psychologists, dietitians and possibly occupational therapists and speech and language therapists. Diagnosis is based on a thorough assessment of eating patterns, behaviour, medical history, and psychological state. Health professionals often use criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or ICD-11.[4]

Dietitians play an essential role in the assessment process, as they are the only professionals that can assess nutritional intake, identify deficiencies and work with individuals to create a nutritionally complete meal plan.

Receiving a diagnosis of ARFID can be a relief and a challenge. For some individuals and families, the diagnosis brings clarity and a better understanding of the eating behaviours that have caused distress for years. However, the diagnosis itself does not necessarily change things immediately. Treatment for ARFID is typically a long-term process that involves gradually increasing food acceptance and addressing underlying psychological or sensory triggers. In many areas in the UK, there is not a dedicated ARFID service, which can lead to disappointment.

When dealing with ARFID, finding the right support and resources is crucial for individuals and their families. The journey to managing this complex eating disorder can feel overwhelming, but numerous support networks, organisations, and professionals are available to provide guidance and care. See **Figure 1** for a list of useful ARFID resources.

Dietetic management of ARFID

Assessment

For any ARFID assessment, dietitians play a crucial role in identifying and addressing nutritional deficiencies. Left unaddressed, such deficiencies can lead to significant health complications and even death.[1, 2]

A comprehensive feeding history from birth is essential to identify early feeding challenges. This should include details of gestational age at birth (term or preterm), birth weight, and any complications during/after delivery that required interventions, such as SCBU/NICU care or nasogastric feeding. Early feeding practices should be explored, including whether breastfed, formula-fed, or a combination. If formula was used, note the type, standard or specialist formulas. Key issues to assess include latching and sucking difficulties, reflux, vomiting, excessive crying, bowel irregularities, and signs of cows' milk protein allergy. Additionally, understanding the frequency of feeds and whether the infant woke for feeds can provide valuable insights into early feeding behaviours.

The process of weaning and introducing complementary foods should be thoroughly discussed, including age and the types of foods initially offered. This includes whether foods were provided as purées, finger foods, or a combination. It is important to evaluate progression through different tastes and textures, specific reactions to new foods, such as acceptance, aversion, gagging, or choking incidents. Additionally, feeding challenges, such as refusal of certain textures/tastes, and any early signs of selective eating patterns, should be explored.

Figure 1: ARFID resources

- The Role of the Dietitian in the Assessment and Treatment of Children and Young people with Avoidant Restrictive Food Intake Disorder (ARFID): **https://bit.ly/4hFQPQO** (Jan 2025).
- Harris G, Shea E (2018). Food Refusal and Avoidant Eating in Children, including those with Autism Spectrum Conditions: A Practical Guide for Parents and Professionals. London, Jessica Kinglsey.
- Bryant-Waugh R (2019). ARFID Avoidant Restrictive Food Intake Disorder: A Guide for Parents and Carers. London, Routledge.
- Bryant-Waugh R (2020). Avoidant Restrictive Food Intake Disorder in Childhood and Adolescence: A Clinical Guide. London, Routledge.
- Eddy KT, Thomas JJ (2018). Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder. Cambridge University Press.
- Rowell K, McGlothlin J (2025). Helping Your Child with Extreme Picky Eating. New Harbinger.
- Mahler K (2015). Interoception The Eighth Sensory System – Practical Solutions for Improving Self-Regulation, Self-Awareness and Social Understanding. AAPC Publishing.
- McCurtin A (2007). The Fun with Food Programme – Therapeutic Intervention for Children with Aversion to Oral Feeding. London, Routledge.
- Legg B (2008) Can't eat, won't eat – Dietary Difficulties and Autistic Spectrum Disorders. London, Jessica Kingsley.
- Lock J (2021). Family based treatment for Avoidant/Restrictive Food Intake Disorder. London, Routledge.
- Be body positive (NHS). ARFID resources: **https://dev.bebodypositive.org.uk/module/avoidant-restrictive-food-intake-disorder**
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Resource Library (ARFID): **https://bit.ly/42VqjP7**
- ARFID Awareness UK: **www.arfidawarenessuk.org**
- BEAT – What is Avoidant/Restrictive Food Intake Disorder? **www.beateatingdisorders.org.uk/types/arfid**
- Sensory Play Toolkit: https://sensoryplaytoolkit.weebly.com
- Pathway for Eating disorders and Autism developed from Clinical Experience (PEACE): **www.peacepathway.org**

Current eating patterns should be reviewed, including typical routine of meals and snacks, and frequency and timing of eating episodes. Identify which foods and fluids are consistently accepted and regularly consumed and note any consumed inconsistently. It can be helpful to categorise accepted foods into food groups to identify any avoided or consumed inadequately. Additionally, consider the child's sensory preferences for certain textures (e.g. crunchy/smooth), temperatures (e.g. hot/cold), or tastes (e.g. salty/bland/sweet).

A detailed 3-day food diary is typically recommended for a comprehensive assessment, although a 24-hour recall may suffice if daily intake is consistent.[4] Ideally, the data should be analysed using a nutritional analysis tool. However, if unavailable, you can identify potential nutritional deficiencies by evaluating the diversity of food groups. A lack of variety or the absence of certain food groups may signal gaps in nutrients.

It is important to determine whether vitamin or mineral supplements are being taken, as well as their form (e.g. liquid, gummy, spray or powder). These supplements should be included in any nutritional analysis.

As part of the assessment, it is important to consider the feeding environment and associated behaviours. Ask who prepares the meals, where, and how they are eaten. Note if the child avoids the kitchen when certain foods or meals are being prepared. Are distractions used during mealtime, such as screens or toys? Investigate whether strategies like praise, rewards or pressure are used to encourage the child to eat. Pay attention to behaviour around food: Do they appear anxious or show signs of distress? Are they eating very slowly, or frequently get distracted and leave the table during meals? Also review eating at school, family life and social interactions (e.g. parties, play dates, etc).

It is essential to review growth from birth by examining the Personal Child Health Record (the 'red book'), which includes details on weight and height. Review growth charts to identify any patterns, such as stunted growth or unexplained weight loss.

It is important to remember that a child can exhibit a normal growth pattern yet still be at nutritional risk. The nutritional analysis, growth assessment, and any clinical signs of deficiency – such as pale skin, easy bruising, poor wound healing or hair loss – should help determine whether a blood test is necessary and what specific nutrients should be tested. If there are notably low intakes of certain vitamins, such as vitamin A or C, these should be considered. However, testing for these requires special sample handling and may not be feasible in a community setting. Contacting the hospital biochemistry department to explain the rationale for testing can be a helpful step.

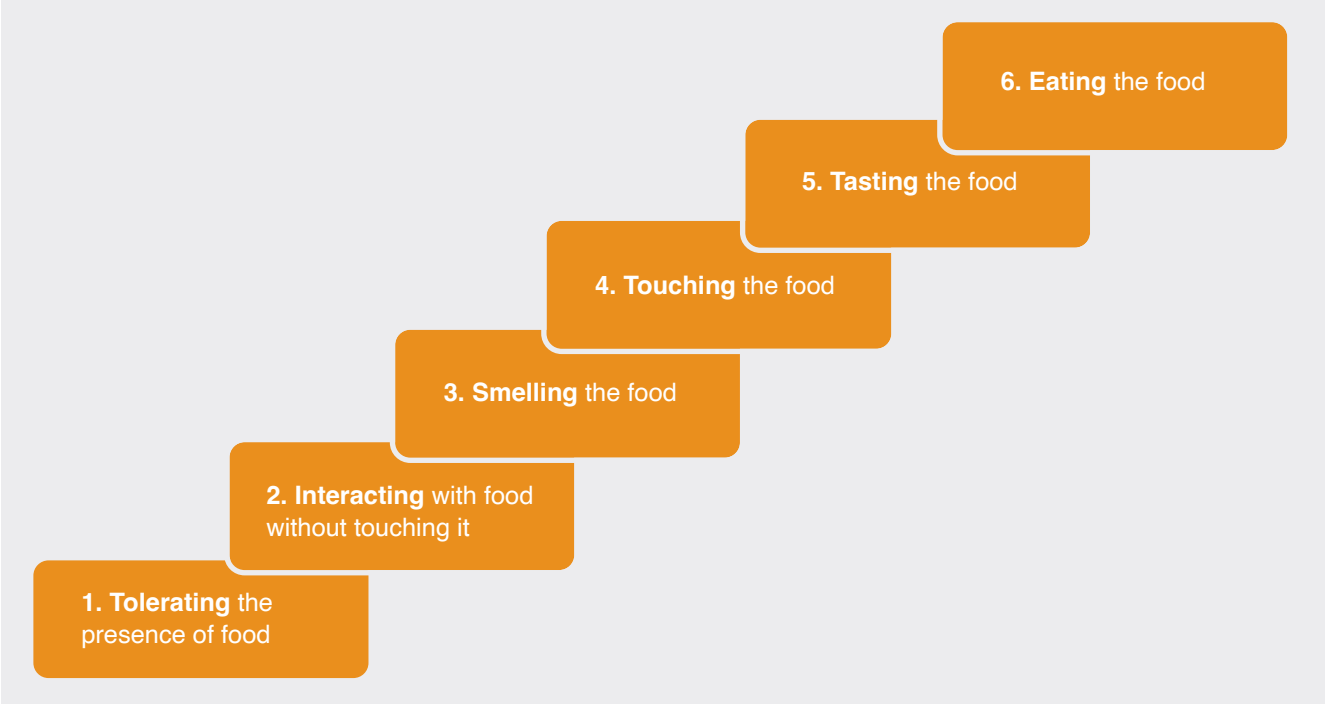
Nutritional adequacy, food exposure & food chaining

Addressing nutritional deficiencies should be the priority, and finding the right vitamin and mineral supplement is crucial. It may take time to identify a preparation that the child can tolerate. Consider if supplementation of individual vitamins and minerals or a complete preparation is required. The BDA ARFID Sub-Group has developed an excellent resource to help guide this process. Begin with a small amount of the indicated supplement and gradually increase dosage until the required amount is reached. Additionally, consider incorporating fortified foods, such as bread, breakfast cereals or milk, to help meet nutritional needs.

For those with inadequate energy and protein, you may aim to increase the quantity of food, which may mean increasing the frequency of eating and additional opportunities to eat such as an additional break at school. For some individuals the use of oral nutritional supplements might be appropriate, although these are not always well accepted.

In terms of trying to expand the repertoire of foods, there are several ways to explore this: **Food exposure therapy** aims to reduce fear and anxiety around food and encourage gradual acceptance of new foods. The '6 Steps to Eating', developed by Kay Toomey, provides a structured framework to guide this process.[5, 6] Each step helps the child engage with food at their own pace, fostering comfort and familiarity; the child always chooses the foods (see **Figure 2**).

Figure 2: 6 steps to eating



This systematic approach ensures the child feels safe at every step, reducing the risk of overwhelm and building positive experiences with food.

Food chaining is another therapeutic approach designed to gradually expand the diet by building on foods already accepted.[7, 8] It involves creating a 'chain' of similar foods that are progressively introduced based on texture, flavour or appearance to minimise rejection. See **Figure 3** for an example.

Food chaining can be effective in creating a sense of safety and success, as it reduces anxiety about new foods by building on familiar ones.

Future work

The work to educate and upskill dietitians across all bandings in recognising and treating ARFID is important to ensure these skills are embedded within the workforce and support for families can be readily accessed. It is known many families will have presented repeatedly to healthcare professionals before receiving the recognition and support they need. Education of GPs, health visitors and school nurses would potentially provide earlier identification. The dietetic workforce is a key element of ARFID treatment, and it is important to continue to make service commissioners aware of this valuable resource, including the workforce numbers required.

Continuing to raise awareness of the importance of access to ARFID services is a key area for development. Currently access is limited or even non-existent in some areas and may involve long distances. There are many examples of excellent services, both established and pilot, but many individuals fall between provisions, with a lack of faltering growth/body mass index leading to dismissal at an early stage. Also, there remains some debate about the most appropriate setting; community services or mental health provision, and this needs to be clarified.

Gathering outcome data on treatment pathways is an important step in assessing treatments; particularly given there are many differing treatment options.

National guidelines on diagnosing and treating ARFID would be very timely.

References: **1.** British Dietetic Association (2022). The Role of the Dietitian in the Assessment and Treatment of Children and Young people with Avoidant Restrictive Food Intake Disorder. Accessed online: https://bit.ly/4hFQPQO (Feb 2024). **2.** Courts and Tribunals Judiciary (2024). Alfie Nicholls: Prevention of future deaths report. Accessed online: https://bit.ly/3ElCk0f (Feb 2025). **3.** Donnelly LM, Thomas JJ (2003). Picky eating or something more? Differentiating ARFID from typical developmental eating behaviors. Current Opinion in Pediatrics. **4.** Schimansky S, *et al.* (2024) Nutritional blindness from avoidant-restrictive food intake disorder - recommendations for the early diagnosis and multidisciplinary management of children at risk from restrictive eating. Arch Dis Child.; 109(3): 181-187. **5.** Toomey K (2011). SOS approach to feeding. Perspect on Swallow & Swallow Disord.; 20(3): 82-87. **6.** Association AP (2022). Diagnostic and statistical manual of mental disorders. Washington, DC: American Psychiatric Association Publishing; 2022. Accessible online: http://bvbr.bib-bvb.de:8991/F?func=service&doc_library=BVB01&local_base=BVB01&doc_number=033051056&sequence=000001&line_number=0001 &func_code=DB_RECORDS&service_type=MEDIA (Feb 2025). **7.** Fishbein M, *et al.* (2006), Food chaining: a systematic approach for the treatment of children with feeding aversion. Nutr Clin Pract.; 21(2): 182-184. **8.** Fraker C (2007). Food Chaining: The Proven 6 Step Plan to Stop Pciky Eating, Solve Feeding Problems, and Expand Your Child's Diet. USA, De Capo Press.

Figure 3: Food chaining – an example