Avoidant/Restrictive Food Intake Disorder (Arfid) P.

Ujwala Rama Chandra[1], K. Lalitha Prassana[2], K. Tejeswini[3], K. Manikarna Teja[4]
Assistant proffesor, Student, Assistant proffesor, Student
Department of pharmacology
Pydah college of pharmacy, Patavala, Kakinada-Yanam Road, Kakinada, E.gt, Andhra Pradesh

***Abstract*—Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating disorder marked by a significant limitation in food intake, resulting in severe nutritional deficiencies, weight loss, and negative impacts on both physical and psychological health. Unlike anorexia nervosa, ARFID is not typically associated with a fear of weight gain or concerns about body image. Instead, it often presents as an intense aversion to certain foods, heightened sensitivity to food textures, tastes, or smells, and a general disinterest in eating. Individuals with ARFID may also experience anxiety, sensory sensitivities, and various medical complications due to inadequate nutrition. While ARFID can affect people of all ages, it is most commonly diagnosed in children and adolescents. Early detection and intervention are critical in preventing long-term health problems. Treatment usually involves a combination of nutritional rehabilitation, cognitive-behavioural therapy (CBT), and addressing underlying psychological factors such as anxiety or trauma. As research into ARFID progresses, the need for improved diagnostic criteria and more effective treatment options becomes increasingly important to enhance outcomes for those affected by the disorder.**

***Index Terms*—Picking Eating, Nutritional Deficiencies, Anxiety Around Food, Meal-time Anxiety, Restrictive Eating, Medical Complications.**

I. INTRODUCTION

Restrictive Food Intake Disorder (RFID) is a recently recognized eating disorder marked by a significant reduction in food intake, leading to nutritional deficiencies, weight loss, and various health complications. Unlike anorexia nervosa, which is typically driven by a fear of gaining weight or a distorted body image, RFID [1] is not primarily associated with concerns about body size. Instead, individuals with RFID often display extreme food selectivity, strong aversions to specific textures, smells, or types of food, and a general lack of interest in eating.

While RFID can affect people of all ages, it is most commonly diagnosed in children and adolescents, though it may persist into adulthood. The disorder can be triggered or worsened by factors such as sensory sensitivities, anxiety, trauma, or underlying medical conditions [2]. It often co-occurs with other mental health issues, such as anxiety or depression. The presentation of RFID can vary widely: some individuals may restrict their intake to a very narrow range of foods, while others may avoid eating altogether due to fear or discomfort.

In severe cases, RFID can lead to life-threatening malnutrition, stunted growth, and significant physical and psychological consequences. Diagnosing and treating RFID can be difficult due to its complex nature, which requires addressing both the physical and emotional aspects of the disorder [3]. Early diagnosis and a comprehensive treatment plan—including nutritional therapy, cognitive-behavioural therapy, and support for any co-occurring mental health conditions—are critical for helping individuals recover and establish healthier eating habits.

Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating or feeding disorder where individuals drastically limit the amount or variety of food they eat [4]. This can lead to malnutrition, weight loss, or difficulties in daily functioning and social situations. Unlike disorders such as anorexia nervosa or bulimia, ARFID is not driven by concerns about body image. Instead, people with ARFID may avoid food due to sensory sensitivities (such as the texture, taste, smell, or appearance of food), low appetite, fear of choking or vomiting, or difficulties with executive functioning [5]. Although it is often linked with being underweight, ARFID can affect individuals across the full weight spectrum.

Fig 1: Restrictive Eating

II. EPIDEMIOLOGY

There is currently a lack of comprehensive epidemiological data on the incidence and prevalence of Avoidant/Restrictive Food Intake Disorder (ARFID) in the general population. Most available data come from clinical settings, with incidence rates ranging from 5% to 14% among patients presenting to tertiary pediatric eating disorder programs, based on retrospectively classified cases [6]. A more recent study reported an incidence of 8% among patients diagnosed with ARFID during their initial assessment. Prevalence estimates for ARFID vary widely, ranging from 1.5% to 23% in children and adolescents who have sought treatment at day programs for eating disorders, pediatric gastroenterology outpatient clinics, and inpatient eating disorder facilities across North America.

ARFID can begin as early as infancy or childhood and may continue into adulthood. It is more commonly diagnosed in males [7], particularly in younger children (ages 4–11), and tends to have a longer duration of illness compared to other eating disorders [5], such as anorexia nervosa (AN) or bulimia nervosa (BN).

Unlike most eating disorders, ARFID may be more common in young boys than in young girls. The ways in which ARFID presents can vary widely from person to person. Research also suggests that parental pressure to eat may negatively affect a child's eating habits, contributing to picky eating and weight loss during childhood [8]. This pressure can interfere with a child's natural hunger cues and may lead to eating driven by emotions rather than physical hunger.

In a study conducted between 2008 and 2012, 22.5% of children aged 7 to 17 enrolled in day programs for eating disorder treatment were diagnosed with ARFID [9]. Additionally, ARFID has been shown to have a high rate of comorbidity with autism spectrum disorder (ASD). A 2021 study found that up to 17% of adults with ASD are at risk for developing disordered eating [10], with some evidence pointing to a genetic link. Among children diagnosed with ARFID, one study reported a 12.5% prevalence of ASD.

Other risk factors for ARFID include heightened sensory sensitivity, gastrointestinal disorders, and anxiety related to eating [11]. Prevalence rates have been estimated at 1.3% among children aged 4 to 7, and 3.7% among females aged 8 to 18. In that older female cohort, those diagnosed with ARFID had an average BMI that was 7 points lower than peers without the disorder.

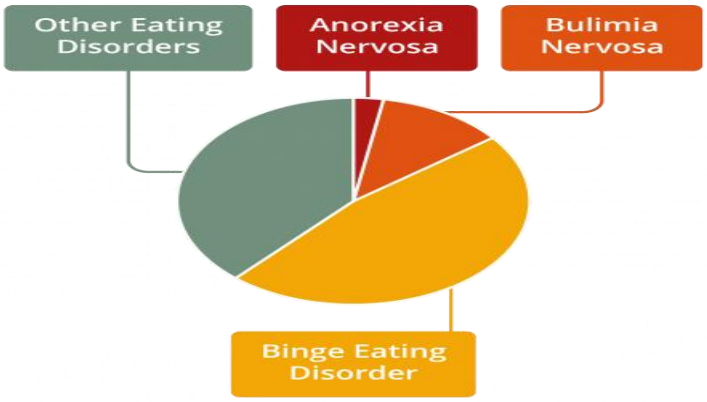

Fig 2: Pie chart ARFID

III. SIGN AND SYMPTOMS

Avoidant/Restrictive Food Intake Disorder (ARFID) goes beyond the typical "picky eating" often seen in toddlers and young children, which usually improves with time [12]. In ARFID, food avoidance or restriction is so severe that it leads to nutritional deficiencies, poor weight gain or significant weight loss, and/or major disruptions in psychosocial functioning.

In some cases, individuals may avoid certain foods or limit their intake due to fears of negative consequences, such as choking, vomiting, or stomach pain[13]. These fears are often rooted in past traumatic experiences involving food. While avoiding these foods may offer temporary relief, continued avoidance can worsen anxiety and prevent the development of more positive, corrective experiences [14]. Over time, the list of avoided foods can expand, and in extreme cases, individuals may avoid nearly all solid foods.

- Abdominal pain and non-specific gastrointestinal issues (e.g., constipation, acid reflux)
- Irregular menstrual cycles
- Abnormal lab results (E.g.: Anemia, low thyroid function, hormone imbalances, low potassium levels)
- Loss of menstrual period in post pubertal females
- Fainting or episodes of syncope
- Sleep disturbances
- Dry, brittle nails
- Fine, soft hair growth on the body (lanugo)
- Dry or flaky skin
- Dizziness or light headedness

Fig 3: Symptoms of ARFID

IV. ETIOLOGY AND RISK FACTORS

Most of the current understanding of Avoidant/Restrictive Food Intake Disorder (ARFID) comes from studies with relatively small clinical samples, primarily from eating disorder programs or individuals seeking specialized medical care [15]. Given that ARFID is a relatively recent diagnosis, much of the research into its prevalence and causes has been based on retrospective studies. Additionally, there is limited knowledge about the characteristics of ARFID in adults, as much of the research has focused on pediatric populations during childhood and adolescence. Despite the lack of precise data, ARFID is estimated to affect about 0.5–5% of the general population, including both adults and children [16]. A study based on the Canadian Paediatric Surveillance Program found an incidence rate of 2.02 per 100,000 children and adolescents aged 5 to 18 years. This study also noted age- and sex-specific differences in diagnostic criteria, medical characteristics, psychiatric comorbidities, eating behavioural, and hospitalization rates.

Zickgraf suggests that the factors influencing eating behaviour in ARFID may be linked to different patterns of restrictive eating [17]. The propose of that ARFID's clinical presentation exists along a three-dimensional continuum, with different severity levels that reflect variations in sensory perception, homeostatic appetite regulation, and negative emotional responses. According to this dimensional model, most individuals diagnosed with ARFID show difficulties in multiple areas related to food intake.

The Etiology of ARFID is believed to involve a combination of biological, psychological, and environmental factors [18]. The propose that sensory sensitivities, anxiety traits, and disruptions in the balance between homeostatic (hunger-driven) and hedonic (pleasure-driven) aspects of eating behaviour may contribute to the development of ARFID. These factors may increase vulnerability to the disorder [19]. The offer a framework that categorizes the contributing factors to ARFID into three groups: predisposing, precipitating, and perpetuating factors, similar to models used for other eating disorders. These factors interact in complex ways to influence the onset and persistence of the disorder.

PHYSICAL SIGNS AND EFFECTS OF ARFID:

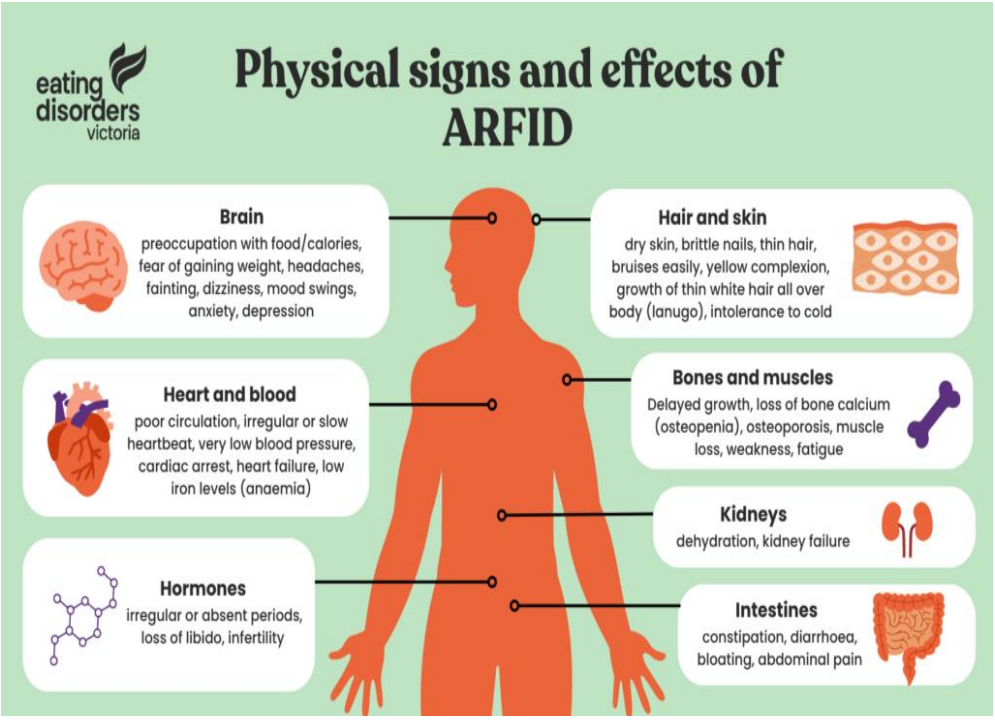

Fig 3: ARFID-Related Health Consequences

V. MEDICAL TERMINOLOGY

1. General Terminology
- ARFID (Avoidant/Restrictive Food Intake Disorder)
- Restrictive eating
- Food neophobia (fear of trying new foods)
- Selective eating
- Extreme picky eating
- Nutritional deficiency
- Growth delay (in children)
- Caloric insufficiency

2. Behavioural Keywords
- Avoidance of specific textures, colors, or smells
- Fear of choking or vomiting
- Limited variety of foods
- Texture aversion
- Food phobia
- Anxiety around eating
- Refusal to eat certain food groups

3. Medical/Health Keywords
- Malnutrition
- Low energy intake
- Underweight
- Vitamin deficiencies
- Electrolyte imbalances
- Gastrointestinal discomfort

TYPES OF ARFID:
- Food Avoidance - Emotional Subtype (e.g., fear of choking or vomiting)
- Food Avoidance - Sensory Subtype (e.g., aversion to certain textures or tastes)
- Food Avoidance - Restrictive Subtype (e.g., rigid or highly selective eating patterns)

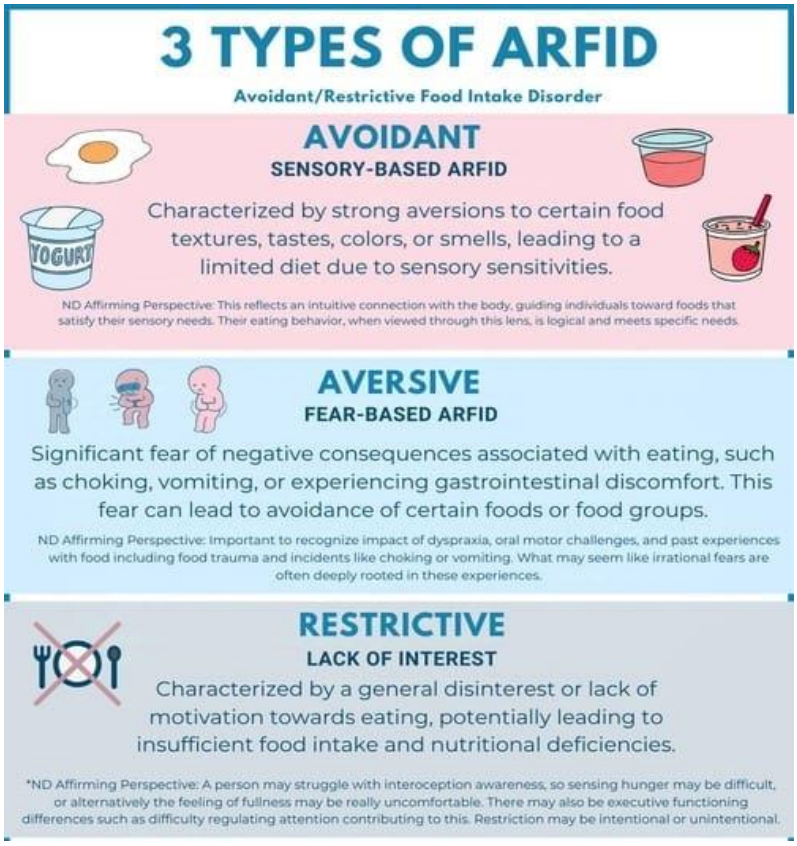

Fig 4: Different Types of ARFID

CAUSES
- Genetic factors
- Environmental influences (e.g., parenting and feeding practices)
- Sensory sensitivities
- Anxiety or obsessive-compulsive traits

TREATMENT:
- Cognitive Behavioural Therapy (CBT)
- Family-Based Therapy (FBT)
- Nutritional Counseling

- Gradual exposure to avoided or feared foods

COMPLICATION:

- Malnutrition
- Significant weight loss

RESOURCES:

- National Eating Disorders Association (NEDA)
- Academy for Eating Disorders (AED)
- American Psychological Association (APA)
- Eating Disorders Coalition (EDC)

PREVENTION:

There is no known way to prevent Avoidant/Restrictive Food Intake Disorder (ARFID). However, early intervention can significantly improve treatment outcomes [20]. Unlike anorexia nervosa and bulimia nervosa, ARFID is an eating disorder that does not involve a distorted body image, but rather is characterized by the avoidance of certain foods or food groups.

Impact on Physical and Mental Health:

Untreated ARFID can lead to severe health consequences, including chronic malnutrition, vitamin deficiencies, delayed physical development, and increased risk of anxiety and depression [21]. This chapter examines both the physiological and psychological effects of ARFID.

DIAGNOSIS:

The diagnosis of ARFID is typically made using a diagnostic checklist to assess whether an individual is displaying specific behaviours and traits [22]. Clinicians will evaluate the variety of foods the person consumes, as well as the portion sizes of accepted foods. They will also consider the duration of food avoidance or refusal and investigate any related medical issues, such as malnutrition.

An eating or feeding disturbance characterized by a consistent lack of interest in food, avoidance due to sensory characteristics of food [23], or concern about negative consequences of eating, as evidenced by persistent failure to meet appropriate nutritional and/or energy needs, leading to one (or more) of the following:

Significant weight loss (or failure to achieve expected weight gain, or faltering growth in children)

Significant nutritional deficiencies

Reliance on enteral feeding or oral nutritional supplements

Noticeable interference with psychosocial functioning

This disturbance is not better explained by a lack of available food or by culturally accepted practices [24]. Additionally, the eating disturbance does not occur exclusively during anorexia nervosa or bulimia nervosa, and there is no evidence of a distorted body image or preoccupation with body weight or shape.

The disturbance is also not attributed to a concurrent medical condition or another mental disorder [25]. If the eating disturbance occurs in the context of another condition, its severity should exceed what is typically seen with that condition and warrant additional clinical attention.

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