WHY WE DON'T USE THE ARFID DIAGNOSIS

By Dr. Kay Toomey

ARFID is a diagnosis that the American Psychiatric Association created in 2013 to replace the old DSM IV-TR diagnosis referred to as Feeding Disorder of Infancy and Early Childhood.

Feeding Disorder of Infancy and Early Childhood (DSM-IV-TR) = Persistent failure to eat adequately (reflected in failure to gain weight or significant weight loss at least 1 month), in the absence of a medical condition severe enough to account for the feeding disturbance.

- The feeding disturbance is not better accounted for by another mental disorder or by lack of available food;
- Onset of disorder had to start be before 6 years of age

A number of studies indicated that the prevalence of the DSM IV-TR's Feeding Disorder diagnosis was only about 3-12% of the population of children with feeding challenges (Burklow et.al., 1998; Rommel et.al., 2003; Field et.al., 2003; Williams et.al., 2009). This low prevalence was due in part to a number of exclusions in the Feeding Disorder of Infancy and Early Childhood diagnosis. To receive this diagnosis, a child needed to be under 6 years of age, they had to have weight loss or failure to gain weight for at least one month, and they could not have a medical or mental health disorder that would account for the child's feeding problem. It is also very important to note that the DSM IV-TR diagnosis was classified under the developmental disorders section of the DSM (Diagnostics and Statistics Manual). We will come back to this point in just a minute.

Due to low usage of the DSM-IV TR's Feeding Disorder diagnosis, the Eating Disorders division of the DSM V committee decided to create the ARFID diagnosis in order to be able to diagnose a larger group of children at earlier ages than the criteria for Anorexia Nervosa or Bulimia Nervosa diagnoses.

Avoidant/Restrictive Food Intake Disorder (ARFID) in the DSM V = An eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss or faltering growth
2. Significant nutritional deficiency
3. Dependence on enteral feeding or oral supplements
4. Marked interference with psychosocial functioning

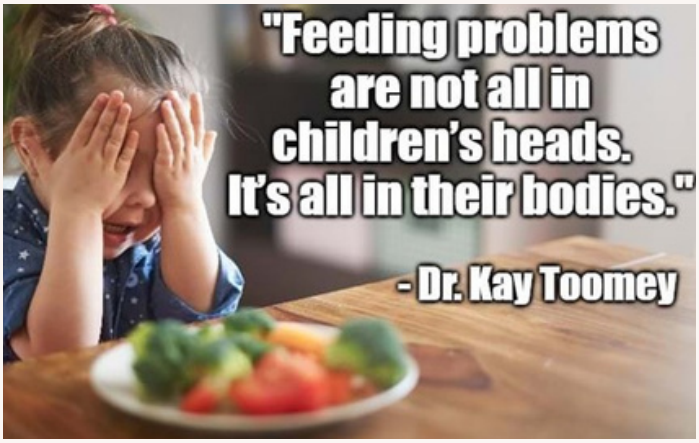
- The eating disturbance is **not attributable to a concurrent medical condition** or not better explained by another mental disorder.
- **When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder** and warrants additional clinical intervention

In the new ARFID diagnosis, the age criteria was eliminated, as was the requirement for weight loss or failure to gain weight. Now, any child who is not meeting their nutrition or energy needs can qualify for ARFID as long as one of 4 issues is present: significant nutritional deficiency; dependence on enteral feeding or oral supplements; marked psychosocial issues; or weight loss/growth faltering. In addition, if there is a medical or mental health issue present, a child can still be diagnosed with ARFID if the child's feeding difficulty was worse than the average feeding problem seen in children with that same medical or mental health issue. The other major change that was made was that this diagnosis was moved out of the Developmental Disorders of Childhood section of the DSM and moved into the Psychiatric Disorders Diagnoses section of the DSM; specifically into the Eating Disorders section.

THERE ARE A NUMBER OF VERY SIGNIFICANT ISSUES WITH THE DIAGNOSTIC CRITERIA OF ARFID AND THE MOVE OF THIS DIAGNOSIS INTO THE EATING DISORDERS SECTION OF THE DSM.

#1 – The shift out of developmental disorders into psychiatric disorders has now psychopathologized feeding difficulties from being a medical/developmental/skill acquisition set of problems to being a mental health disorder (Kirkey, S., 2012. Picky eaters could join ranks of mentally ill. Canada National Post. 1-6.).

The world's leading Feeding Experts disagree with the American Psychiatric Association's classification of feeding problems as mental health disturbances. This disagreement was part of the impetus for these experts, with the help of an organization called Feeding Matters, to create the new Pediatric Feeding Disorder diagnosis which just came into effect as of October 1st, 2021. It is important for professionals to understand "Feeding problems are not all in children's heads. It's all in their bodies". "When children don't eat, it is because something about their body is not working correctly" (Dr. Kay Toomey).



#2 – Because ARFID now is considered an Eating Disorder, any professional who is not an expert in Eating Disorders should NOT be assigning to or treating a child with an ARFID diagnosis.

For a professional to assign an ARFID diagnosis, they should be a physician, psychiatrist, psychiatric nurse, psychologist or another mental health professional who is allowed to give psychiatric diagnoses. In addition, these professionals should be trained enough to also be comfortable assigning an Anorexia Nervosa diagnosis or Bulimia Nervosa diagnosis in order to be qualified to give an ARFID diagnosis. Many professionals do not realize that they now need a different set of qualifications in order to ethically be able to give an ARFID diagnosis and to not step outside of their scope of practice. Additionally, this move of feeding problems into Eating Disorders excludes most Rehabilitation Professionals (such as Speech Pathologists) from giving this diagnosis to or treating their patients.

#3 – The ARFID diagnosis is now so inclusive that almost any child who is power struggling with their parents about food could qualify for this mental health disorder.

This overly broad diagnosis occurs, in part, because there is no clear definition of what is "marked interference with psychosocial functioning". Does this mean the parent doesn't like how their child eats or what their child eats? Does this mean the child's eating is bothersome enough that the parent is asking for help from a professional? Does this mean that the child doesn't like eating in the school cafeteria, but can do it? Or, does this mean that the child is eating by themselves in their bedroom and that they eat none of the same foods as their family members? Having a diagnosis that is this broad is not helpful to us as professionals or parents, in understanding what is happening with our children/clients/patients.

#4 – The last issue with the ARFID diagnosis is with the exclusionary criteria because...

a) most professionals assigning ARFID are not considering the exclusions; b) there is disagreement in the field whether feeding skills deficits should be part of the exclusionary criteria; and c) because to be diagnosed with ARFID in the presence of another medical or mental health issue, your feeding problem has to be worse than the average child with that same exact medical or mental health problem. This latter piece of the exclusionary criteria is the biggest problem with ARFID because we do not have in the field enough data to say what the AVERAGE feeding problem is for children with various medical and mental health diagnoses. For example, we cannot say what an average feeding problem is for a child with Cystic Fibrosis or Down Syndrome or Gastroesophageal Reflux is. We don't know what the average feeding problem is with a child with oral-motor problems or Sensory Processing Disorder or an anxiety disorder. While we have some good ideas about what types of feeding problems children with these issues have, we do not have the data to say what the AVERAGE feeding issue is clearly enough to then say that X child's feeding issues are bad enough to qualify them for ARFID.

IT IS CRITICAL THAT ALL PROFESSIONALS AND PARENTS, ADVOCATE FOR ANY CHILD WITH FEEDING DIFFICULTIES TO BE EVALUATED BY A MULTI-DISCIPLINARY FEEDING TEAM 1ST, BEFORE AN ARFID DIAGNOSIS WOULD EVEN BE CONSIDERED.

Instead, children under the age of 12 should be assessed for a potential Pediatric Feeding Disorder diagnosis as a first possible option rather than immediately categorizing the child into the psychiatric disturbance of ARFID.

Pediatric Feeding Disorder (PFD) = a disturbance in oral intake of nutrients, inappropriate for age, lasting at least 2 weeks and association with 1 or more of the following: medical, nutrient, feeding skills, and/or psychosocial dysfunction,

- In the absence of the cognitive processes consistent with eating disorders, and
- The pattern of oral intake is not due to a lack of food or congruent with cultural norms.

This diagnosis was originally proposed by Goday et.al. in 2019 and the ICD 10 revision committee decided that this should be the accepted diagnosis for all children with feeding challenges. This diagnosis literally just came into effect as of October 1st, 2021.

- R63.31 - Pediatric feeding disorder, acute
- R63.32 - Pediatric feeding disorder, chronic (> 3 months)

We hope information has helped you better understand the concerns and reasons to not assign or accept an ARFID diagnosis.

For more information about the appropriate PFD diagnosis to use with children, please visit Feeding Matters or visit www.sosapproach.com.