PSYCHOTERAPIA 3 (198) 2021
strony: 33–47
DOI: 10.12740/PT/141443

Dorota Maria Sikora

THE TREATMENT OF AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID) WITH PREDOMINANCE OF ANXIETY PRESENTATION. A PROPOSAL OF A PROTOCOL FOR THERAPEUTIC PROCEDURE

Centre for Specialist Diagnosis and Therapy in Pszczyna

avoidant/ restrictive food intake disorder
therapeutic procedure
cognitive-behavioral therapy

Summary

Avoidant/restrictive food intake disorder (ARFID) is a rarely diagnosed disorder in children, adolescents and adults, which is largely due to its relatively recent appearance in the classification of mental disorders. Numerous studies are undertaken abroad in order to increase knowledge about ARFID and search for standards of diagnosis and evidence-based treatment. Therapeutic protocols are proposed, based on cognitive-behavioral therapy, and Family-Based Treatment (FBT) is also used. The author presents the therapeutic interactions undertaken abroad in the treatment of ARFID, at the same time, combining own experience in working with the patient and data from the latest publications, proposes a treatment protocol and describes individual stages of the therapeutic procedure.

Introduction

In 2013 the avoidant / restrictive food intake disorder (ARFID) found its place in the classification of mental disorders of the American Psychiatric Association (DSM-V), but knowledge about it is still limited [1]. Before 2013, people with ARFID symptoms were classified as either eating disorder not otherwise specified (EDNOS) or feeding disorder of infancy and early childhood (FEDIC). During the development of the fifth edition of the DSM, work was undertaken to introduce changes in diagnostic categories to increase their usefulness and reduce the frequency of EDNOS categories by defining new eating disorder units [2]. Information was collected on the clinical presentation of patients displaying restrictive eating behavior but not expressing concerns about body weight or body shape. After placing this unit in DSM-5, in the category of eating disorders, ARFID was accepted by the diagnostic system of the World Health Organization (WHO) and included in the International Classification of Diseases (ICD-11) [1].

It is assumed that ARFID may occur in the full life cycle, however, it is currently known that childhood is a sensitive period for the manifestation of this disorder [3]. The difficulties resulting from ARFID are as serious and even more serious than in the case of other eating disorders, such as anorexia nervosa [4], but they are often underestimated, as the knowledge and understanding of the disorder such as ARFID is still insufficient, e.g. among health professionals [1], to whom patients usually report first [5].

ARFID – characteristics of the disorder

The literature defines three clinical presentations of ARFID (Table 1), namely sensory sensitivity, lack of interest in eating and fear of the aversive consequences of eating, which may occur in isolation or coexist with each other [3, 6]. Studies show that 22 to 50% of patients diagnosed with ARFID have a mixed presentation [7, 8]. Bryant-Waugh postulates that sensory sensitivity, lack of interest in eating and fear of aversive consequences of eating should be treated not as subtypes, but as reasons for avoiding and limiting food intake [1].

Table 1. **Description of ARFID clinical presentations**

Sensory sensitivity
It is characterized by an aversion to specific consistencies and textures, flavours and smells, and its consequence is the avoidance of products with specific characteristics. Therefore, the nutritional repertoire may be very limited, consisting of a dozen or even several products. The individual avoids eating situations (shopping, cooking, shared meals), is rejected by the smell of food, the possibility of touching it, and even looking at it.
No interest in eating
It is associated with not feeling hungry or not needing to eat. The individual forgets about meals and has a limited diet. Exhibits poor appetite. She defines eating as a duty that must be fulfilled, usually not enjoying it or approaching it with indifference.
Fear of the aversive consequences of eating
The individual, due to negative experiences related to certain products, feels fear and avoids eating them. Avoidance may extend to foods with similar characteristics to those rejected first, and then to entire groups of food products. The individual may fear choking, vomiting, gastrointestinal problems, or anaphylactic shock.

Source: own study based on [36].

It is noted that ARFID is often associated with other mental and neurodevelopmental disorders [2, 9, 10], including attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, anxiety disorders [2, 9], and mood disorders [2, 11], obsessive-compulsive disorder, depression, pica or pathological avoidance demand syndrome (PDA) [12]. Kambanis et al. suggest that specific units of mental disorders comorbid with ARFID are associated with the intensity of a specific presentation of this disorder [10]. The results of

their research indicate a relationship between neurodevelopmental disorders (ADHD, ASD) and depressive disorders with the intensification of sensory sensitivity, and anxiety and obsessive-compulsive disorders with the intensity of the anxiety presentation of ARFID. On the other hand, Leme de Souza et al. argue that the symptoms of comorbid disorders, i.e. hyperactivity, attention deficits and depressive mood, increase as the symptoms of ARFID worsen. According to the authors, the escalation of these symptoms makes it more difficult for an individual to function in society [13].

A comparison of patients diagnosed with ARFID to patients with other eating disorders indicates that they are usually younger [14, 15], include a greater percentage of men [2, 15, 16], are more likely to develop comorbid disorders, mainly anxiety disorders [2, 6], later seek treatment [5, 17] and do not present symptoms of disturbed body image [18].

Data on the etiology of ARFID are limited. Currently, there is a multifactorial etiology, taking into account the participation of biological factors (including genetic susceptibility, temperamental conditions, medical conditions), psychological factors (e.g. the basis of anxiety, disgust, attention deficit, tendency to impulsive behavior and a high level of arousal) and socio-cultural factors (e.g. feeding behavior or mental problems of the caregivers) [19, 20]. Attention is drawn to the heterogeneity of the disorder and large diversity of clinical symptoms, which may indicate an interaction between various predisposing, triggering and sustaining factors for ARFID (Table 2) [20, 21].

Table 2. **ARFID predisposing, triggering and sustaining factors**

Predisposing factors	— the presence of neurodevelopmental disorders (ADHD, ASD), — intellectual disability, — anatomical abnormalities, — anxiety tendencies, — experience of abuse or neglect, — attachment disorders
Triggering factors	— experiencing a traumatic eating situation (e.g. abdominal pain, vomiting, choking)
Sustaining factors	— the presence of neurodevelopmental disorders (ADHD, ASD), — disturbed parent-child relationship, — family conflict concerning the food sphere, — high anxiety of parents — avoiding the display of non-preferred food

Source: own study based on [21].

Data on the occurrence of ARFID in the general population are not known, however, there are studies available, including from North America, which confirm that patients suffering from ARFID constitute a recognized clinical population [22]. According to

the available data, the incidence of ARFID in the general population is estimated at 1.5–17.4% [19]. Studies on the pediatric population indicate the incidence from 3% to 23% [9].

Clinical diagnosis of ARFID

According to the American Psychiatric Association's Classification of Mental Disorders (DSM-5), ARFID is an eating impairment associated with difficulties in meeting nutritional and energy needs. The disorder is associated with the presence of at least one of the following factors:

- significant weight loss and / or impaired growth,
- serious nutritional deficiencies,
- the need for oral supplementation or enteral nutrition,
- impaired psychosocial functioning [23].

These problems cannot be the result of the lack of food availability or nutritional practices present in a given culture, they cannot be associated with disturbances in body image and body shape, and fear of weight gain. If ARFID is associated with another medical condition or disorder, in order to diagnose ARFID, it is necessary to state that the severity of the symptoms exceeds the severity of the symptoms characteristic for a given condition or disorder [23, 24].

Weight loss in ARFID usually involves avoiding certain food groups and consuming too few calories for your body's needs. However, ARFID is not always associated with weight loss. Patients often have weight adequate to their age and height or are overweight, which results from the caloric content of their preferred food [25]. Patients choosing highly processed foods provide the body with an excess of kilocalories, while at the same time having a low content of minerals and vitamins [25]. So far, it has not been precisely defined when we can talk about a significant weight loss, mentioned in the DSM-V criteria [26]. Not all weight loss or the lack of the expected weight gain will be an alarming signal, but in this situation observation and implementation are necessary if the problem persists or worsens. Not all weight loss or lack of weight gain will be associated with ARFID [26].

Malnutrition and growth disorders in patients with ARFID may result in the implementation of supplementation or tube feeding [27], which may result in the loss of appetite, difficulties in the transition from enteral to oral feeding, and impaired psychosocial functioning of the child and his family [28, 29]. This form of treatment should be used only in the case of acute malnutrition of the patient and should be used as a temporary tool, aiming at proper nutrition through oral feeding [5].

Psychosocial impairment is defined as difficulties in participating in common social situations. They are formed on the basis of avoiding or limiting eating [26]. The child avoids social situations related to eating, which limits his social contacts [25]. He/she is afraid of eating in company, therefore he avoids peer meetings and family celebrations. He/she experiences dilemmas during meals at an educational institution [30]. Avoids eating situations that generate strong sensory stimuli (e.g. shopping, cooking together) and reacts to them with irritability, anger and fear. He/she may be afraid of going on vacation, especially if his nutritional repertoire is very narrow and "demanding" (the question of access to a given food and its preparation). Smaller height as a consequence of avoiding or restricting food may lead to a decrease in self-esteem and unstable mental state, as well as building a negative body image [2, 9, 21].

It is important that Polish culture is deeply rooted in food – we often celebrate important moments by feasting together. In a child with ARFID, this can cause increased anxiety and withdrawal, and even alienation.

Despite the availability of the ARFID criteria (Table 3), included in DSM-5, there are still uncertainties related to the diagnosis of this disorder. The opinions about criterion A are divided among scientists and clinicians – some of them do not accept the presence of psychosocial impairment as sufficient for a diagnosis of ARFID [31]. However, there was a proposal to extend the diagnosis to people who experience significant psychosocial disorders related to the sphere of eating, but do not show weight loss, growth disorders, nutritional deficiencies and addiction to supplements [15]. An aspect of the diagnostic process that is difficult for clinicians is to assess the significance of the symptoms of other disorders or medical conditions present in the patient and their severity in relation to the symptoms typical of ARFID [32].

In the process of developing a differential diagnosis, a number of medical and psychiatric problems should be taken into account (Table 3). Since ARFID usually begins in childhood [3], it is necessary to differentiate it from food neophobia, which begins at around 18 months of age at the earliest and is characterized by a reluctance to try new foods. Usually, it gradually disappears in childhood [33], in contrast to the difficulties resulting from ARFID, which increase and lead to serious health and psychological consequences [5].

Table 3. **Differential diagnosis of ARFID**

Differential diagnosis of ARFID
• feeding disorders, • eating disorders (anorexia and bulimia nervosa, binge eating disorder, drinking disorder), anxiety disorders (including specific phobia, generalized anxiety disorder, social phobia), obsessive-compulsive disorder, • disorders belonging to the autism spectrum, • psychomotor hyperactivity (ADHD), • intellectual disability, • depressive disorders, • schizophrenia spectrum disorders and other psychotic disorders, • PANDAS / PANS, • reactive attachment disorder, • neurological disorders, birth defects and conditions associated with feeding difficulties, • other medical conditions (irritable bowel syndrome, inflammatory bowel diseases, gastroesophageal reflux disease, allergies, food intolerance, malignant tumors, hyperthyroidism, infectious diseases, nausea, vomiting, diarrhoea, abdominal pain)

Source: own study based on [1, 24].

Treatment of avoidant / restrictive food intake disorder (ARFID)

Taking into account the heterogeneity of symptoms and the unclear multifactorial etiology of ARFID, the planned treatment should take into account various problems, including behavioral, psychological, organic, motor and dietary problems [34]. The multidisciplinary team should include, inter alia, a general practitioner, psychiatrist, neurologist, gastrologist / gastroenterologist, dietitian, psychologist and a speech therapist [5]. Such a team is able to provide the patient with adequate care, supporting him/her not only in terms of difficulties directly related to the disorder, but also in terms of comorbidities resulting from accompanying disorders or secondary effects of ARFID. Interdisciplinary treatment gives a better chance to improve the patient's functioning, also in the socio-emotional sphere. The undertaken actions should be individualized – planned always after carefully studying the patient's situation and difficulties, comorbidities and goals assumed by the patient and their family [21].

The proposed treatment models still assume few interventions for comorbid emotional disorders [11, 35], which may have a significant impact on the persistence of ARFID.

Currently, there is no evidence-based treatment appropriate for all ARFID presentations [36,22]. The interventions undertaken focus on shaping proper eating habits and proper relations with food [12]. Actions implemented by specialists depend on the current health condition of the patient. Too low body weight and nutritional deficiencies, which pose

a serious threat to the health or life of the patient, require rapid behavioral interventions focused on compensating for deficits usually associated with hospitalization. In a situation where the patient's medical condition is stable, outpatient treatment is started [5, 21, 37]. Bryant-Waugh et al. proposed a pre-tested route of outpatient care for children and adolescents with suspicion of ARFID [22].

The scientific literature mentions many therapeutic approaches proposed in working with patients diagnosed with ARFID, including cognitive-behavioral therapy (CBT) [21, 36], Family-Based Treatment (FBT) [35], exposure-based therapy [38, 39], transdiagnostic cognitive-behavioral therapy of emotional disorders [35] and dialectical-behavioral therapy (DBT) [40], however, the effectiveness of each of these approaches in the treatment of ARFID is still being investigated.

CBT-AR and exposure techniques

Evidence-based treatment (EBT) Cognitive-behavioral Therapy (CBT) is used in the treatment of eating disorders and anxiety disorders, and it dominates in therapeutic interventions for children and adolescents. It is the best documented and effective – so far – form of aid [41–43]. Taking into account that anxiety predominates in some patients, the use of the above therapy seems to be a solution that will allow to work through the difficulties, especially in children. CBT-AR used on an outpatient basis is recommended for patients from 10 years of age, who are medically stable and do not require tube feeding [36]. ARFID therapy in the cognitive-behavioral approach lasts from 20 to 30 sessions (patients who are significantly underweight require more sessions in order to work on weight gain). The therapeutic management is divided into 4 stages [36]. In the first one, the therapist deals with psychoeducation of the patient and his caregivers on ARFID and CBT-AR. In the case of an underweight patient, interventions are made to increase the daily intake by 500 kilocalories in order to obtain a weight gain of 0.5–1.0 kg per week [36]. In this situation, the support of a dietitian becomes invaluable. With a patient with a stable body weight, they discuss the set of preferred products and plan the first changes in its scope. The second stage involves psychoeducation about nutritional deficiencies and their effects on health, as well as their role in maintaining ARFID. The patient's nutritional set is further analyzed and appropriate products are selected, in order to gradually eliminate nutritional deficiencies. In the third step, treatment modules are selected depending on the patient's dominant ARFID presentation. In the case of multiple mechanisms supporting the disorder, work should begin with the most primary or the most disabling psychosocial functioning of the patient. Then the exposure technique is introduced [36]. Together with the therapist, the patient create a list of anxiety-generating products / situations so as to define their hierarchy from the least to the most discomforting. Product expositions take place in the office and continue at

home. In the case of patients who are not interested in eating, interoceptive exposures are used in order to familiarize them with the sensations flowing from the body, e.g. related to the filling of the stomach. The fourth step is to assess progress and develop a relapse prevention plan [36].

The technique of exposure to stimuli allows you to test the patient's beliefs that are inconsistent with reality. It consists in creating a new association with the stimulus that initially caused the anxiety through exposure to it. This procedure allows the patient to notice the discrepancy between his own beliefs about the stimulus and its actual impact [44]. The therapist's task is to provide appropriate conditions for him to experience the phenomenon of habituation and modify his own beliefs about anxiety [43]. Studies by Dumont et al. indicate an improvement in the functioning of patients with ARFID as a result of exposure therapy [44].

Thomas et al. [36] presented a cognitive-behavioral model for ARFID, in which the patient's biological predispositions, such as: sensory sensitivity, fear of eating or lack of interest in eating, determine negative predictions about eating (they can be activated or additionally reinforced by trauma related to food). The growing tendency to limit food may lead to weight loss and nutritional deficiencies, which additionally determine the reluctance to eat certain products. Consequently, due to the limited possibilities of exposure, the risk of excluding more products from the nutritional repertoire increases [36].

Proposal of therapeutic protocol – FBT + UP

The proposed treatment for ARFID is the integration of the Family-Based Treatment (FBT) approach and the unified protocol for transdiagnostic treatment of emotional disorders (UP) [45]. Treatment usually begins with techniques typical of the FBT approach – patient weighing, psychoeducation and family involvement in the treatment system, separating the eating problem from the child (externalization) and taking responsibility and control over the child's eating by the child and its parents / guardians [45]. If necessary, weight gain is recommended and arrangements are made for family observation during a joint meal. Then, the UP-C (for children) or UP-A (for adolescents) protocol is included in the treatment. The unified transdiagnostic protocol of UP is an evidence-based treatment (EBT) focusing on emotional disorders in children, adolescents and adults [35], combines various cognitive-behavioral techniques, including cognitive reassessment, exposure, and mindfulness techniques. It allows to focus on the emotional processes that are responsible for the persistence of symptoms of various disorders, which at the same time facilitates work on co-occurring problems. It focuses on the patient's strong, unwanted emotions, aversive reactions or negative beliefs about emotions, and behaviors aimed at avoiding them. It teaches how to anchor in the present and deal with emotions without the need to implement an avoidance strategy [45].

FBT treatment supports the parents first and foremost, and at the same time the entire family system. It does not focus on the causes of the child's nutritional difficulties, which reduces the parents' guilt. The therapist acts as a consultant, and the parent becomes an expert, which weakens his/her sense of helplessness. The family becomes more involved and competent to work with the child, which additionally gives the patient a sense of security. Thanks to externalization (separating the problem of eating from the child), it is easier for parents to recognize and name behaviors resulting directly from ARFID [46]. Strengthening parents through FBT interventions provides the foundation for further work, but in the next stages it should be properly adjusted to the assumed goal. Numerous studies [cf. 35, 46] show that the treatment of a child with ARFID should be individualized, and the methods and techniques selected depending on the present presentation of the disorder (sensory sensitivity, fear of undesirable consequences of eating, lack of interest in eating) or their combinations, as well as the goals that the family want to achieve.

Table 4 presents the proposal of ARFID treatment protocol with the dominance of anxiety presentation. Its individual stages are described. Three adolescents were treated in this way therapeutically, each of whom declared a subjectively perceived improvement in the volume of the nutritional repertoire (2–5 new products) and in the scope of socio-emotional functioning (improvement of relations with the environment, better coping with emotions, including anxiety). The effectiveness of the proposed protocol has not been verified so far. It should be noted that the presented treatment plan may not be effective for every patient diagnosed with ARFID. Treatment should be tailored to the patient's difficulties, therefore a reliable diagnosis of problems resulting from ARFID becomes the key to choosing the treatment path. Future studies need to determine when and for whom FBT + UP is the most effective form of treatment. Proposals for treatment of ARFID with high level of anxiety include cognitive – behavioral therapy (CBT-AR), behavioral therapy, anxiety-focused parental intervention, habit training, family therapy, group therapy and enhanced psychoeducation [22].

Table 4. **Treatment proposal for ARFID with high level of anxiety. Individual stages of treatment.**

Session	Course of the session
FBT session 1–2	Interview with parents. Weighing, psychoeducation (specific to patients with ARFID), externalization of the problem, family involvement and parental control over the child's eating, initial arrangements for using the reinforcement system. Important: psychoeducation of the patient and the family is aimed at increasing the awareness of the experienced difficulties and the mechanisms supporting them. Thanks to this, they are ready to take responsibility for the treatment process. It is important to build a relationship with the child and his family from the very first moment.

table continued on the next page

FBT session 3	Further evaluation of the patient's eating habits, analysis of behaviors that impede success, supporting the family in undertaking the process of helping the child make changes in eating. Suggestion: analysis of recordings of shared meals in order to identify family processes and mechanisms that maintain the problem. Discussion of recordings with parents.
FBT session 4 (and more)	This stage is intended for underweight patients. It builds cooperation with parents, develops the parent's ability to work together on the task of gaining weight and related difficulties, including avoiding meals, concerns about eating, etc. The number of sessions at this stage depends on the progress of growth patient weight. (Patients who are not underweight or are gaining weight adequately go to the UP session.)
FBT+UP-C: Module 1 1–2 sessions	Introduction to a Unified Protocol for Treating Emotional Disorders in Children: At this stage, the child and parents get acquainted with the treatment model and describe the skills that the child is to acquire as a result of it, building emotional awareness begins, and diagnoses the most important problems and adopts treatment goals. These problems may be directly related to ARFID or may be related to comorbid disorders.
FBT+UP: Module 2 1–2 sessions	Getting to know and understanding emotions: In this module, the work focuses on learning to recognize, name and assess the intensity of various emotions. Other tasks to be performed include normalizing emotional experiences, discussing the avoidance cycle, and determining rewards from desired behavior. Proposal: introducing the ARC emotion model (A – preceding circumstances; R – reaction; C – consequences), which will allow for the analysis of emotions experienced by the patient and a better understanding of the situation.
FBT + UP: Module 3 1–2 sessions	Mindfulness of Emotions: The module consists in developing, through regular exercises, the ability to notice emotions experienced by the patient without automatically assessing them. In order to develop mindfulness, we use guided meditation followed by listening to an emotional piece of music. By observing all the components of the emotional response, the patient learns to apply the mindfulness approach. We then help him apply these skills in natural, emotional triggering situations.
FBT + UP: Module 4 3 sessions	Introduction to flexible thinking, identification of cognitive distortions, i.e. „traps in thinking" Suggestion: discussing all types of cognitive distortions and homework exercises to „catch" distorted thoughts and assign them to specific sets. Introducing the concept of „healthy thought". The study of thought research to determine its healthy / unhealthy effects on a patient's functioning.
FBT + UP-C: Module 5 2 session	Counteracting emotional protective behaviors: Defining the concept and types of emotional behavior to avoid, control or run away from emotions. Discussion of the role of these behaviors in maintaining the patient's disorders. Suggestion: the patient is asked to create a list of their own safety behaviors, thanks to which they avoid emotional stress related to eating and eating situations

table continued on the next page

FBT + UP: Module 6 1–2 sessions	Learning to identify body cues for different emotions, practicing experiencing body signals without avoidance or distraction (interoceptive exposures). The patient notices how the sensations of the body influence his thoughts and behavior, and how his thoughts and behavior influence the sensations of the body. An example would be the induction of fullness, nausea, dizziness, etc. Illustrate the interplay between body sensations, thoughts, and behavior in a graph and discuss them with the patient.
FBT + UP: Module 7 1–2 session	Introduction to the concept of using experiments to face strong emotions: Discussion of the exposure technique with the patient and parents. First exercises – using an exemplary situational exposure to emotions. Preparation of a plan of individualized situational exposure to emotions. Proposal: exposures for an intolerant product – we start with the product that evokes the least emotions (it is worth creating a list of products – from the product that causes the least fear to the product that causes the greatest anxiety). Similarly, we can focus on eating situations that cause anxiety at different levels. The level is assessed by the patient. The list may be exposures. We can use all kinds of educational aids, such as felt or wooden fruits or vegetables, books about food, etc. The patient creates a plan that will be used in the next module – the effect is to increase the sense of control, normalize the tension. Important: As part of the first exposure exercise, it is advisable to choose a situation / product that generates the lowest level of anxiety, but noticeable and discomforting.
FBT + UP: Module 8 The number of sessions depends on the number of items in the exposure plan	Implementation of the prepared plan of individualized situational exposure to emotions: Additional activities related to exposure to situational emotions in future sessions and at home. Important: exposures must take place both in the office and at home, with an emphasis on the latter. Initially, the therapist gives support and controls the situation, but gradually he should withdraw from the role for the benefit of the patient (it depends on the patient's age and abilities). The abilities exercised by the patient must be reflected in his everyday life, not only in the office. Here, the help of the family becomes invaluable, therefore it is recommended to consult the parents after each exposure session and implement the exposures plan for the next week at home. It is suggested to extend the session to 1.5 hours: 15–30 minutes – establishing a relationship, discussing well-being and own work, discussing the planned exposure; 30–45 minutes – exposure with discussion; 15–30 minutes – discussion with the parent, planning an exposure at home.
FBT + UP: Module 9 3 sessions	Prepare plan of maintenance strategies and relapse prevention: The plan allows you to „catch" symptoms of recurring difficulties and implement the acquired skills to maintain the effects of the therapy.

Extension and proprietary modification of the proposal of Eckhardt et al. [35] of the FBT + UP combination.

Summary

ARFID is a complex disorder with heterogeneous nature of clinical symptoms and varied etiology, which makes diagnosis difficult [21]. The current knowledge of specialists about this disorder is limited, which has a significant impact on making a correct diagnosis and taking appropriate steps in the treatment, and consequently leads to the intensification of difficulties secondary to ARFID – both medical and psychosocial [9]. The heterogeneous nature of clinical symptoms limits the possibility of establishing a universal treatment [21], and the current proposals need to be tested in terms of effectiveness. Specialists working with children and young people, including doctors, psychologists and speech therapists should have knowledge of the symptoms typical of ARFID, thus increasing the chance for a correct diagnosis and adapting the interventions to the needs of the individual [47].

References

1. Bryant-Waught R. Overview of diagnosis and presentation. W: Bryant-Waugh R, Higgins C, red. Avoidant restrictive food intake disorder in childhood and adolescence: a clinical guide, New York: Routledge; 2020, s. 41–52.
2. Nicely TA, Lane-Loney S, Masciulli A, Hollenbeak CS, Ornstein RM. Prevalence and characteristics of avoidant/restrictive food intake disorder in a cohort of young patients in day treatment for eating disorders. J. Eat. Disor. 2014; 2(1): 21. DOI: 10.1186/s40337-014-0021-3.
3. Thomas JJ, Lawson EA, Micali N, Misra M, Deckersbach T, Eddy KT. Avoidant/restrictive food intake disorder: a three-dimensional model of neurobiology with implications for etiology and treatment. Curr. Psychiatry Rep. 2017; 19(8): 54. DOI: 10.1007/s11920-017-0795-5.
4. Feillet F, Bocquet A, Briend A, Chouraqui JP, Darmaun D, Frelut ML i wsp. Nutritional risks of ARFID (avoidant restrictive food intake disorders) and related behavior. Arch. Pédiatr. 2019; 26(7): 437–441.
5. Brigham KS, Manzo LD, Eddy KT, Thomas JJ. Evaluation and treatment of avoidant/restrictive food disorder (ARFID) in adolescents. Curr. Pediatr. Rep. 2018; 6(2): 107–113.
6. Zickgraf H, Lane-Loney S, Essayli J, Ornstein R. Further support for diagnostically meaningful ARFID symptom presentations in an adolescents medicine partial hospitalization program. Int. J. Eat. Disord. 2019; 52(4): 402–409.
7. Norris ML, Spettigue W, Hammond NG, Katzman DK, Zucker N, Yelle K i wsp. Building evidence for the use of descriptive subtypes in youth with avoidant restrictive food intake disorder. Int. J. Eat. Disord. 2018; 51(2): 170–173.
8. Reilly EE, Brown TA, Gray EK, Kaye WH, Menzel JE. Exploring the co-occurrence of behavioural phenotypes for avoidant/restrictive food intake disorder in a partial hospitalization sample. Eur. Eat. Disord. Rev. 2019; 27(4): 429–435.
9. Davis E, Stone EL. Avoidant restrictive food intake disorder (ARFID), more than just picky eating: a case discussion and literature review. J. Nurse Pract. 2020; 16(10): 713–717.

10. Kambanis P, Kuhnle M, Wons O, Jo J, Keshishian A, Hauser K. i wsp. Prevalence and correlates of psychiatric comorbidities in children and adolescents with full and subthreshold avoidant/restrictive food intake disorder. Int. J. Eat. Disord. 2020; 53(2): 256–265.

11. Duncombe Lowe K, Barnes TL, Martell C, Keery H, Eckhardt S, Peterson CB, Lesser J, Le Grange D. Youth with Avoidant/Restrictive Food Intake Disorder: examining differences by age, weight status, and symptom duration. Nutrients 2019; 11(8): 1955. DOI: 10.3390/nu11081955.

12. Leonidas, Carolina & Souza, Ana Paula & Azevedo, Lívia & Ferreira, Isabella & Pessa, Rosane & Santos, Manoel. (2020). Emotional and feeding aspects of avoidant/restrictive food intake disorder (ARFID): a case report. Int. J. Psychiatr. 5. 21.

13. Kerry H, LeMay-Russell S, Barnes TL, Eckhardt S, Peterson CB, Lesser J i wsp. Attributes of children and adolescents with avoidant/restrictive food intake disorder. J. Eat. Disord. 2019; 7(31). DOI: 10.1186/s40337-019-0261-3

14. Becker KR, Keshishian AC, Liebman R, Coniglio KA, Wang SB, Franko DL. Impact of expanded diagnostic criteria for avoidant/restrictive food intake disorder on clinical comparisons with anorexia nervosa. Int. J. Eat. Disord. 2019; 52(3): 230–238.

15. Fisher MM, Rosen DS, Ornstein RM, Mammel KA, Katzman DK, Rome ES i wsp. Characteristics of Avoidant/Restrictive Food Intake Disorder in children and adolescents: a „new disorder" in DSM-5. J. Adol. Health 2014; 55(1): 49–52.

16. Chew CSE, Siobhan K, MClinc AB, Oh JY, Rajasegaran K, Davis C. First presentation of restrictibe early onset eating disorders in Asian children. Int. J. Eat. Disord. 2021; 54: 81–87.

17. Norris ML, Katzman DK. Change is never easy, but it is possible: reflections on Avoidant/Restrictive Food Intake Disorder two years after its introduction in the DSM-5. J. Adol. Health 2015; 57(1): 8–9.

18. Gupta R. Avoidant restrictive food intake disorder – what is it and what to do with them? J. Med. Nurs. 2021; 2(10): 1–3.

19. Micali N, Cooper-Vince CE. Aetiology and epidemiology. W: Bryant-Waugh R, Higgins C, red. Avoidant restrictive food intake disorder in childhood and adolescence: a clinical guide. New York: Routledge; 2020, s. 41–52.

20. Coglan L, Otasowie J. Avoidant/restrictive food intake disorder: What do we know so far? Brit. J. Psych. Adv. 25. 90–98. DOI. 10.1192/bja.2018.48.

21. Rachel Bryant-Waugh, Rachel Loomes, Alfonce Munuve, Charlotte Rhind, Towards an evidence-based out-patient care pathway for children and young people with avoidant restrictive food intake disorder. J. Behav. Cogn. Ther. 2021; 31(1): 15–26.

22. Gałecki P, Święcicki Ł, red. Kryteria diagnostyczne z DSM-5. Desk reference. Wrocław: Edra. Urban&Partner; 2013.

23. First M. DSM-5. Podręcznik diagnostyki różnicowej. Wrocław: Edra Urban & Partner; 2016.

24. Harshman SG. A Diet high in processed foods, total carbohydrates and added sugars, and low in vegetables and protein is characteristic of youth with avoidant/restrictive food intake disorder. Nutrients 2019; 11(9): 2013. DOI 10.3390/nu11092013.

25. Dovey TM, Kumari V, Blissett J. Eating behaviour, behavioural problems and sensory profiles of children with avoidant/restrictive food intake disorder (ARFID), autistic spectrum disorders or picky eating: Same or different? Europ. Psychiatry 2019; 61: 56–62.

26. Krom H, van der Sluijs Veer L, van Zundert S, Otten M-A, Benninga M, Haverman L i wsp. Health related quality of life of infants and children with avoidant restrictive food intake disorder. Int. J. Eat Disord. 2019; 52:.410–418.

27. Hartdorff CM, Kneepkens CM, Stok-Akerboom AM, van DijkLokkart EM, Engels MA, Kindermann A. Clinical tube weaning supported by hunger provocation in fully-tube-fed children. J. Pediatr. Gastroenterol. Nutr. 2015; 60(4): 538–543. DOI: 10.1097/MPG.0000000000000647

28. Krom H, de Winter JP, Kindermann A. Development, prevention, and treatment of feeding tube dependency. Europ. J. Pediatr. 2017; 176(6): 683–688.

29. Higgins C, Pillay P. Psychological assessment of child and family. W: Bryant-Waugh R, Higgins C, red. Avoidant restrictive food intake disorder in childhood and adolescence: a clinical guide, New York: Routledge; 2020, s. 79–86.

30. Eddy KT, Harshman SG. Becker KR, Bern E, Bryant-Waugh R, Hilbert A i wsp. Radcliffe ARFID Workgroup: Commentary on diagnosis, multi-disciplinary assessment and treatment, and directions for the field. Int. J. Eat. Disord. 2019; 52(4): 361–366.

31. Eddy KT, Thomas JJ, Hastings E, Edkins K, Lamont E, Nevins CM i wsp. Prevalence of DSM-5 avoidant/restrictive food intake disorder in a pediatric gastroenterology healthcare network. Int. J. Eat. Disord. 2015; 48(5): 464–470.

32. Dovey TM, Aldridge VK, Martin CI, Wilken M, Meyer C. Screening avoidant/restrictive food intake disorder (ARFID) in children: outcomes from utilitarian versus specialist psychometrics. Eat. Behav. 2016; 23: 162–167.

33. Sharp WG, Stubbs KH. Avoidant/restrictive food intake disorder: A diagnosis at the intersection of feeding and eating disorders necessitating subtype differentiation. Int. J. Eat. Disord. 2019; 52(4): 398–401.

34. Eckhardt S, Martell C, Duncombe Lowe K, Le Grange D, Ehrenreich-May J. An ARFID case report combining family-based treatment with the unified protocol for transdiagnostic treatment of emotional disorders in children. J. Eat. Disord. 2019; 7(1): 34.

35. Thomas JJ, Wons O, Eddy E. Cognitive-behavioral treatment of avoidant/restrictive food intake disorder. Curr. Opin. Psychiatry 2018; 31(6): 425–430.

36. Mammel KA, Ornstein RM. Avoidant/restrictive food intake disorder: a new eating disorder diagnosis in the diagnostic and statistical manual 5. Curr. Opin. Pediatr. 2017; 29(4): 407–413.

37. Zimmerman J, Fsher M. Avoidant/restrictive food intake disorder (ARFID). Curr. Probl. Pediatr. Adolesc. Health Care 2017; 47(4): 95–103. DOI: 10.1016/j.cppeds.2017.02.005.

38. Zucker NL, LaVia MC, Craske MG, Harris AA, Datta N. i wsp. Feeling and body investigators (FBI): ARFID division – an acceptance-based interoceptive exposure treatment for children with ARFID. Int. J. Eat. Disord. 2018; 52(4): 1–7.

39. Reilly E, Orloff N, Luo T, Berner L, Brown T, Claudat K. i wsp. Dialectical behavioral therapy for the treatment of adolescent eating disorders: a review of existing work and proposed future directions. Eat. Disord. 2020; 28(2): 122–141.

40. Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive-behavioural therapy: a review of meta-analyses. Clin. Psychol. Rev. 2006; 26: 17–31.

41. Southam-Gerow MA, Kendal PC. Cognitive-behaviour therapy with youth: adveqances, challenges and future directions. Clin. Psych. Psychother. 2000; 7(5): 343–366.

42. Popiel A, Pragłowska E. Psychoterapia poznawczo-behawioralna. Teoria i praktyka. Warszawa: Paradygmat; 2008.
43. Dumont E, Jansen A, Kroes D, de Haan E, Mulkens S. A new cognitive behavior therapy for adolescents with avoidant/restrictive food intake disorder in a day treatment setting: A clinical case series. Int. J. Eat. Disord. 2018; 52(4): 444–458.
44. Cassiello-Robbins C, Barlow DH, Boettcher HT, Bentley KH, Bullis JR, Ellard KK i wsp. Transdiagnostyczna terapia poznawczo-behawioralna zaburzeń emocjonalnych. Gdańsk: GWP; 2020.
45. Rosania K, Lock J. Family-based treatment for a preadolescent with avoidant/restrictive food intake disorder with sensory sensitivity: a case report. Front Psychiatry 2020; 11: 350.
46. Ziółkowska B. Zaburzenie polegające na ograniczaniu/unikaniu przyjmowania pokarmów – rozważania w świetle wyników badań. Pediatr. Pol. 2017; 92(6): 733–738.

E-mail address: dorota.zytkowska@gmail.com