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**Article:**

Waller, G. (2019) ARFID: old wine in a new bottle? Commentary on... avoidant/restrictive food intake disorder. *BJPsych Advances*, 25 (2). pp. 99-100. ISSN: 2056-4678

<https://doi.org/10.1192/bja.2018.73>

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**Commentary on: ‘Avoidant Restrictive Food Intake Disorder (ARFID): what do we know so far?’**

**Abstract**

In this commentary, some aspects of the context of this diagnosis are considered. It is suggested that A/RFID is principally a reconfiguration of existing problems. However, it is also stressed that we still need to develop treatments that help patients and their families, given the expectation that has been fuelled by the promotion of the new diagnostic scheme. In developing those therapies, we should not forget that we previously had a number of psychosocial treatment approaches that were helpful for such children when their problems were labelled differently.

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Glenn Waller is Professor of Clinical Psychology at the University of Sheffield. He has worked clinically and researched in the field of eating disorders for over 35 years. He is former President of the international Academy for Eating Disorders. He served on the NICE (2017) Eating Disorder Guideline Development Group. *(50 words)*

## Commentary

The authors address a hot topic in the field of eating disorders – how do we understand eating problems in younger people when those problems are not anorexia nervosa? The review has many educational benefits for clinicians. In particular, the guides to assessing an A/RFID diagnosis and differentiating it from anorexia nervosa are helpful, and would be well placed on the clinician's wall, to remind them what to ask when such a case presents to them. However, there are gaps, too.

The review would have benefitted from more of a history of such cases, to put this diagnostic development into context – after all, we can learn a lot from what went wrong in the past. Such cases have been known for many years, under a range of labels – selective eating, food refusal, food phobia, food avoidance emotional disorder, etc. (e.g., Bryant-Waugh et al., 2010). However, the use of such classifications was relatively rare under DSM-IV, and it was very common to find that clinicians had never heard of these labels. In short, if the diagnosis was not anorexia nervosa, few clinicians knew what to do when it came to diagnosing, managing and treating such a case. Surprisingly, few clinicians working in adult eating disorder services realised that some cases of these patterns are found in adulthood too, leaving the clinicians at a loss. Of course, the lack of awareness meant that many children and adults were not appropriately diagnosed. Given the young age of most cases, many families experienced substantial and extended distress and frustration as a result of this gap in the field.

Therefore, the DSM-5 diagnosis of A/RFID needs to be treated as more of a reconfiguration of existing knowledge than as reflecting a new entity. The main effect of A/RFID is an effort to pull three known behavioural patterns into a single diagnostic framework:

- lack of interest in food (e.g., the child who reports a chronic lack of appetite);
- limited range of sensory preferences (e.g., the child who selectively eats only white foods)

- fearful responses to food (e.g., not eating for fear of choking)

When the old labels (e.g., selective eating, food refusal, food phobia, food avoidance emotional disorder) were predominant, each of these three behavioural patterns had previously been treated successfully using largely behavioural, exposure-based methods (e.g., Nicholls et al., 2001). However, such methods were only applied when the disorders were recognised, which was far less often than should have been the case.

So, what prevented the DSM-IV and other categorisations from capturing the public imagination? Could it be as simple as not having a banner term, such as A/RFID? Quite possibly. It is also worth noting that two strongly interlinked developments appear to be key to the higher profile of A/RFID:

- greater levels of advocacy via parent/carer organisations
- social media as a mechanism for raising awareness of A/RFID

In short, we should see the emergence of A/RFID in DSM-5 as welcome opportunity to ‘relaunch’ these eating and feeding disorders of childhood, only this time with a greater chance of supporting families in seeking help (and often being able to educate clinicians).

However, there is a rather sharp twist in the tail – what ‘help’, exactly? **As the review points out, this condition is not included in established guidelines, meaning that we have a label for these cases but we are still in the early stages of developing treatments to offer the sufferers and their families (e.g., Thomas et al., 2018).**

In explaining their development of a new form of cognitive behaviour therapy (CBT) for A/RFID, Thomas and Eddy (2018) pointed out that successfully promoting the construct of A/RFID has definitely raised awareness. Particularly among parents and carers of children and adolescents, the label of ‘A/RFID’ meant that many realised that their child had a ‘proper’ problem that they could talk about with their family doctor, and the doctor had a label to use in order to make a referral onward. Previously, many of these parents would have

been told that their child's eating problem was not anorexia, so that was that – no help would be known about or forthcoming. Now, DSM-5 (and, presumably, ICD-11, which usually follows suit) are telling families and clinicians that these children have a real problem, so they want help. That is where the problem emerges – *what help?* A/RFID only emerged as a construct in 2013, and without any evidence about what to do to help. Consequently, as Thomas and Eddy (2018) point out and as is clear from this review, we are only just beginning to produce evidence about A/RFID's pathology and evidence-based treatments. Therefore, clinicians are receiving a lot of requests for help, but do not have much evidence about what to do to help these patients and their families. In short, we are still developing the treatments as we go along, and all the while there are understandably frustrated families who expect us to know what to do to help their child recover.

In many ways, this paper shows that it is the treatment recommendations that are the weakest element of this area. The guidance given under all headers is a combination of general clinical management (which would have been better as a series of simpler bullet points) and speculation about psychological therapies that are in development (which would have been better in about three years, when current innovations in CBT, Family Based Treatment and other interventions are more developed). Authors such as Fitzpatrick, Lock, Bryant-Waugh and Thomas & Eddy offer us substantial hope for such therapies, and their work on treatment for A/RFID deserves our attention over the coming years. However, we are not there yet, making this review up-to-date but frustratingly incomplete (through no fault of the authors). Having said that, there is a surprising omission from the literature covered here – what about the behavioural, exposure-based interventions that were useful for these cases before we labelled them differently? Changing the name might have been useful in promoting awareness of these cases, but that change does not mean that we have to forget the treatments that we used previously (e.g., Nicholls et al., 2001). When we bear that in mind, it becomes less supportable for these authors to conclude that we should consider using “chronic disease management models”.

So, is this simply a case of new wine in old bottles? The wine has not changed essentially – we always knew about these disorders. More positively, relaunching the wine in the new A/Rfid bottle has been successful in getting such cases identified. Frustratingly, we are still looking for the best corkscrew to open the bottle – those therapies are still in development. However, we should not forget the possibility that those old behavioural methods are effective with such cases.

#### **Declaration of interest**

The author has no financial or professional interests to consider in presenting this commentary. No financial support has been provided by any grant-awarding body or commercial organisation.

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