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Avoidant and Restrictive Food Intake Disorder (ARFID) in Children and Young People: Psychosocial Interventions

Learning From the Literature and Current Best Practice

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Outline:
We have produced this document because there are no current national guidelines for the treatment of ARFID in children and young people, and we are still awaiting the national guidance for working with children and young people with eating disorders to be refreshed. Currently there are national guidelines for adult services for people with ARFID, but these are not directly transferrable to children and young people. Commissioners and systems have been asking for more support around ARFID provision in our quarterly systems meetings.

This document aims to synthesise the literature and provide a helpful introduction to Avoidant and Restrictive Food Intake Disorder (ARFID). We present an overview of ARFID in children and young people and the current treatment approaches, as well as a good practice case study of how children and young people, and their families, are currently supported by an East of England ARFID service. Whilst the evidence base for the treatment of ARFID is still emerging and we cannot make conclusions on the comparative efficacy of interventions, we have summarised the literature and recommendations to date.

What is ARFID?

Overview

Avoidant and Restrictive Food Intake Disorder (ARFID) is an eating disorder characterised by a person being unable to meet their nutritional needs, leading to significant weight loss, nutritional deficiency, or dependency on supplements. Unlike other eating disorders, ARFID is not driven by body image concerns but by a range of factors including sensory sensitivities, a fear of negative consequences of eating, or a lack of interest in food (American Psychiatric Association, 2013). The disorder often coexists with other mental health and neurodevelopmental conditions such as anxiety, obsessive-compulsive disorder (OCD) and autism (Kambanis et al., 2020).

ARFID can manifest in childhood and persist into adulthood, impacting physical health, social functioning, and overall quality of life. ARFID usually presents in younger children than other eating disorders, symptoms can be present from the age of two or three years, but at this age it can be very hard to distinguish from more normal 'picky eating.' Individuals with ARFID may lack interest in eating or interoceptive awareness related to hunger and satiation or they may avoid food based on its sensory characteristics, such as texture, smell, or taste, leading to a highly limited diet. Additionally, some may have a fear of choking, vomiting, or gastrointestinal distress, which further restricts their food intake (Norris et al., 2016). Due to the avoidance of a broad range of foods, individuals with ARFID are at risk for developing nutritional deficiencies, which can lead to serious health complications including anaemia, weakened immune function, and delayed growth in children (Thomas & Eddy, 2019). Not all children with ARFID are underweight, some can be normal weight or overweight if their diet is restricted to carbohydrates or energy dense processed foods.

The diagnosis of ARFID involves a comprehensive assessment by healthcare professionals to rule out other medical conditions and to understand the underlying causes of the restrictive eating behaviours (see Appendix A for DSM-IV & DSM-5 criteria for ARFID; APA, 2013).

ARFID can lead to what is termed as medical emergencies in eating disorders (MEED) and death. In December 2021 Alfie Nicholls a child with autism in full time education in a special school collapsed and died as a result of severe malnutrition caused by a severely restricted diet. The coroner highlighted that the risks posed by his malnutrition were not recognised by professional until after his death and issued a prevention of future deaths notice in ensure that AFRID was better understood and recognised, and subsequently treated by those working across education, health, and social care.

How Does ARFID Present in Children and Young People?

ARFID is increasingly recognised in clinical settings, particularly among children and adolescents. Studies suggest that ARFID may be relatively common, with prevalence rates ranging from 5% to 14% in paediatric eating disorder services (Norris et al., 2016).

Three broad groups of children and young people with ARFID

Emerging evidence suggests that there are three broad groups of children and young people with ARFID:

1. **Lack of Interest:** Some children with ARFID show a general disinterest in food and eating, which can be mistaken for picky eating but is more severe and persistent (APA, 2013).
2. **Sensory-Based Avoidance:** The young person might avoid certain foods due to their texture, taste, smell, or appearance, resulting in a limited variety of accepted foods (Kambanis et al., 2020).
3. **Concern of Aversive Consequences:** There may be a profound fear of choking, vomiting, or experiencing gastrointestinal distress, which leads to food avoidance (Thomas et al., 2017).

Signs that may be noticed by parents, nursery workers, Early Years Practitioners, or schools:

- Very few accepted foods, typically less than 10 foods.
- The foods are mainly dry carbohydrates: biscuits, crisps, cakes, cereals, toast.
- Accepted foods may be brand and flavour specific e.g. pom bear crisps only.
- Mixed, wet, and ‘slimy’ foods will be avoided and found disgusting – such as most fruit and vegetables.
- New foods will be refused on sight and when offered will result in disgust or anxiety.
- Refusal is based on the sensory properties of the food: the taste, smell, appearance, and texture.
- Refusal is not just based on dislike; it is a strong fear or disgust response.
- The child may struggle to be around food or others eating.
- The food difficulties have a significant impact on family life and the child’s ability to access social opportunities.
- The child may not be growing as expected for their age or suffer from significant lack of energy.

Concerns in younger children should be discussed with the GP with a request for support from either the health visitor or paediatrician. A referral can also be made to a specialist eating disorders service.

With thanks to NHS Lancashire and South Cumbria Integrated Care Board and ARFID AWARENESS UK: ‘When is it not just fussy eating? A booklet for Early Years Provision’ and ‘When is it not just fussy eating? A booklet for Primary Schools.’ RESOURCES | ARFID Awareness UK

ARFID and Neurodiversity

ARFID has been identified as more prevalent in younger children, especially those with co-occurring conditions such as autism and attention-deficit/hyperactivity disorder (ADHD) (Kambanis et al., 2020). Children with autism might experience heightened sensory sensitivities, making certain textures or flavours overwhelmingly unpleasant, which can lead to food avoidance (Kuschner et al., 2015). Similarly, people with ADHD may experience difficulties with appetite regulation or heightened anxiety around eating, contributing to restrictive eating patterns (Fisher & Duncanson, 2020). Traditional methods of treating eating disorders may not always be effective for those with neurodevelopmental disorders, as they might not address the underlying sensory processing or executive functioning differences which influence symptoms (Field et al., 2023).

The Impact of ARFID on Children, Young People, and Their Families

ARFID has profound and multifaceted impacts on children, young people, and their families. The disorder can significantly affect physical and emotional well-being, the family system and can limit social interactions.

Impact on physical health

Children and adolescents with ARFID often experience serious health consequences due to inadequate nutritional intake. This can lead to significant weight loss, failure to grow or gain weight as expected for their age, and nutritional deficiencies (Norris et al., 2016). Common deficiencies include iron, zinc, and vitamins, which can result in conditions like anaemia, weakened immune function, and impaired cognitive and physical development (Bryant-Waugh, 2019; Norris et al., 2016). These health issues can be severe enough to necessitate medical interventions, including hospitalisation for nutritional rehabilitation (Bryant-Waugh, 2019).

Emotional and psychological impact

The psychological impact of ARFID on young people includes heightened anxiety around eating, leading to distress and avoidance behaviours (Thomas et al., 2017). The persistent fear of choking or vomiting can exacerbate anxiety, creating a vicious cycle of avoidance and nutritional deficiency. In a sample of 74 children and young people with ARFID, 54% met criteria for a current comorbid psychiatric diagnosis (Kambanis et al., 2020). The disorder can co-occur with anxiety disorders, autism spectrum disorders, and obsessive-compulsive disorder, compounding the emotional challenges faced by affected individuals (Kambanis et al., 2020).

Family and social impact

The impact of ARFID extends to the family unit, where meal preparation and eating can become a significant source of tension and stress. Parents and caregivers often experience anxiety and frustration as they struggle to ensure their child meets their nutritional needs (Fisher et al., 2014). The constant worry about their child’s health and the need to prepare special meals can strain family relationships and dynamics. Additionally, siblings may feel neglected or resentful due to the disproportionate attention given to the child with ARFID.

Family routines and activities can also be disrupted, as the family's social life may revolve around accommodating the child's eating issues (Bryant-Waugh, 2019).
ARFID can severely limit social interactions for children and adolescents. Mealtimes, which are often social events, can become sources of stress and embarrassment, leading to social withdrawal and isolation (Nicely et al., 2014).

Current Challenges in Supporting Children and Young People With ARFID?

Supporting children and young people with Avoidant and Restrictive Food Intake Disorder (ARFID) presents numerous challenges. These challenges span across diagnostic complexities, treatment approaches, and the broader psychosocial impacts on both individuals and their families.

Lack of societal awareness

The lack of societal awareness around ARFID often leads to misconceptions and myths, such as confusing it with mere picky eating or attributing it to poor parenting (Lackner et al., 2019). Unlike selective eating, ARFID is a complex psychological disorder characterised by severe food aversions and anxiety that can significantly impair an individual's nutritional intake and overall health (NICE, 2022). These misunderstandings stem from a general lack of education about ARFID and can result in the underdiagnosis of ARFID (Katzman et al., 2014; Norris et al., 2015).

Access to care

Access to appropriate care and resources is another major challenge. Many regions lack specialist services for ARFID, and families may need to travel long distances to receive proper care (Fisher et al., 2014). Many families face long wait times for specialist services, and there are a limited number of clinicians trained in ARFID-specific treatments (Bryant-Waugh, 2019).

Diagnostic challenges

One of the primary challenges in supporting children and young people with ARFID is accurate and timely diagnosis. ARFID can be difficult to distinguish from other eating disorders and picky eating, especially in younger children. This complexity is compounded by a lack of awareness and understanding among healthcare professionals, leading to underdiagnosis or misdiagnosis (Norris et al., 2016). The overlap of ARFID with other conditions, such as autism spectrum disorder and anxiety disorders, further complicates the diagnostic process (Kambanis et al., 2020).

Treatment challenges

Treatment for ARFID requires a multifaceted approach, often involving medical, nutritional, and psychological interventions. However, there is a lack of standardised treatment protocols and limited research on effective interventions specifically tailored for ARFID (Fisher et al., 2014). Cognitive-behavioural therapy (CBT) and family-based interventions show promise, but access to specialist care remains a significant barrier.

Policy Recommendations

There are currently no policy recommendations specific to ARFID in children. A framework for good practice in delivering support to adults and older adults with ARFID have been issued by NHS England. They recommend the following potential treatments for adults:

- Cognitive behavioural therapy
- Sensory Desensitization
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Enhanced psychoeducation
- Food chaining
- Food exposure
- Habit acquisition training.

The document also includes a self-assessment tool to help adult services develop, evaluate, and deliver services for people with ARFID.

The Royal College of Psychiatrists (RCPsych) established a peer-review Quality Improvement Network for Community Eating Disorder Services for Children, Young People, and their Families. Here is an overview of the RCPsych standards for intervention and care for children and young people accessing community eating disorder services (Scudder et al., 2023):

- **Involvement in Care Planning**: Young people and their parents/carers, with consent, must be actively engaged in decision-making and care planning. This involves creating a detailed written care plan that includes goals, strategies, and review dates.
- **Collaborative Medication Management**: Medication decisions should be collaborative, with clear goals and risks discussed. Regular reviews of medication efficacy, safety, and side effects are essential, with annual audits of medication use. For those on antipsychotics, regular monitoring is required from eating disorders services for at least the first 12 months until this can be managed within primary care.
- **Support and Self-Help**: Young people should receive guidance on healthy eating and lifestyle choices, self-help approaches, and use of social media. Access to peer support and structured activities like volunteering or education is encouraged.
- **Engagement of Parents/Carers**: Parents/carers should be involved in care decisions and supported with information and access to support networks and carers groups.
- **Routine Outcome Measurement:** Routine outcome measurement is essential. Data on clinical outcomes and progress against user-defined goals is collected at assessment, six months, 12 months, and annually until discharge. This data is reviewed with the young person to track progress and inform care.

Furthermore, in 2019, NHS England developed guidance for adult eating disorder services to support the delivery of community eating disorder services to reduce admissions, length-of-stay and improve outcomes for users, families and carers. The guidance emphasised the value of smooth transitions between young adults transitioning from CAMHS eating disorder services to adult services.

Interventions

At present, there is no NICE guidance for treating ARFID. A systematic review by Willmott et al. (2024) identified the following psychological interventions for ARFID: behavioural interventions, cognitive behavioural interventions, and family interventions to address both the physical and psychological aspects of the disorder. Further treatments include current nutritional rehabilitation and occupational therapy. Due to the limited evidence base for treating ARFID, it is not possible to compare the efficacy of interventions nor suggest which may be the most effective. Willmott et al. (2024) recommend using psychological formulation to guide intervention.

Behavioural interventions

Behavioural interventions have been identified as the most common psychosocial treatment option for children and young people aged from two to 15 with ARFID (Willmott et al., 2024). Behavioural approaches focused on reinforcement strategies. For example, reward-based also known as contingent reinforcement whereby participants are given rewards for overcoming ARFID behaviours or eating food. Differential reinforcement was also a common approach, this is when participants were praised and given attention for their progress and less desirable behaviours were ignored. These behavioural approaches aimed to provide parents with skills to deliver therapeutic modelling and were provided with feedback on their behaviours to support their child's eating.

Cognitive behavioural interventions

Cognitive behavioural interventions involve a range of techniques which focus on modifying thinking and behaviours towards eating. For example, this may include exploring and challenging thoughts about eating and food, overcoming fears, eating avoided foods, and managing anxiety. Research studies investigating cognitive behavioural interventions recruited participants aged ten and above. Manualised Cognitive Behaviour Therapy treatment (CBT-AR; Thomas et al., 2020) includes 20 to 30 sessions on: psychoeducation about ARFID and early change for improving eating behaviours; treatment planning for continued psychoeducation and selecting novel foods to try in treatment; addressing maintaining mechanisms (e.g. engaging in strategies such as exposure to avoided foods); and focusing on relapse prevention in the final phase.

Family interventions

Family-based interventions are often necessary to support not only the child but also the parents and siblings in managing the disorder and its wide-reaching effects. Most studies which employed family interventions used Family-Based Treatment (FBT) adapted for ARFID (FBT-ARFID; Lock et al., 2019). FBT-ARFID involves externalisation by separating the illness from the patient to reduce guilt and blame, highlighting the serious health and developmental risks if left untreated, and empowering parents as primary agents of change. Rather than imposing directive interventions, this approach supports parental decision-making, focusing on practical behavioural strategies to alter dysfunctional eating patterns (Lock & Le Grange, 2013).

Several studies used Multi-Family Therapy (MFT) for treating ARFID. MFT for ARFID involves multiple families participating in joint therapy sessions. MFT may include role-playing exercises where parents practice responding to their child's food refusal and structured meal sessions where families eat together under the guidance of a therapist to model positive eating behaviours. Additionally, families may engage in group discussions to share challenges and solutions and participate in exposure exercises where children gradually try new foods in a supportive, non-pressured environment (Fisher & Duncanson, 2020).

Nutritional rehabilitation

Nutritional rehabilitation in ARFID focuses on gradually increasing the variety and quantity of foods consumed to address nutritional deficiencies and support healthy growth (Cucinotta et al., 2023). Many children with ARFID may rely on nutritional supplements or tube feeding to meet their dietary needs (Bryant-Waugh, 2019). Research has found that those requiring tube feeding, who refuse or cannot take in meals and supplements orally due to physical complications e.g. vomiting, had more rigid behavioural elements to their food refusal, required longer-term behavioural interventions and longer hospital stays (Maginot et al., 2017; Strandjord et al., 2015). Diet plans often begin with the introduction of familiar foods with similar textures to those already tolerated, gradually expanding to new foods through exposure therapy. Nutritional rehabilitation also includes monitoring calorie intake and addressing specific deficiencies, such as supplementing with vitamins or minerals as needed (Thomas et al., 2017).

Occupational therapy

Occupational therapy (OT) in ARFID focuses on addressing sensory sensitivities and improving feeding skills to expand food variety. Therapists work with patients to desensitise them to textures, tastes and smells that cause aversion (Willman et al., 2024). For instance, a therapist might introduce a child to different food textures gradually, starting with foods that are similar in texture to those the child already tolerates (Willman et al., 2024). OT may also involve strategies like play-based activities to reduce anxiety around eating or using adaptive equipment to improve the physical act of eating (Kuschner et al., 2015).

Measuring Outcomes

Willmott et al. (2024) found little consistency in measuring outcomes across 50 intervention studies for treating ARFID. The most common outcome measure was physical health, particularly changes in weight, though this may not always be relevant as ARFID can affect individuals across the weight spectrum. Nutritional changes, such as calorie intake or variety in diet, were also frequently measured. Some studies used validated psychological measures, but outcomes were often tailored to individual patient goals. The lack of standardised measures reflects ARFID's broad and heterogeneous nature. This poses a problem for comparing and determining effective treatments and highlights a need for consensus.

Table 1 presents the most commonly used measures of feeding behaviours, ARFID, mental health and physical health for children and young people within ARFID research and services.

Table 1. Outcome measures used in ARFID research studies and services.

Measure	Summary
The Behavioural Paediatric Feeding Assessment Scale (BPFAS) (Crist & Napier-Phillips, 2001)	The BPFAS (32 items) is a measure of feeding issues in young children from the perspective of the parent. The BPFAS has two sections: one measures the frequency of specific feeding behaviours in children, and the other assesses parents' strategies and stress levels.
Nine-Item ARFID Screen (NIAS) (Burton Murray et al. 2021)	The NIAS is a 9-item self-report measure which assesses avoidant and restrictive eating. The three subscales include picky eating for sensory aversion to food, an appetite subscale for lack of interest in eating, and the fear subscale for concern of aversive consequences.
The Pica, ARFID, and Rumination Disorder Interview ARFID Questionnaire (PARDI-AR-Q) (Bryant- Waugh et al., 2018)	The PARDI-AR-Q is a 32-item measure of ARFID which indicates a likely diagnosis of ARFID, it measures the severity of ARFID, the level of sensory-based avoidance, lack of interest and concern about aversive consequences. There are two versions of the questionnaire for individuals aged 14+ and for parents to complete with a child aged 4+.
The Revised Children's Anxiety and Depression Scale (RCADS) (Chorpita et al., 2000)	The RCADS short-form (25-items) and long version (47-items) identify depression, anxiety, panic disorder, separation anxiety disorder, social phobia and obsessive-compulsive disorder in children and young people. It is completed by children and their parents.
The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001)	The SDQ is a 25-item emotional and behavioural screening questionnaire for children and young people from the perspectives of children, their parents, and teachers. It includes the following five subscales: 1) emotional symptoms; 2) conduct problems; 3) hyperactivity/ inattention; 4) peer relationships problems; 5) prosocial behaviour.
Weight-For-Height (WFH)	WFH compares a child's weight to their height, providing an indicator of whether the child's weight is appropriate for their height. This measure helps clinicians identify undernutrition or reduced growth.

Psychological Formulation

A variety of psychosocial interventions can be used to support patients with ARFID, adaptable to different settings and presentations. However, due to limited evidence and the lack of practice guidelines specific to ARFID, the relative effectiveness of these interventions remains unclear (Willmott et al. 2024). Clinicians should rely on psychological formulation to choose the most appropriate methods and employ a multidisciplinary approach (Bryant-Waugh et al., 2021; Hay, 2020). Key considerations include the patient's demographics, physical or nutritional risks, psychosocial impacts, comorbid conditions, and personal goals. It is important to measure outcomes during treatment, using validated measures relevant to ARFID and broader psychological issues. Treatment goals should be tailored to each patient and clinicians should also evaluate patient and family satisfaction.

Good Practice Case Study

The Norfolk and Waveney Under 18s ARFID Service

The Norfolk and Waveney under 18s ARFID service was launched in April 2023. The service has been developed based on the emerging evidence base for ARFID, including learning from other ARFID teams that have been developed around the country (e.g. the Maudsley). The treatment pathway is based on the Thrive model with a stepped care approach dependent on the level of need (see diagram). As an initial step, a service user may be signposted to other appropriate services at the point of referral or assessment (Getting advice). If a service user is assessed and accepted into the service, they will be offered the parent/carer group (Getting help) which is a 12-week psycho-educational programme designed to educate and support parents to start to make changes with their child. For some young people, this allows enough improvement, and they could be discharged. For other young people, they require more individualised support as well as the psychoeducational group (Getting more help). This may be in the form of CBT, family therapy, occupational therapy, dietetics, or a combination of any of these, depending on need. Getting help and getting more help may overlap depending on need. For those who are identified as high risk at referral, the offer will remain the same but with extra consideration of joint assessments and liaison with other teams, medical/physical health responsibility and care planning approach.

An example of a case where the ARFID team has supported a positive outcome is that of an 11-year-old girl. She presented with a lack of interest in food (poor interoceptive awareness), anxiety leading to being physically sensitive to ‘feeling sick’ and eating a limited range of foods due to ‘textures’ (would eat less than 10 foods, brand specific). This led to poor food intake and low WFH (85%), limited social opportunities, e.g. attending parties, eating out, and having to stop gymnastics due to low energy. She had previously had support to manage generalised anxiety to good effect. In the ARFID team, she was offered the parent/carers group, plus individualised dietetic and occupational therapy input. Intervention focused on establishing regular eating, including energy dense foods, and increasing the variety and quantity of foods, through teaching techniques such as distraction, re-focusing attention away from how her stomach feels and understanding her needs for the environment for eating. Returning to gymnastics was a motivator for her and a later goal was wanting to eat with friends. This young person established a nutritionally balanced regular eating pattern with an increased variety and amount, she grew 4cm, and her energy levels increased. She was able to eat out, socialise and get back to gymnastics. Additionally, her Mum felt less anxious and noticed that she was more emotionally regulated.

There were many considerations and challenges in developing an ARFID service in Norfolk. These included that the evidence base is still emerging and as such ARFID teams vary in their design and offer across the country. ARFID is a diagnosis that is heterogeneous, it has broad and complex aetiologies which interplay and are still not widely understood. There are high numbers of referrals often with minimal information, the expectations from stakeholders and families are vast due to historical and current gaps in provision. Significant gaps in service provisions, such as neurodevelopmental diagnostic services, impact on timely and effective intervention. The need to establish shared care pathways is impacted by delays in other services e.g. CAMHS, Paediatrics, Speech, and Language Therapies. Therefore, many pathways between services need developing thus co-ordinating care is currently labour intensive.

Since the service was launched, there have been actions taken to raise and/or manage these challenges where possible, for example, training for internal and external teams, funding for additional training for the ARFID team, communicating gaps in commissioned clinical resource provision to the ICB, re-defining inclusion criteria based on ongoing learning and provision, and liaising with other services to develop shared care pathways.
With thanks to Dr Katherine Harvey, Principal Clinical Psychologist, and Rachel Wood, Senior Cognitive Behavioural Therapist from the Norfolk and Waveney Under 18s ARFID Service.

Useful Links and Resources:

ARFID Awareness UK

ARFID - Avoidant/Restrictive Food Intake Disorder

Cambridgeshire and Peterborough Children's Nutrition and Dietetics – videos under fussy or selective eating.

Support for Avoidant Restrictive Food Intake Disorder (ARFID) - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Professional support for services working with Avoidant Restrictive Food Intake Disorder (ARFID) - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Featured resources - MCCAED – Maudsley Centre for Child and Adolescent Eating Disorders, ARFID assessment tools and resources.

https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/avoidant-restrictive-food-intake-disorder-(arfid) – Royal College of Psychiatry Guidance on ARFID.

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Appendices

Appendix A: DSM-5 ARFID

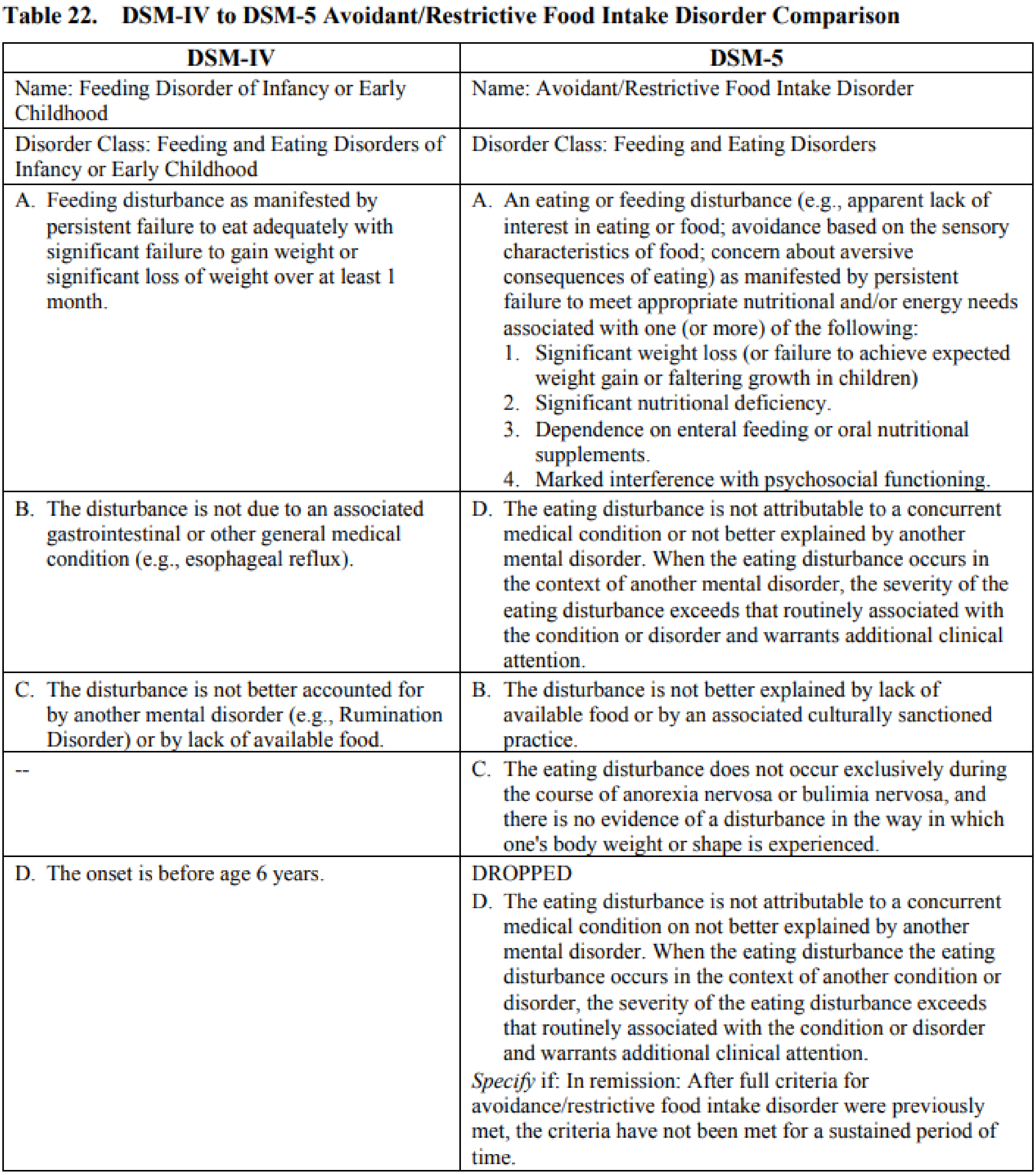

Table 22. DSM-IV to DSM-5 Avoidant/Restrictive Food Intake Disorder Comparison

DSM-IV	DSM-5
Name: Feeding Disorder of Infancy or Early Childhood	Name: Avoidant/Restrictive Food Intake Disorder
Disorder Class: Feeding and Eating Disorders of Infancy or Early Childhood	Disorder Class: Feeding and Eating Disorders
A. Feeding disturbance as manifested by persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least 1 month.	A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) 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 failure to achieve expected weight gain or faltering growth in children) 2. Significant nutritional deficiency. 3. Dependence on enteral feeding or oral nutritional supplements. 4. Marked interference with psychosocial functioning.
B. The disturbance is not due to an associated gastrointestinal or other general medical condition (e.g., esophageal reflux).	D. 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 mental disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
C. The disturbance is not better accounted for by another mental disorder (e.g., Rumination Disorder) or by lack of available food.	B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
--	C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
D. The onset is before age 6 years.	DROPPED D. The eating disturbance is not attributable to a concurrent medical condition on not better explained by another mental disorder. When the eating disturbance 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 attention. *Specify* if: In remission: After full criteria for avoidance/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.