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ARFID- What is it?

Michael F Shaughnessy* and Tammy-Lynne Moore

Eastern New Mexico University Portales, New Mexico

ABSTRACT

On occasion, a new syndrome or diagnosis appears, and there is plentiful research to support it. However, on occasion, a tangential or strange compilation of behaviors and emotions appears that is somewhat strange and esoteric. These conditions then appear in the Diagnostic and Statistical Manual and are readily accepted by some and questioned by others. This paper will attempt to review this syndrome or condition and examine and explore the elements of this diagnosis.

***Corresponding author**

Michael F. Shaughnessy, Eastern New Mexico University Portales, New Mexico.

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Avoidant/Restrictive Food Intake Disorder (ARFID) appeared in the Diagnostic and Statistical Manual of the APA in 2013. It is located on pages 337-338 and this paper will cursorily review this condition and its elements and question whether or not this condition really occurs.

Apparently, this condition limits the food intake of an individual but is not caused by poor self-esteem or self- concept or self-worth. The client does not want to change or modify their body weight.

There apparently is some fear and or anxiety about food or more specifically the consequences of eating. Choking seems to be a factor in some cases.

Apparently, ARFID can cause an individual to
- Experience some anxiety about the consequences of eating. They may fear vomiting or actually choking on food.
- This may result in the individual losing all interest in eating.
- In some cases, they may attempt to avoid certain specific foods due to their color or taste or smell or texture.

Sometimes ARFID is referred to as a "selective eating disorder". A child may choose to eat only certain things- for example mashed potatoes. Another behavior seen in this realm is the client/patient will prefer to eat their food in a very specific order.

There may be certain specific signs and symptoms such as:
- A significant weight loss or constipation.
- Low body temperature and or lethargy.
- There may be feelings of dizziness or nausea or a feeling of pending fainting.
- Muscle weakness may be seen as the person may be neglecting nutrient rich foods

In terms of behavior, according to DSM and other sources- the person may:
- Limit how much food is consumed or only eat very specific foods that have certain textures or colors
- Cognitively they may express a fear of what could occur following their mean like vomiting or choking or something similar. On occasion the "finicky" eating gets more problematic, and parents become concerned. There may be irrational thoughts or cognitions that certain foods may harm the human body.
- Emotionally, there appear to be emotional feelings such as anxiety and fear and trepidation. This condition is most often found in children and there seems to be an early traumatic event that revolves around food- such as a parent force feeding a child or perhaps food insecurity or an episode of choking.
- In some instances, the child may have eaten something that they were allergic to and had a very bad reaction. Peanut allergies seem to be more and more common.
- There are medical concerns such as dehydration, anemia, malnutrition- as parents may not notice the strange eating behavior and low blood pressure. There may be changes to one's physical growth and the child appears "stunted"
- There are some medications that can be used to stimulate the appetite of the child.

The Diagnostic Criteria on page 334 indicate:
A An eating or feeding disturbance 9 e.g. apparent lack of interest in eating or food, avoidance based on the sensory characteristics of food, concern about aversive consequences) as manifested by persistent failure to meet appropriate nutritional and or energy needs associated with one (or more of the following)

1Significant weight loss (or failure to achieve expected weight gain or falering growth in children 0

2Significant nutritional deficiency

3Dependence on enteral feeding oe oral nutritional supplements

4Marked interference with psychosocial functioning

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 eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. While the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinerly associated with the condition or disorder and warrants additional clinical attention (p 334-338)

In general, cognitive behavior therapy is suggested to examine the irrational or illogical beliefs that the child/adolescent/adult may hold.

Below is a case study of the second author who has graciously shared her experience with this condition.

Case Study

The DSM-V states that an ARFID diagnosis cannot be made when symptoms are better explained by a concurrent medical diagnosis. The first half of this case study illustrates such a situation. The second half, however, once recovery from the medical condition began, would have met criteria for ARFID.

I (the second author) was first diagnosed with gastroparesis when I was about 15. When I ate, most food did not make it into my stomach because the valve between my esophagus and stomach wasn't opening. I ended up vomiting it back up no matter how hard I tried not to.

What did make it into my stomach, mostly just rotted because the exit valve from my stomach into my intestines was not opening.

After an upper GI series, barium swallow, and host of other tests, the gastroenterologist prescribed Domperidone and after a few months, my valves seemed to reset, opening and closing when they should. Another mild flare-up happened 3 years later and then nothing until April 2018. I was 41 at that time.

For the next 10 weeks, I did not eat. Not really. My stomach was so seized up that I had trouble keeping water down. The GI Specialist I saw when I was 15 had long since retired, so I found a new one. He was progressive. More tests, including a "Smart pill study" that tracked the length of time it took for the pill to travel from my mouth through my entire GI tract.

He prescribed Zofran to help with the nausea, and I regularly went into the clinic to get IV fluids to combat the perpetual dehydration that came with vomiting and limited liquid intake.

I had to take water in small sips.

I could not eat solid foods.

Soup was done a few teaspoons at a time with breaks of 10 minutes or more between each 3-4 teaspoon serving. Twelve teaspoons was the maximum I could do for at least 4-6 hours. I discovered an ice cream, which no longer exists now, made for people with digestive difficulties by an athlete who ended up in an accident and was looking for a way to still get the nutrients needed in a form that was actually palatable. That also helped. I had trouble swallowing so the frozen state forced me eat slowly and just tiny bits of liquid with protein and vitamins and undoubtedly other stuff, could trickle into my stomach.

I was back on Domperidone – a small feat in and of itself in the U. S., getting regular EKGs to make sure it was not affecting my heart.

I was on medications for constipation and slow motility, so when I was not throwing up, I often had severe bouts of diarrhea. I was afraid to eat and drink. I had vomited so much that I had esophageal tears. As if vomiting what I just ate or drank was not bad enough, I occasionally threw up small amounts of blood.

I was scared. I was tired.

The GI specialist kept trying different treatments, different tests and I was wasting away to nothing.
I could not work and had to go on long-term disability. I went from 165 lbs to 114 lbs in 10 weeks, which works out to losing an average of 5 lbs per week, 20 lbs per month.

I never felt hungry, and if I am being honest, I am grateful for that – the pain and discomfort from everything else was bad enough – I didn't need hunger pangs thrown on top.

My GI Specialist was honest with me. He said he was out of ideas and wanted to refer me for gastric bypass surgery in Dallas. He informed me the stomach was not considered an essential organ.

Or, he could send me to the Mayo clinic.

Researching is second nature for me.

I looked at what the Mayo clinic would want to do and which one my health insurance would cover (Arizona), the amount I was looking at for travel, and I decided that whatever tests I could get done in Texas that Mayo wanted, would save me money and the amount of time I'd have to be in Arizona.

That led me to finding a GI Specialist who was an expert in gastroparesis and other slow motility illnesses. More tests, and eventually, a second diagnosis of Cyclic Vomiting Syndrome (CVS), which is tied to migraines, but not the same as abdominal migraines. He added Doxepin to my meds after Amytriptaline was making me too lethargic. Eventually, I was titrated up to a dosage that stopped the vomiting cycle.

I was able to return to work in August, 16 weeks after the ordeal began, no longer a size 14/16 but a mere size 0, sometimes a 2. And so began the phase where an ARFID diagnosis could have been made.

While the vomiting stopped, my appetite didn't come back. I didn't ever feel hungry and had to set reminders to eat. I continued with the ice cream.

I also had very small amounts of yogurt, which was something I relied on when I was sick as well. A couple of teaspoons did the job. I continued with powdered peanut butter because I could control the thickness so I could swallow it and get protein, but at a much thinner consistency.

People who cared about me remained concerned, regularly told me I needed to eat. Over that16 weeks, I tried to explain that

I just couldn't. I was invited out to lunches and dinners. I was grateful for the opportunity to socialize, but I made everyone I was with uncomfortable because I could not eat and they felt bad for eating in front of me. I tried to explain that it did not bother me, that food looked no different than if they were eating paper. I had no longing for it, I did not miss it, I didn't want it. I longed however, for the social interactions, the connections with people.

When I was finally recovering, people didn't understand that every time I ate, I wondered if the food was going to come back, if the vomiting was going to start, and if it did, how long would it be before it ended again. They did not understand why I continued just interesting liquids and soft foods instead of jumping into solids.

If I told the truth – part of the allure of eating soft foods was that they went down easy; likewise, if it came back up, it did so much easier than solids and lessened the likelihood of esophageal tears – I got looks of sympathy and pity, which just made me uncomfortable and once again, disconnected.

The only thing that could allay those fears was time and repeated successful experiences with eating. It was slow. Introducing back more foods was very gradual and it was the same with quantities. It wasn't until a year or more after I returned to work before I was able to eat 'normally' – meals instead of just snacks, a whole cup of yogurt instead of counting teaspoons, and actually feeling hungry, wanting to eat, and not forgetting that it was necessary.

Today, I eat like anyone else and I've put more weight back on than I should have and I'm okay with that.

The fear of another flare up still lingers in the back of my mind. I'm very aware of how my body responds when I eat, and I adjust accordingly.

Today, I get hungry, I crave foods, and I enjoy the many flavors and textures of food. While there are still shadows of the trepidation for eating and fear of vomiting, it no longer holds me back from eating and drinking. My intake is no longer restricted, and an ARFID diagnosis today, would not apply.

Summary and Conclusions

This brief paper has examined ARFID (Avoidance / Restrictive Food Intake Disorder307. 59) a condition described in the DSM-5th Edition (see pages 334-338) and has attempted to provide a brief overview of the condition. A case study of sorts by the second author provides some insight into the severity of this condition. While it may not fit the exact specifications of DSM-5, it certainly provides some insight into the eating difficulties/disorders that some individuals experience in life in this realm.

References

1. (2013) Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Washington DC. American Psychiatric Association.