Brief report

A case report on avoidant restrictive food intake disorder in an adolescent female

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Abstract

Avoidant restrictive food intake disorder as introduced in the DSM 5, is an eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional and/or energy needs, associated with significant loss of body weight and nutritional deficiencies. The disorder should not occur during the course of anorexia or bulimia nervosa. We describe a 14-year old adolescent girl who presented with clinical features that met the above criteria, and discuss the diagnostic and management challenges, which occurred during the course of therapy. This case report outlines how the management of this presentation differs from that of a classical eating disorder.

Key words: eating disorder, anorexia nervosa, avoidant restrictive food intake disorder

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Case history

N. was a 14-year old school girl who was studying in grade 9. She presented to child and adolescent services with a history of headache and severe weight loss of nine months duration. Her headache had started gradually and progressed, leading to interruption of daily routines and education. At the same time, she started refusing food, claiming that she disliked the taste of the food, even though her appetite was normal. There was no objective evidence of body image distortion such as repeated mirror gazing or frequent weighing, or a desire to be thin. She did not report weight reducing strategies such as binging, purging or excessive exercises. During the latter part of the illness, the food refusals were also manifested when she was angry, as well as to gain attention of her parents. Her parents were submissive, gave in to most of her demands, but also criticized her food habits frequently. By nature Miss N. was a perfectionist, meticulous teenager with excellent grades. Whenever examinations neared, she preferred to study continuously without attending school until she felt confident. She had few close friends, but tended to be reserved – she did not easily share her worries or concerns with parents or friends. At times of difficulties, she preferred to withdraw or even deny conflicts.

N. did not report negative cognitions suggestive of depression, such as helplessness, worthlessness, hopelessness or suicidal ideas. She preserved interest in her daily activities even though she did not have the physical strength to perform them. The diagnosis of a body image disorder was also unlikely since there were no preoccupations with a particular body part, and no body image distortion. There were no associated features such as excessive mirror gazing or other health consulting behaviors to change any perceived body distortions. She did not have intrusive, distressing and repugnant thoughts of food – for example, of food being contaminated – suggestive of obsessive compulsive disorder. There were no compulsions. There were no phobic or psychotic features. There were no associated neurological symptoms or signs, and no history of fever or loss of appetite.

Physical examination and investigations

Her physical examination revealed a body mass index of 10.7, which was significantly low; her height was 164 cm and weight was 28.8 kg. There was lanugo with carotinaemia. There were no specific signs such as Russell's sign or evidence of perimylolysis. Her muscle mass was reduced, with evidence of cold intolerance and dehydration.The biochemical, radiological, hormonal and metabolic parameters were normal except for the fact that she developed hypophosphataemia during the course of re-feeding. Multiple medical investigations which had been done prior to presentation to mental health services, including MRI brain, were also normal.

Diagnosis

N. was diagnosed to be suffering from avoidant/ restrictive food intake disorder. Features supporting this diagnosis were that she had a feeding disturbance characterized lack of interest in food, and a distaste of food based on the sensory characteristics of the food, together with a failure to meet appropriate nutritional and energy needs; this resulted in a significant weight loss and a requirement for enteral feeding. This disturbance did not occur as a part of anorexia or bulimia.

Principles of management

Re-feeding was commenced initially at the intensive care unit, in liaison with the pediatric team and nutrition

medical officers. The total calorie requirement was 2500 kcal per day. Feeding was done orally as well as via a nasogastric tube.

Cognitive therapy – i.e., rethinking was considered a challenge, since the patient did not report any body image distortion. The main aim of therapy was to build up a satisfactory therapeutic alliance and to provide psycho-education regarding the effects of starvation and promotion of a healthier life style. Gradual exposure to avoided food was carried out. Body mass index was measured weekly until it was within the normal range.

N.'s parents were given the responsibility of supervising meal times. Extensive, repeated family meetings were held, to explore family dynamics and intervene regarding possible maintenance factors. The main focus was to regulate negative emotions inside the family and to explore with more healthy ways of coping as a unit. Attempts were also made to modify N's perfectionist traits using cognitive reconstruction. Coping mechanisms and healthy ways of coping were also explored and further discussed.

Discussion

According to DSM-5, a person with a classical eating disorder such as anorexia nervosa would have restriction of energy intake leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health, together with an intense fear of gaining weight or becoming fat, even though underweight; and there will be disturbance in the way in which one's body weight or shape is experienced (1). But N. had neither body image distortion nor a desire to be thin.

This indicated a diagnosis of avoidant restrictive food intake disorder, with an eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs and significant nutritional deficiency, leading to dependence on enteral feeding or oral nutritional supplements and marked interference with psychosocial functioning (1).

With regards etiology, N. had several predisposing factors, namely temperamental factors such as perfectionist traits, and enmeshed family background with submissive parenting. Anxiety associated with impending examinations was a likely precipitating factor. Maintaining factors were refusal of feeds, poor coping mechanisms, temperamental factors, family enmeshment, criticism towards her eating habits and not having confiding peer /sibling relationships. It should be noted however that these factors are not specific to avoidant restrictive food intake disorder, but can be associated with anorexia nervosa as well (2).

While there are no elaborated etiological formulations or detailed guidelines on management principles of avoidant restrictive food intake disorder, general principles applicable for treatment of all eating disorders could be used (3). These management principles include having a person-centered approach and treatment in the least restrictive setting, ideally as an outpatient unless there are specific contraindications. Involvement of the family and significant others are also a key aspect of management, and should include informed treatment as appropriate for a recovery-oriented practice. These management strategies require the input of a multidisciplinary team, incorporating medical and psychiatric personal and dieticians. Moreover, the care should be transferred in a stepped and seamless manner between the many teams involved as well as the many treatment settings. Finally, a dimensional and culturally informed approach to diagnosis and treatment is a must (3, 4). In avoidant restrictive food intake disorder, the management should also be symptomatic – aimed at restoring weight and correcting nutritional deficiencies, with gradual introduction of avoided food (5).

Enhanced cognitive behavior therapy for eating disorders includes refeeding and rethinking (2). The problem of rethinking in avoidant restrictive food intake disorder is that sufferers do not have a body image distortion or desire to be thin. Instead there are other reasons to avoid food such as apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; and concern about aversive consequences of eating. Our patient reported that she found food distasteful. So the main strategy of therapy with regards to N. was to gradually introduce the avoided food items, while promoting a healthy body concept and enhancing the consequences of healthy eating. Her perfectionist traits were challenged by cognitive restructuring, for example, by highlighting the discrepancy between the current illness behavior and the problems with achieving her goals for the future. Other aspects of management included addressing family issues by exploring family dynamics, and helping the family to cope with the illness by externalizing the eating disorder (6).

With regards to prognosis, perfectionism and enmeshment were poor prognostic features in this patient (2, 6). The early onset is considered a positive prognostic factor for other eating disorders, even though it is yet to be explored in terms of avoidant restrictive food intake disorder. There is also a chance of developing anorexia or bulimia in the future, since the interchange of eating disorders during the course of illness is well described (7).

This case highlights the complexity of presentations of clinical syndromes in adolescence and the challenges in management faced by clinicians. The fact that her body image is still not fully developed also has to be considered when making the diagnosis. This presentation

could be a developing classical eating disorder even though at present she does not meet the exact diagnostic criteria. In the absence of standard management guidelines for avoidant restrictive food intake disorder, a symptomatic and patient tailored approach is recommended.

Declaration of interest

None declared

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