Avoidant Restrictive Food Intake Disorder
ARFID

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History, epidemiology, etiology, and comorbidity

- Added to DSMV in 2013
- Limited studies on prevalence
  - 0.5-5% of children and adults – based on only 1 study!
  - 8% of our patients currently in ED treatment at CentraCare have ARFID
- Prevalence in males may be higher than females and average onset is younger compared to AN/BN populations (UpToDate).
- Generally, very little known about etiology, psychopathology, pathophysiology.
- Most common comorbid condition is GAD.
  - Other common cooccurring conditions include panic disorder, social anxiety disorder, ADHD, mood disorders, ASD, internet gaming disorder, substance use disorder.

Picky eater → problem feeder → ARIFD

Picky Eater	Problem Feeder
Eat >/= 30 different foods	Eat < 20 foods
Accept food they haven't eaten for 2 weeks	Rarely accept food after 2-week break
Reluctant to try new foods but can do it	Emotional reaction when presented with new food
Eat at least 1 food from most texture and nutrition food groups	Refuse entire categories of textures or nutrition food groups
May eat different food from family but do eat with the family	Almost always eat different food and often don't eat with the family
Occurring for < 2 years	Occurring for > 2 years

ARFID occurs when a problem feeder develops medical complexities and/or psychosocial dysfunction because of nutritional deficiencies.

Diagnosis

- Eating or feeding disturbance based on the sensory characteristics of food, concern about adverse consequences (choking, vomiting, etc.) of eating which results in persistent failure to meet appropriate nutritional needs and are associated with one or more of the following:
  - Significant weight loss
  - Significant nutritional deficiency (inadequate intake, lab abnormality, etc.)
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning
- Not related to food insecurity or cultural practices.
- Does not occur with anorexia or bulimia nervosa and there is no drive for thinness or overvaluation of body shape/size.
- Is not attributable to a concurrent medical condition or better explained by another mental disorder.

Subtypes

- Aversive
- Avoidant
- Restrictive
- Mixed
- ARFID-plus

Aversive

- Individuals have limited variety of intake due to sensory processing variations
  - Sensory aversion: texture, smell, taste, visual
  - Sensory over-stimulation: mixing foods, too many components
  - May have sensory processing disorder at baseline.
    - ASD
- Treatment: psychologist, OT, RD, medical provider
  - Weight restoration, create safe/off limits food lists, anxiety management, food exposure hierarchy, family therapy

Avoidant

- Individual's food refusal is related to traumatic or adverse experience with food.
- Typical presentations are fear of choking, vomiting, anaphylaxis, contamination, illness.
- Are often sensitive to physical body sensations * (talk about the process of undernourishment causes abd pain w/ eating typically so many patients present stuck in this cycle) *
- Treatment: psychology, RD, medical provider
  - Weight restoration, anxiety management, fear hierarchy, trauma therapy, CBT

Restrictive

- Individuals who don't eat enough and show little interest in eating
- Common presentations
  - Distractable or forgetful: ADHD, on appetite suppressing medications
  - Correlation with gaming, vaping, and social media use
  - Cooccurring depression or anxiety
    - Anhedonia leading to low motivation to eat
    - Anxiety leading to appetite suppression causing inability to eat
- Treatment: psychologist, RD, medical provider
  - Address cooccurring conditions, nicotine cessation, media restriction

Mixed

- Typically, are restrictive at baseline and develop components of the other two over time.
- Clinically, most patients have some degree of a mixed type presentation.

ARFID Plus

- Individuals have avoidant, aversive, or restrictive types and then begin to develop feature of anorexia nervosa.
- Example: ARFID diagnosis in childhood and then AN develops separately.
- Acknowledges patients can have anorexia nervosa AND sensory processing disorder, emetophobia, SUD, etc.

MN Starvation Experiment

- Overlap of anorexia and Anorexia Nervosa – an important distinction and inflection point in a patient's disease process.
- Ancel Keys, 1944
- 36 conscientious objectors to WWII
- 3 months eating 3,200 cal/d, 6 months restricted diet 1,570 cal/d, 3 months nutrition rehabilitation, 2 months unrestricted eating.
- Men lost 25% of their weight
- The lack of eating (anorexia) caused a wide variety of symptoms we now recognize as symptoms of starvation and predispose a person to the development of AN
  - Food obsessions, dream and fantasize about food, read and talk about food, food rituals, fatigue, irritability, depression, apathy, etc.

Case Study #1

- 9 y/o M
- Described as a "picky eater" all his life. Always struggled with texture, smell, and visual appearance of foods.
- Had an incident at daycare where he was forced to eat a fear food.
- Developed severe anxiety with eating which developed to vomiting when looking at fear foods.
- 11 lbs of weight reduction in 3 months. Glucose 63. Vitals stable.
- Mixed type ARIFD: started with aversive (sensory) and then a traumatic event with food occurred which begins overlap with avoidant (avoiding food d/t adverse event)

Case Study #2

- 22 y/o female
- Mild sensory aversions throughout adolescence but never caused medical or psychosocial complications.
- Overall low appetite/drive to eat.
- Vapes daily. Social media 5+ hours per day.
- MDD and ADHD
- On adderall and wellbutrin
- BMI 17, phosphorus 2.3, significant symptoms of undernourishment interfering with refeeding process

Treatment

- Treatment teamtypically includes medical provider, dietitian, and psychologist and may also include OT and/or SLP.
- See previous slides for treatment specific to each sub-type of ARIFD.
- Medical: weight restoration/medical stability, eating symptom management, anxiety management, substance cessation PRN.
- Dietitian: increase food confidence and variety, increase consistency of eating.
- Psychology: decrease anxiety around food, trauma therapy PRN, assess and treat barriers of eating and cooccurring psychiatric diagnoses.

Referrals

- Limited specific ARFID treatment programs in the US.
- Amb consult eating disorders – CentraCare Outpatient Program treats ARFID
- If higher level of care is needed - Emily Program, Melrose Center, or Center for the Treatment of Eating Disorders (CTED Children's Hospital of St. Paul).

Sources

- UpToDate
- https://doi.org/10.1186/s40337-022-00578-x
- https://sosapproachtofeeding.com/picky-eater-questionnaire-parent/
- The psychology of hunger
- They Starved So That Others Be Better Fed: Remembering Ancel Keys and the Minnesota Experiment - The Journal of Nutrition

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- Contact carla.griffin@centracare.com with questions or for a CME transcript.

Clinical Updates

Avoidant Restrictive Food Intake Disorder (ARFID)

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Objective:

At the conclusion of this presentation, participants should be able to:

1) Have an understanding of what ARFID is.

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