Everything You Wanted to Know About ARFID...But Were Afraid to Ask!

**Workshop**
March 18, 2015

**Disclosures**

- Research Funding
  - National Institute of Health (DK)
  - Canadian Institute of Health Research (DK)
  - Thrasher Foundation (DK)
- Other
  - Lippincott (DK)
  - Pfizer (DK)
- Drs. Ornstein and Kreipe—nothing to disclose

**Objectives**

- At the conclusion of this workshop, participants will be able to:
  - Understand the reasons behind the changes in the DSM-5, with a focus on ARFID.
  - Identify adolescents and young adults with clinically significant eating problems that meet the DSM-5 criteria for ARFID.
  - Understand the development, course, and clinical expression of ARFID.
  - Distinguish ARFID from other medical and psychiatric disorders.

**Who has ARFID?**

**Brent**

- 11.5 year old boy with disruptive behavior at school related to presumed peanut allergy and gluten sensitivity.
- He checks what other children are eating to avoid peanut- or gluten-containing foods.
- “Freaked out” when boy sitting next to him on school bus opened a package of peanut butter crackers
- Other kids started making fun of him.
- Parents demand that all traces of peanuts and gluten be removed from his school environment.

**DSM-IV to DSM-5**

- The goal in developing the 5th Edition of the Diagnostic and Statistical Manual (DSM-5) was
  - to produce an evidence-based manual that was useful to clinicians in helping them accurately and consistently diagnose mental disorders
  - to provide a basis for research criteria

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**History of Present Illness**

- Weight dropped from 60th to 40th%ile over past 4 months.
- Past Medical History
  - Height 20th%ile
  - Eczema and asthma in childhood, now resolved.
- Family History
  - Mother with depression
  - Dad with anxiety
  - Both obese
- School nurse & counselor calling for advice.
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DSM-5 and Feeding and Eating Disorders

- Changes to DSM-5
  - Conceptual
  - Structural
  - Diagnostic
  - Let’s look at Feeding and Eating Disorders...

DSM-IV to DSM-5: Conceptual

- The goal of the DSM-5 Eating Disorder Working Group
  - To make feeding and eating disorders recognizable to non-psychiatrists to facilitate better diagnosis by clinicians
  - Adopt a lifespan approach
  - Appreciate that symptoms of eating disorders vary according to age and stage of development
  - Some types of feeding disturbances seen in young children persist into later childhood, adolescence and adulthood
  - Allow for updates and integrating new findings

DSM-IV to DSM-5: Structural

- Multiaxial system diagnosis discontinued
  - Axis I: Clinical disorders
  - Axis II: Personality disorders, Mental retardation
  - Axis III: General medical
  - Axis IV: Psychosocial and environmental problems
  - Axis V: Global assessment of functioning
  - Incompatible with the rest of medicine
  - Not consistent with WHO and ICD guidelines

DSM-IV to DSM-5: Diagnostic

Feeding Disorders of Infancy and Childhood

Feeding and Eating Disorders

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DSM-IV to DSM-5: Diagnostic

- Eating disorder diagnostic challenges
  - > 50% of children and adolescents do not meet full criteria
  - "Refusal to maintain weight" implies pejorative motivation
  - Eating disorder criteria were not developmentally sensitive
  - Children should not maintain/lose a small amount of weight
  - Children and young adolescents do not experience their body in the same way adults do
  - Amenorrhea irrelevant for boys or pre-menarchal girls.

DSM-IV to DSM-5: Diagnostic

- Feeding disorder of infancy and early childhood diagnostic challenges
  - Rarely used
  - Limited information available on the characteristics, course and outcome of these children
  - This diagnostic criteria was not exclusively seen in young people < 6 years

DSM-IV to DSM-5: Diagnostic

- DSM - IV Criteria
  - Anorexia nervosa - suggested weight cutoffs + amenorrhea ≥ 3 months
  - Bulimia nervosa - binging and purging ≥ 2x/week for ≥ 3 mos.
  - Eating Disorder Not Otherwise Specified included Binge Eating Disorder (BED) in Appendix - binging ≥ 2x/week for ≥ 6 mos.

- DSM-5 Criteria
  - Anorexia Nervosa (AN) – amenorrhea + numeric weight cutoffs eliminated; developmental considerations incorporated.
  - Bulimia Nervosa (BN) – binging and purging 1x/wk for ≥ 3 mos.
  - Binge Eating Disorder (BED) - binging 1x/wk for 3 mos.
Avoidant/Restrictive Food Intake Disorder (ARFID)

- Eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs leading to one or more of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning

Avoidant/Restrictive Food Intake Disorder (ARFID) – what it is not

- ARFID is NOT the result of lack of available food or an associated culturally sanctioned practice.
- ARFID is NOT associated with any abnormalities in the way in which one perceives their body weight or shape.
- ARFID is NOT explained by another medical or mental disorder, so that if you treat that, the eating problem will go away.

Context for development of ARFID

- ARFID replaces and extends FDoIEC + EDNOS
- Aim is to improve clinical utility by
  - adding more detail from well described presentations
  - widening criteria to be applicable across the age range to better reflect clinical reality
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ARFID and Pediatricians (Katzman et al, 2014)
- Canadian Pediatrics Surveillance Program (CPSP) one-time short survey
- Distributed to CPSP participants (2490 pediatricians) to
  - Provide more information on current knowledge/understanding of diagnosis (diagnostic criteria)
- 657/2490 (26.4%) pediatricians responded
- 418/657 (63%) were unfamiliar with ARFID
- 239/657 (36%) suspected a diagnosis of ARFID
- 72/239 (30%) inappropriately applied the exclusion, resulting in misdiagnosis

ARFID and Pediatricians (Katzman et al, 2014)
- Still a relatively new diagnosis (2 years old)
- Many clinicians (pediatricians) are
  - unfamiliar with the new diagnostic category or
  - specific diagnostic criteria that define ARFID
- Challenges in identification
- More education needed on feeding and eating disorders in the new DSM-5
  - this will ultimately facilitate early recognition and immediate treatment of children and adolescents

ARFID unleashed...
- How does ARFID seem to be performing as new diagnostic category?
- Evidence is accumulating....

Recent studies on ARFID – Tertiary Care Centers
  - Tertiary care adolescent medicine eating disorder programs
  - New patient presenting for assessment
  - 12 to 14% prevalence of ARFID
- Canadian study (Bronen et al, 2013)
  - Tertiary care adolescent medicine eating disorder program
  - 11-year retrospective chart review
  - 5% prevalence of ARFID

Recent studies on ARFID – Day Hospital
- Eating disorder day hospital program (Norby et al, 2014)
  - US tertiary care center
  - 8-17 years old
  - 4-year retrospective chart review
  - 23% prevalence of ARFID
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Recent studies on ARFID – GI Network

- Pediatric GI healthcare network (Eddy et al., 2014)
  - Retrospective chart review of 2231 consecutive new referrals to 19 Pediatric GI clinics in Boston
  - 1.5% prevalence
  - 2.4% additional cases meeting ≥ 1 criteria but with insufficient info to confer or exclude diagnosis

Recent studies on ARFID – Community

- Swiss study (Kurz et al., 2014)
  - Screening of community sample of 1444 8- to 13-year olds using self-report
  - New screening instrument Eating Disturbances in Youth-Questionnaire (EDY-Q)
  - 3.2% prevalence of ARFID features

Demographics (Fisher et al., 2014)

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>NUMBERS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients</td>
<td>719</td>
</tr>
<tr>
<td>ARFID n, (%)</td>
<td>98 (13.6%)</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>12.9</td>
</tr>
<tr>
<td>Gender (Females) n, (%)</td>
<td>70 (71.3%)</td>
</tr>
<tr>
<td>Subcategories</td>
<td></td>
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<tr>
<td>Restrictive eaters/picky</td>
<td>28 (28.7%)</td>
</tr>
<tr>
<td>Generalized anxiety</td>
<td>21 (21.4%)</td>
</tr>
<tr>
<td>Gastrointestinal symptoms</td>
<td>19 (19.4%)</td>
</tr>
<tr>
<td>Choking/vomiting episode</td>
<td>13 (13.1%)</td>
</tr>
<tr>
<td>Food allergy</td>
<td>4 (4.1%)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (13.1%)</td>
</tr>
</tbody>
</table>

Characteristics (Fisher et al., 2014)

<table>
<thead>
<tr>
<th></th>
<th>ARFID</th>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98</td>
<td>N=98</td>
<td>N=66</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>12.9 ± 2.5</td>
<td>15.6 ± 1.9</td>
<td>16.5 ± 1.3</td>
<td>p &lt;.001</td>
</tr>
<tr>
<td>% Medium BMI</td>
<td>86.5 ± 15.1</td>
<td>81.0 ± 9.2</td>
<td>107.5 ± 16</td>
<td>p &lt;.001</td>
</tr>
<tr>
<td>Lowest Wt (lbs)</td>
<td>76.9 ± 26.2</td>
<td>91.0 ± 16.1</td>
<td>117.3 ± 21.0</td>
<td>p &lt;.001</td>
</tr>
<tr>
<td>Highest Wt (lbs)</td>
<td>89.7 ± 33.1</td>
<td>118.7 ± 28.3</td>
<td>142.9 ± 27.2</td>
<td>p &lt;.001</td>
</tr>
<tr>
<td>Length of illness (mos)</td>
<td>33.3 ± 41.3</td>
<td>14.4 ± 12.2</td>
<td>23.5 ± 17.1</td>
<td>p &lt;.001</td>
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</table>

Comorbidities (Fisher et al., 2014)

<table>
<thead>
<tr>
<th></th>
<th>ARFID</th>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
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<td></td>
<td>n=98</td>
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<td>n=66</td>
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<tr>
<td>Medical Condition/Symptom</td>
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<td></td>
<td></td>
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<tr>
<td>Yes, related</td>
<td>34.6</td>
<td>8.2</td>
<td>4.6</td>
<td>p &lt;0.001</td>
</tr>
<tr>
<td>Yes, unrelated</td>
<td>16.3</td>
<td>2.0</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>49.1</td>
<td>89.8</td>
<td>89.3</td>
<td></td>
</tr>
<tr>
<td>Mood Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDD/Dysthymia</td>
<td>7.2</td>
<td>19.4</td>
<td>23.1</td>
<td>p &lt;0.001</td>
</tr>
<tr>
<td>Other</td>
<td>11.3</td>
<td>11.2</td>
<td>35.4</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>81.5</td>
<td>69.4</td>
<td>41.5</td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD</td>
<td>28.6</td>
<td>14.3</td>
<td>7.6</td>
<td>p &lt;0.001</td>
</tr>
<tr>
<td>OCD</td>
<td>6.1</td>
<td>8.2</td>
<td>1.5</td>
<td></td>
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<tr>
<td>Other</td>
<td>23.5</td>
<td>13.3</td>
<td>24.2</td>
<td></td>
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<tr>
<td>None</td>
<td>41.8</td>
<td>64.2</td>
<td>68.7</td>
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Medical/Developmental Issues (Fisher et al., 2014)

<table>
<thead>
<tr>
<th></th>
<th>ARFID</th>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
<th>P value</th>
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<tr>
<td></td>
<td>n=98</td>
<td>n=98</td>
<td>n=66</td>
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<tr>
<td>Sensory issues</td>
<td>20.4</td>
<td>1</td>
<td>0</td>
<td>p &lt;0.001</td>
</tr>
<tr>
<td>History of choking</td>
<td>14.3</td>
<td>1</td>
<td>0</td>
<td>p &lt;0.01</td>
</tr>
<tr>
<td>Swallowing Difficulties</td>
<td>10.2</td>
<td>1</td>
<td>0</td>
<td>p &lt;0.01</td>
</tr>
<tr>
<td>Secondary gain</td>
<td>7.1</td>
<td>1</td>
<td>0</td>
<td>p &lt;0.05</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>6.1</td>
<td>0</td>
<td>0</td>
<td>p &lt;0.01</td>
</tr>
<tr>
<td>Food allergy</td>
<td>6.1</td>
<td>1</td>
<td>0</td>
<td>p &lt;0.05</td>
</tr>
<tr>
<td>Autism spectrum</td>
<td>5.1</td>
<td>0</td>
<td>0</td>
<td>p &lt;0.05</td>
</tr>
</tbody>
</table>
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Patient characteristics (Nicely et al., 2014)

<table>
<thead>
<tr>
<th></th>
<th>ARFID (N=39)</th>
<th>AN (N=93)</th>
<th>BN (N=20)</th>
<th>OSFED/UFED (N=21)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs)</td>
<td>11.1 ± 1.7</td>
<td>14.0 ± 1.5</td>
<td>14.9 ± 1.1</td>
<td>14.2 ± 1.7</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>% Male</td>
<td>20.5</td>
<td>4.3</td>
<td>0</td>
<td>9.5</td>
<td>0.008</td>
</tr>
<tr>
<td>%MBW</td>
<td>87.1 ± 13.0</td>
<td>82.6 ± 9.2</td>
<td>108.1 ± 19.5</td>
<td>93.2 ± 6.8</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>%BW lost</td>
<td>10.5 ± 8.4</td>
<td>18.5 ± 10.2</td>
<td>6.4 ± 6.5</td>
<td>14.8 ± 12.2</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Duration of illness (mos)</td>
<td>9.8 ± 13.2</td>
<td>8.6 ± 7.9</td>
<td>15.9 ± 11.9</td>
<td>9.8 ± 4.9</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

No significant difference between ARFID and AN with respect to %MBW.

Symptoms and Features (Nicely et al., 2014)

<table>
<thead>
<tr>
<th></th>
<th>ARFID (N=39)</th>
<th>AN (N=93)</th>
<th>BN (N=20)</th>
<th>OSFED/UFED (N=21)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>95</td>
<td>100</td>
<td>75</td>
<td>100</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Self-induced vomiting</td>
<td>0</td>
<td>6</td>
<td>95</td>
<td>38</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Nutrition supplements</td>
<td>46</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Fear of choking/vomiting</td>
<td>44</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Sensory issues</td>
<td>26</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Body image concerns</td>
<td>21</td>
<td>87</td>
<td>95</td>
<td>90</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Cognitive distortions</td>
<td>44</td>
<td>90</td>
<td>90</td>
<td>95</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Excessive exercise</td>
<td>15</td>
<td>68</td>
<td>65</td>
<td>52</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Food allergy</td>
<td>24</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Recent medical specialist consult</td>
<td>46</td>
<td>19</td>
<td>20</td>
<td>33</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

All numbers represent percentages.

ChEAT scores by DSM-5 Diagnosis (Nicely et al., 2014)

General Conclusions

- Younger age
- Higher percentage of males than other EDs
- Equally as underweight as those with AN
- Co-morbid anxiety more common while co-morbid depression less common

Psychiatric comorbidities (Nicely et al., 2014)

<table>
<thead>
<tr>
<th>Co-morbid psychiatric disorder</th>
<th>ARFID (N=39)</th>
<th>AN (N=93)</th>
<th>BN (N=20)</th>
<th>OSFED/UFED (N=21)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorder</td>
<td>33</td>
<td>48</td>
<td>80</td>
<td>76</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>72</td>
<td>37</td>
<td>25</td>
<td>14</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.005</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>N.S.</td>
</tr>
<tr>
<td>Learning Disorder</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>26</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>&lt; 0.0001</td>
</tr>
</tbody>
</table>

All numbers represent percentages.

Avoidant/Restrictive Food Intake Disorder

- 3 Recognized Subtypes
  - individuals who do not eat enough/show little interest in feeding
  - individuals who only accept a limited diet in relation to sensory features
  - individuals whose food refusal is related to aversive experience, e.g. choking, vomiting
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Key areas to assess when considering ARFID
- Current food intake
- Oral supplement or tube feed dependency
- Persistence of problem
- Social/emotional functioning
- Weight and height (BMI percentile)
- Signs of nutritional deficiency
- Lack of interest in food
- Sensory-based avoidance
- Fear/aversion

Current food intake
- Ascertain whether this represents an adequate age-appropriate amount
  - Is the diet sufficient in terms of overall energy intake?
- Ascertain whether this includes an adequate age-appropriate range
  - Does it include major food groups and essential micronutrients?

Oral supplements/tube feeding
- Is the individual taking oral nutritional supplements?
  - What kinds?
- Is the individual fed via gastrostomy/nasogastric tube or other form of enteral feeding?
- Is there dependence on these other methods to ensure sufficient intake?

Persistence of problem
- How long have there been eating difficulties characterized by avoidance or restriction?
  - This is to ascertain whether this is a persistent problem rather than a transient one.

Social and emotional functioning
- Is there evidence of any associated significant distress?
- Is there evidence of associated impairment to the individual's social and emotional development or functioning?
  - In the case of children or younger adolescents, this can include disruptions to normal family function that negatively affect the child.

Weight and height
- Measurement of weight and height
- Plot measurements and compare to previous documented or reported weight and height / weight and height percentiles
  - Allows assessment of whether growth is faltering
- Allows determination of presence of weight loss, or static weight when should be increasing

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Nutritional deficiency

- Does the individual present with clinical or laboratory signs and symptoms of nutritional deficiency or malnutrition?
- Markers might include lethargy secondary to iron deficiency anemia, delayed bone age as a consequence of chronic restricted intake

Lack of interest

- Is the avoidance or restriction associated with a lack of interest in food?
- Is the avoidance or restriction associated with an apparent failure to recognize hunger?

Sensory based avoidance

- Is the avoidance or restriction based on sensory aspects of food?
  - Texture
  - Taste
  - Appearance – including colour
  - Smell
  - Temperature

Presence of fear/ aversion

- Does the avoidance or restriction follow an aversive experience associated with intense distress or discomfort?
- This might include a choking incident, an episode of vomiting or diarrhea, or a medical procedure such as barium swallow

Treatment...where are we at?

Treatment of ARFID

- No published data
- Some groups are using FBT
- Some are using exposure therapy
- We don’t know what is effective at this time, but...
Day program with family-centered approach

- Parents and families incorporated into treatment and re-feeding process
- Attend a therapeutic meal daily
- Provide psycho-education on eating disorders and management of eating disordered behavior
- Attend all sub-specialty appointments
- Participate in a support group, multi-family meal-planning group and family therapy sessions
- In charge of the meal plan while at home and are given behavioral training and assistance with developing contingencies

Exposure-response prevention

- Behavioral intervention typically used for anxiety and phobias
  - When applied to eating disorders, patients are repeatedly exposed to feared foods
  - Response prevention refers to blocking compulsive behaviors such as vomiting, exercise or restriction
- Hildebrandt et al. (2010) concluded that interventions in family based treatment mimic those used in exposure and response prevention.
- Steinglass et al. (2011) proposed that ERP may be a new and beneficial approach to prevention relapse in individuals with AN

Weight Improvement Across Treatment

<table>
<thead>
<tr>
<th></th>
<th>ARFID</th>
<th>AN</th>
<th>BN</th>
<th>FEDNEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE %MBW</td>
<td>87.1 ± 13.0</td>
<td>82.6 ± 9.2</td>
<td>108.1 ± 19.5</td>
<td>93.2 ± 6.8</td>
</tr>
<tr>
<td>POST %MBW</td>
<td>96.2 ± 9.6</td>
<td>94.6 ± 6.9</td>
<td>108.0 ± 16.3</td>
<td>96.9 ± 5.9</td>
</tr>
</tbody>
</table>

Significant improvements in %MBW gained within groups (p < .0001), but not between groups (ARFID vs. those with other eating disorders).

Length of Stay

Children with ARFID spent fewer weeks in program than those with other EDs (7.4 vs. 11.0, p = 0.0001)

Treatment Course

- No significant differences between percentage of patients with ARFID requiring subsequent inpatient admission (15.8%) vs. those with other eating disorders (22.7%); p = 0.362

Total ChEAT Score Across Treatment

Within subjects: scores on ChEAT improved for all subjects across treatment (p <0.0001)
Food Acceptance and Fears Survey

- 88-item survey
- Designed by our treatment team, including psychologists, therapists, and dietitians
- Assesses foods currently eaten, foods never eaten, and foods feared

Food Acceptance and Fears Survey

<table>
<thead>
<tr>
<th>Food Acceptance</th>
<th>ARFID</th>
<th>AN</th>
<th>BN</th>
<th>FEDNEC</th>
</tr>
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<tbody>
<tr>
<td>Foods Eaten</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake</td>
<td>43</td>
<td>33</td>
<td>33</td>
<td>37</td>
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<tr>
<td>Discharge</td>
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<tr>
<td>Foods Feared</td>
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<tr>
<td>Discharge</td>
<td>9</td>
<td>12</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

Within Subjects: All patients made significant improvement in both the number of food items accepted and the number of food items no longer feared across treatment (p < .05), by parental report.

Conclusions

- Children with ARFID are able to make similar improvements to more traditional eating disorder peers in a family centered day program on the following parameters
  - Weight gain
  - Eating disorder symptoms
  - Depression and anxiety symptoms
  - Food acceptance

Implications

- Children with ARFID can be managed in a day program with more traditional eating disordered patients of similar age.
- No negative impact of peer modeling on ED symptom development for patients with ARFID

Tyler

- 13-year old boy with 10-year history of being a picky eater
- Recently manifested in decreasing portion size and variety + stomach aches
- Pediatrician concerned about lack of increase in height and weight over past year
  - 1 kg weight gain over last year
Everything You Wanted to Know About ARFID...But Were Afraid to Ask!

Tyler

- PMHx:
  - Always a picky eater
  - As an infant had difficulty going from smooth textured infant foods to variety of textures – resulted in gagging
  - As an a toddler textures resolved but only ate PB&J sandwiches, chocolate chip cookies and pizza, chicken fingers and fries from very specific restaurant location, drinks milk
  - Worries about taste of foods
  - Concerns about mouth feel
  - No fear of gaining weight, no body image concerns
  - Losing weight would be a "bad thing"
  - No rules or rituals around food
  - Went to summer camp last summer and refused to eat camp food
  - Complained of "stomach aches"
  - Could only eat bread and water X 17 days

- Diet History
  - 2100-2500 kcal/day as per mom's food records
  - Eats with family and is always last to finish

- Exercise History
  - Gym class 2 X per week for 45 minutes
  - Hockey 2 X per week 60 minutes
  - Football or soccer at recess

- PMHx: non-contributory

- Social History
  - Lives at home with both parents
  - does well in school; has lots of friends
  - denies substance use; denies trauma history
  - Not sexually active; interested in girls.

- Who has ARFID?

  - Current Weight = 41.0 kg (10-25%)
  - Height = 155 cm (25%)
  - Expected body weight = 47kg
  - Growth Curve

Sophia

- 10 year old girl with 8 lbs weight loss and difficulty eating solid food due to fear of choking over past 3 months
- Onset of symptoms coincide with the death of her paternal GF due to Alzheimer’s
  - He was unable to eat at end-of-life
  - Younger sister had a h/o choking episode a year ago

- HPI
  - Slightly picky eater prior to this but no major concerns
  - h/o anxiety over the years
    - Trouble sleeping in her own bed at night
    - Seeing a therapist for 2 years
  - No fear of weight gain or becoming fat; no body image issues
  - Chews food for an extensive period of time before swallowing

- Diet history
  - Liquids including Boost supplements
  - ice cream, overcooked noodles, inside of grilled cheese sandwich

- Exercise history
  - Plays softball and lacrosse
  - Decreased energy currently
Everything You Wanted to Know About ARFID...But Were Afraid to Ask!

Sophia

- PMH
  - Noncontributory
- FH
  - Father with anxiety disorder
  - Sister with asthma
  - Maternal aunts and uncles with schizophrenia, bipolar disorder, and severe autism/MR
- Social History
  - Lives with mother, father, and 2 sisters
  - 5th grade in the gifted program
  - very intense about school

Take Home Points

- Appreciate the major changes to DSM-5
- Understand changes and impact of Feeding and Eating Disorders
- Recognize the core clinical features of ARFID

Sophia

- Growth parameters
  - Height 141.4 cm (50th percentile)
  - Weight 28.1 kg (61.8 lbs) (10th percentile)
  - BMI 14.1 (3rd percentile)
  - 83% of MBW of 74.5 lbs
  - Prior weight of 70 lbs ~10 months ago (so was probably higher)

Sophia

- Treated in PHP for 3 mos
- ERP plus a combination of sertraline and mirtazapine
- Discharge weight 37.5 kg (82.7 lbs)
- Eating a variety of solid foods, no longer using nutritional supplements, completing meals in a normal amount of time

References

- Highlights of Changes from DSM-IV-TR to DSM-5, APPI. 2013.