SAHM
SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE

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

Workshop
March 18, 2015
2:15-3:45 pm

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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.

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.

Brent

- 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 call asking for advice.

DSM-IV to DSM-5

- The goal in developing the 5th Edition of the Diagnostic and Statistical Manual (DSM-5) was
  - provides a common language to communicate about mental disorders
  - 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

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-5 *NOT* DSM V

- Allow for updates and integrating new findings
- Different approach to future revisions
- DSM-5.1

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

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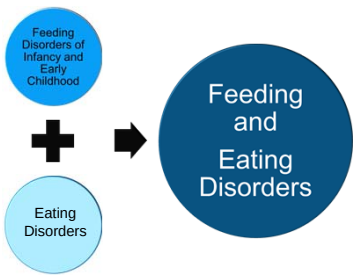
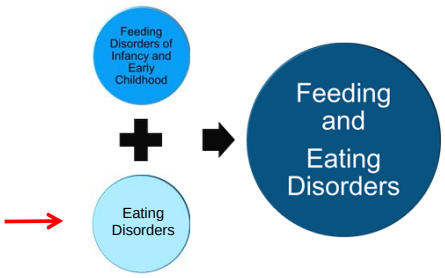
DSM-IV to DSM-5: Diagnostic



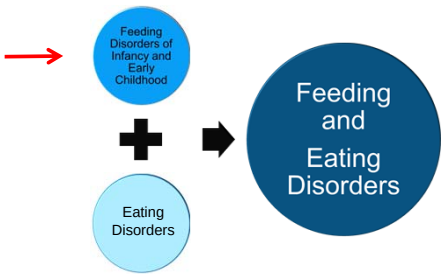
DSM-IV to DSM-5: Diagnostic



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 same way adults do
    - Amenorrhea irrelevant for boys or pre-menarchal girls.

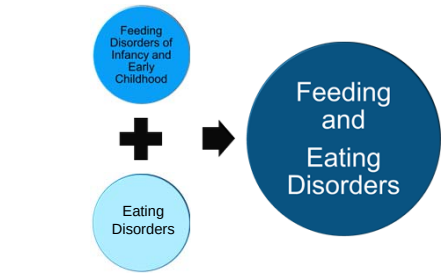
DSM-IV to DSM-5: Diagnostic



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	→ DSM-5 Criteria
Anorexia nervosa - suggested weight cutoffs + amenorrhea ≥ 3 months	Anorexia Nervosa (AN) – amenorrhea & numeric weight cutoffs eliminated; developmental considerations incorporated.
Bulimia Nervosa-binging and purging ≥ 2x/week for ≥ 3 mos.	Bulimia Nervosa (BN) – binging and purging 1x/wk for ≥ 3 mos.
Eating Disorder Not Otherwise Specified included Binge Eating Disorder (BED) in Appendix-binging ≥ 2x week for ≥ 6 mos	Binge Eating Disorder (BED) - binging 1x/ week for 3 mos.

DSM – IV Criteria	DSM-5 Criteria
Eating Disorder Not Otherwise Specified	Eating Disorders Not Otherwise Specified **eliminated** Avoidant/Restrictive Food Intake Disorder (ARFID) Other Specified Feeding and Eating Disorders ▪Atypical AN (not underweight) ▪Purging disorder ▪Sub-threshold BN (<1x/wk or <3 mos) ▪Sub-threshold BED (<1x/wk or <3 mos) ▪Night eating syndrome Unspecified Feeding and Eating Disorders
Feeding Disorders of Infancy or Early Childhood	Feeding Disorders of Infancy or Early Childhood eliminated Avoidant/Restrictive Food Intake Disorder (ARFID) Pica Rumination

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

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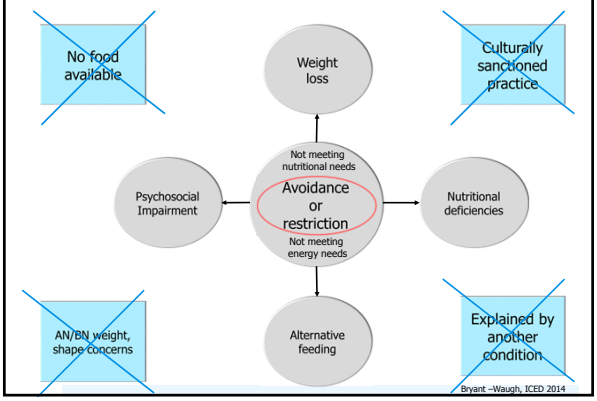
Avoidant/Restrictive Food Intake Disorder (ARFID) – what it is not

- 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.

Avoidant/Restrictive Food Intake Disorder of Childhood



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

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)

ARFID and Pediatricians (Katzman et al, 2014)

- 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

- Multicenter North American studies (Ornstein et al., 2013; Fisher et al., 2014; Forman et al., 2014)
  - Tertiary care adolescent medicine eating disorder programs
  - New patient presenting for assessment
  - 12 to14% prevalence of ARFID
- Canadian study (Norris 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 (Nicely et al., 2014)
  - US tertiary care center
  - 8-17 years old
  - 4-year retrospective chart review
  - 23% prevalence of ARFID

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)

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

Characteristics (Fisher et al., 2014)

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

Comorbidities (Fisher et al., 2014)

	ARFID n=98 (%)	Anorexia Nervosa n=98 (%)	Bulimia Nervosa n=66 (%)	P value
Medical Condition/Symptom				
Yes, related	34.6	8.2	4.6	
Yes, unrelated	16.3	2.0	6.1	p <0.001
None	49.1	89.8	89.3	
Mood Disorder				
MDD/Dysthymia	7.2	19.4	23.1	p <0.001
Other	11.3	11.2	35.4	
None	81.5	69.4	41.5	
Anxiety Disorder				
GAD	28.6	14.3	7.6	
OCD	6.1	8.2	1.5	p <0.001
Other	23.5	13.3	24.2	
None	41.8	64.2	66.7	

Medical/Developmental Issues (Fisher et al., 2014)

	ARFID n=98 (%)	Anorexia Nervosa n=98 (%)	Bulimia Nervosa n=66 (%)	P value
Sensory issues	20.4	1	0	P<0.001
History of choking	14.3	1	0	P<0.01
Swallowing Difficulties	10.2	1	0	P<0.01
Secondary gain	7.1	1	0	P<0.05
Cognitive Impairment	6.1	0	0	P<0.01
Food allergy	6.1	1	0	P<0.05
Autism spectrum	5.1	0	0	P<0.05

Patient characteristics (Nicely et al., 2014)

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

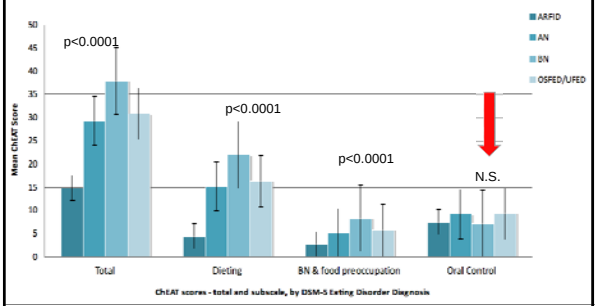
No significant difference between ARFID and AN with respect to %MBW

Symptoms and Features (Nicely et al., 2014)

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

All numbers represent percentages

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



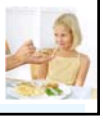
Psychiatric comorbidities (Nicely et al., 2014)

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

All numbers represent percentages

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



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

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

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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?

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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?

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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.

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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.

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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

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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?

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Sensory based avoidance

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

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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

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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

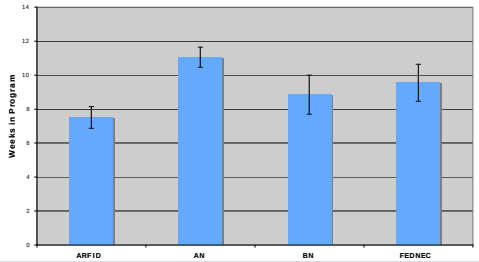
- Behavioral intervention typically used for anxiety and phobias
  - When applied to eating disorders, patients are repeatedly exposed to feared foods
  - Response prevention refers to blocking compulsive behaviors such as vomiting, exercise or restriction
- Hildebrandt et al. (2010) concluded that interventions 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

	ARFID	AN	BN	FEDNEC
PRE %MBW	87.1 ± 13.0	82.6 ± 9.2	108.1 ± 19.5	93.2 ± 6.8
POST % MBW	96.2 ± 9.6	94.6 ± 6.9	108.0 ± 16.3	98.9 ± 5.9

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

Length of Stay

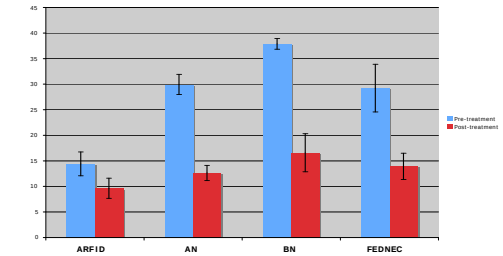


Children with ARFID spent fewer weeks in program than those with other EDs (7.4 vs. 11.0, $p < 0.0001$)

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	I eat this food	I never ate this food	I am fearful or anxious eating this food
Dairy Products			
Skim Milk			
2% Milk			
Whole Milk			
Chocolate Milk			
Milkshake			
Yogurt			
Cottage Cheese			
Sliced Cheese			
Shredded Cheese			
Cheese Cubes			
Cheese Stick			

Spaghetti/Lasagna			
Mac and Cheese			
Rice (brown/white)			
Popcorn			
Crackers			
Desserts			
Cake			
Cookies			
Pie			
Doughnut			
Frozen yogurt			
Ice cream			
Pudding			
Brownies			
Beverages			
Soft drink diet			
Soft drink regular			
Flavored water			
Lemonade			
Fruit Juice			

Food Acceptance and Fears Survey

Food Acceptance	ARFID	AN	BN	FEDNEC
Foods Eaten				
Intake	43	33	33	37
Discharge	59	63	63	57
Foods Feared				
Intake	26	41	31	32
Discharge	9	12	9	11

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 ($p < .0001$), 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

Tyler

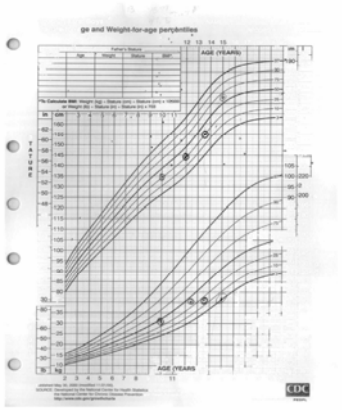
- PMHx
  - Always a picky eater
  - As an infant had difficult going from smooth textured infant foods to variety of textures – resulted in gagging
  - As an a toddler textures resolved but only ate PBJ sandwiches, chocolate chip cooks and pizza, chicken fingers and fries from very specific restaurant 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

Tyler

- 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
- Family History – 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.

Tyler

- 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

Sophia

- 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

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

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

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

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