The Kaleidoscope of ARFID: Viewing Its Many Clinical Presentation Designs

"Amy's Gift": QC Eating Disorders Consortium
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Disclosure Statement

The speakers have no conflicts of interest to disclose.

Program Description

- *This presentation will describe what Avoidant/Restrictive Food Intake Disorder (ARFID) is and differentiate it from other types of eating disorders. The varied clinical presentations of ARFID will be considered, as well as best practice treatment models. The importance to taking a multidisciplinary approach in treating the patient experiencing ARFID will be emphasized.*

Learning Objectives

Upon completion of this presentation, participants will be able to:

1. Differentiate ARFID from other types of eating disorders.

2. Identify multiple ways that ARFID presents itself in the clinical setting.

3. Describe evidence-based practices that demonstrate hope in the treatment of ARFID.

4. Explain the importance of a multidisciplinary healthcare team approach in caring for patients diagnosed with ARFID.

Initial Word About Eating Disorders

- **Eating disorders are serious, life-threatening illnesses**
  - Approximately 30 million Americans struggle with eating disorders
  - Anorexia nervosa, Bulimia nervosa, Binge eating disorder, Orthorexia, Pica, ARFID…
  - Affects people of all genders, ages, races, religions, ethnicities, sexual orientations, body shapes, and weights
    - *Peak age of onset adolescent and young adult years*
    - *Considered a primarily Western culture bound syndrome*
- ***Eating Disorders are deadly!***
  - *10% mortality rate--the highest of any mental illness!*
  - *Claims a life every 63 minutes!*

(Source: NEDA website, 2024)

What is ARFID?

- Avoidant/Restrictive Food Intake Disorder
- Psychiatric disorder newly introduced as an eating disorder diagnosis in the DSM-5
- More than “picky eating"
- Varying clinical presentations of this eating disorder
- Can also reach serious life-threatening level
- Need for further understanding, detection, and treatment

Diagnostic Definition of ARFID

According to the DSM-5-TR:

"Persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning"

(Source: DSM-5TR, American Psychiatric Association, 2022)

Diagnostic Criteria & Clinical Manifestations

- **ARFID is associated with 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*
- **May be related to**
  - *Sensory characteristics of food*
  - *Concern about aversive consequences of eating*
  - *Lack of interest in food, poor appetite/hunger cues*
- **Different from other eating disorders**
  - *No disturbance in body image or fear of gaining weight*
- **Continuum of severity**
  - *Drawing the diagnostic line*

(Sources: DSM-5TR, American Psychiatric Association, 2022, *Thomas, J. et al., 2021*)

ARFID Self-Test

- **Nine-item ARFID screen (NIAS)**
- Rate self on 0-5 Likert Scale SD-SA about eating themes
  - *1. picky eater*
  - *2. dislike of foods*
  - *3. foods will eat < foods won't eat*
  - *4. no interest/lack of appetite*
  - *5. push self to eat*
  - *6. hard to eat enough*
  - *7-9. avoid, restrict, or small food portions because afraid of GI distress, choking*

(Source: Zickgraf, H.F, and Ellis, J.M., 2018)

Recent Research Findings

- Online screening sample of over 50,000 adults for NEDA: 4.7% met criteria for ARFID (D'Adamo et al., 2023)
- Individuals screening positive for ARFID:
  - Non-White
  - Latino
  - Lower income
  - Younger and male
  - 35%: suicidal ideation
  - 80%: lack of interest in eating

Comorbidity

- Most common comorbid disorders are ADHD (26%), anxiety, and autism
- Significant correlation between ARFID and GI issues in adults
- Child/Adolescent study (N=74) (Kambanis et al., 2020):
  - 45%: comorbid psychiatric diagnosis
  - 14%: lifetime suicidality
  - Different types of ARFID:
    - **sensory sensitivity** associated with neurodevelopmental and conduct disorders, anxiety, obsessive-compulsive, and trauma-related and depressive/bipolar disorders
    - **fear of aversive consequences** associated with anxiety, obsessive-compulsive, and trauma-related disorders

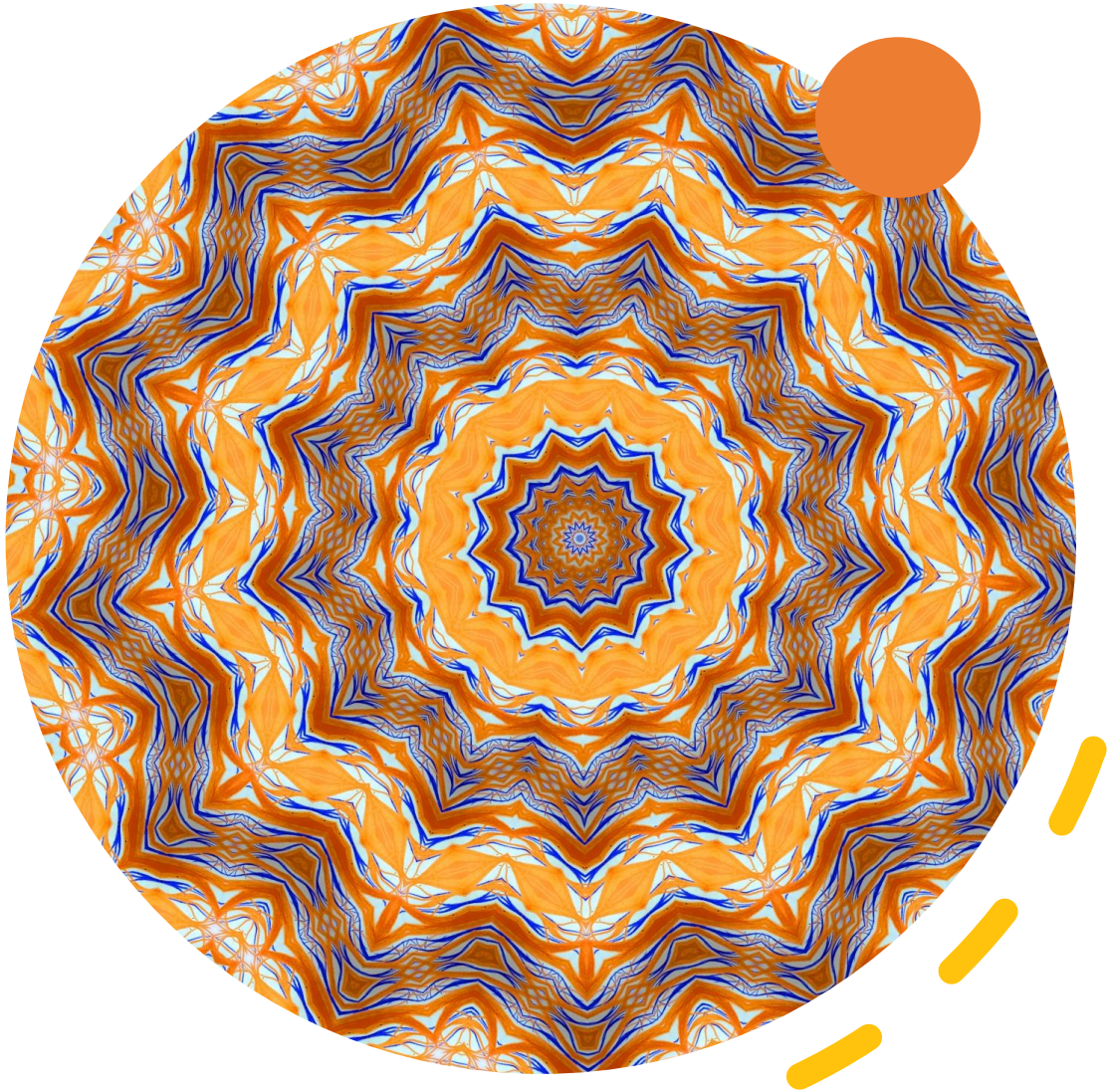
Variety of Clinical Presentations

- There is not just one diagnostic profile
  - *“ARFID is not just ARFID”*
  - *Experienced differently by every individual*
- Diagnosed in children, adolescents, and adults
- May present with
  - *A different specific symptom set*
  - *Multi-symptom set*
  - *Comorbidities*
- Different etiologies and contributing factors
- Clinical presentations often rooted in exploring developmental history
  - *Patients need to “tell their story”*
  - *Becomes a process of discovery for the patient and healthcare team*
  - *Requires an individualized, holistic assessment and personalized care plan*

The “Kaleidoscope”

Viewing the Colorful Clinical Designs of ARFID:

1. *Sensory related*
2. *Fear related*
3. *Gastrointestinal related*
4. *Trauma related*
5. *Obsessive-compulsive related*
6. *Post-COVID-19 Infection*
7. *“Picky eating” related*
8. *Autism-spectrum disorder related*
9. *Many other case examples: Physical health concerns, grief, allergy-based, “force-fed as a child”…*



Case 1: Sensory

“Avery”

- **21-year-old transgender male presenting with weight loss, 82% ideal target weight, restrictive food intake, and chronic poor appetite**
  - *“I’m getting tired of being called anorexic by my family and friends!”*
  - *“I know I’m too skinny and I want to gain weight.”*
  - *“I think I was just born this way and have always been a really picky eater.”*

- **Multiple sensory sensitivity symptoms related to food items**
  - *Aversion to texture, visual appearance, smell, taste, temperature, and even sound of food items*
  - *“Lots of foods are just disgusting to me!”*
  - *Extremely limited dietary intake/food choices*
  - *Cycles with becoming fixated on certain “safe” foods*

Case 2: Fear

“Walker”

- **28-year-old male presenting with significant weight loss, 85% of ideal target weight, and poor hunger cues**
  - *“I’ve always been small built.”*
  - *“I’m trying to gain weight, but I can’t.”*
- **Intense anxiety, avoidance, and fear of food contamination**
  - *“I got food poisoning once when I was a kid and it was awful!”*
  - *“I have a hard time trusting food being prepared for me.”*
  - *“I can visualize the bacteria crawling on the food I’m cooking.”*
- **Multiple GI sensitivity symptoms**
  - *Nausea, vomiting, diarrhea*

Case 3: Gastrointestinal

- **“Marilyn”**
- **13-year-old female presenting with significant food restriction due to GI distress resulting in 30-pound weight loss over 2 months**
  - *Unintentionally reduced to 61% of ideal target weight*
  - *“I started losing weight after I kept getting sick.”*
- **Excessive nausea and abdominal pain despite negative GI work-ups**
  - *Began to self-induce vomiting as attempt to relieve pain*
  - *“The thought of food makes me want to barf!”*
- **Extremely limited nutritional intake**
  - *Excluded multiple foods associated with becoming “queasy”*
  - *“I didn’t want to get sick, so I had to cut out tons of foods.”*
  - *Eventually led to eating only granola bars*

Case 4: Trauma

“Sharon”

- **54-year-old female presenting with significant weight loss pattern, reducing to 70% of ideal target weight over past year**
  - *Loss of interest in food and increased GI upset and anxiety with eating*
  - *“I used to be so built and fit. Now I look like a walking skeleton…what’s wrong with me?!”*
  - *Comorbid psychiatric dx of PTSD*

- **Recent arising of PTSD symptoms**
  - *Experiencing disturbing, repressed memories related to childhood trauma (sexual, emotional, physical)*
  - *Trauma associated with specific foods and meal situations*
  - *Flashbacks and nightmares triggered by foods/eating experience*

Case 5: Obsessive-Compulsive

- **“Beatrice”**
- **60-year-old female presenting with long-term, chronic severe weight loss**
  - *Reduced and maintained in 60% ideal target weight range*
  - *Had originally been diagnosed with AN for 40+ years and had multiple failed inpatient treatments and frequent relapse*
  - *Comorbid psychiatric dx of obsessive-compulsive disorder*

- **Extreme ritualistic eating behaviors and food restriction**
  - *Eliminates food items that are “not white”*
  - *Related to obsessions about cleanliness/purity*
  - *Some religious-based and compulsions*

Case 6: Post COVID-19 Infection

“Jerry”

- **34-year-old male presenting with significant weight loss and decreased oral intake**
  - *Reduced to 72% of ideal target weight*
  - *Did not see self as having an “eating problem”*
  - *Death of father one year prior to admission leading to initial weight loss*

- **COVID-19 infection**
  - *Loss of interest in food due to lack of taste or smell during and post virus*
  - *Experienced nausea/vomiting with eating post COVID-19 infection*
  - *Food avoidance/restriction persisted 14 months post COVID-19 recovery*

Case 7: “Picky Eating”

“Madeline”

- **32-year old cisgender married woman**
  - *Stable weight in healthy range*
  - *No body image concerns*
  - *Describes self as “picky eater” from childhood onward (does not consume fruits or vegetables)*
  - *Highly anxious*

- **Desire to get pregnant**
  - *Increased guilt feelings regarding her eating behaviors*
  - *Criticized by others for her food choices*
  - *Wants to face her anxiety about not eating certain types of foods*

Case 8: Autism-Spectrum Disorder

“Joey”

- **19-year old cisgender man**
  - *No body image concerns*
  - *History of Autism-Spectrum Disorder (support services while in K-12)*
  - *Living at home and working a part-time job*
  - *Multiple sensory sensitivities but weight and labs used to be stable*

- **Choking Incident**
  - *Choked on a French fry*
  - *Has lost 10lbs since*
  - *Avoids all foods now in the shape of a French fry or of a similar color or texture*
  - *Less willing to address and work through sensory sensitivities*

Treatments for ARFID

Evidence-Based Practices for Adults with ARFID? Limited

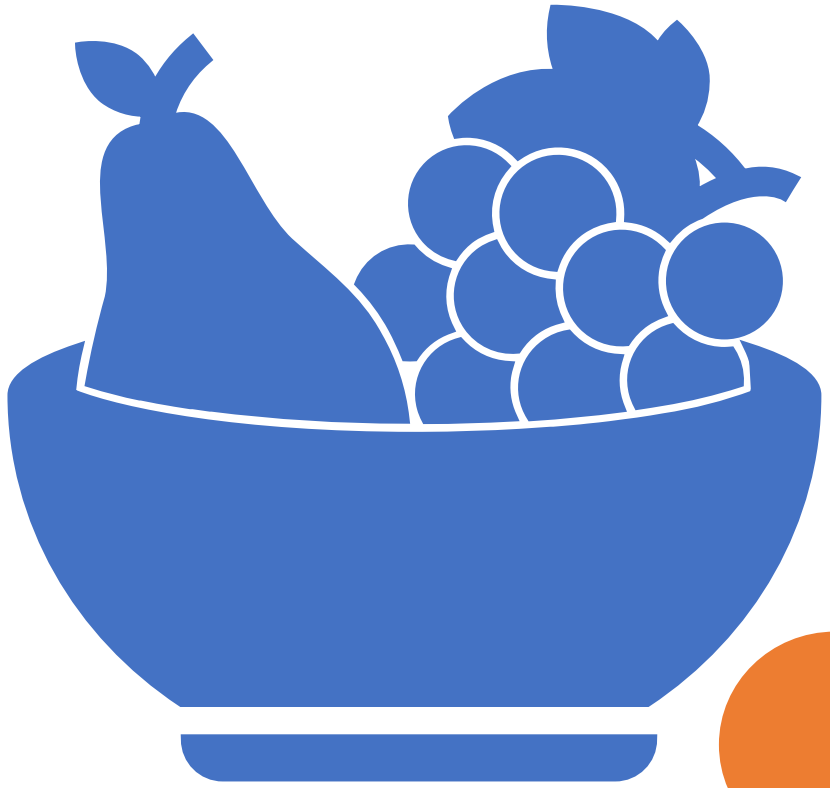
- Medical Stabilization and Medications
- Nutritional Rehabilitation/Responsive Feeding Therapy (RFT)
- Cognitive-Behavioral Therapy (CBT-AR)
- Dialectical Behavior Therapy (DBT)
- Acceptance-Commitment Therapy (ACT)
- Family-Based Therapy (FBT)

Medical Stabilization and Medications

- Rule out underlying comorbid medical conditions, food allergies
- Close monitoring of weight/labs
- Medications
  - Vitamin and mineral supplements
  - Gastrointestinal meds
  - Psychotropic meds
- Prescribed kcal nutritional intake
  - Oral nutritional supplements
  - Nasogastric tube feedings

Nutritional Rehabilitation

- Initial nutrition assessment and food lists
  - *“Always, Sometimes, Never”*
  - *“Comfortable eating, Willing to try, Not currently eating, Never tried”*
- Regular dietitian consultations
- Use approved food lists to gradually introduce variety
  - *Pace varies*
- Advance to making more independent selections
- Gradual increase of food intake
- Achieve restoration or maintenance level
- Responsive Feeding Therapy (RFT): eating in a low stress, relaxed atmosphere with patient listening and responding to hunger cues



Cognitive Behavioral Therapy (CBT-AR)

- Monitor self-talk, identify cognitive distortions and pursue cognitive restructuring
- Exposure therapy— *"face your fears"*

- *CBT-AR Strategies*
- 1. Tasting –small amounts of simple, safe, new foods
  - *5-step sensation mindfulness strategy*
- 2. Learn more about new and mixing foods
- 3. Incorporate foods into meals/snacks
  - *Fade it in*
  - *Add some spice*
  - *Chain to a goal*
  - *Switch it up*
  - *Deconstruct*

(Source: Thomas, J. and Eddy, K. 2019)

Additional Therapeutic Models

- **Dialectical Behavior Therapy (DBT)**
  - *Validation, Mindfulness, Emotional regulation, Distress tolerance, Interpersonal effectiveness*
- **Acceptance-Commitment Therapy (ACT)**
  - *Psychological flexibility, Values clarification, Take action towards a committed direction*
- **Family-Based Therapy (FBT)**
  - *Involve parent(s) in care, Emphasize seriousness of ARFID, Behavioral strategies and Practical focus*

Outcome Goals

WEIGHT STABILIZATION OR RESTORATION

HEALTHY RELATIONSHIP WITH FOOD

IMPROVED PSYCHOSOCIAL FUNCTIONING

BETTER QUALITY OF LIFE

Concluding Thoughts on ARFID

- **We need to learn more!**
  - *From our clients and clinical experience*
  - *Pursue research*
- "Nature vs Nurture"
- An ARFID case is “not just an ARFID case”
  - *Letting the patient's history and etiology guide treatment strategies*
  - *One clinical case can contain multiple ARFID type presentations*
- Further exploration of subtypes
- *Continue to create and understand the “kaleidoscope”*

1.

Q/A Time

Please share your professional experiences and insights

What have you learned from working with patients with ARFID?

How do you approach this patient population in comparison to other patients with eating disorders?

What are questions you have or difficulties you have experienced in helping patients with ARFID symptoms?

Thank You!

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