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Understanding & Treating ARFID:

Advances in Diagnosis,
Neurobiology, and Evidence-Based
Care

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Disclosures

What is ARFID?

Avoidant/Restrictive Food Intake Disorder (ARFID)

- **ARFID** is an eating or feeding disturbance characterized by a persistent failure to meet appropriate nutritional and/or energy needs, leading to one or more significant physical or psychosocial consequences.
- Unlike anorexia nervosa or bulimia nervosa, ARFID is not driven by concerns about body weight or shape. Instead, avoidance may stem from:
 - Sensory sensitivity,
 - Fear of aversive consequences (e.g., choking, vomiting),
 - Or lack of interest in eating or food.
- ARFID can affect children, adolescents, adults
 - Often associated with anxiety disorders, ASD, ADHD, and gastrointestinal conditions
 - Severity ranges from mild (e.g., selective eating) to severe (e.g., nutritional failure requiring feeding tube).
- *Limited understanding* poses challenges to effective treatment and management, impacting growth, development, nutrition, and psychosocial well-being, particularly in children and adolescents.

DSM-5-TR Diagnostic Criteria for ARFID (APA, 2022)

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A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
2. Significant nutritional deficiency.
3. Dependence on enteral feeding or oral nutritional supplements.
4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or better explained by another mental disorder.

When ARFID occurs in the context of another condition (e.g., autism spectrum disorder, anxiety), the severity of the eating disturbance must exceed what is typically associated with that condition.

A little bit of history...

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Let's start at the beginning..

- **Pre-20th Century:** Early Observations of "Picky Eating"
 - Feeding disturbances in children were recognized informally by pediatricians and caregivers, often labeled as "fussy" or "picky eaters," but not pathologized.
 - No formal psychiatric framework existed for these behaviors.

Initially, feeding disorders were largely limited to early childhood and NOT considered within the broader spectrum of eating disorders.



- **1960s–1980s:** Introduction of Pediatric Feeding Disorders
 - Infantile Anorexia, Feeding Disorder of Infancy and Early Childhood became recognized in pediatric and developmental psychology literature.
 - These disorders typically affected infants and toddlers, often linked to mother-infant interaction problems, oral-motor dysfunction, or failure to thrive.

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First official category...

1980 (DSM-III): Feeding Disorder of Infancy and Early Childhood

Eating disorders are psychiatric conditions characterized by these main patterns of behavior:

- DSM-III introduced "Feeding Disorder of Infancy or Early Childhood" for the first time.
 - Criteria focused on failure to eat adequately leading to weight loss or failure to gain weight.
 - Onset restricted to under 6 years of age.
- Did not account for older children, adolescents, or adults with food avoidance not tied to body image.

1990s–2000s: Growing Recognition of Atypical Restrictive Eating

- Increasing clinical awareness of eating disorders without body image distortion.
 - Examples: Children with selective eating, those with food-related phobias, or extreme sensory sensitivities (often comorbid with ASD or anxiety).
- Term "Selective Eating Disorder" was used informally in clinical settings and early research papers, especially in connection with sensory processing issues.
 - Example: Some children would only eat a limited number of foods due to smell, texture, or fear of choking, but were not concerned about weight or shape.

2007–2011: DSM-5 Development and ARFID Proposal

- As part of the DSM-5 revision process, experts identified a gap in the classification system:
 - Children, teens, and adults with significant nutritional and psychosocial impairments from restrictive eating, but no body image issues, did not fit anorexia nervosa or bulimia nervosa criteria.
- Researchers proposed a new diagnosis: Avoidant/Restrictive Food Intake Disorder (ARFID).

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Since the diagnosis...

- **2014–2019: Initial Clinical and Research Focus**
 - Clinical case series, small trials, and retrospective chart reviews began to explore:
 - Prevalence, comorbidities (ASD, anxiety, ADHD).
 - Validity of proposed subtypes.
 - Emerging assessment tools like PARDI and NIAS.
 - Growing interest in family-based and CBT-based interventions adapted for ARFID.
- **2020s: Expansion of Research and Neurobiological Inquiry**
 - Surge in publications and studies:
 - Neurobiological correlates (e.g., sensory processing networks, fear circuitry).
 - Genetic links with neurodevelopmental disorders.
 - Better characterization of ARFID in adults.
 - Increased integration with eating disorder treatment centers, pediatric GI clinics, and mental health programs.
- **2024 Highlights:**
 - Narrative reviews and multicenter studies (e.g., Fonseca, 2024; Di Cara, 2023) solidifying ARFID's place in eating disorder literature.
 - Proposals for research diagnostic criteria to increase precision in clinical trials (e.g., Radcliffe ARFID Workgroup, 2019).

Year	Milestone
1980	DSM-III includes Feeding Disorder of Infancy and Early Childhood
1990s–2000s	Growing use of terms like "Selective Eating Disorder" in clinical contexts
2013	DSM-5 introduces ARFID, broadening scope beyond early childhood
2014–2019	Initial research on assessment tools, subtypes, and treatment begins
2020–2024	Rapid expansion of neurobiological, genetic, and treatment research

Why ARFID was needed as a diagnosis?

- Prior to DSM-5, many children and adolescents with eating disturbances (who did NOT meet criteria for AN or BN) were diagnosed with EDNOS (Eating Disorder Not Otherwise Specified), a vague residual 'catch-all'
- Studies prior to DSM-5 suggested that up to 40–60% of pediatric patients with significant eating disturbances were diagnosed with EDNOS
 - Nicholls et al. (2011): EDNOS was the most common diagnosis in child/adolescent eating disorder services in the UK.
 - Swanson et al. (2011): In adolescents, EDNOS was more common than AN or BN combined.
- EDNOS was too broad and heterogenous
 - EDNOS included individuals with:
 - Atypical anorexia.
 - Subthreshold bulimia.
 - Non-body-image-related restriction (now classified as ARFID).
 - This lack of specificity limited research, treatment development, and insurance reimbursement.
- Yet clinicians kept seeing children and adolescents with:
 - Clinicians observed children and adults with:
 - Sensory-based food aversion.
 - Post-traumatic feeding disturbances (e.g., after choking).
 - Profound lack of interest in food/eating.
 - They often had medical complications, psychosocial impairment, or nutritional deficiencies, but no body image concerns.
 - These were often complex cases requiring multidisciplinary, tailored treatments

Yet...

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How common is ARFID?

Prevalence of ARFID

- **Prevalence of ARFID in children & adolescents**
 - In the general pediatric population:
 - Estimated prevalence ranges from 1.5% to 5%.
 - One U.S. school-based study reported 3.2% of children aged 8–13 met criteria for ARFID.
 - Kurz et al., 2015. Int J Eat Disord.
 - Pediatric specialty clinics:
 - Rates are substantially higher in eating disorder clinics (5%–22%) and feeding clinics (up to 64%).
 - Fisher et al., 2014. Int J Eat Disord.
 - Children with chronic medical conditions (e.g., GI disorders, food allergies):
 - Higher prevalence of ARFID symptoms, particularly fear-based and sensory-based subtypes.
 - Zucker et al., 2019. J Adolesc Health.
- **Prevalence of ARFID in adults**
 - Estimated at ~0.3%–3.2% in community samples, but likely underdiagnosed.
 - Adult cases often emerge from childhood-onset ARFID that was never recognized or treated.
 - Neuropsychiatric Disease and Treatment, 2022.
 - A study in the UK found a 1.2% lifetime prevalence in adults aged 18–40, using structured diagnostic tools.
 - Kerr-Gaffney et al., 2022. J Psychiatr Res.

Gender Distribution & Common Comorbidities

- **Gender distribution**
 - Unlike anorexia or bulimia, ARFID affects males and females at similar rates.
 - Some studies suggest ARFID may be more common in males, particularly those with neurodevelopmental comorbidities.
 - Bryant-Waugh, 2019. Curr Opin Psychiatry.
- **Common Comorbidities**
 - Neurodevelopmental and anxiety-related disorders are common:
 - Autism Spectrum Disorder (ASD): 13%–32%
 - ADHD: ~10%–25%
 - Generalized Anxiety Disorder (GAD): 15%–30%
 - Obsessive-Compulsive Disorder (OCD): 8%–15%
 - Norris et al., 2021. J Am Acad Child Adolesc Psychiatry.
 - Koomar et al., 2021. J Clin Psychiatry.

Prevalence of ARFID Subtypes

- **Clinical Samples (Tertiary Care / Eating Disorder Programs)**
 - Zickgraf & Ellis, 2018 – Adult ARFID patients (n=71)
 - Sensory sensitivity: 65%
 - Fear of aversive consequences: 20%
 - Appetite/low interest: 45%
 - Multiple presentations: 36% had 2 or more drivers
 - Norris et al., 2021 – Pediatric tertiary care ARFID patients (n=130)
 - Sensory-based avoidance: 63%
 - Fear of aversive consequences: 26%
 - Appetite/low interest: 32%
 - Overlapping subtypes: 48% had more than one subtype
- **Key takeaways**
 - Sensory-based avoidance is the most consistently prevalent subtype across clinical and community samples.
 - Fear of aversive consequences is least common overall, but often prominent in sudden-onset or post-traumatic ARFID cases.
 - Many individuals present with overlapping subtypes — estimates range from 30–50% with mixed features.
- **Neurodevelopmental or Psychiatric Samples**
 - Koomar et al., 2021 – ARFID in neurodevelopmental clinics (n=256)
 - Sensory subtype was most common in children with ASD or ADHD traits
 - Fear subtype less common in ASD, more in anxiety-prone youth
 - Appetite subtype more often comorbid with depression
- **Pediatric/community setting**
 - Kurz et al., 2015 – Community pediatric sample (n=1,600)
 - Low interest in food: 60% of those meeting ARFID criteria
 - Sensory avoidance: 49%
 - Fear of consequences: 12%

What causes ARFID?

Environmental Influences

- Traumatic Feeding Experiences
 - Traumatic events like choking, vomiting, or food poisoning can lead to food-related fear and avoidance, often resulting in conditioned aversions to food (Bryant-Waugh et al., 2019; Thomas et al., 2017).
 - These aversions can persist even after the physical threat has passed, especially in children with high anxiety sensitivity (Zickgraf et al., 2019, Int J Eat Disord).
- Family Dynamics
 - Pressuring children to eat, restricting certain foods, or using food as a reward are associated with greater feeding difficulties and can increase ARFID risk (Farrow & Blissett, 2008; Steinsbekk et al., 2018).
 - High-conflict or anxiety-provoking mealtimes contribute to negative associations with eating and lower food variety intake (Harshman et al., 2019, IJED)..
- Cultural Influences
 - Cultural norms around cleanliness, food safety, or body purity can drive food restrictions independent of weight concerns (Kauer et al., 2023, Current Opinion in Psychology).
 - Some cultures with rigid food rules or sensory boundaries may inadvertently reinforce sensory-based avoidance (Kerzner et al., 2015, Pediatrics).

Neurobiology & Genetics

- Neurobiological insights
 - fMRI studies show hypoactivation in the insular cortex and amygdala when ARFID patients are exposed to food cues — areas involved in interoception, disgust, and fear (Seiverling et al., 2023, JAMA Netw Open).
 - ARFID has been linked to heightened sensory sensitivity — possibly from hyperconnectivity in sensory integration areas (Benoit et al., 2023, Nutrients).
- Genetic Considerations
 - Twin studies show ARFID has high heritability (~0.79), comparable to other eating disorders (Dinkler et al., 2022, JCPP Advances).
 - Genetic correlations with ASD, OCD, and neuroticism suggest ARFID shares neurodevelopmental and temperamental pathways with other internalizing disorders (Koomar et al., 2021, J Clin Psychiatry).

Mechanism #1: Sensory Processing Differences

- Many individuals with ARFID have heightened sensory sensitivity (taste, smell, texture), especially in the Avoidant subtype.
 - Associated with heightened reactivity in sensory integration areas (insula, somatosensory cortex).
 - Neuroimaging evidence suggests overlap with sensory processing pathways seen in autism spectrum disorder (ASD).
 - (Kambanis et al., 2020; Zickgraf et al., 2022; Breiner et al., 2022)
- Sensory hyper-responsivity may lead to aversive conditioning and food neophobia.
 - Especially relevant in "sensory sensitivity" ARFID phenotype.
 - (Norris et al., 2014; Dovey et al., 2008)

Mechanism #2: Fear-based Learning & Conditioned Avoidance

- ARFID can develop through aversive interoceptive conditioning, such as pairing food with pain, choking, or vomiting.
 - Engages insula, amygdala, and anterior cingulate cortex (ACC).
 - Similar mechanisms are seen in specific phobia and PTSD.
 - ((Thomas et al., 2017; Bryant-Waugh et al., 2019; Kambanis et al., 2020)
- Anxious/aversive subtype of ARFID shows elevated trait anxiety, and may be associated with intolerance of uncertainty.
 - (Kambanis et al., 2022)

Mechanism #3: Interoceptive Dysfunction

- Impaired interoceptive awareness (i.e., sensing hunger/fullness cues) is noted in some ARFID subtypes.
 - Involves the insula, ACC, and ventromedial prefrontal cortex.
 - Links to dysregulated homeostatic signaling and avoidance of hunger cues.
 - (Pollatos et al., 2008; Kambanis et al., 2020; Zucker et al., 2019)

Mechanism #4: Reward Processing Differences

- Reduced motivation or "reward value" for food noted in some patients.
 - May involve dopaminergic pathways (VTA-NAc-PFC axis).
 - Hypofunction of reward circuitry overlaps with anhedonic presentations or comorbid ASD/ADHD.
 - ((Thomas et al., 2017; Kambanis et al., 2020; Zucker et al., 2019)

Detecting & diagnosing ARFID

DSM-5-TR Diagnostic Criteria for ARFID (APA, 2022)

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B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or better explained by another mental disorder.

When ARFID occurs in the context of another condition (e.g., autism spectrum disorder, anxiety), the severity of the eating disturbance must exceed what is typically associated with that condition.

ARFID Subtypes

- **As per DSM-5-TR and research by Thomas et al., 2017:**
 - Sensory-Based Avoidance
 - Driven by heightened disgust/sensory aversion
 - Linked to ASD traits and sensory over-responsivity
 - Fear of Aversive Consequences
 - Driven by prior choking, vomiting, or pain
 - Conditioned fear and somatic vigilance
 - Low Appetite / Lack of Interest
 - Characterized by low interoceptive hunger cues
 - Often overlaps with anxiety or depression
 - These subtypes may overlap and are not mutually exclusive (Zickgraf & Ellis, 2018).

Screening for ARFID

- **NIAS: Nine Item ARFID Screen**
 - A brief, self-report questionnaire to screen for ARFID symptoms in adolescents and adults.
 - Key Features:
 - 9 Likert-scale items divided into 3 subscales:
 - Sensory Sensitivity
 - Fear of Aversive Consequences
 - Appetite/Interest
 - Validated for use in both clinical and non-clinical populations.
 - Often used as a first-line screener in outpatient clinics, schools, or research.
 - Scoring:
 - Higher scores indicate greater symptom severity.
 - While not diagnostic alone, it helps identify individuals who should receive further evaluation, such as with the PARDI or EDE-ARFID.

Nine Item Avoidant/Restrictive Food Intake disorder screen (NIAS) - Child

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	I am a picky eater	☐	☐	☐	☐	☐	☐
2	I dislike most of the foods that other people eat	☐	☐	☐	☐	☐	☐
3	The list of foods that I like and will eat is shorter than the list of foods I won't eat	☐	☐	☐	☐	☐	☐
4	I am not very interested in eating; I seem to have a smaller appetite than other people	☐	☐	☐	☐	☐	☐
5	I have to push myself to eat regular meals throughout the day, or to eat a large enough amount of food at meals	☐	☐	☐	☐	☐	☐
6	Even when I am eating a food I really like, it is hard for me to eat a large enough volume at meals	☐	☐	☐	☐	☐	☐
7	I avoid or put off eating because I am afraid of GI discomfort, choking, or vomiting	☐	☐	☐	☐	☐	☐
8	I restrict myself to certain foods because I am afraid that other foods will cause GI discomfort, choking, or vomiting	☐	☐	☐	☐	☐	☐
9	I eat small portions because I am afraid of GI discomfort, choking, or vomiting	☐	☐	☐	☐	☐	☐

Individuals respond to each question on a scale from 0 (*Strongly Disagree*) to 5 (*Strongly Agree*). Subscales are each scored on a scale from 0–15, with higher scores indicating higher levels of each metric (picky eating, lack of interest, and fear). All items may also be summed to calculate a total score, ranging from 0–45, with higher scores indicating higher levels of avoidant/restrictive eating broadly.

Assessing ARFID with the EDE

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- **EDE-ARFID – the gold standard, with diagnostic depth (adult version in development/research settings)**
 - The EDE-ARFID is a semi-structured, clinician-administered interview specifically adapted from the Eating Disorder Examination (EDE) to assess Avoidant/Restrictive Food Intake Disorder (ARFID) symptoms in children, adolescents, and adults.
 - Developed to provide a comprehensive, standardized assessment of ARFID based on DSM-5 criteria, and to distinguish it from other eating disorders like anorexia nervosa or bulimia nervosa
 - Includes specific modules for:
 - ARFID core symptoms (e.g., food avoidance behaviors, nutritional impact)
 - Functional impairment
 - Subtypes:
 - Sensory-based avoidance
 - Fear of aversive consequences
 - Lack of interest/appetite
 - Captures:
 - Detailed qualitative and quantitative data on the nature, duration, and severity of avoidant/restrictive eating patterns.
 - Behavioral indicators (e.g., food refusal, avoidance behaviors).
 - Nutritional/medical consequences, including supplemental feeding.
 - Scoring
 - Designed for both diagnostic decision-making and tracking treatment progress.
 - Ratings reflect severity and frequency of ARFID symptoms over the past 28 day
 - Reference: Bryant-Waugh, F., Micali, N., Cooke, L., Lawson, E. A., Eddy, K. T., & Thomas, J. J. (2019).

Assessing ARFID with the PARDI

- **PARDI: Pica, ARFID, and Rumination Disorder Interview – a broader tool, with “differential diagnosis”**
 - A semi-structured, clinician-administered diagnostic interview designed to assess symptoms of:
 - Pica
 - ARFID
 - Rumination Disorder
 - (Collectively referred to as feeding and eating disorders of infancy and early childhood, though the tool is usable across the lifespan.)
 - Key Features:
 - Covers DSM-5 diagnostic criteria for each disorder.
 - Available in multiple versions (e.g., child, adolescent, adult; parent-report vs self-report).
 - Includes severity ratings and functional impairment scales.
 - Assesses ARFID subtypes (sensory sensitivity, fear of aversive consequences, lack of interest).
 - Reference: Bryant-Waugh et al., 2019.
 - Available here:
 <https://mccaed.slam.nhs.uk/wp-content/uploads/2022/02/PARDI-Self-14-V.2.1-Oct-2020.pdf>

Treating ARFID

First of all, what's missing (or “in progress”) in our ARFID arsenal?

- **Consensus Guidelines**
 - As of 2025, there are no international or national consensus treatment guidelines for ARFID akin to those published by:
 - APA for AN/BN
 - NICE (UK) for eating disorders broadly
 - Clinical protocols vary widely across clinicians
- Fonseca (2024) and others highlight the urgent need for:
 - Standardized diagnostic algorithms
 - Treatment staging by severity
 - Recommendations based on subtype (sensory/fear/interest)
 - Guidance for integrating care in complex comorbid cases (e.g., ASD, GI disorders)

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Manualized Treatment Protocols for ARFID

- CBT-AR (Cognitive Behavioral Therapy for ARFID)
 - The most developed manualized treatment model to date:
 - Developed at Massachusetts General Hospital (Thomas et al., 2020).
 - Includes structured, modular components tailored to ARFID presentations (sensory-based, fear-based, low interest).
 - Published and available, but not yet universally adopted or included in formal clinical practice guidelines
 - Because there aren't formal practice guidelines yet...
- Family-Based Therapy Adaptations for ARFID
 - Several programs (e.g., Stanford, University of Chicago) have adapted FBT principles for ARFID.
 - No consensus yet on structure or session sequencing.
 - Some empirical support (Lock et al., 2019), especially in youth, but no standardized manual published for ARFID-specific FBT.

Pharmacological Options

- Very limited data from controlled ARFID specific studies
 - Medication strategies often extrapolated from similar populations (i.e. AN, anxiety disorders)
- Mirtazapine – appetite stimulation, sedation, anxiety reduction (Fisher et al., 2014).
- Olanzapine – useful in underweight cases or comorbid OCD traits (Koman et al., 2020).
- SSRIs may help in cases with comorbid anxiety or OCD traits (Bryant-Waugh, 2019).
- There are no RCTs yet for pharmacologic treatment specifically targeting core ARFID symptoms (as of 2025).
- Medications should be considered adjunctive, not first-line — and always in the context of a multidisciplinary team.
- Potential candidates for medication are those with:
 - Significant comorbid anxiety
 - Impaired participation in therapy due to fear
 - Appetite dysregulation or sleep disturbance

Mirtazapine (for appetite stimulation, sedation, anxiety reduction)

- Mechanism: Noradrenergic and specific serotonergic antidepressant (NaSSA); blocks 5-HT_{2A/C} and H₁ receptors → increases appetite, reduces anxiety, and promotes sedation.
- Evidence in ARFID or related conditions::
 - Fisher et al. (2014) – *Not an ARFID-specific trial*, but includes case series involving patients with significant food avoidance.
 - Mirtazapine has been used off-label for:
 - Patients with low appetite/lack of interest subtype
 - Comorbid anxiety and weight loss
 - Often used in patients with ARFID-like presentations prior to the DSM-5 formalization
- May be most effective in ARFID patients with low appetite, generalized anxiety, and sleep disturbances.
 - Goal of stimulating weight gain and reducing food-related anticipatory anxiety.
 - a. Reference: Fisher, M. M., Rosen, D. S., Ornstein, R. M., et al. (2014). Characteristics of avoidant/restrictive food intake disorder in children and adolescents: a “new disorder” in DSM-5. *J Adolesc Health*, 55(1), 49–52. Includes ARFID patients in descriptive capacity, but not a controlled drug trial.

Olanzapine (for weight gain, OCD traits)

- Mechanism: Second-generation antipsychotic; dopamine D2 and serotonin 5-HT2A antagonist.
- Evidence in ARFID:
 - Koman et al. (2020) – This paper discusses use of olanzapine in pediatric feeding disorders, including cases resembling ARFID, but not exclusively ARFID-labeled.
 - Known for use in anorexia nervosa, where it can reduce obsessionality and rigidity.
 - Koman, S. L., et al. (2020). Olanzapine for severe feeding aversion in children: a case series. *J Dev Behav Pediatr*, 41(5), 403–408.
 - Not an ARFID specific study, but a case series on feeding aversion, likely overlapping with ARFID
- May be helpful in ARFID patients with:
 - Extreme sensory rigidity
 - Weight loss + food refusal
 - OCD-like food rituals
- Use caution due to metabolic side effects (weight gain, insulin resistance).

SSRIs (for comorbid anxiety, OCD...)

- Mechanism: Selective serotonin reuptake inhibition; standard treatment for anxiety and OCD.
- Evidence in ARFID:
 - Bryant-Waugh (2019) – Review suggests SSRIs may help manage comorbid anxiety or OCD-spectrum symptoms in ARFID, though not core ARFID symptoms like food avoidance or sensory aversion.
 - SSRIs have not been shown to increase appetite or improve food variety directly.
 - Bryant-Waugh, R. (2019). ARFID: Avoidant/restrictive food intake disorder. *Current Opinion in Psychiatry*, 32(6), 476–481.
 - This as a specific review paper on ARFID; but recommendations are extrapolated from clinical practice and comorbidity research.
- Consider SSRIs when:
 - Anxiety is interfering with exposure therapy
 - Panic/fear of aversive consequences (vomiting, choking) dominates
 - There are concurrent generalized anxiety, social anxiety, or OCD diagnoses

Outcomes & Prognosis

Recovery Rates

- Recovery is most favorable in young children with early intervention (Norris et al., 2021, J Am Acad Child Adolesc Psychiatry).
 - In a large multicenter study, children under age 12 diagnosed with ARFID had significantly better treatment response than adolescents and adults.
 - Early intervention (defined as “within 6 months of symptom onset”) was associated with:
 - Shorter illness duration
 - Lower symptom severity
 - Fewer entrenched avoidance patterns
 - Children responded more quickly to behavioral feeding therapies and required less intensive intervention to expand dietary variety and improve weight gain.

Better physical recovery rates than AN, but slower psychological/dietary variety gains

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- Key findings from a study by Menzel & Perry (2024):
 - Compared to patients with anorexia nervosa (AN), individuals with ARFID:
 - Regain weight faster, particularly when weight loss is not volitional
 - Have fewer medical complications associated with starvation or purging
- However, they show slower improvements in:
 - Food flexibility (increasing the number of safe/accepted foods)
 - Cognitive anxiety around mealtimes
 - Social eating and participation in normal eating contexts
- Why might psychological recovery be slower...?
 - ARFID is not ego-syntonic (not aligned with self-image), but avoidance is often deeply fear-based (e.g., fear of choking) or rooted in sensory processing issues.
 - Food exposure often requires systematic desensitization, not just normalization of eating behavior.
 - Many patients remain nutritionally stable but socially impaired (e.g., can't eat at restaurants, with peers, or at family events).
- Other supporting studies:
 - Harshman et al. (2019): Weight gain in inpatient ARFID patients occurred more rapidly than in AN, but variety increased minimally during admission.
 - Eddy et al. (2020): Despite physical stabilization, ARFID patients often need longer durations of outpatient CBT or feeding therapy to achieve broad dietary range.

Clinical Implications

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- Education is advocacy:
 - Pediatricians, school counselors, and parents play a crucial role in early identification and referral.
- Early intervention
 - Delay in treatment (even 1–2 years) can increase the risk of:
 - Chronicity
 - Need for inpatient/residential treatment
 - Comorbid psychiatric conditions (e.g., anxiety, depression)
- Don't equate weight restoration with full remission.
- Treatment goals should include:
 - Expanding variety
 - Reducing avoidance behaviors
 - Building flexibility and distress tolerance in eating situations
- Physical stabilization is the first step. Full recovery includes psychosocial functioning and diverse, flexible eating.
- Relapse prevention is crucial:
 - Long-term follow-up data show that symptom resurgence is common when individuals return to unstructured environments (Eddy et al., 2020, IJED).

Relapse Prevention in ARFID

Meal Support & Family Involvement

- Continued structured meal support — even after acute phase — helps maintain eating behavior consistency and reduce regressions.
- In youth, parental involvement remains critical even post-treatment:
 - Parents may need to prompt variety
 - Maintain household exposure practices
 - Serve as buffers during high-stress events (school transitions, travel)
- Thomas et al. (2020) recommend a "fade-out" plan: gradually decreasing intensity of parental supervision while teaching the child to self-monitor and self-regulate.

Anxiety Management

- Since many ARFID cases are maintained by fear (e.g., choking, vomiting) or social/anticipatory anxiety, relapse prevention includes continued anxiety management tools:
 - Cognitive restructuring (e.g., "I've eaten this food safely before.")
 - Somatic tools (e.g., diaphragmatic breathing, mindfulness)
 - Distress tolerance for sensory or novelty discomfort
- Even after successful refeeding or nutritional stabilization, anxiety may re-emerge in novel contexts (vacation, new school, changing routines).
- Reference: Bryant-Waugh, R., et al. (2019). Treatment and outcomes in ARFID: A systematic review. IJED.

Ongoing Food Exposure & Flexibility Training

- Relapse risk is inversely proportional to food flexibility (Thomas 2020)
 - Patients with <20 accepted foods are far more likely to regress.
 - Flexibility buffers against disruption (e.g., when a preferred food is unavailable).
- Maintenance phase should include:
 - Continued exposure hierarchy practice (e.g., new foods weekly)
 - Eating in diverse environments (school, restaurants, social events)
 - Rotation schedules to avoid food rigidity and dependency
- References:
 - Thomas, J. J., Eddy, K. T., & Eddy, K. T. (2020). CBT-AR.
 - Harshman, S. G., et al. (2019). Nutritional and psychosocial outcomes in inpatient ARFID care. IJED.

How we approach ARFID at Center for Change

Center for Change ARFID Program

- **Individualized Care Plans:**
 - Treatment is tailored to each individual's specific needs, considering the unique challenges presented by ARFID.
- **Multidisciplinary Team:**
 - The care team comprises professionals from various disciplines, including therapists, dietitians, and medical staff, collaborating to address the complex nature of ARFID.
- **Specialized Nutritional Support:**
 - Registered dietitians with expertise in ARFID work closely with patients to expand food variety and address nutritional deficiencies.
- **Therapeutic Interventions:**
 - Evidence-based therapies are employed to address the psychological aspects of ARFID, such as anxiety related to eating and food avoidance behaviors.
- **Family Involvement:**
 - Family therapy sessions are incorporated to support the patient's recovery process and address familial dynamics that may influence eating behaviors.

Recap & Lessons learned at CFC

Thank You

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