

Avoidant/Restrictive Food Intake Disorder

DSM-5-TR 307.59 | ICD-10-CM F50.82

Restricted intake causing weight, nutritional or psychosocial consequences, without body image disturbance or fear of weight gain.

PREVALENCE

~0.3-3.7% (youth samples)

TYPICAL ONSET

Early childhood; can persist

SEX RATIO

Near 1:1; more male than AN

COURSE

Chronic without treatment

CLINICAL PICTURE

- Three overlapping presentations: low interest in eating, sensory-based avoidance of texture, smell or color, and fear of aversive consequences.
- Fear-driven cases often follow a choking, vomiting or allergic event, with abrupt onset and rapid weight loss over a few weeks.
- Sensory-based avoiders eat a fixed list of 10-20 accepted foods, usually beige carbohydrates, and refuse novel items with intense distress.
- Children show faltering growth, micronutrient deficiency and reliance on oral supplements while denying any concern about body shape or weight.
- Meals become family battlegrounds with prolonged mealtimes, coaxing and distraction, plus avoidance of eating with peers at school or parties.
- Adults present with weight loss, dependence on nutritional drinks, repeated dysphagia workups, or avoidance of restaurants and travel.

DIAGNOSTIC CRITERIA AT A GLANCE

- The eating disturbance must cause at least one of significant weight loss or faltering growth, nutritional deficiency, supplement or tube dependence, or psychosocial interference.
- Body image disturbance and drive for thinness are absent, which is the single feature that most cleanly separates ARFID from anorexia nervosa.
- The restriction cannot be explained by food unavailability, a culturally sanctioned practice, or another medical or mental disorder that fully accounts for it.
- No minimum duration is specified, but the disturbance must be persistent rather than a transient reaction to an acute illness or hospitalization.
- It may be diagnosed alongside autism, ADHD, anxiety disorders or GI disease when intake problems exceed what those conditions alone would explain.

NEUROBIOLOGY & PHYSIOLOGY

- Sensory over-responsivity and supertaster phenotypes with heightened PROP bitterness sensitivity underpin the sensory avoidance presentation.
- Appetite regulation differs by subtype, with low-interest presentations showing reduced hunger drive, altered ghrelin and delayed gastric emptying.
- High overlap with autism and ADHD points to shared neurodevelopmental differences in interoceptive awareness and executive function.
- Conditioned taste aversion mediated by amygdala and insula learning explains the abrupt fear-based subtype after a single choking or emesis event.
- Nutritional sequelae include iron, zinc, vitamin C, vitamin D and B12 deficiency, with published cases of scurvy, rickets and optic neuropathy.
- Chronic restriction produces bradycardia, hypothermia, delayed puberty and low bone density, matching the starvation physiology seen in anorexia.

PSYCHOLOGICAL MECHANISMS

- Classical conditioning after an aversive event followed by operant avoidance maintained through anxiety reduction mirrors specific phobia mechanics.
- Parental accommodation through separate meals, purchased safe foods and prolonged coaxing removes exposure opportunity and entrenches the food range.
- Interoceptive awareness deficits leave children unable to identify hunger, so eating must be externally scheduled rather than appetite-driven.
- Rigidity, need for sameness and low novelty seeking in autistic patients make a change of brand or packaging sufficient to trigger total refusal.
- Anticipatory anxiety and catastrophic beliefs about choking or vomiting far exceed realistic risk and respond well to graded exposure.

DIFFERENTIAL & COMORBIDITY

- Separate from anorexia nervosa by the absence of shape concern, and from ordinary picky eating by demonstrable impairment or medical consequence.
- Exclude eosinophilic esophagitis, achalasia, oropharyngeal dysphagia, celiac disease, food allergy and reflux, any of which may also coexist with ARFID.
- Consider specific phobia of vomiting, OCD contamination fears, delusions about contaminated food, and major depression with appetite loss.
- Comorbidity includes anxiety disorders in 50-70%, autism in 10-30%, ADHD, and GI disorders, with mood disorders more prominent in adults.
- Medical risk mirrors anorexia, so check electrolytes, phosphate, ECG, growth velocity, iron studies, vitamin D and B12 at the initial visit.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA-approved for ARFID, and pharmacotherapy remains adjunctive to nutritional rehabilitation and exposure-based psychotherapy.
- Mirtazapine 7.5-30 mg/day** is used off-label to stimulate appetite and reduce anxiety, supported by open-label pediatric case series only.
- Cyproheptadine 2-8 mg three times daily** may increase appetite in younger children, with sedation and anticholinergic effects limiting the dose.
- SSRIs such as **fluoxetine** or **sertraline** address comorbid anxiety and fear-of-consequences presentations rather than intake volume itself.
- Low-dose olanzapine is occasionally used for rigid, anxiety-driven refusal; obtain informed consent and monitor metabolic parameters closely.

PSYCHOTHERAPY

- CBT-AR** across 20-30 sessions builds intake volume first and then variety through in-session food exposure, with family involvement for children.
- Graded exposure and systematic desensitization are the core intervention for fear-based ARFID, closely mirroring specific phobia protocols.
- Family-based treatment adapted for ARFID** empowers parents to take charge of intake and suits young, medically compromised children.
- Responsive feeding guidance and behavioral parent training reduce mealtime coercion, prolonged meals and accommodation in preschoolers.
- Occupational therapy sensory approaches and food chaining expand accepted textures, though the supporting evidence base remains preliminary.

ADJUNCT & SUPPORTIVE

- A multidisciplinary team including a dietitian, physician, speech-language pathologist and occupational therapist is standard rather than optional.
- Oral supplements or nasogastric feeding stabilize acute cases, but wean deliberately so that tube dependence does not replace the original problem.
- Correct micronutrient deficiency with iron, zinc, vitamin D, B12 and a multivitamin, then repeat laboratory studies after 8-12 weeks.
- Use the **PARDI** or the Nine Item ARFID Screen to define subtype and track change, with growth trajectory as the primary outcome measure.
- Arrange school lunch accommodations, and use day programs or inpatient meal support when growth stalls despite adequate outpatient care.

CLINICAL PEARLS

- No body image concern: that single question separates ARFID from anorexia at the bedside.
- Picky eating becomes ARFID only when growth, nutrition or function is measurably harmed.
- Boys and autistic patients are overrepresented, so do not screen only girls for eating disorders.

References

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NOTE

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