Avoidant/Restrictive Food Intake Disorder

Code: 307.59 (F50.8)

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Diagnostic Criteria 307.59 (F50.8)

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 not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
Specify if:
In remission: After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

Diagnostic Features

Avoidant/restrictive food intake disorder replaces and extends the DSM-IV diagnosis of feeding disorder of infancy or early childhood. The main diagnostic feature of avoidant/restrictive food intake disorder is avoidance or restriction of food intake (Criterion A) manifested by clinically significant failure to meet requirements for nutrition or insufficient energy intake through oral intake of food. One or more of the following key features must be present: significant weight loss, significant nutritional deficiency (or related health impact), dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning. The determination of whether weight loss is significant (Criterion A1) is a clinical judgment; instead of losing weight, children and adolescents who have not completed growth may not maintain weight or height increases along their developmental trajectory.
Determination of significant nutritional deficiency (Criterion A2) is also based on clinical assessment (e.g., assessment of dietary intake, physical examination, and laboratory testing), and related impact on physical health can be of a similar severity to that seen in anorexia nervosa (e.g., hypothermia, bradycardia, anemia). In severe cases, particularly in infants, malnutrition can be life threatening. "Dependence" on enteral feeding or oral nutritional supplements (Criterion A3) means that supplementary feeding is required to sustain adequate intake. Examples of individuals requiring supplementary feeding include infants with failure to thrive who require nasogastric tube feeding, children with neurodevelopmental disorders who are dependent on nutritionally complete supplements, and individuals who rely on gastrostomy tube feeding or complete oral nutrition supplements in the absence of an underlying medical condition. Inability to participate in normal social
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activities, such as eating with others, or to sustain relationships as a result of the disturbance would indicate marked interference with psychosocial functioning (Criterion A4). Avoidant/restrictive food intake disorder does not include avoidance or restriction of food intake related to lack of availability of food or to cultural practices (e.g., religious fasting or normal dieting) (Criterion B), nor does it include developmentally normal behaviors (e.g., picky eating in toddlers, reduced intake in older adults). The disturbance is not better explained by excessive concern about body weight or shape (Criterion C) or by concurrent medical factors or mental disorders (Criterion D).
In some individuals, food avoidance or restriction may be based on the sensory characteristics of qualities of food, such as extreme sensitivity to appearance, color, smell, texture, temperature, or taste. Such behavior has been described as "restrictive eating," "selective eating," "choosy eating," "perseverant eating," "chronic food refusal," and "food neophobia" and may manifest as refusal to eat particular brands of foods or to tolerate the smell of food being eaten by others. Individuals with heightened sensory sensitivities associated with autism may show similar behaviors.
Food avoidance or restriction may also represent a conditioned negative response associated with food intake following, or in anticipation of, an aversive experience, such as choking, a traumatic investigation, usually involving the gastrointestinal tract (e.g., esophagoscopy); or repeated vomiting. The terms functional dysphagia and globus hystericus have also been used for such conditions.

Associated Features Supporting Diagnosis

Several features may be associated with food avoidance or reduced food intake, including a lack of interest in eating or food, leading to weight loss or faltering growth. Very young infants may present as being too sleepy, distressed, or agitated to feed. Infants and young children may not engage with the primary caregiver during feeding or communicate hunger in favor of other activities. In older children and adolescents, food avoidance or restriction may be associated with more generalized emotional difficulties that do not meet diagnostic criteria for an anxiety, depressive, or bipolar disorder, sometimes called "food avoidance emotional disorder."

Development and Course

Food avoidance or restriction associated with insufficient intake or lack of interest in eating most commonly develops in infancy or early childhood and may persist in adulthood. Likewise, avoidance based on sensory characteristics of food tends to arise in the first decade of life but may persist into adulthood. Avoidance related to aversive consequences can arise at any age. The scant literature regarding long-term outcomes suggests that food avoidance or restriction based on sensory aspects is relatively stable and long-standing, but when persisting into adulthood, such avoidance/restriction can be associated with relatively normal functioning. There is currently insufficient evidence directly linking avoidant/restrictive food intake disorder and subsequent onset of an eating disorder.
Infants with avoidant/restrictive food intake disorder may be irritable and difficult to console during feeding, or may appear apathetic and withdrawn. In some instances, parent-child interaction may contribute to the infant's feeding problem (e.g., presenting food inappropriately, or interpreting the infant's behavior as an act of aggression or rejection). Inadequate nutritional intake may exacerbate the associated features (e.g., irritability, developmental lags) and further contribute to feeding difficulties. Associated factors include infant temperament or developmental impairments that reduce an infant's responsiveness to feeding. Coexisting parental psychopathology, or child abuse or neglect, is suggested if feeding and weight improve in response to changing caregivers. In infants, children, and prepubertal adolescents, avoidant/restrictive food intake disorder may be associated with growth delay, and the resulting malnutrition negatively affects development and learning
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potential. In older children, adolescents, and adults, social functioning tends to be adversely affected. Regardless of the age, family function may be affected, with heightened stress at mealtimes and in other feeding or eating contexts involving friends and relatives. Avoidant/restrictive food intake disorder manifests more commonly in children than in adults, and there may be a long delay between onset and clinical presentation. Triggers for presentation vary considerably and include physical, social, and emotional difficulties.

Risk and Prognostic Factors

Temperamental. Anxiety disorders, autism spectrum disorder, obsessive-compulsive disorder, and attention-deficit/hyperactivity disorder may increase risk for avoidant or restrictive feeding or eating behavior characteristic of the disorder.
Environmental. Environmental risk factors for avoidant/restrictive food intake disorder include familial anxiety. Higher rates of feeding disturbances may occur in children of mothers with eating disorders.
Genetic and physiological. History of gastrointestinal conditions, gastroesophageal reflux disease, vomiting, and a range of other medical problems has been associated with feeding and eating behaviors characteristic of avoidant/restrictive food intake disorder.

Culture-Related Diagnostic Issues

Presentations similar to avoidant/restrictive food intake disorder occur in various populations, including in the United States, Canada, Australia, and Europe. Avoidant/restrictive food intake disorder should not be diagnosed when avoidance of food intake is solely related to specific religious or cultural practices.

Gender-Related Diagnostic Issues

Avoidant/restrictive food intake disorder is equally common in males and females in infancy and early childhood, but avoidant/restrictive food intake disorder comorbid with autism spectrum disorder has a male predominance. Food avoidance or restriction related to altered sensory sensitivities can occur in some physiological conditions, most notably pregnancy, but is not usually extreme and does not meet full criteria for the disorder.

Diagnostic Markers

Diagnostic markers include malnutrition, low weight, growth delay, and the need for artificial nutrition in the absence of any clear medical condition other than poor intake.

Functional Consequences of Avoidant/Restrictive

Food Intake Disorder
Associated developmental and functional limitations include impairment of physical development and social difficulties that can have a significant negative impact on family function.

Differential Diagnosis

Appetite loss preceding restricted intake is a nonspecific symptom that can accompany a number of mental diagnoses. Avoidant/restrictive food intake disorder can be diagnosed concurrently with the disorders below if all criteria are met, and the eating disturbance requires specific clinical attention.
Other medical conditions (e.g., gastrointestinal disease, food allergies and intolerances, occult malignancies). Restriction of food intake may occur in other medical condi-
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tions, especially those with ongoing symptoms such as vomiting, loss of appetite, nausea, abdominal pain, or diarrhea. A diagnosis of avoidant/restrictive food intake disorder requires that the disturbance of intake is beyond that directly accounted for by physical symptoms consistent with a medical condition; the eating disturbance may also persist after being triggered by a medical condition and following resolution of the medical condition.
Underlying medical or comorbid mental conditions may complicate feeding and eating. Because older individuals, postsurgical patients, and individuals receiving chemotherapy often lose their appetite, an additional diagnosis of avoidant/restrictive food intake disorder requires that the eating disturbance is a primary focus for intervention.
Specific neurological/neuromuscular, structural, or congenital disorders and conditions associated with feeding difficulties. Feeding difficulties are common in a number of congenital and neurological conditions often related to problems with oral/esophageal/pharyngeal structure and function, such as hypotonia of musculature, tongue protrusion, and unsafe swallowing. Avoidant/restrictive food intake disorder can be diagnosed in individuals with such presentations as long as all diagnostic criteria are met.
Reactive attachment disorder. Some degree of withdrawal is characteristic of reactive attachment disorder and can lead to a disturbance in the caregiver-child relationship that can affect feeding and the child's intake. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and the feeding disturbance is a primary focus for intervention.
Autism spectrum disorder. Individuals with autism spectrum disorder often present with rigid eating behaviors and heightened sensory sensitivities. However, these features do not always result in the level of impairment that would be required for a diagnosis of avoidant/restrictive food intake disorder. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and when the eating disturbance requires specific treatment.
Specific phobia, social anxiety disorder (social phobia), and other anxiety disorders. Specific phobia, other type, specifies "situations that may lead to choking or vomiting" and can represent the primary trigger for the fear, anxiety, or avoidance required for diagnosis. Distinguishing specific phobia from avoidant/restrictive food intake disorder can be difficult when a fear of choking or vomiting has resulted in food avoidance. Although avoidance or restriction of food intake secondary to a pronounced fear of choking or vomiting can be conceptualized as specific phobia, in situations when the eating problem becomes the primary focus of clinical attention, avoidant/restrictive food intake disorder becomes the appropriate diagnosis. In social anxiety disorder, the individual may present with a fear of being observed by others while eating, which can also occur in avoidant/restrictive food intake disorder.
Anorexia nervosa. Restriction of energy intake relative to requirements leading to significantly low body weight is a core feature of anorexia nervosa. However, individuals with anorexia nervosa also display a fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, as well as specific disturbances in relation to perception and experience of their own body weight and shape. These features are not present in avoidant/restrictive food intake disorder, and the two disorders should not be diagnosed concurrently. Differential diagnosis between avoidant/restrictive food intake disorder and anorexia nervosa may be difficult, especially in late childhood and early adolescence, because these disorders may share a number of common symptoms (e.g., food avoidance, low weight). Differential diagnosis is also potentially difficult in individuals with anorexia nervosa who deny any fear of fatness but nonetheless engage in persistent behaviors that prevent weight gain and who do not recognize the medical seriousness of their low weight—a presentation sometimes termed "non-fat phobic anorexia nervosa." Full consideration of symptoms, course, and family history is advised, and diagnosis may
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be best made in the context of a clinical relationship over time. In some individuals, avoidant/restrictive food intake disorder might precede the onset of anorexia nervosa.
Obsessive-compulsive disorder. Individuals with obsessive-compulsive disorder may present with avoidance or restriction of intake in relation to preoccupations with food or ritualized eating behavior. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and when the aberrant eating is a major aspect of the clinical presentation requiring specific intervention.
Major depressive disorder. In major depressive disorder, appetite might be affected to such an extent that individuals present with significantly restricted food intake, usually in relation to overall energy intake and often associated with weight loss. Usually appetite loss and related reduction of intake abate with resolution of mood problems. Avoidant/restrictive food intake disorder should only be used concurrently if full criteria are met for both disorders and when the eating disturbance requires specific treatment.
Schizophrenia spectrum disorders. Individuals with schizophrenia, delusional disorder, or other psychotic disorders may exhibit odd eating behaviors, avoidance of specific foods because of delusional beliefs, or other manifestations of avoidant or restrictive intake. In some cases, delusional beliefs may contribute to a concern about negative consequences of ingesting certain foods. Avoidant/restrictive food intake disorder should be used concurrently only if all criteria are met for both disorders and when the eating disturbance requires specific treatment.
Factitious disorder or factitious disorder imposed on another. Avoidant/restrictive food intake disorder should be differentiated from factitious disorder or factitious disorder imposed on another. In order to assume the sick role, some individuals with factitious disorder may intentionally describe diets that are much more restrictive than those they are actually able to consume, as well as complications of such behavior, such as a need for enteral feedings or nutritional supplements, an inability to tolerate a normal range of foods, and/or an inability to participate normally in age-appropriate situations involving food. The presentation may be impressively dramatic and engaging, and the symptoms reported inconsistently. In factitious disorder imposed on another, the caregiver describes symptoms consistent with avoidant/restrictive food intake disorder and may induce physical symptoms such as failure to gain weight. As with any diagnosis of factitious disorder imposed on another, the caregiver receives the diagnosis rather than the affected individual, and diagnosis should be made only on the basis of a careful, comprehensive assessment of the affected individual, the caregiver, and their interaction.

Comorbidity

The most commonly observed disorders comorbid with avoidant/restrictive food intake disorder are anxiety disorders, obsessive-compulsive disorder, and neurodevelopmental disorders (specifically autism spectrum disorder, attention-deficit/hyperactivity disorder, and intellectual disability [intellectual developmental disorder]).
Anorexia Nervosa
Diagnostic Criteria

A. Restriction of energy intake relative to requirements, leading to a significantly low body