

Factors associated with clinicians' accurate identification of Avoidant/Restrictive Food Intake Disorder (ARFID)

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Introduction

- ARFID is an eating disorder characterized by significant weight loss, nutritional deficiencies, dependence on feeding tubes or supplements, and/or interference with functioning (APA, 2022)
- Challenges have been observed with clinicians accurately diagnosing ARFID (e.g., Harshman et al., 2021)
- ARFID has 3 primary motivating factors: (1) concerns about aversive consequences of eating, (2) avoidance based on the sensory characteristics of food, and (3) apparent lack of interest or drive to eat food
- The current study investigated the ability of licensed mental health professionals to accurately identify and diagnose ARFID via vignettes
- We hypothesized that accuracy of diagnosis would vary based on the motivating factor present

Method

- Participants (N = 103) were licensed mental health providers recruited via postings to professional organizations, direct contact to mental health clinics, and social media posts
- 4 vignettes were created and validated, a control vignette depicting major depressive disorder and 3 ARFID vignettes depicting each of the 3 primary motivating factors
- All participants responded to the control vignette and were randomly assigned to one of the ARFID vignettes
- Participants indicated what they believed the diagnosis was for each vignette and made various confidence ratings

68% of licensed clinicians correctly identified ARFID and diagnostic accuracy varied significantly across the three primary motivating factors



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Results

- Participants were 77% cisgender female and 84% White (scan the QR code for more demographic information about the sample)
- Participants accurately identified depression (95%) at higher rates than ARFID (68%)
- Supporting our hypothesis, accuracy of ARFID diagnosis varied significantly across the 3 vignettes (Figure 1)
- Participants were comparable in their level of confidence in their ARFID diagnoses regardless of vignette, despite their accuracy differing significantly by vignette (Figure 2)

Figure 1. Diagnostic Accuracy Across ARFID Motivating Factors

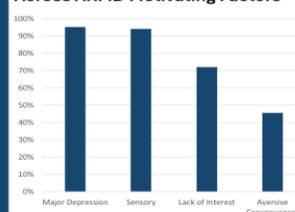
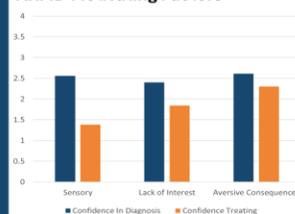


Figure 2. Confidence in Diagnosis and Ability to Treat Across ARFID Motivating Factors



Authors: Hunter Baril, BS; Hanna Anderson, BS; Makayla Dehmer, BA; Morgan Anderson, PhD, Jessica Harper, PhD; Travis Osborne, PhD, Ariel Ravid, PhD

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Introduction

Avoidant/Restrictive Food Intake Disorder (ARFID) is a relatively novel feeding and eating disorder characterized by significant weight loss, nutritional deficiencies, dependence on feeding tubes or supplements, and/or interference with psychosocial functioning (American Psychiatric Association, 2022). ARFID is driven by a heterogeneous mix of motivating factors, including (1) concerns about the aversive consequences of eating (e.g., choking, vomiting), (2) avoidance based

on the sensory characteristics of food (e.g., too mushy, too bitter), and/or (3) an apparent lack of interest or drive to eat food (APA, 2022). Accurate diagnostic evaluation of ARFID has been identified as a challenge (Coelho et al., 2021; Eddy et al., 2019; Harshman et al., 2021). The present study investigated the ability of licensed mental health professionals to accurately identify and diagnose ARFID via clinical case vignettes.

Methods

Four vignettes were created and validated using a previously described methodology for this purpose (St. Marie et al., 2021). The first vignette, which all participants in the study received as a control, described a client with major depressive disorder. Experts in depression (N = 6) rated this vignette as highly valid (Clarity = 10/10; Accurately reflected depression = 10/10). Additionally, three ARFID vignettes were created that were identical to each other, except for two sentences in the middle of each that described one of the three motivating factors for disordered eating (described above). Eating disorder experts (N = 3) rated and provided feedback about the initial ARFID vignettes. Vignettes were then modified based on this feedback and given to a different group of eating disorder experts (N = 6), whose ratings and feedback reflected high validity for the vignettes (ARFID Consequences of Eating - Clarity = 10/10, Accurate = 9.5/10; ARFID Sensory - Clarity = 10/10, Accurate = 9.2/10; ARFID Lack of Interest - Clarity = 10/10, Accurate = 9.5/10). See Appendix 1 (below) for the vignettes used in this study.

Participants were recruited via postings to professional organizations (e.g., APA, ABCT, AMHCA, NASW), direct contact to mental health clinics, and social media posts (e.g., LinkedIn, Facebook group for psychiatrists). Participants completed a demographics questionnaire, including information about their professional background and work setting. They were also presented with the depression vignette and then were randomly assigned to view one of the three ARFID vignettes. After reading each vignette, participants reported what they thought the primary diagnosis was, confidence in their response, other diagnoses they were considering, confidence providing treatment for that client, treatment components they would consider for the client, and level of care that would be appropriate. Lastly, participants reported on whether they used any resources when considering a diagnosis (e.g., DSM-5) and their familiarity level with ARFID. This poster presents a subset of the study's findings.

Results

One hundred and three licensed mental health professionals (77% cisgender female; 84% White) participated in the study. Table 1 reflects the demographic and professional characteristics of the sample. Of the 103 participants, 95.1% (n = 98) correctly identified the diagnosis for the depression vignette as Major Depressive Disorder or Depression, and 68% (n = 70) were able to correctly identify Avoidant Restrictive Food Intake Disorder or ARFID from the ARFID vignette they saw (collapsing across all three ARFID vignettes).

There was a significant difference ($X^2(2, N=103) = 21.11, p < .001, V = .45$) in the ability of clinicians to identify ARFID depending on which ARFID vignette they were assigned to (see Figure 1). Of those randomly assigned to the vignette describing avoidance of sensory characteristics, 94.1% (n = 34) identified ARFID as the primary diagnosis. Of those assigned to the vignette describing an apparent lack of interest in food or drive to eat, 72.0% (n = 25) identified ARFID as the primary diagnosis. Of those assigned to the vignette describing concerns about the aversive consequences of eating, 45.5% (n = 44) identified ARFID as the primary diagnosis. (See Figure 1).

Clinicians who identified as eating disorder specialists ($X^2(1, N=103) = 4.91, p = .03, V = .22$), but not anxiety specialists ($X^2(1, N=103) = .29, p = .59$) were significantly more likely to accurately identify ARFID. Although there was a significant difference in clinician diagnostic accuracy across the three ARFID vignettes, there was no significant difference in reported confidence clinicians had in the diagnosis they provided ($F(2,100) = 0.37, p = .69$). There was a significant difference in which vignette clinicians felt most confident providing treatment for ($F(2,100) = 4.60, p = .01$), with clinicians reporting the highest confidence rating in response to the fear of aversive consequence vignette (see Figure 2).

Discussion

Consistent with our hypothesis, nearly all clinicians sampled were able to accurately identify depression (our control condition). Also consistent with our hypotheses, rates of accurate diagnosis of ARFID were notably lower than for depression and also varied depending on which of the three primary motivating factors were described. The vignette describing avoidance of sensory characteristics as the primary motivating factor yielded the highest diagnostic accuracy, while the vignette describing fear of aversive consequences as the primary motivating factor yielded the lowest diagnostic accuracy. These data suggest a need for more thorough clinical training about ARFID and, in particular, all of the symptom profiles and primary motivating factors that can be present in individuals with ARFID.

Interestingly, although diagnostic accuracy for ARFID varied significantly across the three conditions, confidence in diagnostic accuracy did not. This finding is concerning as it highlights that clinicians were not necessarily aware of what they did not know, which has important implications for the possibility of providing incorrect treatment for clients with ARFID. Additionally, this lack of awareness about accuracy of diagnosis could also result in clinicians being less likely to consult additional resources that could help guide them to an accurate diagnosis of ARFID.

The results of this study demonstrate that more robust training across all mental health professionals is needed regarding identification and diagnosis of ARFID (particularly since eating disorder specialists, who have more training in ARFID, were more accurate in diagnosing the condition than non-specialists). Future studies could aim to explore specific gaps in knowledge around ARFID, with the goal of identifying ways to increase clinician competency with diagnosing and treating this disorder.

Table 1. Sample Demographic and Professional Characteristics

	<i>n</i> or Mean	% or <i>SD</i>
Age	42.5	11.4
Gender Identity		
Cisgender Female	79	76.7
Cisgender Male	17	16.5
Gender Fluid	1	1
Questioning or unsure	1	1
Use a different term	5	4.9
Current Sexual Identity		
Straight/Heterosexual	69	67
Bisexual	14	13.6
Lesbian	5	4.9
Gay	4	3.9
Queer	4	3.9
Questioning or unsure	1	1
Other	1	1
Prefer not to answer	5	4.9
Race/Ethnicity		
White	86	83.5
Hispanic or Latino	7	6.8
American Indian or Alaska Native	2	1.9
Asian	2	1.9
Black or African American	1	1
Native Hawaiian or Pacific Islander	1	1
Other	1	2.9
Declined to answer	1	1
Education		
Doctoral Level	66	64.1
Master's Level	37	35.9
Years Licensed	10.1	9.8

Figure 1. Diagnostic Accuracy Across ARFID Motivating Factors

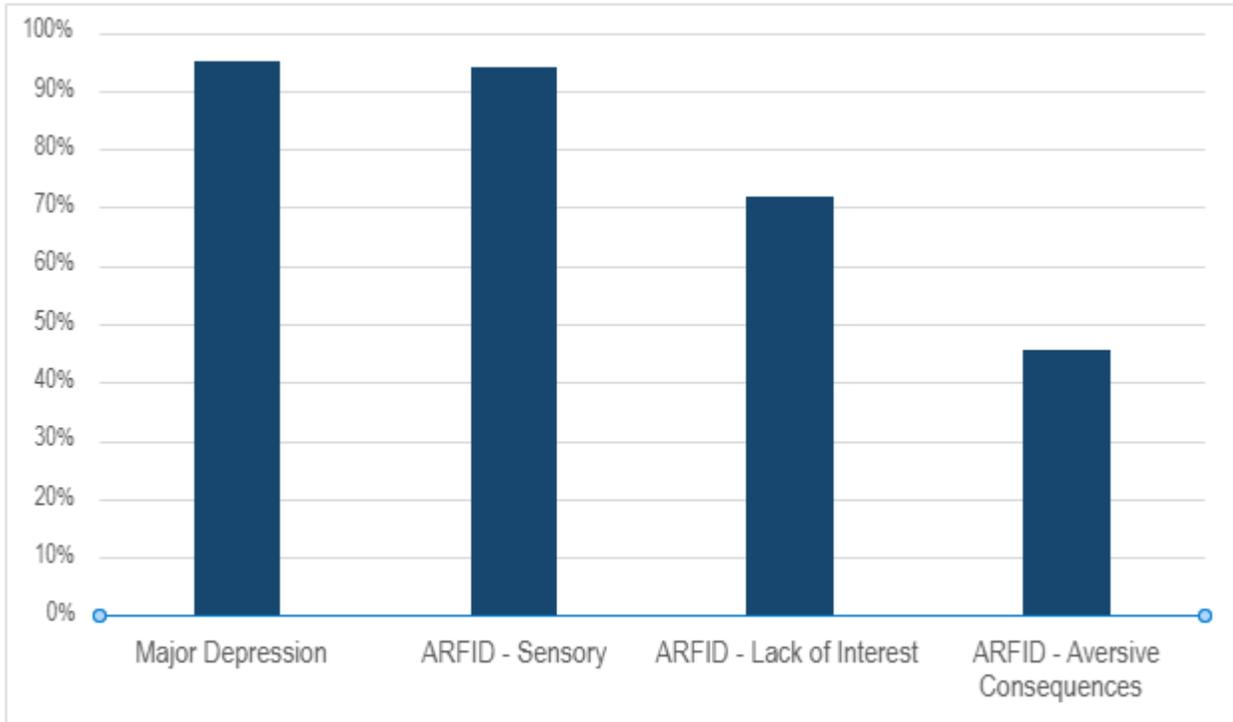
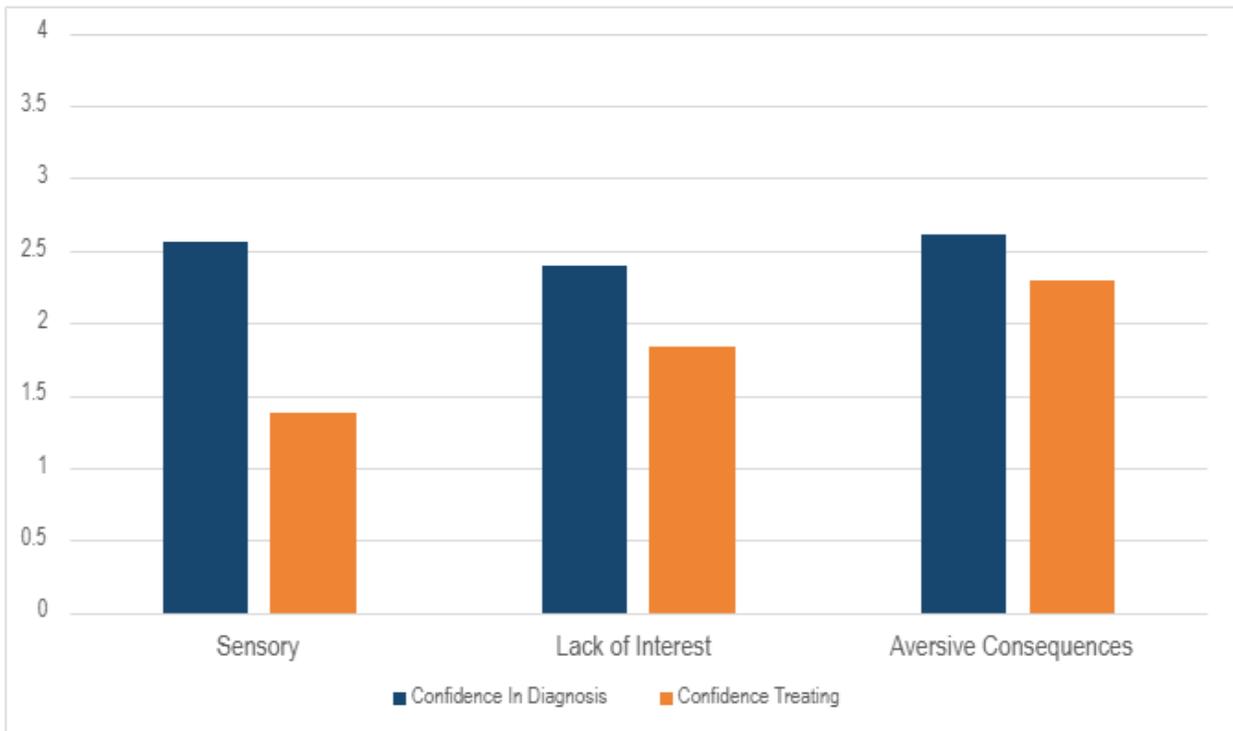


Figure 2. Confidence in Diagnosis and Ability to Treat Across ARFID Motivating Factors



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Appendix 1. Vignettes Presented to Participants

Depression

A 26-year-old client scheduled an intake with you because they have been feeling sad and finding little enjoyment in things. They stay up many nights, not being able to fall asleep for hours, and feel run down much of the day. They have been losing weight unintentionally, not feeling much of an appetite. They have been spending a lot of time thinking about how they just don't measure up to their own expectations, or the expectations of others. A few times per week, they feel things might be better if they were not alive. The client says they have been feeling this way for a couple of months and do not know why. A doctor has ruled out medical reasons for their symptoms.

ARFID - Avoidance of Sensory Characteristics

A 17-year-old client's parents scheduled an intake appointment because the client has been having difficulty eating. The client reports that they have found many foods off putting since early childhood, especially foods with certain textures. The client feels disgust even at the thought of these foods, new foods feel out of the question, and the list of foods they are willing to eat is narrowing. As a result, the client has significantly reduced the amount of food they eat, leading to weight loss, so much so that their medical doctor is concerned. The doctor has ruled out medical reasons for the weight loss and ongoing symptoms. The client's parents report spending increasing amounts of time preparing food that the client will eat and trying to get the client to consume adequate calories and nutrients. The client has no desire to lose weight and feels bad that they skip out on social activities where eating might be involved.

ARFID - Lack of Interest

A 17-year-old client's parents scheduled an intake appointment because the client has been having difficulty eating. **The client says they have had little interest in food since childhood and now it is presenting more of a challenge. They say they never feel hungry, feel full after eating small amounts, and eating feels like a chore.** As a result, the client has significantly reduced the amount of food they eat, leading to weight loss, so much so that their medical doctor is concerned. The doctor has ruled out medical reasons for the weight loss and ongoing symptoms. The client's parents report spending increasing amounts of time preparing food that the client will eat and trying to get the client to consume adequate calories and nutrients. The client has no desire to lose weight and feels bad that they skip out on social activities where eating might be involved.

ARFID - Consequences of Eating

A 17-year-old client's parents scheduled an intake appointment because the client has been having difficulty eating. **The client reports a deep fear that eating food will upset their stomach and they will throw up. Factors that increase distress related to eating include foods with unknown preparation or expiration date and sensations of feeling full.** As a result, the client has significantly reduced the amount of food they eat, leading to weight loss, so much so that their medical doctor is concerned. The doctor has ruled out medical reasons for the weight loss and ongoing symptoms. The client's parents report spending increasing amounts of time preparing food that the client will eat and trying to get the client to consume adequate calories and nutrients. The client has no desire to lose weight and feels bad that they skip out on social activities where eating might be involved.