The Newest Eating Disorder: Avoidant/Restrictive Food Intake Disorder (ARFID)

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Breaking News

LIVE 'Dis not cookie! Cookie Monster angry!

TVN EXCLUSIVE
Learning Objectives

- Define and explain Avoidant/Restrictive Food Intake Disorder (ARFID)
- Assessment of ARFID
- Medical considerations
- Treatment options
Contributors to Feeding Disorders/ARFID?

- Etiological contributors (Biopsychosocial model) to feeding problems:
  - medical, anatomical, developmental, temperamental, social, and environmental factors
- Physiological factors
  - Anatomical abnormalities, motor dysfunction, oral-motor dysfunction, respiratory, cardiac, and gastrointestinal problems
- Psychological/Social
  - Includes emotional difficulties between parent and child
  - Over controlling, under controlling, chaotic, disorganized, excessively anxious, or insensitivity to cues of the child may disrupt the parent-child relationship
  - Child’s health status, physical problems, dietary restrictions, temperament, or traumatic experiences related to feeding may indirectly affect parent-child relationship by influencing both parental responses to the child and parental anxiety about the feeding process

- Silverman & Tarbell, 2009; Garro, Thurman, Kerwin, & Ducette, 2005
In a prospective, general population study of over 4,000 children (1.5 - 6 years old), 10–30% were identified as picky or selective eating at different developmental ages. Almost half of all these children exhibited selective eating at some point during the study (Cano et al., 2015).

“Don’t worry, he’ll grow out of it.” - This statement represents one of the most commonly delivered pieces of advice given to parents of young children who have difficulties at mealtime.

14% to 20% of parents report that their preschooler is picky or has selective eating. Yet, the fact that a behavior is relatively common does not mean that it is harmless (Zucker, 2015).
Feeding Difficulties and ARFID

- This Pediatrics study found that both moderate and severe levels of selective eating are associated with psychopathological symptoms (anxiety, depression, attention-deficit/hyperactivity disorder) both concurrently and prospectively. Additionally, the severity of psychopathological symptoms worsened as selective eating became more severe (Zucker et al., 2015).

- Cano’s (2015) prospective study found that remittance was very high, however, selective eating persisted in approximately 4% of these children.

- We cannot take the “wait and see” approach.
Avoidant/Restrictive Food Intake Disorder

- 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:
  - 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.

https://www.youtube.com/watch?v=V__Ji6fZkKU

-American Psychiatric Association (2013)
Avoidant/Restrictive Food Intake Disorder

- ARFID is NOT the result of a lack of available food or an associated culturally sanctioned practice.
- ARFID is NOT associated with any abnormalities in the way in which one perceives their body weight or shape.
- ARFID is NOT explained by another medical or mental disorder, so that if you treat that, the eating problem will go away.
Key areas to assess when diagnosing ARFID

- Current food intake
- Oral supplement or tube feed dependency
- Persistence of problem
- Social/emotional functioning
  https://www.youtube.com/watch?v=zfLqpFNueHw
- Weight and height (BMI percentile)
- Signs of nutritional deficiency
- Lack of interest in food
- Sensory-based avoidance
- Fear/aversion
ARFID and Co-Occurring Medical Conditions

- ARFID cannot be diagnosed in cases where the presence of a concurrent medical or mental health disorder can account for the behavior observed, but may be diagnosed if the severity of the eating disturbance exceeds what typically associated with the medical or psychiatric condition in question.
Co-Occurring Medical Conditions

PAIN WITH EATING

- Eosinophilic Esophagitis (EoE)
- Food Allergies
- Constipation
Co-Occurring Medical Conditions

PAIN WITH EATING

- Gastroesophageal Reflux Disease (GERD)

- Treated with medications or Nissen Fundoplication
Co-Occurring Medical Conditions

PAIN WITH EATING

- **Diagnostic tests**
  - Upper GI Series (X ray)
  - Upper GI Endoscopy with biopsy
  - Blood work and skin tests for allergies

- Treat with medication and elimination diets
Co-Occurring Medical Conditions

MOTOR
- Ability to swallow effectively
- Tongue lateralization
- Rotary chewing
- Cheek movement

SENSORY
- Response to taste, textures, temperature
- Hyper/hypo responsiveness
- Sensory Modulation
- Oral praxis
Treatment of ARFID

- Currently, there are no evidence-based methods for treating ARFID.
- Most institutions/providers use evidence-based treatments for behavior (e.g., Parenting-Training), anxiety (e.g., Exposure Response Prevention), and eating disorders (e.g., Family-Based Therapy).
- Children and adolescents with persistent ARFID, g-tube dependency, and/or who suffer from significant interference with psychosocial functioning may benefit from a multidisciplinary outpatient/inpatient program.
- Medically unstable patients will likely require inpatient medical stabilization for an eating disorder before continuing with day-treatment and/or intensive outpatient therapy.
Outpatient Therapies

- Psychology – BT (e.g., meal hygiene, positive reinforcement, parent training, etc.) CBT (e.g., relaxation techniques, response prevention therapy, systematic desensitization, graded exposure), family-based therapy (e.g., meal coaching, parent empowerment).
- Nutrition – nutritional needs assessment, meal planning, BMI calc., nutritional counseling, etc.
- Occupational Therapy – anatomical, motor and sensory assessment; swallow safety; sensory exploration positive reinforcement; meal hygiene, etc.
- Pediatrician – ensure age-appropriate height, weight, growth, and medical stability.
Treatment Options

- Consider referral to outpatient Psychology for general picky eating, fear of foods (choking incident), or weight loss due to feeding behaviors.
- CHOC Children’s Multidisciplinary Feeding Program is intended for children who have struggled with feeding issues and have not been successful with traditional outpatient feeding therapy.
- CHOC Children’s Multidisciplinary Eating Disorder Medical Stabilization program is designed for children and adolescents with ARFID resulting in medical instability.
Behavioral intervention is typically used for anxiety and phobias.

When applied to eating disorders, patients are repeatedly exposed to feared foods.

Exposure occurs gradually and with relaxation training to tolerate fear food.

Response prevention refers to blocking compulsive behaviors such as vomiting, exercise or restriction.
Food Chaining

- When introducing new foods, start with ones similar to patient’s current diet and gradually expand
  - McDonald’s chicken nuggets
  - Tyson chicken nuggets
  - Chicken tenders
  - Lightly breaded homemade nuggets/tenders
  - Chicken breast
Contingencies & Consequences

- Grandma’s Rule
  - You cannot do something you want to do until you do something you don’t want to do
  - Use “first, then” language
  - Once you select a reward, limit it only to mealtimes
- Use preferred foods as rewards
  - First banana, then cracker
- Use tangible nonfood rewards
  - Stickers, games, books, TV/videos, toys
  - If mid-meal, 15-20 seconds unless accept next bite
- Token program
  - Stickers, sticker charts, point system – can “cash-in” for another reward
Nursing support at school

- Nurses may coordinate with parents about an individualized approach to monitoring student in a school setting
- Nursing can monitor lunches and/or snacks at school
- Help determine appropriate school activities, such as lunch times/snack times, Physical Education (P.E.), sports, or other organized physical activity
- Coordinating make-up work for any missed school assignments during scheduled snacks/lunches
Case Example: Behavioral

Level of care: Outpatient

- 6 year old African American male, ASD, no medical hx contributing, 3rd percentile for weight, only ate chicken nuggets, milk, supplements – no fruits, vegetables, or meat
- Permissive parenting, parents very wary at first, already tried everything, now exhausted and distraught
- Many tantrums in office, throwing food, refusal to sit in high chair
- Worked with family 10 weekly/biweekly sessions, family practiced at home, brought in videos and provided parent coaching in session
- Child slowly became less fearful of new foods, child gaining weight well according to pediatrician. Also less fearful in general, trying new hobbies, went to first birthday party and ate there
Level of care: Outpatient

12 year old Caucasian female, choking incident 1 year prior. Had developed aversion/fear of many solid foods (e.g., meat, many vegetables, liked only soft foods).

Referred by pediatrician, patient fell below 5th percentile for weight over the course of 1 year. No malnourishment, patient was on vitamin supplements. Did not show any vital sign changes given gradual nature of weight loss.

Over the course of 12 sessions, used graduated exposure techniques and desensitization to aversive foods. Slowly patient started eating a greater variety of foods and increasing in weight.
Case Example: G-tube Dependent

Level of care: Feeding program

- 4 year old Hispanic male with history of Down’s syndrome, had anatomical esophageal differences and swallowing challenges, was G-tube dependent since infancy. Also had behavioral challenges, spitting food out frequently, crying and tantrums when tried to wean from G-tube on outpatient basis, failed outpatient and required higher level of care.

- Intensive feeding program for 3 weeks, with 3x daily meal support from OT to assist with coaching of chewing and swallowing challenges, learning to use a fork/spoon independently.

- Psychology provided support regarding behavioral component, provided coaching for mealtime behaviors.
Case Example: Medical Co-Morbidity

Level of care: Inpatient

- 13 year old Hispanic female, PH, with 3 month history of weight loss and food refusal, slowly decreasing portion size, anxiety re foods, abdo pain, BMI < 5th %ile. Admitted to CHOC for vital sign instability and orthostatic changes, put on eating disorder guidelines.
- Noticed chewed for long periods of time, needed to increase meal times to 1 hour. Swallow study performed. Endoscopy performed, significant for Chron’s.
- Provided mealtime coaching to mother regarding differential reinforcement strategies. With gradual exposure to foods and meal coaching, she decreased mealtimes to 30 minutes.
- Discharge plan: Follow-up with Psychology, Nutrition 1x weekly, GI, and PCP. Return to School
Selected References