Beyond ARFID 101

Debunking Myths, Understanding Subtypes, and Exploring Interventions that Affect Change

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Presentation Outline

I. Debunk common myths about ARFID

II. Explore the three subtypes including mixed presentations

III. Interventions

IV. ARFID IOP

Introduction

- Amanda Smith, LICSW, CEDS
- Regional Director of Virtual Programming
- Director of ARFID Programming
- Program Director for Waltham Virtual Programming
- 10+ years experience treating eating disorders within inpatient, residential, partial hospitalization, and intensive outpatient programming
- Special interest in the treatment of children and adolescents who struggle with ARFID
- Working on getting less panicky during media opportunities

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Who We Treat

Everyone is Welcome

All Genders, All Diagnoses

We appreciate all that makes you, you. No matter who you are, where you are on your path to wellness or what circumstances have brought you here, you have found a warm place to heal.

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Common Myths

Associated with ARFID

Common Myths

WEIGHT REQUIREMENTS

"In order to be diagnosed with ARFID, you need to be under weight."

WEIGHT IS NOT A REQUIREMENT

Although clinical criteria includes inability to achieve or maintain appropriate weight, it is not a requirement for diagnosis

NATURE OF FOODS

Individuals may maintain appropriate weight for age and development due to the nature of the foods they prefer (i.e. high calorie, starchy foods)

TOLD TO BE ON TRACK

Families and individuals are often delayed in seeking care as they are told there is no problem as weight is on track developmentally

Common Myths

A PHASE TO GROW OUT OF

"ARFID is just a phase, you will outgrow it/get over it."

SEE MORE VARIETY AT AGE 5

Although it is developmentally appropriate at younger ages to seek preferred foods and identify preferences for flavors, this considerably reduces around age 5

REQUIRES PROFESSIONAL HELP

ARFID does not remit on its own

DELAYING TREATMENT HEIGHTENS RISK

Identification of the symptoms of ARFID as a phase prolongs accessing appropriate treatment and increases risk for significant health concerns

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Common Myths

A CHILDHOOD ILLNESS

"ARFID only affects young children."

SHAME & GUILT

Increases shame and guilt due to continued struggle or eating "like a kid"

TREATMENT NOT AVAILABLE

Belief that treatment is not available due to it being a childhood illness

ADULT CHALLENGES

ARFID impacts personal and professional growth

Common Myths

LACKING BODY IMAGE ISSUES

"You have body image distress, therefore, you can't struggle with ARFID."

SOCIAL PRESSURES

Although body image distress is not the main reason for restriction, those who struggle with ARFID have bodies that are impacted by the same social pressures as everyone else

IDENTITY CONCERNS

Concerns related to body image often are associated more with identity than with desire to be thinner, smaller, more muscular, etc.

CHANGES DURING TREATMENT

Sensory sensitivities can increase in other domains as body weight or shape changes during treatment

Common Myths

CURE ALL IS OUT THERE

"You had treatment, so you can eat everything now."

MAGIC BULLET

Treatment is seen as the magic bullet such as with other eating disorders

NO MORE STRESS DURING MEALS

Personal expectations and the expectations of others can be that following treatment individuals will be able to eat all foods with limited to no distress

BURNOUT

Frustration and burnout can occur if expectations are not set realistically from the beginning of treatment

Common Myths

RECOGNIZING NATURAL FULLNESS

"You stop eating when you are full, therefore, you don't have an eating disorder and your body is getting what it needs."

SUBTYPES MISIDENTIFIED

Symptoms of the various subtypes are misidentified as the body's natural fullness and hunger cues are minimized

LISTENING TO YOUR BODY

Belief that individuals are eating what "their body needs" can lead to a reduction in opportunities to increase eating episodes and exposure to new foods and eating environments, inadvertently worsening symptoms to ARFID

Common Myths

LACKING SENSORY ISSUES

"You cannot have ARFID, you do not struggle with textures."

SUBTYPES MISUNDERSTOOD

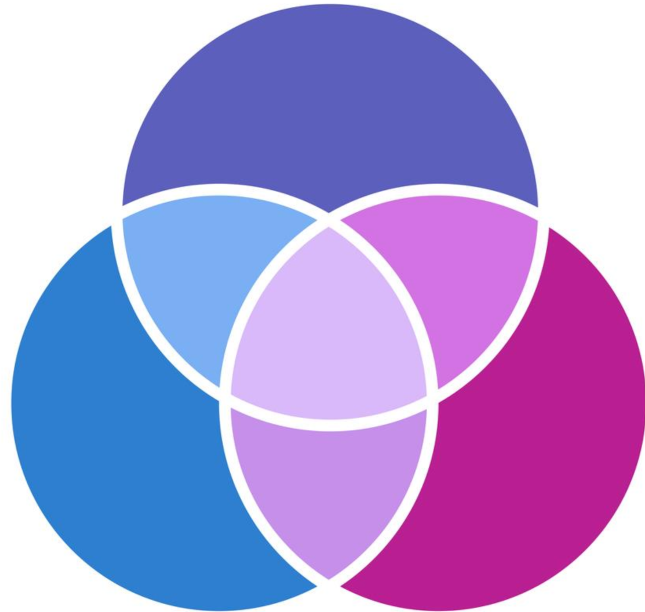
There are three subtypes of ARFID and sensory sensitivities is just one of them

ONE OR MORE SUBTYPE

Individuals may struggle with one, two, or all three of the subtypes

UNNECESSARY PROCEDURES

Misunderstanding of ARFID diagnosis often leads to multiple medical procedures to determine cause for stomach distress, vomiting, etc.



ARFID Subtypes

Understanding the three subtypes

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Sensory Sensitivities

Avoidance or restricting food due to sensory characteristics of food:

- Taste
- Textures
- Color
- Smell

Fear of Aversive Consequences

- Choking, vomiting, GI distress
- Allergic reactions
- Anaphylactic reactions
- Getting the "stomach bug" after eating a certain food and then not being able to eat it again
- Connection made that if X happens, then Y will happen

Lack of Interest in Eating or Food

- Low hunger, lack of enjoyment of eating
- Always had a small appetite
- Doesn’t show interest in mealtimes
- Can “take it or leave it”

Mixed Presentations

- Individuals can struggle with one, two, or all three of the subtypes
- Using tools such as the PARDI-AR-Q can assist with determining the subtypes as well as which subtype is presenting most impactful on an individual's daily functioning
- Subtypes are treated in order of priority/functional impairment

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Interventions

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Interventions

Two prong approach: weight restoration then increased variety

1. Weight restoration
   - Increase intake of highly preferred foods until pattern of weight restoration is established
   - May need to increase by 500 calories each day
   - Increase frequency of eating, "eating by the clock" every 3-4 hours regardless of hunger cues
   - Add calorically dense foods vs. increasing volume.

Interventions

EXPOSURES/ADDITIONS FOR SENSORY SENSITIVITIES

- Chosen with the individual completed in session with clinician then continued at home
- Choose 5 foods to try in sessions; utilize 5 senses to walk through each food toward taking a bite
- Individuals will choose 1-2 foods tried to incorporate throughout the week; they are asked to try items on 10 separate occasions before determining if they like it or not
- Trying a food may be a small bite initially and then increase in amount
- Exposures can be successful even if an individual is not able to take a bite; the purpose is for them to interact with the food

Interventions

STRATEGIES FOR INCORPORATING NEW FOODS

- Fade it in: Start with a large proportion of preferred food and mix in a small amount of the new food, gradually increase the portion of the new food
- Add some spice or a sauce to help tolerate a new food
- Chaining: Use preferred foods to help link to new foods
- Try different presentations of new foods
- Don’t just try foods in one form
- Deconstruct more complex foods to work backwards to the constructed combination food

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Interventions

EXPOSURES/ADDITIONS FOR FEAR OF AVERSIVE CONSEQUENCES

- Provide psycho-education about avoidance and exposure
- Individuals creates a hierarchy utilizing SUDS (0-100)
- Will utilize session to solidify the hierarchy and to begin with introduction of foods moving up the hierarchy
- Utilizing the hierarchy will continue to slowly increase exposures toward 100 on the scale
- Can use strategies to incorporate like sensory sensitivities

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Interventions

EXPOSURES/ADDITIONS FOR LACK OF INTEREST

- Interoceptive exposures to induce feelings of fullness, nausea, etc. and then completion of a highly preferred food
- Assist in identifying ability to eat through these uncomfortable feelings
- Serve as a way to reset internal scales of hunger and fullness

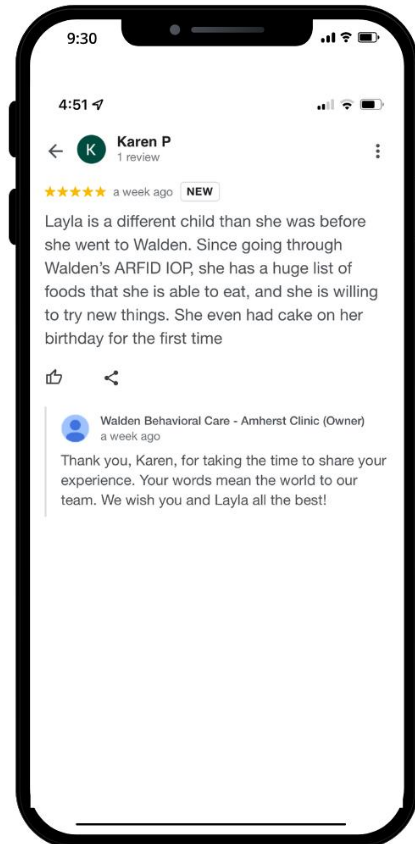
Adolescent ARFID IOP

Specialized Intensive Outpatient Program for adolescents and families struggling with ARFID

- Ages 10-18, all genders
- 10 weeks
- Family involvement needed

Utilization of CBT-AR, in collaboration with MGH, modified for an IOP format

- Family Supported Treatment model for all adolescents in program



Adolescent ARFID IOP

Incorporation of registered dietitian on every treatment team

- Meets with families bi-weekly

Weekly family sessions

- Exploration of treatment goals, incorporation of exposures, personal formulation of ARFID

Two multi-family groups and three family dinners a week

- Parent and adolescent psycho-education related to nutrition, ARFID, and CBT

Once a week parent only psycho-education and support group

Questions & Answers

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Let's be in touch!

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