ARFID:
How Family-Based Treatment can Transform Your Client's Eating Habits

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Our Time Today

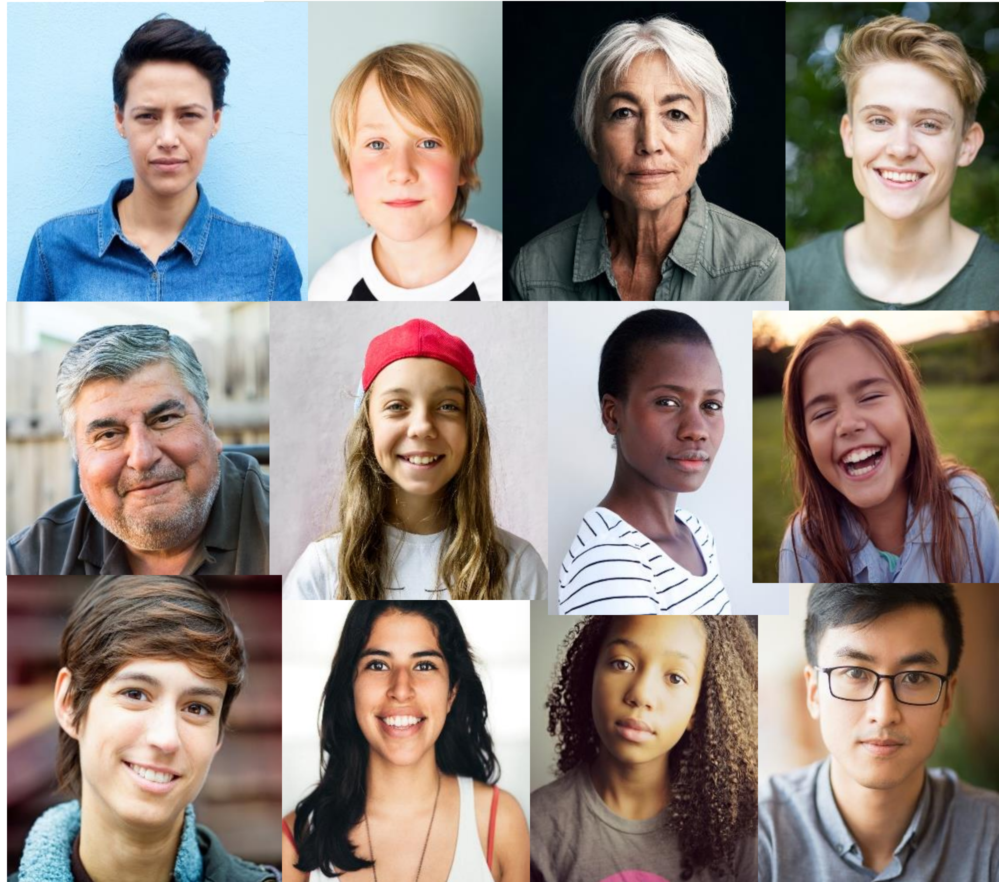
- Distinguish between picky eating and Avoidant/Restrictive Food Intake Disorder (ARFID).
- Understand when professional referrals are appropriate.
- Identify sensory and fear components of ARFID.
- Identify several strategies for beginning to support families and patients struggling with ARFID.

Who We Are

Walden Behavioral Care is a nationally-recognized mental health care system specializing in the treatment of all eating disorder diagnoses.

Accepting most major insurances, we work hard to increase accessibility for every individual who may benefit from our services.

Who We Treat



Specialized Eating Disorder Support for
All Ages * All Genders * All Diagnoses

From our CEO

"Our commitment to using evidence-based interventions at all levels of care, and our emphasis on treating the whole person have been catalysts in helping more than 22,000 individuals receive the specialized care they need and deserve. If you are looking for an inclusive, affirming and compassionate place to heal, you have found it with Walden. "

-Stu Koman, Ph.D.

The Continuum of Care

Inpatient

Outpatient

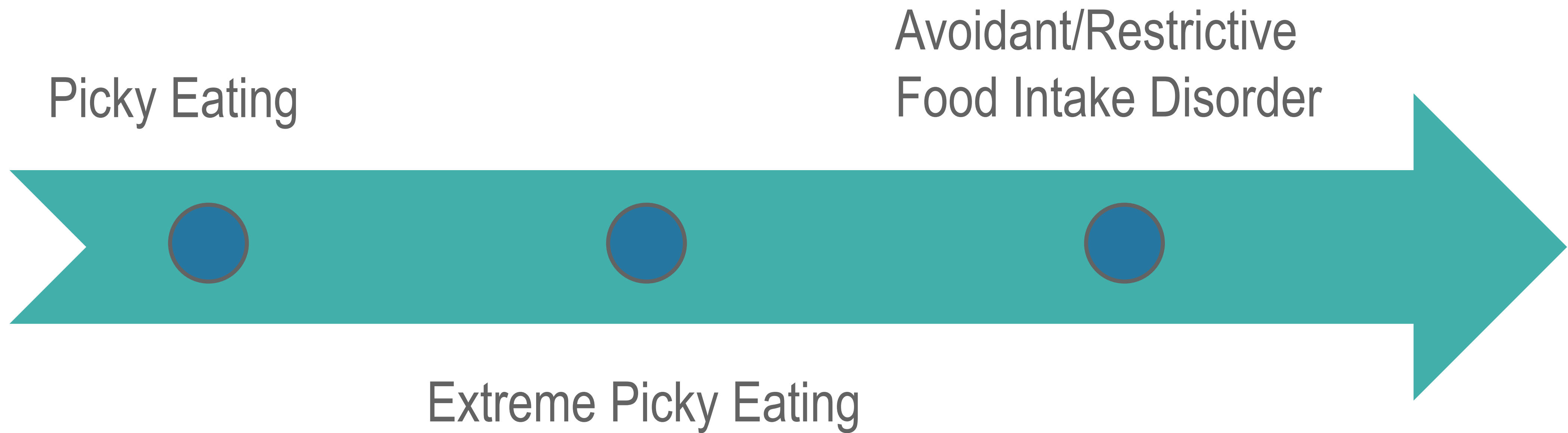
Residential

Depending on acuity, a patient may
- Enter at any level
- Move in any direction
- Skip over levels of care

Intensive Outpatient

Partial Hospitalization

When Should I be Concerned?



Typical vs. Extreme Picky Eating

Typical Picky Eating	Extreme Picky Eating
Onset 15-18 months	Onset at start of solid foods or earlier
Strongly preferred options yet able to consume other foods	Highly fearful and avoidant of foods and/or full food groups e.g. meats and veggies
Whines or tantrums briefly; consistent with developmental phase progression	Sensory processing diagnoses, anxiety, OCD or autism spectrum disorders; often associated with medical, anatomic or developmental challenges
Prefers carbs	Prefers carbs
Reduces considerably by age 5	Chronic and does not remit on its own

Avoidant/Restrictive Food Intake Disorder (ARFID)

A. An eating or feeding disturbance 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.

Avoidant/Restrictive Food Intake Disorder (ARFID)

- **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.

Avoidant/Restrictive Food Intake Disorder (ARFID)

Facts

- Seek treatment at average age of 12 (Fisher, 2014)
- 14% of patients incoming to treatment centers have ARFID, 30% are male (Fisher, 2014)

Three presentations (DSM-5):

- Sensory sensitivity
- Apparent lack of interest in eating or low appetite
- Avoidance due to traumatic experience, such as choking or vomiting

Picky Eating or ARFID?

- When did the "picky eating" begin and how long has it lasted?
- What does "picky" mean for the individual and family?
- What does "picky eating" look like?
  - Include foods easily consumed and those avoided, utilizing a food hierarchy (Always/Sometimes/Never or Green/Yellow/Red).
  - Gather information related to what happens at the meal including emotions, behaviors, and statements.
  - What the are the concerns, such as eats too little, not getting enough nutrients, etc.
- What interventions have been tried previously?
- Are there other co-morbid diagnoses which could be impacting eating?

Picky Eating or ARFID?

- Gather medical history including:
  - Weight history (including growth charts whenever possible)
  - Nutrient deficiencies
  - History of G tubes, intubations, or surgeries
  - Low muscle tone
  - Gastroesophageal reflux
  - Chronic illnesses

Evaluation for ARFID

What is the individual saying?

- “I cant”
- “I don’t like that”
- “It hurts”
- “I don’t want to”
- “I’m scared”

Oral Motor and Swallowing

- Does the individual/family identify any of the following:

Tongue thrusting	"Losing food" in mouth
Using fingers to get food to back molars	Mashing food to the roof of the mouth
Chewing in the front of mouth	Food falling out when eating

- It would be appropriate to seek evaluation by OT/SLP for initial treatment prior to FBT

Options for Treatment

Adults	Adolescents
Inpatient	Inpatient
Residential	Residential
Partial Hospitalization	Partial Hospitalization
Intensive Outpatient	Intensive Outpatient
Outpatient (therapist, RD, PCP, OT/SLP, etc.)	Outpatient (therapist, RD, PCP, OT/SLP, etc.)

Treatment for Adults

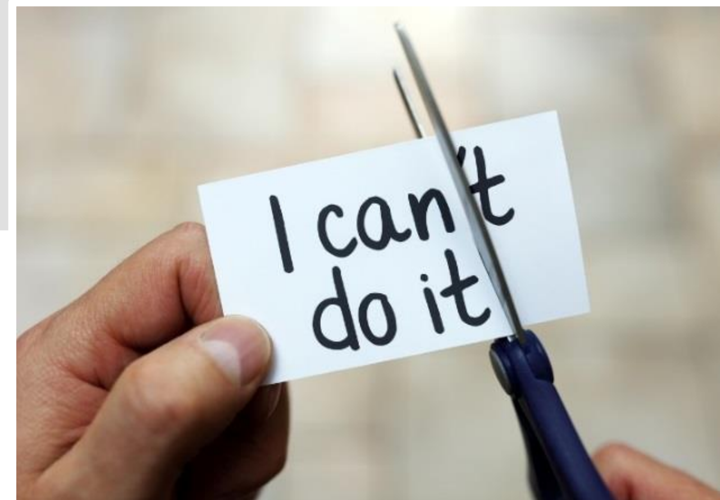
- Focus is on developing skills and strategies to tolerate increased exposure to non-preferred foods, while maintaining or improving medical stability.
- Utilize DBT and CBT strategies.
- Practice non-preferred foods in various life situations such as home and work. As well as with others and alone.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) helps patients to identify negative thoughts then challenge cognitive distortions in order to make behavioral changes related to their eating disorder

Interventions:

- Big "B" little "c"
- Thought Records
- Rebuttals



Dialectical Behavior Therapy

DBT Teaches

Practical ways to tolerate distress

Regulations of emotions

Strategies to be more interpersonally effective

Treatment for Adolescents

- Empower caregivers with strategies and confidence to successfully support adequate nourishment and increased variety, as appropriate.
- Utilize pre-existing evidence based treatment modality to support consistent caloric intake, Family Based Treatment (FBT).
- Manualized treatment for adolescents with eating disorders with modifications by Dr. James Locke and Dr. Daniel le Grange for treating ARFID.
- Look to caregivers to assist with increasing intake of non-preferred foods.

Family Based Treatment (FBT)

Structural Family Therapy

- Family rules, patterns and structure

Milan School

- Postmodern understanding of reality as socially and linguistically constructed

Strategic Family Therapy

- Therapist takes responsibility for directly influencing people (goals, interventions and assess outcomes)

Narrative Therapy

- Externalizing Eating / Feeding Disorder and creating a more helpful family narrative

Family Based Treatment (FBT)

Developed to replace traditional therapy where "parent-ectomies" took adolescents away from the family during treatment

Key Characteristics:

- Remove blame
- Parents are in charge of treatment
- Increased levels of supervision around food and opportunities to use behaviors
- FBT can still be effective even if adolescent is expressing ambivalence.
- Viewed weights.

Treatment That Works: FBT

Phase 2: Returning Control

Phase 3: Establishing Healthy Adolescent Identity

Phase 1: Weight Restoration/Cessation of Behaviors

Interventions

COACHED MEALS

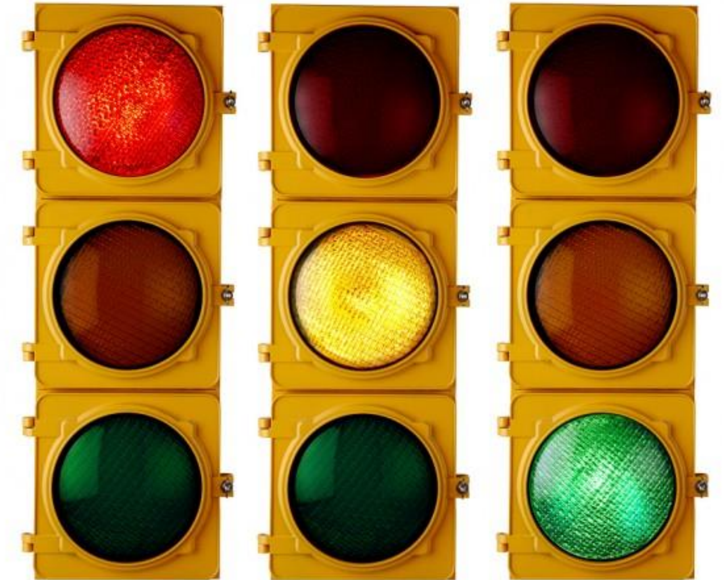
"Evidence suggests a significant relationship between family meal time interactions and disordered eating in young persons. Mealtime conflict, high parental control and critical parental comments are positively associated with disordered eating. Parental support, mealtime structure, healthy communication and a positive atmosphere are negatively associated with disordered eating." Godfrey et al (2013)

Interventions

- Always plate a full portion of preferred foods. Expectation will be to complete 100% of these foods within FBT model.
- Non-preferred foods should be pre-decided with some input from adolescent.
- Initial presentations of challenge food should be ***one*** bite.
  - Typical expectation will be to complete this bite, some variations may be tolerating food on plate with exposures of yellow/red and red foods.
  - Same FBT coaching skills are appropriate to assist parents in supporting adolescent to completed expectation.
- Subsequent presentations will increase in size based upon progress with acceptance of food.

Interventions

- Utilize a food hierarchy completed by patient and caregivers as appropriate.
- Include individual in determining challenges and rewards
  - Adolescents may be more involved in choosing foods than traditional eating disorders
- Teach age-appropriate coping skills
- Externalization eating difficulties, e.g. "sensory superpowers"
- Charting exposures with anticipatory and actual experience



Interventions

FOOD HIERARCHY

GREEN	YELLOW	RED

Interventions

Sample Chart:

Date:	Exposure:	Rating 0-10 Before Exposure:	Coping Skill Planned:	Coping Skill Used:	Rating 0-10 After Exposure:	Rewards:	Things for next time:

Other Recommendations

- ***Remember:*** Always provide enough food, regardless of type to restore/maintain weight
- Find what motivates the individual, internally and externally
- Gradual food exposures set individual up for success (just not ***too*** gradual)
- Reset meal time routine and cues, particularly if meal times have become aversive

ARFID Support Team Glossary

- The **speech-language pathologist** evaluates and treats oral-motor and sensorimotor deficits as well as swallowing disorders. S/he may provide sensory-based treatment.
- The **physical therapist** evaluates and treats postural/trunk control issues affecting oral motor function and assists with proper seating for meals.
- The **occupational therapist** evaluates and treats fine motor skills for independent feeding as well as sensory processing disorders that may keep child from enjoying a variety of flavors and textures.
- The **gastroenterologist** assesses the structure and function of the gastrointestinal system to determine whether medical factors contribute to feeding difficulties and treats accordingly.
- The **otolaryngologist** assesses the structure and function of the airway, head, and neck and evaluates for medical problems (eosinophilic esophagitis or enlarged tonsils/adenoids, for example) and other possible contributors to swallowing comfort.

Resources and References

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Thank You!

Let’s be in touch

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