Treatment of Avoidant/Restrictive Food Intake Disorder: one size does not fit all!

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Workshop aims

• To provide an overview of the most common ARFID presentations
• To link assessment of presenting features with treatment goals and type of intervention
• To provide practical tools to enable structured planning for the treatment of ARFID
• To facilitate sharing and discussion about treatment successes and commonly encountered difficulties
• To enhance confidence and competence in the management of the full range of ARFID presentations
Overview

• Clinical presentation and diagnosis of ARFID

• Structuring assessment

• Treatment planning

• Interventions – what, when and how?
Key ingredient....

• Your willingness to join in!

• Open discussion about clinical cases and treatment successes and challenges
Note of caution......
Overview

• Clinical presentation and diagnosis of ARFID

• Structuring assessment

• Treatment planning

• Interventions – what, when and how?
ARFID Criterion A  (DSM-5, APA 2013)

Eating or feeding disturbance (for example, apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; or concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs leading to one or more of the following:

1. significant weight loss (or failure to gain weight or faltering growth in children);
2. significant nutritional deficiency;
3. dependence on enteral feeding or oral nutritional supplements;
4. marked interference with psychosocial functioning
ARFID Criteria B, C, & D (DSM-5, APA 2013)

B. The eating disturbance is not better explained by lack of available food or 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 better explained by a concurrent medical disorder or another mental disorder. When occurring in the context of another medical disorder or mental disorder, the severity of the eating disturbance exceeds that routinely associated with the medical disorder or mental disorder and warrants additional clinical attention.
**ARFID as ‘umbrella’ diagnosis**

- **apparent lack of interest** in eating or food
  - Food avoidance emotional disorder; infantile anorexia; low food responsivity

- **avoidance based on the sensory characteristics** of food
  - Selective eating; sensory food aversions; extreme picky eating; neophobia

- **concern about aversive consequences** of eating
  - Phobia affecting food intake (e.g. emetophobia); fear of choking; functional dysphagia
Low interest  sensory  fear
Is this relevant to me?
Overview

- Clinical presentation and diagnosis
- Structuring assessment
- Treatment planning
- Interventions – what, when and how
Key areas to assess to make a diagnosis but also to inform treatment approach

1. Current eating behaviour
2. Persistence of problem
3. Interest in food and eating
4. Sensory based avoidance
5. Fear/aversion related to eating behaviour
6. Weight and height (and BMI or BMI centile)
7. Nutritional adequacy of intake/ consequences
8. Oral supplement or tube feed dependency
9. Social/emotional functioning
10. Personal circumstances and context
11. Rule out eating disorder and weight/shape concerns
12. Ascertainment of other medical or mental disorder(s)
Current eating behaviour and food intake

• Is the eating behaviour characterized by avoidance or restriction?

• Review of intake to ascertain:
  – Does it represent an adequate age-appropriate amount – i.e. sufficient in terms of overall energy intake?
  – Does it include an adequate age-appropriate range – i.e. does it include major food groups and essential micronutrients?
Persistence of problem

• How long have there been eating difficulties characterized by avoidance or restriction, leading to insufficient intake?

• This is to ascertain whether this is a persistent problem rather than a transient one (defined as present for a minimum of 1 month)

• Acute onset extreme presentations likely to be associated with high familial anxiety
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Interest in food and eating

• Is the avoidance or restriction associated with a lack of interest in food?

• Is the avoidance or restriction associated with an apparent failure to recognize hunger?

• Is this mood related? Arousal? Attention?
Sensory based avoidance

• Is the avoidance or restriction based on sensory aspects of food and eating?

• This might include:
  – Texture
  – Taste
  – Appearance (e.g. uniformity; colour)
  – Smell
  – Temperature
Presence of fear/ aversion

• Does the avoidance or restriction follow an aversive experience associated with intense distress or discomfort?

• This might include a choking incident, an episode of vomiting or diarrhoea, or a medical procedure such as barium swallow
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Weight and height

• Measurement of weight and height – calculate BMI/BMI centile as well as weight and height centiles

• Plot measurements and compare to previous documented or reported weight and height / weight and height centiles

• Allows assessment of whether growth is faltering

• Allows determination of presence of weight loss, or static weight when should be increasing
Nutritional adequacy of intake/consequences

• Does the individual present with clinical or lab based signs and symptoms of nutritional deficiency or malnutrition?

• Markers might include lethargy secondary to iron deficiency anemia, delayed bone age as a consequence of chronic restricted intake
Oral supplements/tube feeding

• Is the individual taking oral nutritional supplements?
  – Clarify what

• Is the individual fed via gastrostomy/ naso-gastric tube or other form of enteral feeding?

• This is to ascertain whether there is a dependence on these other methods to ensure sufficient intake
Social and emotional functioning

• Is there evidence of any associated significant distress?

• Is there evidence of associated impairment to the individual’s social and emotional development or functioning?

• In the case of children this can include disruptions to normal family function that negatively affect the child.
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Personal circumstances and context

• Is there evidence of neglect or hardship?

• Is the avoidance or restriction related to a socially accepted practice? (e.g. religious fasting; normative dieting/healthy eating)

• To address first exclusion criterion
Rule out ED or weight/shape concerns

• Screen for AN or BN as these trump ARFID

• Check individual’s views about their own size and shape

• To address second exclusion criterion
Other medical/mental disorder(s)

• Check medical history, current physical state, infections, etc, plus presence of any symptoms (incl. constipation, diarrhoea, vomiting, coughing)

• Any medication?

• Clarify if other mental disorder (or symptoms of) or neurodevelopmental disorder present

• To address third exclusion criterion

• Can also help with understanding lack of interest and fear of aversive consequences
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D. The eating disturbance is not better explained by a concurrent medical disorder or another mental disorder. When occurring in the context of another medical disorder or mental disorder, the severity of the eating disturbance exceeds that routinely associated with the medical disorder or mental disorder and warrants additional clinical attention.
Other relevant information

- Developmental history/level of functioning
- Feeding history
- Family context and family history
- Mealtimes and family relationship with food and eating
- Temperament, general behaviour
- Sensory processing
- School/peer and educational functioning
CURRENT FEEDING PRESENTATION
What is problem/duration?
Who feeds and how?
What food, when and where?
Who problem for?
What is impact?

MEDICAL/PHYSICAL
Birth, med hx, treatments, oral-motor, chest infections
Weight and growth centiles
Gastro-intestinal sx

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FAMILY/ENVIRONMENT
Parenting style/feeding practice
Mealtime stress
Fam med hx + hx growth/eating
Parental MH/eating beh/beliefs
Siblings/wider family factors
Other systemic factors

CHILD FACTORS
Sensory issues/sensitivity/disgust
Psychological factors/anxiety
Developmental hx/learning style
Temperament/rigidity
Behaviour home/school

FEEDING/EATING HISTORY
Breast/bottle feeding
Weaning
Preferences/Refusal
Supplements (oral/enteral)
Previous tx/experience

APPETITE REGULATION
Medical conditions
Medication
Attention difficulties
Chronic restricted intake
Alternative-supplementary feeding
Overview

• Clinical presentation and diagnosis of ARFID

• Structuring assessment

• Treatment planning

• Interventions – what, when and how?
Stepwise management planning

1. Ascertain the nature and severity of the problem: **clinical evaluation** - current risk and diagnosis where appropriate

2. Identify factors that may be contributing to current clinical presentation: **formulation** – to include predisposing and precipitating factors – both individual and interactional

3. Identification of maintaining factors: allowing **targeting** of intervention

4. Evaluating effects/impact of problem: allowing **prioritisation** of intervention
### The impact grid – ‘clinical significance’

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Is current intake ‘good enough’ nutritionally?</td>
<td>Is current intake sufficient to maintain growth and development?</td>
</tr>
<tr>
<td>Is the eating problem having a negative impact on social/emotional development or functioning?</td>
<td>Is the eating problem having a negative impact on family interaction/functioning?</td>
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Treatment recommendations

• Limited evidence base related to presentations and matched interventions – field lacks RCTs

• Treatment generally informed by main areas identified as contributing to and maintaining the difficulty

• Some groups are using FBT, some exposure therapy and other behavioural approaches....

• Typically requires a multi-disciplinary approach due to combined need for physical and psychological care
Toolkit

• Psychological interventions
  – Behavioural - exposure, hierarchies, food chaining, desensitization
  – CBT
  – Parent - focussed skills training, anxiety management
  – Family – mealtime modelling; addressing interaction

• Nutritional interventions/ tube weaning

• Medical interventions – monitoring and management

• Sensory management
Overview

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• Interventions – what, when and how?
Selecting from the toolkit

• Be clear what you are trying to change and end point
  – In addressing avoidance or restriction:
    • Working on range?
    • Working on amount?
  – Eliminating or reducing tube or supplement dependence

• Select from existing evidence based approaches – anxiety based interventions in particular

• Helpful to use impact grid and planning steps
Intervention – what, when and how?

• Risk assessment
  – Weight and growth
  – Nutritional adequacy
  – Impact on social and emotional development
  – Impact on family function and relationships
Low interest

Structure
Routine
Learning

Sensory

Sensory diet
Environmental
Disgust/intolerance

Fear
Exposure
CBT
Family int.
Intervention – what, when and how?

Exotic Underwear Always Causes Chaos

Explore - Understand – Accept – Challenge - Change
Intervention – what, when and how?

- Engagement, reframing, motivation
  - Exploring and understanding the difficulty
  - Accepting and ‘sense making’ so it can be owned
  - Considering change
  - Working on goals

Explore - Understand – Accept – Challenge - Change
Intervention – what, when and how?

• Provision of information, e.g.
   – ‘Good enough’ diet
   – Pubertal development and associated needs
   – Consequences of nutritional compromise
   – Physiology of fear/anxiety
   – Sensory processing
Intervention – what, when and how?

• Goal setting and starting treatment
  – Agreeing goals for treatment
  – Being clear what the priorities are and why
  – Being clear how priorities will be addressed
  – Being clear what barriers to change may be
  – Make sure everyone on the same page
  – Setting expectations and time frames
Case example: George

• 15 year old boy with longstanding selective diet dating back to weaning. Reported to have consistently had clear food preferences and a limited diet.
• Currently evening meals in particular are highly tense and stressful, often ending in disputes.
• Previous input aged 7 – parents advised to only offer preferred foods.
• Increased support sought recently due to declining intake in quantity since secondary school transfer and concern re weight, growth and development
Key areas to assess to make a diagnosis but also to inform treatment approach

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Assessment

Current eating behaviour
Decreasing range of foods accepted; finds snack foods easier; limited range of ‘meals’; never finishes; avoidance of social eating; tentative and slow eater; intake tails off by end of day

Persistence of problem
Definitely noticeable since age of 4, worsening from age 11, now 15
Assessment

Interest in food and eating

Needs to be reminded to eat; does not look forward to eating

Sensory based avoidance

Taste and texture sensitivities and preferences

Fear/aversion related to eating behaviour

Finds many foods extremely challenging; significant negative associations with being confronted with unpalatable foods
Assessment

Weight and height (and BMI or BMI centile)
40.9kg (6th centile), 159.3cm (17th centile); 84% median BMI (5th BMI centile)

Nutritional adequacy of intake/ consequences
lacking vitamins and micronutrients – no fruit or veg, low iron/minerals

Oral supplement or tube feed dependency
on WellTeen

Social/emotional functioning
Concerned about not being considered ‘normal’; low in mood; withdrawing; SI
Assessment

Personal circumstances and context
Well cared for with no significant psychosocial adversity; no direct cultural or family explanation

Rule out eating disorder and weight/shape concerns
Concerned about growth and weight; concerned about eating difficulties

Ascertainment of other medical or mental disorder(s)
Low mood; ASD had been considered
Other relevant information

- Developmental history/level of functioning
- Feeding history
- Family context and family history
- Mealtimes and family relationship with food and eating
- Temperament, general behaviour
- Sensory processing
- School/peer and educational functioning
Stepwise management planning

1. Ascertain the nature and severity of the problem: clinical evaluation – ARFID, moderate risk

2. Identify factors that may be contributing to current clinical presentation: formulation – sensory sensitivities, rigidity, temperament, social anxiety

3. Identification of maintaining factors: allowing targeting of intervention – mismatch of understanding /expectations; mealtime conflict; sensory issues; mood; negativity

4. Evaluating effects/impact of problem: allowing prioritisation of intervention
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• Physical interventions – monitoring and management

• Sensory management
George’s letter

If you would like access to this letter please email me on rachel.bryant-waugh@gosh.nhs.uk
Thank you for your attention

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