Making Room at the Table: A Transdiagnostic Approach to Identifying and Treating Avoidant Restrictive Food Intake Disorder

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(She/her/hers)

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Objectives

1. Participants will be able to differentiate ARFID diagnosis from other eating disorders.
2. Participants will be able to identify strategies for reducing and eliminating avoidance behaviors associated with ARFID.
3. Participants will be able to develop a sample ARFID exposure hierarchy.

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Introduction of ARFID

- Prior to this new name, a range of terms were used such as "picky eating," "selective eating" and "selective food refusal"
- Clinicians have treated "selective eating" for years using different guiding models of practice
- Patients with ARFID are clinically distinct from those with AN, BN, BED

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ARFID Diagnosis

Food avoidance or restriction leading to persistent failure to meet nutritional needs, causing >1 of the following:

- Significant weight loss
- Significant nutritional deficiency
- Dependance on tube feeding or oral supplements
- Psychosocial impairment

Not due to lack of available food or cultural practice

No fear of weight gain or body image disturbance

Not accounted for by another medical or psychiatric condition

DSM-5, 2013, APA

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Child/Adult with ARFID May Experience:

Common Symptoms:

- Picky/selective eating habits
- Sensory sensitivity
- Generalized anxiety
- GI symptoms
- Fears of choking/vomiting
- Food allergies
- OCD/depression in adults

Foods that are "safe" and "unsafe"

- Some perceive certain types of food as inedible and describe food using non-food substances (e.g. insects, dirt, lawn clippings)

(Fox, Coulthard, Williamson & Wallis, 2018)

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Signs of ARFID

- Avoidance of whole food groups or textures (e.g. fruit. meat, vegetables; slimy and mixed textures).
- Sensitivity to aspects of some foods e.g. temperature.
- Gagging or retching at the smell or sight of a particular food(s).
- Difficulty being in the presence of another person eating a non-preferred food.
- Having a diet that is limited to (usually less than 10) 'preferred foods' ('safe foods').
- Lack of interest in eating or missing meals completely (not feeling hungry).
- Attempting to avoid social events where food would be present.
- Struggling to stay and/or eat at a table during family mealtimes; eats only with distraction e.g. television.
- Needing to take supplements to meet their nutritional needs and where energy intake is impaired.

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Nine Item ARFID Screening (NIAS) Zickgraf & Ellis, 2018

- I am a picky eater
- I dislike most of the foods that other people eat
- The list of foods that I like and will eat is shorter than the list of foods I won't eat
- I am not very interested in eating; I seem to have a smaller appetite than other people
- I have to push myself to eat regular meals throughout the day, or to eat a large amount of food at meals
- Even when I am eating a food I really like, it is hard for me to eat a large enough volume at meals
- I avoid or put off eating because I am afraid of GI discomfort, choking, or vomiting
- I restrict myself to certain foods because I am afraid that other foods will cause GI discomfort, choking, or vomiting.
- I eat small portions because I am afraid of GU discomfort, choking, or vomiting

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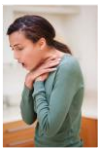
ARFID Subtypes

Sensory sensitivity: avoidance based on sensory characteristics of food (e.e. texture, smell)

Fear of aversive consequences: associated with food intake (e.g. choking, vomiting)

Lack of Interest: in food or eating



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ARFID or AN?

- ARFID and Anorexia Nervosa can not be diagnosed concurrently according to the DSM-V. This means if a client is exhibiting characteristics of ARFID but reports a fear of weight gain or being fat, or engages in behaviors that prevent weight gain a diagnosis of AN, BN, or OSFED will be more appropriate.

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What do we do with ARFID tendencies?

- Clients diagnosed with AN, BN, BED, or OSFED, that also present with ARFID tendencies may be observed struggling with the sensory characteristics of specific types of food, a fear of fullness associated with being sick as opposed to weight gain, a fear of eating certain foods for fear of being sick, chocking, or some other trauma usually around their mouth, swallowing, eating stomach, esophagus, etc.
- THE UT IS TRANSDIAGNOSTIC!!! It is specifically designed for individuals with eating disorders and co-occurring fears around food!

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ARFID Risk Factors

- Having had a distressing experience with food such as choking, vomiting, infant acid reflux, other GI conditions
- People with autism spectrum conditions are more likely to develop ARFID, as are those with ADHD and intellectual disabilities
- Children who don't outgrow normal picky eating or picky eating is severe
- Many with ARFID also have co-occurring anxiety disorder and high risk for other psychiatric disorders

arfidawarenessuk.org

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Where do we begin?

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Unifying Case Conceptualization

Individuals with emotional disorders

- experience negative affect more intensely and frequently;
- view emotional experiences as unwanted and intolerable;
- use maladaptive emotion regulation strategies (attempts to avoid or dampen the intensity of uncomfortable emotion)

Maladaptive strategies ultimately backfire & contribute to the maintenance of symptoms.(i.e., ED symptoms, substance abuse, self harm, etc.) and interpersonal disconnection

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RESEARCH-PRACTICE

David Barlow, Ph.D., ABPP

Research treatments are not used in practice

Most patients do not just have one problem

GAP

Many manuals for single disorders

Hard to combine treatments

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Solution to the Problem

Unify proven treatment principles to treat the same shared underlying problems that drive different emotional disorders

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THE UNIFIED PROTOCOL (U.P.)

UP distills and incorporates key principles of evidence-based CBT treatments and emotion science

Address the core, underlying mechanisms of common emotional disorders

Alternative to the myriad of treatment approaches and manuals for specific disorders.

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THE WHAT AND THE WHY

- What is Renfrew's Unified Treatment Model?
- Why do we incorporate it the UT into the treatment of ARFID therefore treating ARFID transdiagnostically?

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Unified Protocol
Evidence-Based Principles

- Re-evaluating maladaptive cognitive appraisals
- Changing maladaptive action tendencies associated with emotions
- Preventing emotion avoidance
- Utilizing emotion exposure procedures to promote tolerance
- Increase psychological flexibility in emotion regulation

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Maintaining Factors of EDs

Effects of altered nutrition	Cognitive rigidity/pro-ED beliefs	Systems	Relational response to ED behavior
Temperament: harm avoidant, perfectionistic, impulsive			Neuroticism: anxiety about anxiety!

Experiential Avoidance (limited behavioral repertoire)

Emotional Intolerance of negative affect

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Core disturbance/ mechanism

Experiential Avoidance

Key maintaining factor for many psychiatric illnesses:

Drive to avoid negative emotional experiences

Recovery requires experiential challenge (doing things that have been habitually avoided) **and reducing avoidance strategies**

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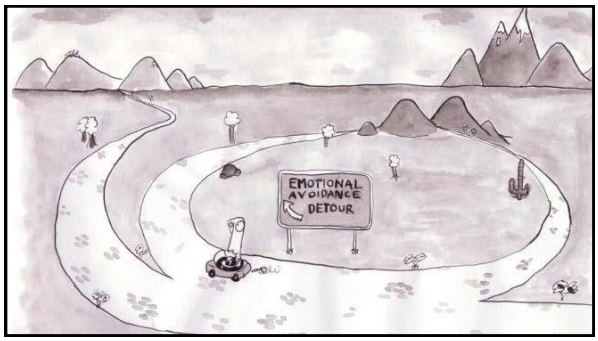

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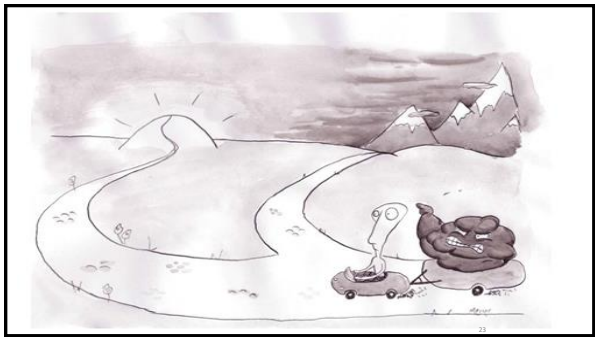

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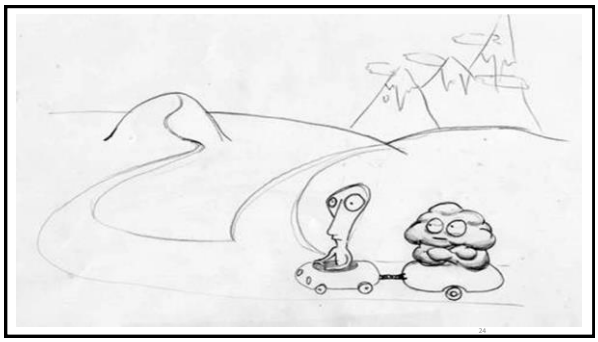

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Diverse Symptoms Function Similarly

Unpleasant Internal Experience

Emotional Avoidance and Unwillingness

Avoidant, Symptomatic Behavior

Temporary Relief from Unpleasant Internal Experience

Long Term Consequences

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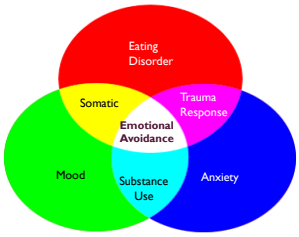
Treating the whole person: a transdiagnostic approach



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Transdiagnostic Approach

- Categorizes disorders based on common **underlying mechanism** or **core disturbance**--cuts across DSM-5 disorders
- Treatment targets core mechanism, not specific disorders
- Provides a **unifying case conceptualization** to the treatment of complex clients
- Working with one set of therapeutic principles is comprehensive and effective
- Able to address co-morbidity, as well as sub-threshold symptoms
- **More efficient training for clinicians**
- **Easier for patients to understand**

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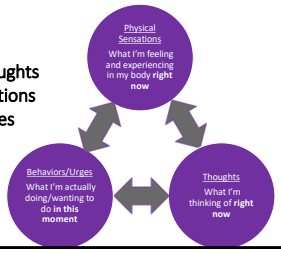
Three components of an emotional experience
"3 Component Model"

1. Cognitive/Thoughts
2. Physical Sensations
3. Behaviors/Urges



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Emotion awareness training

Help patients cultivate an increased awareness to their emotional experiences intentionally in a non-judgmental way:

- Build awareness of emotional experiences in context, ***as they are happening right now***
- Reactions often rooted in **perceived past** failures/**future** threats and uncertainties
- Distinction between **primary and secondary** emotional responses "Emotions about emotions"
- Teach the **consequences** of judgment-laden attention

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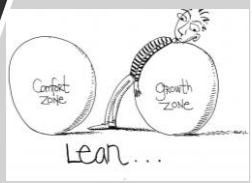
Ultimate goal of emotion awareness training

To ***practice*** applying skills in response to emotional experiences as they occur.



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CBT-AR

A Staged Approach

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For Whom is CBT-AR Appropriate?

Children, adolescents, or adults who:

- Have a diagnosis of ARFID
- Are able to cognitively engage in treatment
  - Are ages 10 and up
  - If a developmental disorder is present, it is of mild severity
- Are eating by mouth
  - Are at least able to orally consume liquids or soft foods
  - Do not require tube feeding
- Monitored by a physician
  - ARFID can have serious medical consequences
  - Patients who are underweight are at risk for re-feeding syndrome

Massgeneral.org/eatingdisorders

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CBT-AR

WHAT IT IS

- Achieve or maintain a healthy weight
- Correct any nutritional deficiencies
- Eat foods from each of the five basic food groups
- Feel more comfortable eating in social situations

WHAT IT IS NOT

- Trying to change your personality
- Making you eat very unusual foods
- Force feeding

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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Research

Includes children, adolescents, and adults who cannot meet their nutritional needs, typically because of:	No evidence-based treatment for older children, adolescents, or adults	Cognitive-behavioral therapy for ARFID (CBT-AR) developed and refined at Massachusetts General Hospital
• Sensory sensitivity • Fear of aversive consequences • Apparent lack of interest in eating or food		• Early data indicates that, on average, patients who receive CBT-AR add 17 novel foods, gain 11 lbs (if underweight), and significantly reduce food neophobia after treatment completion

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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CBT-AR Goals

01 — **Learn about ARFID and make early changes**
- Keep records to figure out what maintains symptoms
- If underweight, increase volume of preferred foods
- Make early changes in variety

02 — **Continue early changes and set big goals**
- Set goals to face fears
- Continue increasing volume and/or food variety

03 — **Face fears**
- Gain exposure with new or feared foods
- Taste small amounts at first, then incorporate larger amounts

04 — **Prevent relapse**
- Develop skills plan to keep practicing on your own

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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4 Stages of CBT-AR

1. Psychoeducation and early change (2-4 sessions)
2. Treatment planning (2 sessions)
3. Address maintaining mechanisms in each ARFID domain (14-22) sessions
   a. Sensory Sensitivity
   b. Fear of aversive consequences
   c. Lack of interest in food or eating
4. Relapse prevention (2 sessions)

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Outline of Session

1. Set session agenda
2. Weigh patient (outpatient)
3. Review homework
4. Implement intervention related to treatment stage
5. Review agenda items and questions
6. Plan homework

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CBT-AR: Stage 1

- Psychoeducation on ARFID
- Monitoring (self or parent)
- Regular eating (eating preferred foods)
- Personalized formulation
- If underweight – begin to restore by increasing volume of preferred foods. Conduct in session therapeutic meal to provide coaching and guidance
- If not underweight – make small changes in presentation of preferred foods and/or reintroduce recently dropped foods

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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CBT-AR: Stage 2

- Psychoeducation about 5 basic food groups and nutrition deficiencies
- Select new foods to learn about in Stage 3

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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CBT-AR: Stage 3

- Exposures targeting three domains

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Sensory Sensitivity

- Systemic desensitization to novel foods by repeated in-session exploration of sight, smell, texture, taste, chew
- Specific detailed plans for out of session practice with tasting and incorporation

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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Fear of aversive consequences

- Psychoeducation about how avoidance maintains anxiety
- Development of fear / avoidance hierarchy
- Graded exposure to feared foods and situations in which choking, vomiting, or other feared consequences may occur

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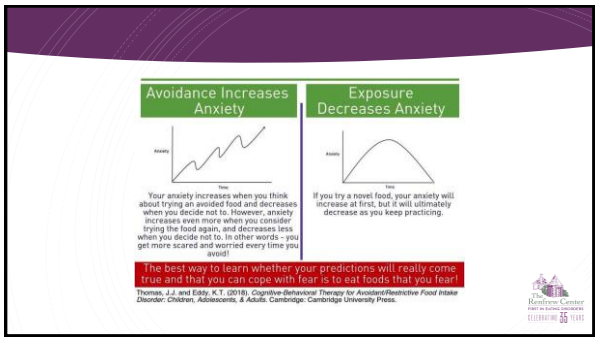

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Lack of interest in food or eating

- Interoceptive exposure to bloating, fullness, and/or nausea
- In-session exposure to highly preferred foods

Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

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CBT-AR: Stage 4

- Evaluate treatment progress (CBT-AR is designed to expand diet, restore weight, correct nutritional deficiencies and reduce psychosocial impairment.
- Create relapse prevention plan including future goals

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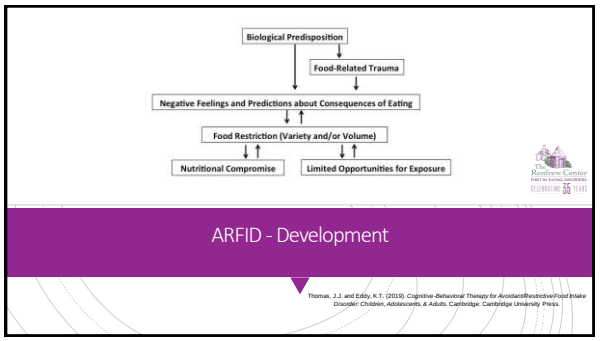
Biological Predisposition
Food-Related Trauma
Negative Feelings and Predictions about Consequences of Eating
Food Restriction (Variety and/or Volume)
Nutritional Compromise
Limited Opportunities for Exposure
ARFID - Development
Thomas, J.J. and Eddy, K.T. (2019). Cognitive-Behavioral Therapy for AvoidantRestrictive Food Intake Disorder: Children, Adolescents, & Adults. Cambridge: Cambridge University Press.

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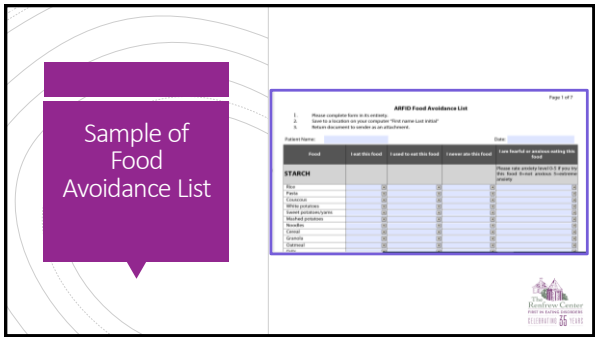
Sample of Food Avoidance List
ARFID Food Avoidance List

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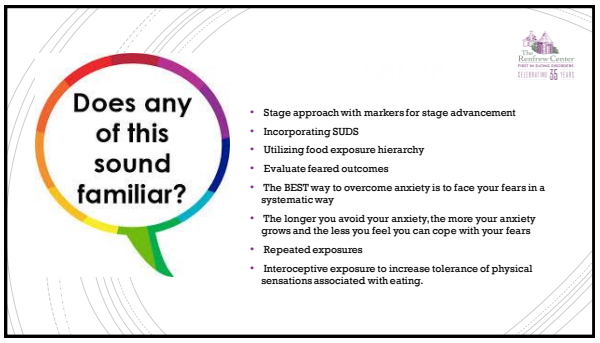
Does any of this sound familiar?
Stage approach with markers for stage advancement
Incorporating SUDS
Utilizing food exposure hierarchy
Evaluate feared outcomes
The BEST way to overcome anxiety is to face your fears in a systematic way
The longer you avoid your anxiety, the more your anxiety grows and the less you feel you can cope with your fears
Repeated exposures
Interoceptive exposure to increase tolerance of physical sensations associated with eating.

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Exposures

Individual, meal times, and home

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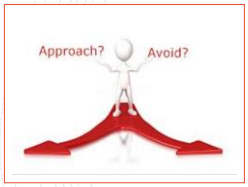
Approach mindset vs. Avoid mindset



- Lay out the rationale early in treatment.
- All treatment decisions are based on this foundation

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ARFID & Exposures

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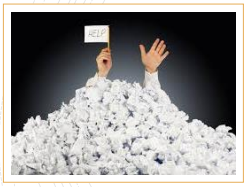
Misperceptions about Exposure Therapy



- Have to do the hardest thing
- It has to be really scary/intense/overwhelming
- I'm going to have to do something I don't want to do
- I can't set my limits, you'll set them for me

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Exposure is NOT …

- **Not** "throwing someone into the deep end of the pool"
- **Not** "FEAR FACTOR"
- **Not** to make people "get over" it or "cure themselves"
- **Not** "white knuckling" it
- **Not** just making people do stuff they are afraid of
  - Not about "making" them do it
  - Not about a surprise or a mystery challenge

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So what's the point?

Primary goal is **not** to reduce the experience of negative emotions or physiological arousal.

The goal is to **promote tolerance of emotions** within a structure that enhances the consolidation and retrievability of inhibitory learning ***(to NOT act)*** over contexts and time.

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Food Avoidance & Discovery List

Food	I eat this food	I used to eat this food	I never ate this food	I am fearful or anxious eating this food
STARCH				Please rate anxiety level 0-5 if you try this food 0=not anxious 5=extreme anxiety
Rice				
Pasta				
Couscous				
White potatoes				
Sweet potatoes/yams				
Mashed potatoes				
Noodles				
Cereal				
Granola				
Oatmeal				
Grits				
Quinoa				
Matzo				

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Food Avoidance Hierarchy

Food Avoidance Hierarchy Form

List foods you are currently avoiding in order to prevent uncomfortable reactions from occurring, starting with the worst or most distressing foods. Rate the degree to which you avoid each of the foods you describe, and the degree of distress they cause. For each, write the applicable number in the space provided.

Do Not Avoid	Hesitate To Enter But Rarely Avoid		Sometimes Avoid		Usually Avoid		Always Avoid
0	1	2	3	4	5	6	7	8
No Distress	Slight Distress		Definite Distress		Strong Distress		Extreme Distress

	Descriptions	Avoid	Distress
1 WORST			
2			
3			
4			
5			
6			
7			
8			

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EXPOSURE

Facilitate corrective learning through:

- Building emotional tolerance
- Disconfirmation of expected negative outcomes
  - Including, "I must do X to avoid Y."
  - Including, expectation of not being able to cope

ALL Exposures are EMOTION Exposures

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CONDUCTING EMOTIONAL EXPOSURES

Proper structure

Expectations (Before & After)

No SAFETY Behaviors

"Desirable Difficulty"

Variety of stimuli & context

Repetition, Repetition, Repetition

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Goals of ARFID Tasters and Exposures

Frequent short exposures

Repetition, repetition, repetition

Think: What are we targeting

Not about completing 100% until it becomes an exchange

Part of the agreed upon exposure goal may be to increase volume

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Tips and Tricks for Successful Exposures

- Set a goal
- Eat with the patient
- Utilize SUDs
- Asking about emotion experience (thoughts, physical sensations, urges & behaviors)
- Re-visit motivation and values
- Approach the emotion and validate
- Make requests that match goals: take another bite, don't put fork down
- Remember this isn't about you, step away from the power struggle
- Join with the patient, not the eating disorder

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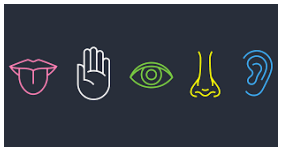
Be an investigator



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Emotion Exposure Form

Record of Emotion Exposure Practice

Exposure Task: _____

Prior to the task:

Anticipatory Distress (0-8): _____

Thoughts, Feelings, and Behaviors you noticed before the task:

Reevaluate your automatic appraisals about the task:

After completing the task:

Thoughts, Feelings, and Behaviors you noticed during the task:

Number of minutes you did the task: _____

Maximum distress during the task (0-8): _____

Distress at the end of the task (0-8): _____

Any attempts to avoid your emotions (distraction, safety signals, etc.)?

What did you take away from this exposure task? Did your feared outcomes occur? If so, how were you able to cope with them?

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Common Subtle Avoidance/EDBs in Patients During Exposures

Behavioral

- Hesitation
- Pacing, shaking
- Asking for reassurance
- Looking away, other postural issues (hands in pockets or folded arms)
- Compulsions/rituals/undoing

Cognitive

- Distraction
- Dissociation ("pretending")
- Thought suppression
- "Steaming through"
- Use of humor
- Intellectualizing
- Procrastinating
- Over-discussing
- Misuse of reappraisals

Safety signals

- "Stuff": cell phone, water, medication, good luck charm, etc.
- Being with a "safe" person
- Doing it in the office vs. in natural setting

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Ask yourself these FIVE questions when approaching a new food!
Trying a new food can be overwhelming at first. The next time you encounter a new food, slow down and give yourself a few minutes to explore it as if you've never seen it before. Try to use neutral words without describing foods as good or bad.
The Five Steps
#1
What does it look like (e.g., green, round)?
#2
What does it feel like (e.g., smooth, rough)?
#3
What does it smell like (e.g., strong, bitter)?
#4
What does it taste like (e.g., sweet, salty)?
#5
What is the texture like (e.g., chewy, soft)?
The Renfrew Center
Thomas, J.J. and Eddy, K.T. (2019). Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults. Cambridge: Cambridge University Press.

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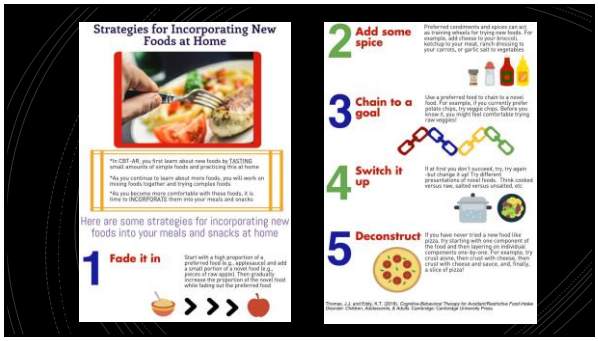
Strategies for Incorporating New Foods at Home
Here are some strategies for incorporating new foods into your meals and snacks at home
1 Fade it in
2 Add some spice
3 Chain to a goal
4 Switch it up
5 Deconstruct

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Sample Taster – Eaten Alongside Meal
Example – Patient struggles with texture of applesauce and has already tried it in session. It now appears with her lunch to increase frequency of exposure. Patient continues to still drink their juice in order to meet the full exchange.
Taster items are given two or three times and are then incorporated into the meal plan as a whole exchange.

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RENFREW UNIFIED TREATMENT MODEL: UNIFYING PRINCIPLE OF TREATMENT

Emotional Intolerance, Avoidance, Symptoms

TREATMENT

Emotional Tolerance, Acceptance, Regulation, Flexibility

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ARFID Resources

- Patient and Family Workbook https://bit.ly/2WvDdy6
- Fudo App
- Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder
  - (Thomas & Eddy)

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