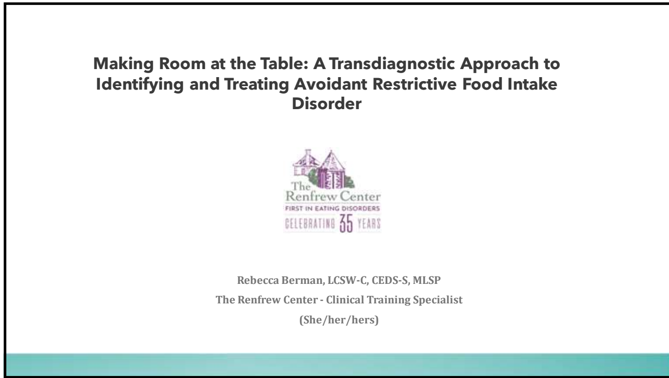


1

## LEARNING 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 learn treatment interventions specific to each ARFID subtype.

2

## INTRODUCTION TO 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

3

## 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
  - Dependence 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

4

## 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)

5

## 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.

6

## 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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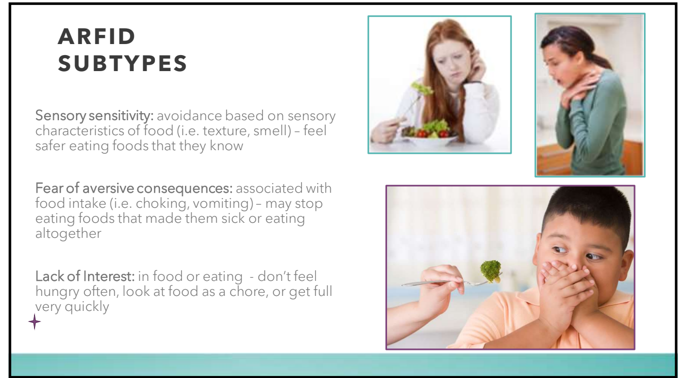

## ARFID SUBTYPES

Sensory sensitivity: avoidance based on sensory characteristics of food (i.e. texture, smell) – feel safer eating foods that they know

Fear of aversive consequences: associated with food intake (i.e. choking, vomiting) – may stop eating foods that made them sick or eating altogether

Lack of Interest: in food or eating - don't feel hungry often, look at food as a chore, or get full very quickly

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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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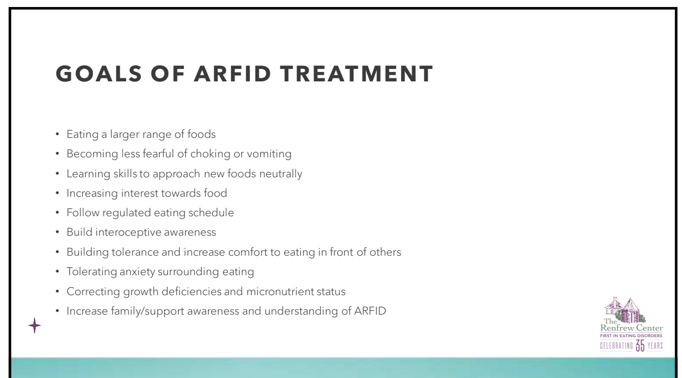

## GOALS OF ARFID TREATMENT

- Eating a larger range of foods
- Becoming less fearful of choking or vomiting
- Learning skills to approach new foods neutrally
- Increasing interest towards food
- Follow regulated eating schedule
- Build interoceptive awareness
- Building tolerance and increase comfort to eating in front of others
- Tolerating anxiety surrounding eating
- Correcting growth deficiencies and micronutrient status
- Increase family/support awareness and understanding of ARFID

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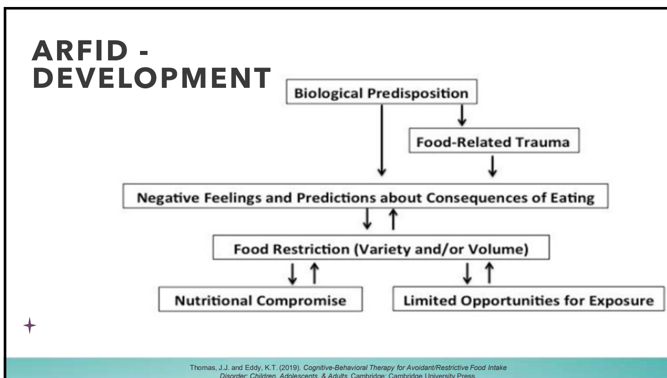
## ARFID - DEVELOPMENT




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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## 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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# TRANSDIAGNOSTIC - THE UT

EATING DISORDERS ARE EMOTIONAL DISORDERS

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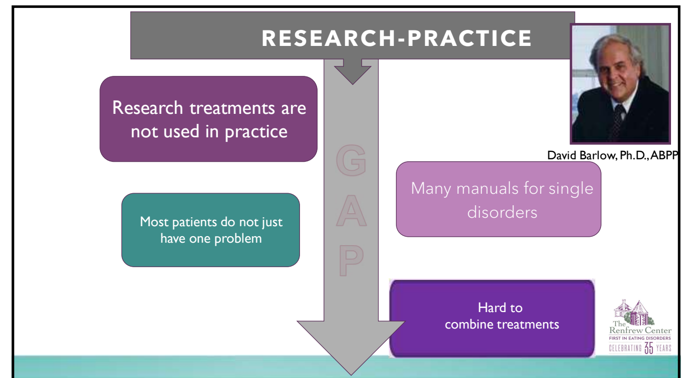


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## SOLUTION TO THE PROBLEM

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

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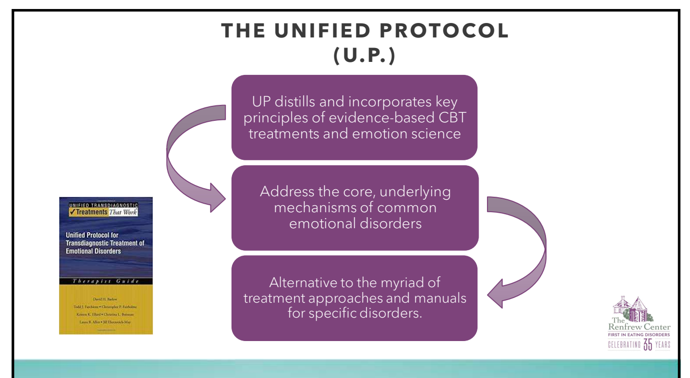


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## UNIFIED PROTOCOL EVIDENCE-BASED PRINCIPLES

- 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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## 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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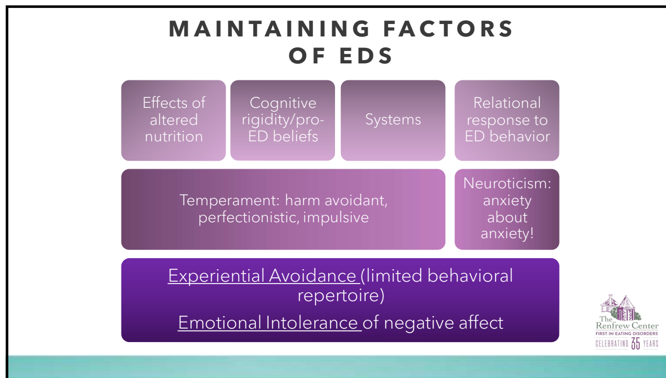


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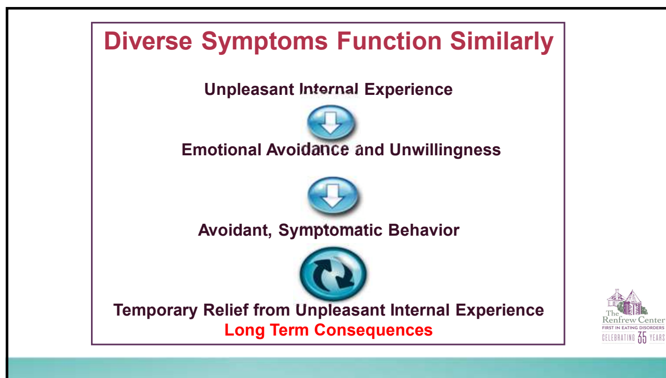


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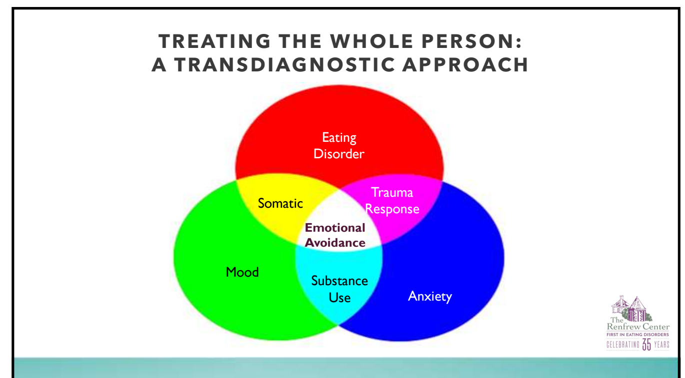


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## TRANSDIAGNOSTIC APPROACH

- 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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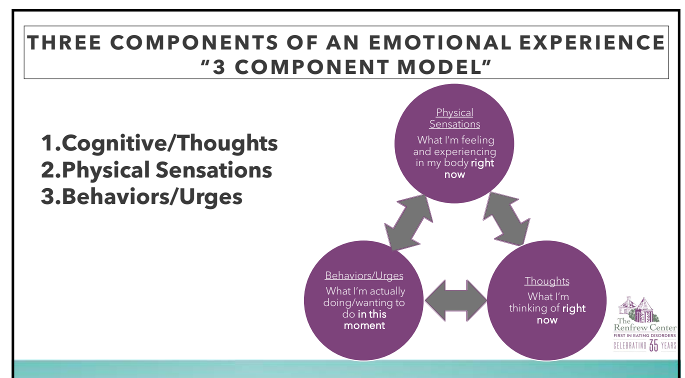


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# CBT-AR

A STAGED APPROACH

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**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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## 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

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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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**Includes children, adolescents, and adults who cannot meet their nutritional needs, typically because of:**
- Sensory sensitivity
- Fear of aversive consequences
- Apparent lack of interest in eating or food

**No evidence-based treatment for older children, adolescents, or adults**

**Cognitive-behavioral therapy for ARFID (CBT-AR) developed and refined at Massachusetts General Hospital**
- 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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Does any of this sound familiar?

## CBT-AR

- 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.

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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## SENSORY SENSITIVITY PRIMARY INTERVENTIONS

- Psychoeducation on necessity of repeated exposure to enhance liking for novel foods.
  - Example: Our preferences change over time; mere exposure can enhance liking. *Music example
- Psychoeducation on the Five Steps
- 3 Key Points
  - The purpose of exposure is to learn about a new food, not necessarily to like it even on multiple tries
  - Patient should always take the lead on which foods to learn about.
  - Primary goal = help patient taste the food.
- Systemic desensitization to novel foods by repeated in-session exploration of sight, feel, smell, taste, texture
- May need to focus in on a particular sense at first to build tolerance
- Specific detailed plans for out of session practice with tasting and incorporation

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## WHAT IS A SUPERTASTER?

- Flavor preferences are partly genetic
- You may even be a "supertaster" - meaning you could have been born with a high concentration of taste buds on your tongue and dislike bitter foods, like vegetables



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## HOW IS A LIMITED DIET A MAINTAINING FACTOR FOR ARFID?

- Eating the same foods all the time makes new foods taste even more different
- Certain nutrition deficiencies can change the way food tastes, making new food even less appealing
- Eating a particular food over and over may also make you tired of that food and stop eating it, further limiting your diet
- Eating a limited diet can cause health problems due to an imbalance of nutrients
- It may be hard to eat with others, causing you to miss out on opportunities to learn about new foods and build connection

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

- Negative experiences with food such as choking, vomiting, an allergic reaction, or pain after eating can be traumatic
- These experiences might cause a limited diet to prevent further trauma. May even avoid any food that reminds them of the traumatic experience or stop eating altogether
- "Safety behaviors" may be used to try and prevent another traumatic experience from happening. Safety behaviors prevent us from testing negative predictions about eating. The more you avoid eating, the scarier it becomes!

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 PRIMARY INTERVENTIONS

- 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
- Building tolerance of physical sensations - *first step = awareness

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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## WHY EXPOSURE WORK IS HELPFUL

- Avoidance is a short term solution to anxiety .
- The longer you avoid your anxiety, the more your anxiety grows and the less you feel you can cope with your fears
- You miss opportunities to test out expectancies and learn your feared consequences are unlikely.
- The BEST way to overcome anxiety is to face your fears in a systematic way!
- Create a hierarchy of your fears from least anxiety-provoking to most anxiety-provoking, using a scale from 0-8 called subjective units of distress (SUDS)
- One at a time, face your fears, evaluate whether your feared outcomes come true, and watch what happens to your anxiety
- Over time, you will probably see your anxiety decrease and you will feel more confident in handling situations that used to be scary

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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**Avoidance Increases Anxiety**

Anxiety / Time

Your anxiety increases when you think about trying an avoided food and decreases when you decide not to. However, anxiety increases even more when you consider trying the food again, and decreases less when you decide not to. In other words - you get more scared and worried every time you avoid!

**Exposure Decreases Anxiety**

Anxiety / Time

If you try a novel food, your anxiety will increase at first, but it will ultimately decrease as you keep practicing.

The best way to learn whether your predictions will really come true and that you can cope with fear is to eat foods that you fear!

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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## LACK OF INTEREST IN FOOD OR EATING PRIMARY INTERVENTIONS

- Interoceptive exposure to bloating, fullness, and/or nausea
- In-session exposure to highly preferred foods
- Working with and through hunger fullness scale
- Identify alternative signs of hunger: headaches, dizziness, increased difficulty concentrating

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## LACK OF INTEREST - PSYCHOED

- How hungry you feel and how much pleasure you get from eating is partly due to your genes
- Eating very little can cause you to feel full quickly, even though you are not getting enough nutrients
- Eating without a regular schedule of meals and snacks can dull hunger cues, especially if you go long periods without eating
- Eating too little can promote excessive fullness when you do eat an adequate amount because your stomach capacity decreases with chronic food restriction

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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## LACK OF INTEREST IN FOOD OR EATING INTEROCEPTIVE EXPOSURES

**1. Reduce discomfort after eating**

Interoceptive exposures

*Increasing your tolerance of full sensations can help you eat enough

*Types of exposures you can do with your therapist in session are: pushing your belly out, gulping water, and spinning in a chair
-Try all three and then practice the hardest
-Plan practices as homework (e.g., chug several full glasses of water before lunch each day)

| Internal physical sensations that individuals with ARFID may find difficult to tolerate | Exposure exercises that will elicit these internal physical sensations |
|---|---|
| Bloating | Pushing belly out as far as possible for at least 30 seconds |
| Fullness | Gulping several glasses of water |
| Nausea | Spinning in a chair for at least 30 seconds |

Thomas & Eddy 2019

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## 2. Increase your hunger
### Recognizing Hunger Cues

*Over time, eating too little confuses your hunger and fullness cues

*The best way to help increase your awareness of hunger cues is to keep track of how hungry you feel before you eat, and how full you feel afterward

*To begin shifting your hunger cues, you will need to start eating at a 3 or 4 (neither hungry nor full), rather than waiting for a 1 (extreme hunger). You will also need to keep eating until a 6 or a 7 (extreme fullness), rather than stopping at a 4 or 5 (neither hungry nor full)

A person who is eating regularly will experience normal hunger cues.

1 Extreme Hunger — 4 Neutral: Neither Hungry Nor Full — 7 Extreme Fullness

A person who is chronically food restricted has learned to ignore hunger cues. In cases where others would feel hungry, the food restricted person feels neutral.

1 Extreme Hunger — 4 Neutral: Neither Hungry Nor Full — 7 Extreme Fullness

The best way to shift hunger cues back to normal is to (1) eat by the clock, and (2) increase awareness through self-monitoring.

## 3.Increase enjoyment of eating
### Notice what you like about your preferred foods

*Remind yourself of foods you have eaten during happy occasions, such as eating birthday cake with your friends and family

*Pick 5 foods you prefer or used to really enjoy and closely describe them using "The Five Steps" handout

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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# EXPOSURES

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## APPROACH MINDSET VS. AVOID MINDSET

Approach? Avoid?

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

The Renfrew Center
FIRST IN EATING DISORDERS
CELEBRATING 35 YEARS

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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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## MISPERCEPTIONS ABOUT EXPOSURE THERAPY

HELP

- 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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## 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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## 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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Record of ARFID Food Exposure Practice Form

Food/drink exposure:______

**Prior to the exposure:**

SUDs (0-8):____

Expectancies:______

Goal for exposure:______

**After completing the exposure:**

Thoughts, Physical Sensations, Urges/Behaviors:

______

SUDs (0-8):____

Any avoidance strategies used during the exposure?______

Looking back at your expectancies, did your feared outcomes occur? If so, how were you able to cope with them?______

What did you take away / learn from this exposure?______

What is your plan next regarding this food/drink?______

Record of ARFID Food Exposure Practice Form

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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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ARFID Self-Monitoring Record

| Date | Food/Beverage | SUDs 0-8 Before | Thoughts | Physical Sensations | Urges/Behaviors | SUDs 0-8 After |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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ARFID Self-Monitoring Record

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## ARFID RESOURCES

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

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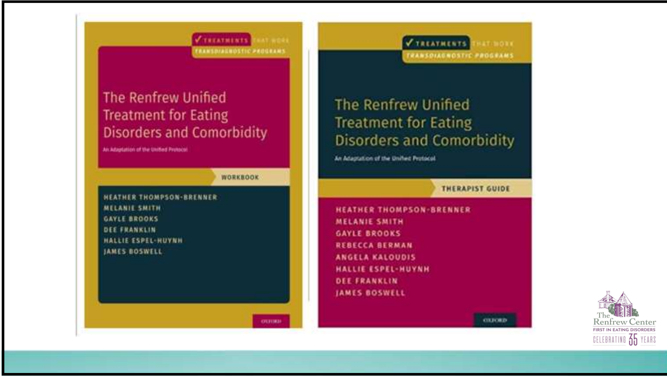


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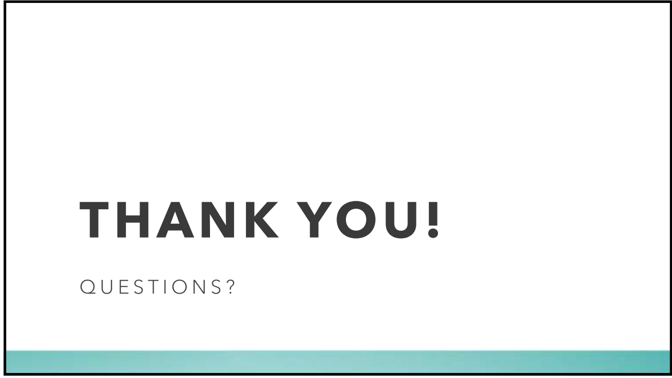


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