EXPLORING ARFID TREATMENT STRATEGIES:

Insights from Dietitians for Mental Health Clinicians

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Acknowledgement of Country

Acknowledgement of Lived Experience

Presenting today

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Learning objectives

1. Characteristics of ARFID and the factors contributing to the rising numbers of referrals.
2. Role and contributions of dietitians in supporting and complementing the treatment team's efforts.
3. Identify when to collaborate and integrate a dietitian within the treatment team to enhance patient care.

Overview


Learning Outcomes
What is ARFID, really?
What does a Dietitian do?
Moving forward together
Questions

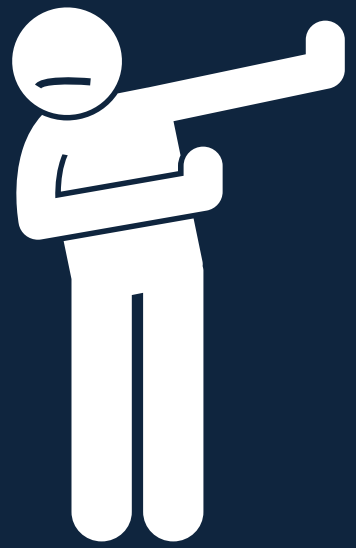
What is ARFID, really?

The official definition

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

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.

Different presentations



Sensory aversions

Lack of interest

Fear of consequences

Natural variation and change in eating behaviours

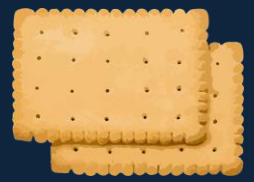
Neophobia

- Reluctance to try new or unfamiliar food
- Evolutionary significance – stopped small children from eating dangerous things
- Typical developmental stage, peaks 2-6 years old
- Common source of worry for parents
- Most kids will grow out of it and follow the eating pattern modeled to them

Bialek-Dratwa et al 2022

Sensory

- Reduced dietary variety based on the sensory characteristics of food
    - Visual appeal – colour, shape, size, imperfections
    - Smell – sweet, savoury, strong
    - Texture – to touch and in the mouth
    - Temperature – also changes the smell and texture
- Increases stress in family unit, resulting in increased likelihood of parents using coercive strategies resulting in further negative mealtime experiences



Selective or restrictive

- Generally described as diet limited to 10-15 foods
- Common among Autistic individuals
- May “jag” (get stuck or sick of) preferred foods
- Can be sensory in nature or not appear to follow any pattern
- Foods may cycle or be consistent for years at a time

Speed humps

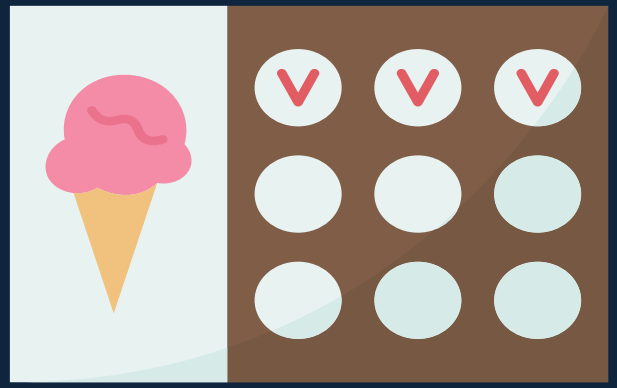
- Transitions (high school, moving house…)
- Increased awareness of societal norms
- Health information and advice
- Family stress (relationship breakdown, family violence)
- Adolescence / hormonal changes / growth
- Family expectations, rigidity, pressure

Co-morbidities for consideration

- Developmental differences – Autism, ADHD, Intellectual disability
- OCD
- Anxiety Disorders
- Gastro-intestinal issues
- Allergies
- Malnutrition

What does a dietitian do?

My process



From star charts

Gag orders

Responsive Feeding Theory

Related theories and frameworks

- Responsive parenting
- Humanistic psychology
- Attachment theory and interpersonal neurobiology,
- Theories of development
- Self-determination theory (SDT)
- trauma physiology

Definition

- "… facilitates the (re)discovery of internal cues, curiosity, and motivation, while building skills and confidence. It is flexible, prioritizes the feeding relationship, and respects and develops autonomy"

Values

- Autonomy
- Relationship
- Competence
- Intrinsic Motivation
- Holism

Responsive Feeding Theory – in practice

Relationships

- Parent and child/teen
- Pressure and worry > nagging and negotiating

Mealtimes

- Collaboratively trialing different ideas
- Understanding different members of the family's preferences and needs

Confidence

- Planning and preparing food
- Accepting fluctuations – the flag that something's going on

Neurodivergence

Definition

Neurodivergence as an innate form of neurocognitive functioning that is significantly different from societal understandings of ‘typical’.

The terms neurodivergence and neurodivergent encompass autism, attention deficit/hyperactivity disorder (ADHD), dyslexia, dyspraxia, dyscalculia, dysgraphia, apraxia, misophonia, intellectual/learning disability, giftedness, synaesthesia, and Tourette’s syndrome (TS).

Cobbaert & Rose (2023). Eating Disorders and Neurodivergence: A Stepped Care Approach.

Neurodivergence

Assumptions of standard eating practices

- Dietary guidelines > eating the rainbow > shame/ guilt
- Family meals in ND households

Past experience

- Family meal times and expectations
- Extended family
- Coersion / Applied Behavioural Analysis
- Desensitization

Neurodivergence

Need for individualised approach

- Who is trying to achieve what?
- Capacity?
- Aiming for change or return to baseline?

Lived experience

- Cassidy Arvidson “For me, in my journey, I don't believe that ARFID or that recovery for ARFID is real. I think that there is coping. But in my experience, I don't believe that there's something to recover…. because I've always just been this way”

Help seeking

Who is driving the request for help?

- Adolescent, young person or adult?
- Family member or Partner?
- Doctor or other allied health recommendation?

Perceived severity of the problem

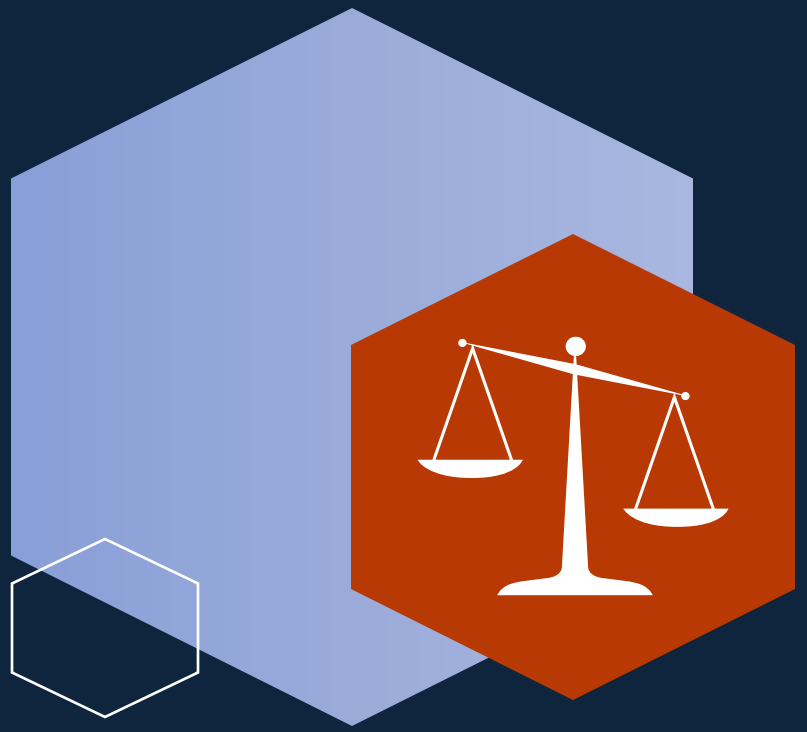
- Impact of school/work, social life
- Impact on family cohesion or relationships
- Risk to growth, physical and mental health

Accessibility of supports

- Children and families more frequent contact with health professionals
- NDIS allied health and medical
- Adolescents and adults…

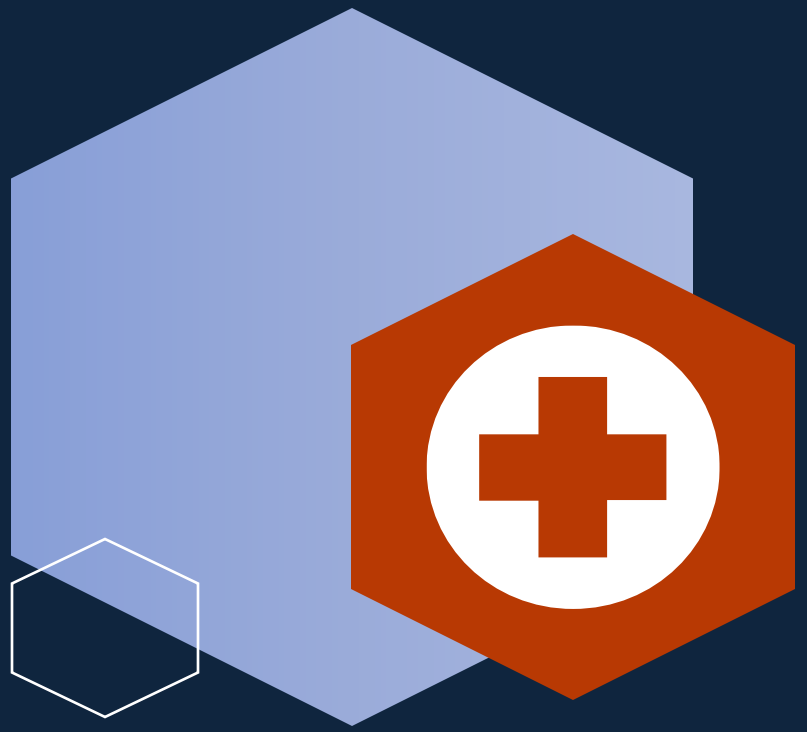
The nitty gritty of assessment

Level of concern



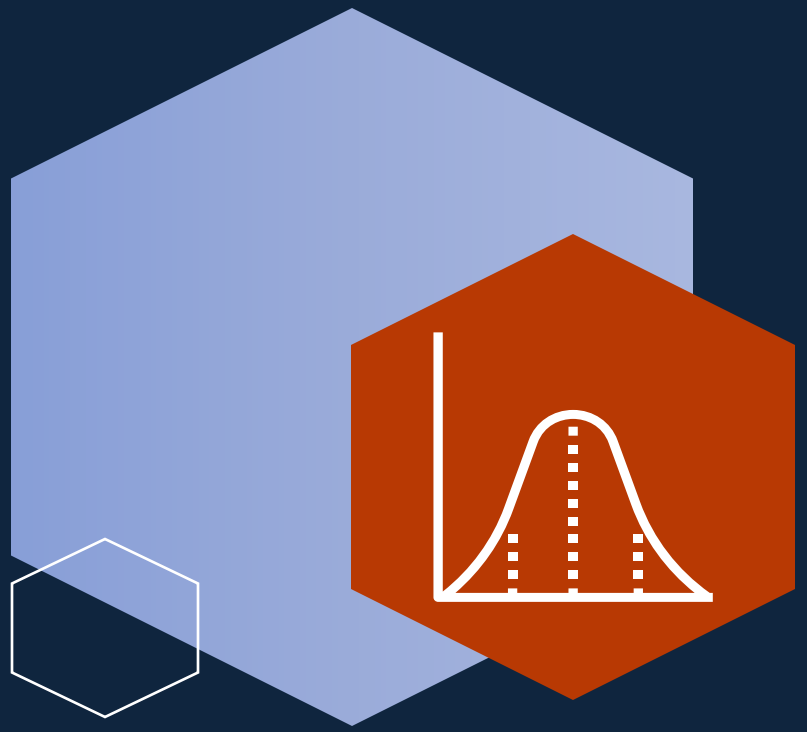
- Who is requesting help?
- Family and relationship risk
- Medical and nutritional risk (short V long term)

Medical history



- Developmental history / neurodivergence (diagnosed?)
- Looking out for those speed bumps
  - Mental health, anxiety, depression, OCD
  - Trauma
  - Allergy
  - Swallowing difficulty
- Any multi-disciplinary input, and associated goals

Growth and weight history



- Children growth charts
  - Tracking along their normal or has there been change in trajectory? Z-scores can be very useful if high or low on percentiles (peditools.org)
  - Weight and height (head circumference in young children), comparison between
- Adults and teens
  - Weight history

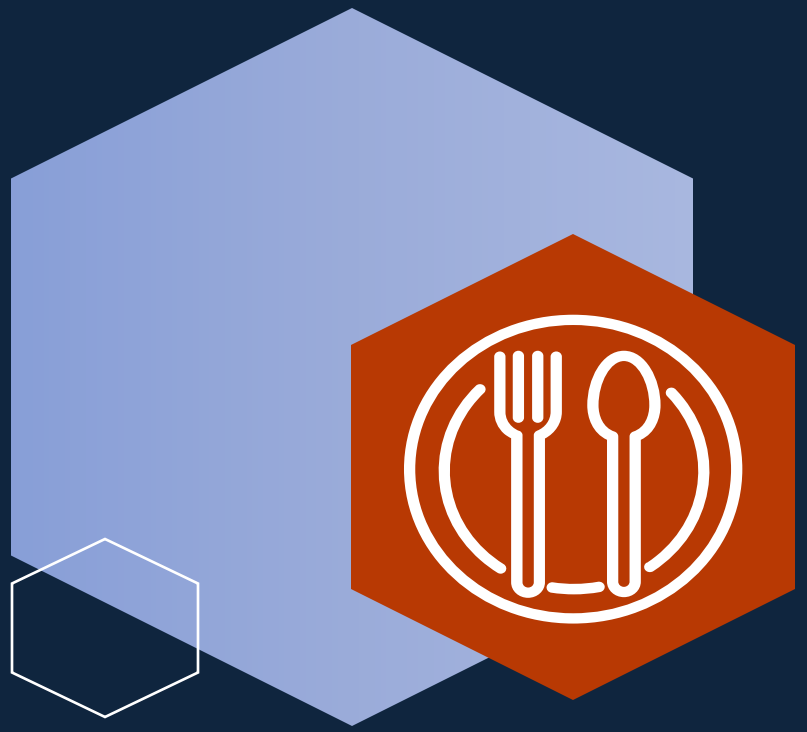
Past interventions

- What has been tried in the past?
- What worked and didn't? Short and long term impacts?
- Perception of intervention

Social history

- Family dynamics
- School / work attendance
- Social life and impact of food / mealtimes
- Physical activity

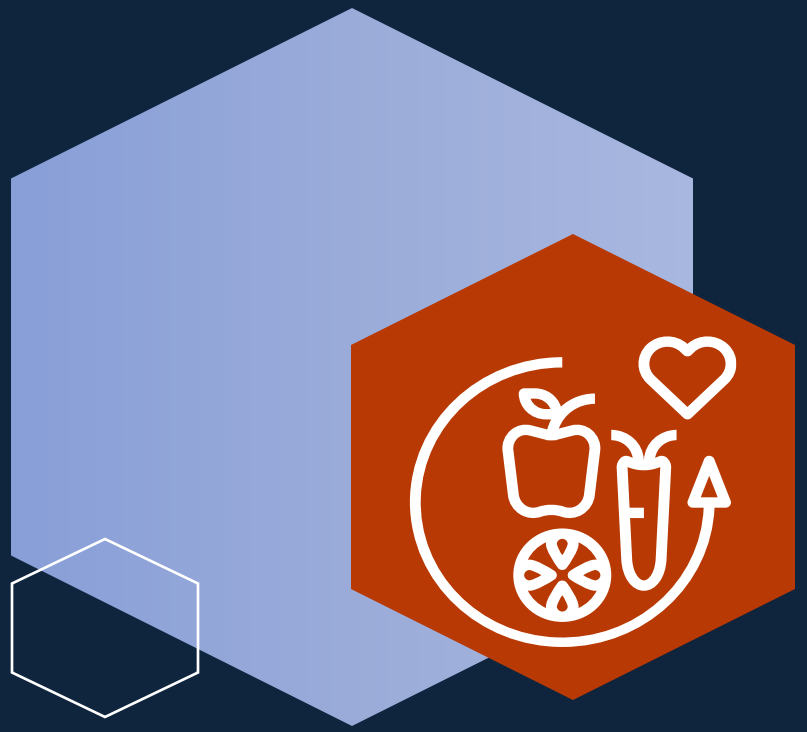
Nutrition intake



Can be assessed in multiple ways

- Diet history, “walk me through a typical day of what you eat and drink starting from when you get up”
- Food groups preferences table. What foods are always/sometimes/never accepted from each of the food groups
- 24 hour recall
- Food diary

Mealtime environment



- Aim is to paint a picture of mealtimes
- Different times of day, location
- Lead up to a meal, during and after
- Consider all the environmental elements
  - Who is present, does it change? Impact?
  - What is served, rules and expectations?
  - When is the meal decided upon? Planning?
  - Where is the meal eaten? What else is around

    TV, music, busy or calm?
  - How is the meal presented / served?

What do we find?

Good enough

Not ok

“Good enough”

BF – weetbix/porridge with milk or toast

L – crunchy snacks, maybe yoghurt

AT – more crunchy snacks

D – pasta, sausages, chicken nuggets

S – chocolate, cake, chips, biscuits

What I see:

Bread – fortified (iron, protein, fibre)

Dairy – yoghurt or cheese common

Protein – nuggets, sausages

Multivitamin (vegemite!)

“Good enough”

Nutritional adequacy

- Combination of food, nutrition supplements, vitamin supplements
- Meeting both macronutrient and micronutrient requirements.
- Limited or no apparent impact on physical function and growth

Social and community participation

- Eating with family and Friends
- Able to eat at both home and at school

Opinion of the young person

- Do they see a need for change?
- What adaptations or hacks are working for them?
- Is this their normal?

“Not ok”

BF –

L – crunchy snacks

AT –

D – pasta or chips

S – crunchy snacks

Dietary variety and pattern have reduced. The person is struggling to find any food or drinks they can tolerate in sufficient quantities to meet their needs.

“Not ok”

Nutritional adequacy

- Combination of food, nutrition supplements, vitamin supplements NOT enough. Likely unable to take supplements.
- Multiple micronutrient deficiencies
- Noted sustained or high-risk impact on physical function and/or growth

Social and community participation

- Unable to eat with any flexibility regarding where or who they are with. E.g. only eating at home, with specific person or alone. AND is impacting ability to participate in life they way they want to as a result.

Opinion of the young person

- Now it gets tricky – like many ED’s even if the person is not concerned our (risk) assessment says some action is needed.

The bigger picture

Zoom out

- Taking into consideration all the different information and perspectives. What's the real risk?
  - To whom?
  - In what time frame?

Collaborate and invite

- Even when our professional level of concern is high, matching the referrers/parents but the young person isn't seeing it – we need to work together to find common ground and a path forward.

How do we move forward together?

How’s our road looking?

Planning together

Emphasize autonomy

- Share concern
- Provide a menu of options
- Invite collaboration and shared goal setting
- Be realistic with boundaries and limits

Team work

- Internal or external
- Who's already connected in and may be of support?
- Long term, who's going to stay connected?

General Recommendations

Recommendation that assessment and treatment should be approached from a multi-disciplinary and multi-modal perspective *

Where can Dietitians be found

- Within hospital setting
- Local Community Health Service- Outpatient
- Mental health teams
- Private practice (+/- NDIS)
- Pediatric feeding clinics

Collaboration of teams- Multidisciplinary

Helpful discussions

- Shared formulation for clear understanding of problem
- Client goals
- Approach of each clinician- who is doing what
- Who and what role do supports play
- Treatment specifics as tailored to client- eg. More helpful ways for communication ?

What to ask the Dietitian?????

Additional resources

Insights from those with lived experience

- Podcast ARFID unmasked
- ARFID awareness interest group
- ARFID awareness on tiktok
- Kevin does ARFID Insta

References with links

Cobbaert & Rose (2023). Eating Disorders and Neurodivergence: A Stepped Care Approach

Ellyn Satter's Division of responsibility in feeding

Rowell, Wong, Cormack & Moreland (2023). Responsive feeding theory: Values and Practice (version 2).

References with links

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Caldwell AR, Krause EK. Mealtime behaviours of young children with sensory food aversions: An observational study. Aust Occup Ther J. 2021 Aug;68(4):336-344. doi: 10.1111/1440-1630.12732.

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Thank you

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