Avoidant and Restrictive Food Intake Disorder

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What is Avoidant and Restrictive Food Intake Disorder (DSM V)

- An eating or feeding disturbance e.g. an apparent lack of interest in eating or food usually avoidance based on the sensory characteristics of food.
- Concern about aversive consequences of eating.
- Persistent failure to meet appropriate nutritional and or energy needs associated with one or more of the following:
What is Avoidant and Restrictive Food Intake Disorder (DSM V)

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

• NHS England commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop Eating Disorders Guidance: Access and Waiting Times (2015).

• Included Atypical Eating Disorders which do not meet full diagnostic criteria for typical eating disorders e.g. Anorexia Nervosa, Bulimia Nervosa.
Food Intake

• Normal intake is subjective.

• What we eat is determined by culture/sub culture and foods available.

• What we eat in infancy predicts those that we eat in later childhood and adulthood.

• We learn to eat foods that are seen as safe (watching others eat/way food looks/is packaged).
Birth

- Inherited factors which determine certain foods which may be accepted or rejected.
- Innate taste preferences that will endure throughout life (sweet and fat).
- Innate dislike tastes (bitter, beetroot, radishes and olives).
Learning about taste (4-6 months)

- Window of acceptance for new tastes (complementary tastes).
- Preference is a function of exposure.
- Preference is based on taste and smell.
Taste preference

- Sweet tastes are innately preferred.
- Salt and sour taste acceptance is easier than bitter.
- Bitter tastes are usually associated with toxicity in the plant world, and are therefore more often rejected unless there is early exposure.
Learning about textures (6-12 months)

• Sensitive period for the introduction of solid textures.
• Oral motor skills are learned from food texture experience.
• Tongue movements required for textured foods are learnt.
• Chewing skills develop most markedly around 6-10 months.
• ...........but only if the infant has experience of food in the mouth. After this time individuals may become orally defensive to texture.
Inherited traits

• Sensory hypersensitivity – affects reactivity to taste, smell and touch. Willingness to try new foods may be related to food fussiness, food refusal and texture acceptance.

• Food responsiveness – affects food acceptancy in infancy and early childhood - relates to food enjoyment can also be linked to easy weight gain.
Sensory hypersensitivity predicts texture rejection

- Meat, fish, fruit, vegetables.
- Non fatty foods of smooth texture will be tolerated e.g. yogurt.
- Foods introduced in the first year are recognised by their taste, texture....and the way they look (sensory properties of food).

Food acceptance is a function of exposure:
- I see the food.
- I see others eat the food.
- I recognise the food as safe to eat.
- I learn to like the food and anticipate eating it with pleasure.
Neophobic stage (around 20 months)

A developmental stage where new foods and some previously accepted foods will be rejected. Children at this stage:

- Refuse new foods **on sight** without tasting.
- Refuse food which has a mark on it or is the wrong colour.
- Refuse foods which they have had before – if they differ on subsequent presentation.

Thought to be of evolutionary benefit – to avoid poisoning.

Toddlers go into neophobic stage but some don’t necessarily come out of it particularly in autism.
Neophobic stage (around 20 months)

Associated with changes in the child’s cognitive development.

Toddlers have not developed the ability to make generalisations about food categories.

They attend to the local detail of a food rather than the global detail.
Neophobic response

Gradually declines with age:

- 69% of 2 year olds refused a novel food.
- 29% of 3 year olds.
- 1% of 5 year olds.

- Neophobia tends to decrease with age.

- However, the number of exposures required to induce a taste/texture preference increases with age.

- From one or two exposures in the first six months to 14 or so in later childhood which can make acceptance more difficult for some individuals.
Neophobic response

Differs according to:

• Exposure – to foods during early infancy.

• Genetic factors – that influence texture acceptance and visual hypersensitivity.

However, we all retain our disgust and contamination fears e.g.

• We would not eat trifle and shellfish on the same plate.

• We usually have certain foods that we strongly dislike.
Avoidant & Restrictive Food Intake Disorder (DSM V, 2013)

- Apparent lack of interest in food – parents often report that a individual never seems hungry, doesn’t seek food, goes long periods without eating.
- Avoidance is based on sensory characteristics – individual avoids foods which look different, sensitive to taste, texture and smell.
- Concern about the aversive consequences of eating – this may relate to reflux, force feeding and choking episodes.
- Failure to gain weight, faltering growth – more likely if individual does not have access to preferred foods.
- Nutritional deficiency – related to small range of foods accepted.
- Enteral feeding - last resort as difficult to remove once tube is in.
- Marked interference with psychosocial functioning – individual highly anxious around food, unable to join in mealtimes, family dynamics and activities affected.
Typical clinical presentation of an individual with ARFID

- Will only eat a few foods (range 5-10).
- Show brand loyalty (the packaging predicts the safety of the food).
- Only eat one flavour of an accepted food.
- Child demonstrates extreme anxiety if offered new foods or foods that they don’t like.
- Child may gag or vomit if offered disliked foods.
- Usually boys.
- Often associated with ASD.
- Associated with strong cross modal hyper-sensitivity (visual, olfactory, gustatory, tactile).
Children with ARFID

- Do not move out of neophobic stage in 2nd year of life.
- Fear of new foods remains and can last until adulthood.
- New foods can evoke a disgust or fear response which can lead to gag reflex.
- Texture refusal can worsen as a child becomes more orally defensive.
- Acceptance can become more problematic if the child is pushed to eat.
ARFID Examples

• Foods touching each other on plates.
• Preference to certain utensils/dishes.
• Refusal of disliked foods.
• Mixed foods (casseroles, stews, mixed veg).
• Foods with ‘things’ in them (raisins in biscuits, nuts in cake, seeds on bread).
• Refusal of different colours of food items (apples) and textures (oranges, grapefruit).
• Acceptance of similar colours (brown/beige – chicken nuggets and chips), diet coke.
Case Study

- Referral for 19 year old female
- Very limited diet
- Change from child to adult respite service
- Parents and sister going on holiday
Autism and Eating Intervention Ideas

What not to do:

- Hiding or disguising food in another.
- Withholding preferred foods or only giving ‘healthy’ foods.
- Reward systems.
- Imitating others.
- Over encouragement, pressure or forcing to eat.
- Leaving the person to ‘go hungry’.
What works:

• Allow individual to have preferred foods (maintains weight and growth).
• Reassurance and education (psychosocial approaches, family work).
• New foods in new contexts (activity away from home (holidays, trips out, new activities), food and context are ‘paired’.
• ‘Spreading the sets’ new foods from already accepted categories, perceptually similar e.g. new type of biscuit, use of visual aids, choice making.
• Desenstisation and sensory work - increase sensory stimulation, messy play, oral desensitisation.
• Taste trials – new food for 1st time, away from mealtimes, rating scales.
• Relaxation – combine with taste trials and relaxation (breathing, progressive muscle relaxation, imagery), effective for individuals who are developmentally able.
Summary

• The first year of life is of rapid acceptance.
• Food refusal based on the appearance and packaging of food starts in the second year of life.
• At this stage, children tend to focus on the local details of food rather than the global characteristics.
• Children with sensory hyper-sensitivity (often children with ASD) continue with local processing and only eat foods recognised by sight.
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References and Further Reading


