Avoidant Restrictive Food Intake Disorder - ARFID

Ursula Philpot and Sarah Fuller
Specialist Eating Disorder Dietitians
• Introduction to ARFID and understanding the importance of the assessment and therapeutic letter
  — BREAK
• Patient experience and case study
  — LUNCH
  Case studies
• What works and what does not in ARFID
  — BREAK
• Food chaining and therapeutic interventions in ARFID
• Q&A
  — HOME
Avoidant & Restrictive Food Intake Disorder (DSM 5, 2013)

Eating or feeding disturbance including but not limited to 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 associated with 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
4. Marked interference with psychosocial functioning
ARFID (DSM 5)

B. There is no evidence that lack of available food or an associated culturally sanctioned practice is sufficient to account alone for the disorder.

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 of which one's body weight or shape is experienced.

D. If the eating disturbance occurs in the context of a medical condition or another mental disorder, it is sufficiently severe to warrant independent clinical attention.
ARFID (DSM 5)

• Apparent lack of interest in eating or food – parents often report that a child never seems hungry, finishes after a small amount of food or goes for long periods without eating

• Avoidance based on sensory characteristics – child avoids foods that look different, sensitive to taste, texture, smell

• Concern about the aversive consequences of eating – this may relate to reflux, GI symptoms, force feeding, choking episodes
ARFID (DSM 5, 2013)

- Failure to gain weight/faltering growth – more likely if child does not have access to preferred foods
- Nutritional deficiency – related to small range of foods accepted
- Enteral feeding /sip feeds– last resort, as very hard to remove the tube once in
- Marked interference with psychosocial functioning – child highly anxious around food, unable to join in mealtimes, family dynamics and activities affected.
Comorbidities,

• Common psychiatric comorbidities, including anxiety disorders, autism spectrum disorder, and attention deficit hyperactivity disorder (ADHD)

• case reports suggest that comorbid ADHD treated with stimulant medication is sometimes a barrier to increasing caloric intake in individuals with ARFID who are underweight, because a common side effect of stimulant medication is decreased appetite.
Commonly mistaken for AN

• The researchers found some overlap between ARFID and anorexia nervosa. In a review of treatment modalities for both disorders, many individuals who had ARFID diagnosis were sent for eating disorder treatment, up to 22% in chart reviews

• Zickgraf, H. F., Franklin, M. E., & Rozin, P. (2016, October 29). Adult picky eaters with symptoms of avoidant/restrictive food intake disorder: comparable distress and comorbidity but different eating behaviors compared to those with disordered eating symptoms
Overlap with AN

- Norris et al. 24 found that 12% of patients with ARFID transitioned to a diagnosis of AN during treatment, suggesting that a diagnosis of ARFID may serve as a risk factor for the development of AN.

- Case reports presented by Maertens et al. suggest that weight concerns may emerge after refeeding in some individuals with comorbid ARFID and obsessive-compulsive disorder, resulting in the later diagnosis of AN that was not evident when patients were very underweight.

ARFID can lead to RED’s and then to AN?

- Starvation can trigger AN in genetically susceptible individuals?
FEAST online survey (2015)
What precipitated weight loss prior to AN?

<table>
<thead>
<tr>
<th>Cause</th>
<th>Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deciding to eat healthily</td>
<td>90</td>
<td>32%</td>
</tr>
<tr>
<td>Dieting to lose weight</td>
<td>77</td>
<td>27%</td>
</tr>
<tr>
<td>Overtraining in athletics</td>
<td>38</td>
<td>14%</td>
</tr>
<tr>
<td>Illness related loss of appetite (e.g., pneumonia)</td>
<td>18</td>
<td>6%</td>
</tr>
<tr>
<td>Becoming vegan/vegetarian</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>Fasting for religion/24 hour fast</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>44</td>
<td>16%</td>
</tr>
</tbody>
</table>
Multi-dimensional

• nearly half of individuals with ARFID who present for psychological treatment exhibit eating difficulties in multiple ARFID domains.

• A typical example would be a young person with long-standing selective eating (sensory sensitivity) and chronic low appetite (lack of interest in eating) who loses weight precipitously following an acute choking episode (thus developing fear of aversive consequences)
Three-Dimensional Model of the Neurobiology of ARFID

Which?

- Atypical AN normal WT
- Low weight ARFID
- Normal wt ARFID
- Atypical AN-high WT
- High Wt ARFID
A new semi-structured multi-informant interview—(PARDI) has recently been developed to diagnose ARFID in children and adults. The PARDI also provides dimensional ratings of relevant presentations (selective sensory-based eating; low interest or low appetite food avoidance; and restrictive eating due to fear of aversive consequences) and overall ARFID severity.

The PARDI appears acceptable to respondents and preliminary evidence of reliability and validity has been demonstrated in an initial sample. Larger-scale validation studies are currently underway. The PARDI is freely available to clinicians and researchers.

ARFID/AN? - need to dig into the detail.

**Similar**
- Weight loss
- Restricted intake
- Mealtime conflict
- Social isolation
- Impact on family
- Systemic anxiety/compensation
- OCD/rigidity
- Weight/shape concern

**Different**
- Weight/shape issues take different form e.g. concern re number only or taking up space- no fear of Normal wt
- Diet composition- less “diet focused”
- Onset of difficulty earlier
- Sensory issues
- Non food sensory and cognitive clues e.g. numbers or colours, smells/images that stay
Consider ASD

<table>
<thead>
<tr>
<th>Sensory aversions to some foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interoceptive difficulties sensing hunger</td>
</tr>
<tr>
<td>General sensory processing difficulties</td>
</tr>
<tr>
<td>Alexithymia</td>
</tr>
<tr>
<td>Emotional dysregulation</td>
</tr>
<tr>
<td>Social difficulties</td>
</tr>
<tr>
<td>Intolerance of uncertainty</td>
</tr>
<tr>
<td>Rigidity</td>
</tr>
<tr>
<td>Concrete, literal thinking around food, weight, diet</td>
</tr>
<tr>
<td>Special interest/obsessional thinking about food, weight, exercise</td>
</tr>
</tbody>
</table>
Stepwise management plan

1) **Assess nature and severity of the problem:**
   **Risks and diagnosis**

2) **Formulation- 5P’s individual and interactional**

3) **Identification of maintenance factors for targeted treatment**

4) **Evaluating effects/impact of problem: allowing Prioritisation of intervention**

REF: Dr Bryant-Waugh
Assessment

- By experienced team e.g. psychologist/psychiatrist/eating disorders dietitian/family therapist

**Risk assessment**

- Weight
- Nutrition
- Development- socially/developmentally
- Impact on family functioning
- Long term
## Assessment of risk

<table>
<thead>
<tr>
<th>Category</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional</td>
<td></td>
<td>Vit and min deficiencies</td>
<td>Protein energy malnutrition</td>
</tr>
<tr>
<td>Socially/</td>
<td></td>
<td>Social problems with going to friends/going out/fitting in</td>
<td></td>
</tr>
<tr>
<td>developmentally</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systemic</td>
<td>Adaptations within the family to the problem- accepted small portion sizes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td>Stunted growth and low weight for age</td>
</tr>
</tbody>
</table>
## Assessment of risk

<table>
<thead>
<tr>
<th></th>
<th>Short term</th>
<th>Medium term</th>
<th>Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td>nutritional</td>
<td>High risk malnutrition</td>
<td></td>
<td>High risk of consequences of malnutrition e.g. osteoporosis</td>
</tr>
<tr>
<td>Socially/developmentally</td>
<td>Eating out and socializing</td>
<td></td>
<td>Risk to relationships</td>
</tr>
<tr>
<td>systemic</td>
<td>Family adaptations to poor appetite</td>
<td></td>
<td>Issues with transitioning from home environment where needs are catered for</td>
</tr>
<tr>
<td>weight</td>
<td>risk of starvation</td>
<td></td>
<td>Risk of consequences of starvation e.g. short stature, and delayed puberty</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Significant risk for MH as adult</td>
</tr>
</tbody>
</table>
Assessment- CBT / Psychological formulation

• Explanation of precipitating and maintaining factors

• CBT formulation- thoughts, feelings, physical sensations and behaviour on exposure to situation

• .....Examples after lunch
Assessment - education

• Feedback from risk assessment and consequences of remaining as now

Goal
• To improve eating enough to reverse risk and ensure minimal adequacy in terms of nutrition.

.......Examples after lunch
BREAK TIME
Living with eating disorders and ASD

Caroline Griffith
Typical presentation
ARFID- sensory

• Eating is rigid and inflexible
• extreme anxiety if offered new foods, or foods that they don’t like
• child may gag or vomit if offered disliked foods
• More common in boys/ ASD
• Associated with strong hypersensitivity. In other areas (but not exclusively)
ARFID- sensory

- Taste and smell of food
- Feeling of food – on hands, face and in mouth
- Look of food – hyper-vigilance
- Not touching foods with hands
- Wanting to keep a clean face
- Avoiding mealtime situations
- Hiding food
- Smells and sounds really bother
ARFID- sensory

Will only eat very few foods – Under 20 is a cause for concern nutritionally- seek RD assessment

Same products/packets the packaging

May only eat one flavour of an accepted food

Will go hungry rather than try new foods
ARFID- sensory

e.g. 3 chicken nuggets
specific containers which must be sealed in a certain way
an arrangement of food on the plate
an order of eating
using same cutlery/utensils
## Food diary

<table>
<thead>
<tr>
<th>Time</th>
<th>Food</th>
<th>Now</th>
<th>Previously</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breakfast 8am</strong></td>
<td>potato waffle</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>orange juice</td>
<td>150ml</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mid morning</strong></td>
<td>toast &amp; butter</td>
<td>1 slice</td>
<td>0</td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td>crusty bread or jacobs crackers</td>
<td>1 roll</td>
<td>half</td>
</tr>
<tr>
<td></td>
<td>tuna</td>
<td>30g</td>
<td>15g</td>
</tr>
<tr>
<td></td>
<td>crisps /wotsits</td>
<td>1 packet</td>
<td>1 packet</td>
</tr>
<tr>
<td></td>
<td>2 finger kitkat /breakaway biscuit</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>raisins</td>
<td>small packet</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>water</td>
<td>500ml</td>
<td></td>
</tr>
<tr>
<td><strong>After school 3pm</strong></td>
<td>weetos</td>
<td>25g</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>oj</td>
<td>100ml</td>
<td>0</td>
</tr>
<tr>
<td><strong>Tea 5pm</strong></td>
<td>fish cakes birds eye</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>fish finger</td>
<td>or 2</td>
<td>or 1</td>
</tr>
<tr>
<td></td>
<td>mini cocktail pork sausages</td>
<td>or 4</td>
<td>or 2</td>
</tr>
<tr>
<td></td>
<td>sausage roll</td>
<td>or 1</td>
<td>or half</td>
</tr>
<tr>
<td></td>
<td>pizza</td>
<td>or small</td>
<td>or small</td>
</tr>
<tr>
<td></td>
<td>potato waffles</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>vit/calcium/iron supplement</strong></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Supper</strong></td>
<td>pitta bread</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>fortijuice orange</td>
<td>half bottle /100ml</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>crisps</td>
<td>25g</td>
<td>15g</td>
</tr>
<tr>
<td></td>
<td>chocolate</td>
<td>50g</td>
<td>25g</td>
</tr>
</tbody>
</table>

https://www.weldricks.co.uk/products/fortijuice-orange-200ml
Presentation

- 12 year old boy
- Extreme “fussy eating” from weaning, but got worse
- Lack of appetite
- Height and weight plateau- short and low centile (5th) dropping from 50th+ 0-6m. Delayed puberty likely
- Protein and energy inadequate
- Fibre and micronutrients inadequate
- High salt and sat fat
- Liked food cold and crisp
Treatment

• Psychoeducation:
  Explaining sensory issues
  Explaining risks - priority was calories and protein
  Explaining fullness and hunger as did not recognise
  Prescribing portions in increments
  Setting out clear expectations (with rewards- his idea!)
Systemic

- No pressure to eat anything other than safe foods
- Wrote to school- to allow to take in cold pack and store in fridge so can eat at lunchtime.
- Allowed to take own food on school trips.
- No pressure to eat from teachers
- Increased safe food portions- permission for parents to enforce this expectation.
Changes

1) Increased portions of accepted foods plus OJ and raisins as had when younger

2) then

- breakfast! most of the time but worry it may slip - was motivated with computer game he wanted.
- Forti juice - 100ml a day - again when I remember to push it - he doesn't really like it but will have most of it
- mid morning toast - he used to do this before but perhaps does it more now
- after school snack - happens when I remember to push it
After
Top tips from Becky

Dr Becky Hull – Chartered Psychologist
BScHons; MSc; DClinPsy; Cpsychol

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Sensory

Interoception differences –

• Take care to reduce the right input and not too much!
• Hypersensitivity e.g., restriction help to manage these and make them predictable.
• Hypo sensitivity e.g., running gives vestibular feedback to help feel alert/connected/able to cope
• If hypo can become bored/agitated/lethargic/procrastinate which makes change difficult.
ARFID — anxiety/fear of consequences of eating

• Eating is rigid and inflexible
• Extreme anxiety if offered new foods
• Anxiety is high, but higher at meal times—sometimes cannot eat at all
• Maybe low weight
• No fear of Normal wt/shape
• Hypervigilance of internal sensations
• Early satiety/GI symptoms common
Case study

Fear of consequences of eating

• 14 year old girl referred to CAMH ED team with ? Anorexia nervosa. Acute onset of weight loss following the death of her twin sister. Lost 6kg in 4 weeks. Eating ~500kcal/day.
  – On assessment did not present with any weight or shape concerns and thought that she looked ‘too skinny’
  – Sister had died choking on food at a friends house
  – Developed a fear of choking and restricted foods to puree / soft textures

• TREATMENT
  – Nutrition support from the Dietitian – increasing the volume of foods eaten and supplement drinks added
  – Individual work on dealing with grief as well as fear of choking
  – Gradually established more textures into diet and stopped losing weight.
Be aware of comorbidity of neurodevelopmental conditions

• eg dyspraxia can cause swallowing difficulties/fear of choking

• Context blindness in ability to self soothe: need to understand factors around discomfort AND predict end to it.

Deficits lead to reliance on predictability and control in order to avoid distress
Critical thinking deficits in ASD

• Cannot always appraise source of “facts” and then get paralysed by knowledge and unable to reconcile diet messages e.g. “avoid carbs” vs “need 30g fibre” therefore just don’t eat.

• RD input can really help here!
ASD changes

Get the minutia to aid formulation. e.g. not just “do you eat eggs”? but where do you buy your eggs? What size eggs? What happens if you can’t buy those particular eggs? Important to tailoring behaviour change at the correct level.

Dig into the details!
Presentation of ARFID into early AN 12 Year old girl

- Coeliac and always been “fussy re food”
- Anxiety and bullying- focused on appearance
- Gastritis and not able to pick up eating after
- Rigid meal plan and very limited range of foods
- Weight loss over 6 months
- Dramatic drop in centiles height and weight
- 2nd Centile weight
- Lots of Investigations via GP- and endocrinologist
- False reassurance given re “eating enough” - 3 meals a day
Assessment

• Less than ½ calories needed for energy expenditure
• Symptoms of starvation including early satiety /reflu x and nausea-RED
• Formulation-
  Anxiety and control
  Welcomed wt loss- was high centile, but no fear of weight gain
  Fear of GI symptoms (coeliac and gastritis)
  Fear of eating more = hard to elicit exactly
• Systemic issues- anxiety and control
Treatment

- Increase calories in accepted foods - take out pressure to eat any variety
- Education re anxiety and fullness/starvation
- CBT model
- Parental coaching re support
- Help with family issues/areas of high anxiety
- Agreed to keep in ballet as helped with negotiations
Treatment

- Eating bigger portions of safe foods
- Gaining weight – no symptoms of starvation. Agreed to go to 50\textsuperscript{th} centile and see if menstruation returns
- Recognised ridged and inflexible thinking - working on challenging
- Work on social issues and self esteem
What does not work in children ARFID and why

Sarah Fuller – Advanced Specialist Eating Disorders Dietitian
Bedfordshire & Luton Specialist CAMH
East London NHS Foundation Trust
Been there, done that...

• Families will often be able to list off the ‘first line advice’ that they have been given e.g.
  – Bribery
  – Hiding foods
  – Rewards / threats
  – Changing the environment of meals (distractions, no distractions, school etc...)
    – Changing who is around at meals (friends / family etc...)
• At best these tactics result in no progress, at worst eating less with weight loss and increased anxiety around food
• Knowing what NOT to do in ARFID is just as helpful as knowing what to do!
Common foods accepted in ARFID

- **Beige carbohydrates** - Texture, visual and taste sensitivities
- **Smooth textures** e.g. yoghurt, custard, fruit puree – no surprise 'bits', easily processed in the mouth
- **Smooth chocolate** - texture sensitivities, melt in the mouth, easily processed in the mouth
- **Bite and dissolve** e.g. crisps, wafer biscuits - melt in the mouth, easily processed in the mouth
- **Processed** foods e.g. chicken nuggets – texture sensitivity, they are 'pre chewed' in processing, visual (usually branded)
- **Branded** foods – visual sensitivity and taste consistency
Are you ready?

Understanding that not all children develop at the same time is really important. Developmentally, around the age of 8y is when most children will start to show an interest in trying new foods again. You may need to go slower than you think, changes can take a long time to adapt to (especially with ASD). Try keeping a record, over time things will progress and you will be able to adjust your expectations to this.
Pressure to eat

This can look like

- Encouragement – clapping when something was eaten
- Persuasion / Prompting – ‘this looks yummy, eat up’ (actually reduces intake compared to children not prompted)
- Guilt – ‘starving children in Africa’
- Threats – ‘if you don’t eat it you will go to bed early’ / ‘you’ll sit here until its eaten’
- Force feeding

TRY

Try not to over react when a new food is tried.
Try the first exposure to be without parents, as this will come with less social pressures
Hiding / disguising foods

• Very tempting to:
  – Blend in vegetables / additional calories (food fortification)
  – Change the shape of the food to one that is accepted
  – Changing the packaging to one that is tolerated

In ARFID there is often sensory hypersensitivity, strong disgust reactions, fears of contamination so they become hypervigilant around food and will easily reject it.

Even new foods placed next to tolerated foods may be rejected (and in the worst case scenario the tolerated food may become rejected)
Withholding ‘safe’ foods

‘You wont get your chocolate until you have eaten your greens’
  – Usually works for most children!
  – In ARFID it results in increased anxiety around eating and results in refusal and potentially weight loss

Parents need to be educated around what is healthy eating
  – Everyone’s primary nutritional need is enough calories
  – Second to that is a healthy balanced diet
  – So, are you aiming to increase the amount of food eaten or the range of foods eaten?

So when working with a child who has a restricted intake, healthy eating maybe having chocolate every day or eating chips daily
  – This is difficult when we live in an obese environment and health promotion is geared to one message
Rewards / bribery

No amount of bribery in the world would get me to eat a bowl of puss drained from an abscess... as its DISGUSTING!

In ARFID we know that the disgust response is very strong and 9 times out of 10 the reward just is not enough e.g. TV time... BUT you may delay your puberty may be enough to facilitate change (not to eat disgusting things!)

Ask your patients what foods they find disgusting – common themes may be foods that have a strong smell (bananas), too slimy (mushrooms), too lumpy (rice pudding). This will you to identify the themes that are acceptable e.g. smooth textured foods and this will be the building blocks for development.
Let them go hungry

Often advised but rarely successful.

In ARFID the child misunderstands what is going on
- They have little interest in eating
- Lack of recognition of hunger

RISKS medical destabilisation – dehydration and weight loss.
Imitating others

Often helps young children and is seen both at home and in more social settings e.g. school.

In ARFID this can lead to DISASTER – sensory overload, heightened anxiety and food refusal.
Top tips for parents / carers

Don’t pressure the child to eat
Don’t hide / disguise food
Don’t withhold preferred foods
Don’t reward / bribe
Don’t let the child go hungry
Don’t expect them to imitate others

**DO** seek professional support around managing anxiety at meals
ARFID teens

• Still anxious but able to move on! Having motivation to change is key
• Stepwise approach
  1. Keep the allowed foods to ensure growth, may need a vitamin and mineral supplement
  2. Regular eating is still key, many anxious teens will avoid breakfast (school anxiety) and lunch (I eat odd foods) but will then make up for this as soon as they get home – try setting alarms when to eat, even if it is something small
  3. Identify a food to work on then practice desensitisation
     • Increased exposure around food e.g. cooking or going to a café
     • Taste trials (can take up to 10 exposures to be tolerated, need to be on a regular basis) or food chaining
  4. Anxiety management
ARFID teens

• When ready:
  – Encourage independence e.g. shopping for, preparing and cooking meals
  – Encourage attendance and participation in social eating
    • Snacks / Coffee shop
    • Restaurant
    • Social foods e.g. birthday cake
BRILLIANT RESOURCE!
Treatments

• Explanation of precipitating and maintaining factors
• Psycho education
• Behavioural experiments
• Anxiety management
• Cognitive restructuring
Sensory Properties  
- need to consider

• Food and environment
• Colour/shape
• Texture
• Noise on eating
• Taste

• Psychologist/OT can do sensory profile
Graded Exposure

- Play/handling, near plate, on plate, touching head/face, touching lips, on tongue, chew and spit, swallow (see handout)
- Tiny amounts e.g finger tip size
- No pressure to eat
- Introduce textures gradually
- Hierarchy of fear foods
- Includes mental visualization, writing and verbally talking through steps to exposure, practicing distress coping skills and cognitive behavioural therapy to address negative thoughts, and life practice sessions to sensitize clients to various situations and foods
Food chaining

<table>
<thead>
<tr>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain &amp; Expand Current Taste &amp; Texture</td>
<td>Vary Taste &amp; Maintain Texture</td>
<td>Maintain Taste &amp; Vary Texture</td>
<td>Vary Taste &amp; Texture</td>
</tr>
<tr>
<td>Other brands and sizes of chicken nuggets (i.e., strips/popcorn/bites, both fast food &amp; home-prepared); fried chicken patties cut into pieces (fast food &amp; home prepared)</td>
<td>Different flavoured chicken nuggets (BBQ, honey mustard, smoked, etc.) Use sauces/dips to vary tastes.</td>
<td>Chicken strips (not breaded); chicken leg/drumstick; chicken breast; ground chicken patties</td>
<td>Breaded seafood (scallops, shrimp); breaded fish (fast food &amp; home-prepared); breaded turkey breast; breaded vegetables; breaded baked chicken; crusted/breaded pork tenderloin; ground meats</td>
</tr>
</tbody>
</table>

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Example

[Image of BDA Mental Health Specialist Group]

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Consider

• Texture
• Colour
• Smell
• Size
• Shape

• Ask your child to rate the new food on a scale of 1 to 5, with 5 being “I like that food so much that I can try that again next time.” Wait a day and try a lower-scoring food again; if it’s a 1 or 2, take a step back and make a smaller change. If it’s a 3 or 4, keep offering it.
From Buttered Bow Ties to Whole-Grain Spaghetti With Sauce

Strategy: Change colour gradually. Picky eaters prefer pasta with butter in part because the dish is all white.

1. Favourite pasta shape with butter
2. Other shapes with butter
3. Pasta dipped into cream sauce
4. Whole-grain pasta dipped into cream sauce
5. Whole-grain pasta coated with cream sauce
6. Whole-grain pasta coated with pink sauce; stir smooth tomato sauce into cream sauce (gradually increase the amount)
7. Whole-grain spaghetti with chunky tomato sauce
From Pizza to Burritos

Strategy: Implement smaller changes (like switching the kind of cheese or crust) before tackling the bigger ones (such as mixing in a different ingredient).

1. Favourite cheese pizza slice
2. Thin-crust cheese pizza
3. Melted mozzarella cheese and pizza sauce on a flatbread
4. Cheese and pizza sauce on a tortilla
5. Mozzarella cheese and pizza sauce wrapped like a burrito in a flour tortilla
6. Sauce gradually mixed with a smooth salsa and a mix of mozzarella and cheddar cheese wrapped like a burrito in a whole-grain tortilla
7. Cheddar cheese and salsa gradually mixed with refried beans in a burrito
ASD and making food

- Mono-attention
- Can follow complex one pot recipes eg from scratch curry, but can't make beans on toast as involves two tools at same time
- Consider food preparation as cause for repetition
- May wish to eat beans alongside toast - may need separate 2 bowls
ASD recovery?

- Services focus on outcomes
- ASD indv focus on process eg car example
- Adopt a strength model eg solutions lie in strengths not getting rid of deficits
- Don’t ask clients for examples outside their lived experience eg what would you do if, but instead what did you do when?
- Make the implicit explicit give more rationale and explanation than for neurotypicals
- Review plans annually even when recovered to avoid getting stuck into bad habits that are then difficult to change eg scoop example
ARFID Recovery?

• Weight: If always followed a low-percentile trajectory, restoration to the median height/weight centile may not be necessary.

• Variety: it is unclear how many foods within each of the basic food categories (e.g., fruits, vegetables, proteins, grains, dairy) must be regularly consumed to resolve nutritional deficiencies or reduce psychosocial impairment >20?

• Safe vs optimal!!