In-person
March 13-16, 2024

Virtual
May – July 31, 2024

45th National Conference on Pediatric Health Care

Is it Just a Picky Eater, Behavioral Food Opposition or ARFID?

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1

Speaker Disclosure

- I have no financial disclosures or conflicts of interest.

2

Learning Objectives

- Define the most common behavioral differences in picky eating, eating oppositional behaviors or ARFID (Avoidant Restrictive Food Intake Disorder).
- Identify key history taking findings and physical assessment and diagnostic evaluations (including laboratory tests) that would provide necessary information to determine a diagnosis.
- Recognize normal and abnormal findings of assessment to assist in differentiating normal "picky eating" versus more concerning behavioral outcomes and nutritional disorders that result in poor weight and nutritional status.
- Describe key documentation to support diagnosis, coding and referral, if necessary.
- Identify necessary patient education and resources for best patient management for picky eaters, children using behavioral outcomes to manipulate the eating environment or children with ARFID.

3

Important Definitions

- **ARFID**: feeding or eating disturbance characterized by avoidance or restriction of food intake and clinically significant failure to meet requirements for nutrition through oral food intake (DSM-5, 2013)
- **Picky eating**: common feeding difficulty behavior in early childhood characterized by strong food preferences and refusal to try new foods or even consistently eat familiar ones (Taylor et al., 2015)
- **Behavioral food opposition**: behavioral response using food as an oppositional factor in leverage to produce reciprocal responses from parental or adult caregivers

4

What do we know about how our food preferences begin?

- Dietary habits reflect basic biology which predisposes them to prefer sweet tastes and to avoid bitter-tasting foods.
- Once adapted, the adoption of this food environment places them at risk for obesity and numerous other conditions.
- Flavors from the mother's diet are transmitted to amniotic fluid and breast milk.
- Children will have repeated and varied opportunities to learn to like the flavors' of healthful foods they will likely encounter after initial experiences.

5

What do we know about how our food preferences begin? (cont.)

- Dietary habits reflect basic biology which predisposes them to
- After weaning, 8-10 exposures to food will increase intake even if the food is initially rejected.
- Further exposures may be required to increase liking.
- Exposing infants and young children to a variety of flavors promotes infants' willingness to consume novel foods.

6

What does that mean for food adoption for infants?

7

What does that mean for food adoption as adults?

- Hunger
- Appetite
- Taste
- Cost
- Availability
- Culture
- Peers
- Media

8

Think back to childhood…Favorites?

9

Three different patients…..

- **John** is a 15-year-old male (full term, well nourished at birth)
- Unremarkable early eating behaviors
- 2–3-year history of declining dietary habits
- Poor weight gain, poor growth chart consistency
- Increasing social isolation related to food choices (or lack thereof)
- Increased stress in family dynamics related to mealtime

10

John…..

- Was within typical norms on growth curves, then plateaued..and has since fallen off growth curve
- Physical exam shows a very thin, pale, anxious male
- 24 hour food recall is about 50-75% of the ideal caloric intake
- Portion sizes are small
- He complains of early satiety
- He refuses to go to any sleep overs or birthday parties

11

John……..and John's food…..

12

Three different patients.....

- **Sammy** is an 11-year-old male (full term, well nourished at birth)
- Unremarkable early eating behaviors when away from home
- Prefers proteins, will not drink any milk, will try to hide food to "get dessert"
- Good weight gain, growth chart consistency
- Increasing behavioral confrontations related to food choices (or lack thereof) at home
- Increased stress in family dynamics related to mealtime,

13

Sammy.....

- Was within typical norms on growth curves, but has been consistent at the 95% for the last 4 years
- Physical exam shows an overweight, interactive male
- 24 hour food recall is about 100-150% of the ideal caloric intake
- Portion sizes are adequate, not as many fruits and vegetables
- Eats dessert at every meal
- Parents report that they frequently give in "to his tantrums" when trying to support healthy eating choices
- Will sometimes eat same (fight provoked) food when out with friends

14

Sammy.....and Sammy's food

15

Three different patients.....

- Taylor is a 12 year old girl.....
- Has a "slow to warm up" personality.....
- Eats slowly and methodically....meals can take a LONG time
- Will try new foods, but only after closely inspecting it
- Trying of new foods means only a nibble or two on initial introduction
- Finds it difficult to try "new" restaurants if she does not know the menu

16

Taylor……..

- Full term, well-nourished at birth
- Is within the typical norms on growth curves
- Physical exam shows a smiling, interactive child
- 24 hour food recall is about 75-90% of the ideal caloric intake
- Portion sizes are small with frequent repeats of food
- Snacks twice daily
- Her nutritional bloodwork demonstrates mild IDA
- She attends social functions easily

17

Taylor…..and Taylor's food

18

Thinking about picky eaters vs. ARFID?

The picky child will eventually eat….

The ARFID child could starve to death….

19

Significant ARFID findings (Physical and Psychological)

- Significant weight loss
- Abdominal pain
- Fatigue
- Cold intolerance
- **No body image struggles**
- **No fear of weight gain**

20

Significant ARFID food and eating behaviors

- Worsening picky eating (caregivers are now noticing)
- Avoid or refuse entire food group
- Sensitive to smell, texture and temperature
- Only eating food of a similar color, brand or texture
- Severe anxiety around new foods
- Lack of interest in food
- Fears around food: fear of vomiting, choking, allergies
- Avoid social events

21

Differences Between ARFID and Picky Eating

	ARFID	Picky Eating
Feeding tubes/Nutritional supplements	May require nutritional supplements or feeding tubes to be able to have sufficient nutrition during treatment.	Does not usually require supplementation to meet their caloric needs and maintain typical growth and development
Psychosocial Functioning	Significant interference with psychosocial functioning	No significance interference with psychosocial functioning

22

Differences Between ARFID and Picky Eating

	ARFID	Picky Eating
Treatment Priorities	Requires intensive, multi-disciplinary approach including family therapy, adjunct medications and additional psychotherapy.	Requires a less intensive approach. Uses parental or adult modeling, repeated exposures to unfamiliar foods. Promotes positive mealtime preferences and offers mealtime options when possible.

23

What causes ARFID? (Not known, may be multifactorial)

- Child's temperament
- Genetic basis
- Triggering events
- Concurrent medical/developmental/psychological conditions
- A child who is already predisposed to ARFID due to biological or genetic makeup may be triggered by environmental or psychosocial situations, such as a traumatic event

24

Making an Eating Disorder Friendly Office…

- Consider getting “blind weights” in underwear or paper gowns
- Maintain a neutral demeanor when obtaining weight
- Do not talk about food in terms of “calories”, consider exchanges
- Stress the importance of “exchanges” meeting the necessary nutrients and energy needs
- Providers should know the basic caloric requirements for each age group and have a “caloric blinded” template to offer the patient/family.

25

What can the PNP do to provide care for these patients and families?

Assessment

- VS including blood pressure, consider orthostatic measures
- Temperature
- EKG (may be done as an outpatient)
- Complete physical
- Screen for anxiety/depression

26

Managing Initial Eating Disorder Assessments Lab work-Chemistry

Test	Considerations	Norms (may vary by lab)
Glucose	Main energy sources, lows may cause dizziness, seizure	70-100 (may be low)
Albumin	Longer term assessment of protein	3.4-5.4 g/dl (may be low)
Prealbumin	Better assessment of more recent protein intake	15-36 mg/dl
BUN	Kidney function, low may indicate dehydration	5-18 mg/dl, 10-20 mg/dl
Creatinine	Malnutrition may cause it to be low	Vary with age, gender
Calcium	May be low if deficient	9-10.5 mg/dL

27

Managing Initial Eating Disorder Assessments Lab work-Chemistry

Test	Considerations	Norms (may vary by lab)
Ionized calcium	Better indicator of calcium status	4.4-5.4 mg/dL
Sodium	May vary with hydration	135-145 mEq/l
Phosphorous	May drop early in refeeding, varies with fluid shifts	2.4-4.1 mg/dL
Potassium	May vary with hydration and activity level	3.5-5 mEq/L
Magnesium	May drop early in refeeding	1.7-2.2 mg/dL
Chloride	May vary with hydration	98-108 mmol/L

28

Managing Initial Eating Disorder Assessments Lab work-Hematology/Nutrient

Test	Considerations	Norms (may vary by lab)
Hemoglobin	Protein carrying oxygen in blood	Norms based on age and gender
Hematocrit	Can be influenced by low levels vitamins/nutrients	Norms based on age and gender
Serum Iron	Low with lack of iron containing foods: red meat and green leafy vegetables	60-170 mcg/dL
Zinc	Supports the immune system	Can vary, 0.66-1.10 mcg/mL
Vitamin B12	Maintains nerve function, production of blood cells	200-900 ng/dL
Folate	High risk for deficiency in vegetarians and vegans	2.5-10 ng/ml
Vitamin D	Helps body absorb calcium	Greater than 30 ng/ml

29

Goals for ARFID and beyond….

- Thinking of food for energy, acknowledge the role it plays in our life
- Achieve and maintain a healthy weight and healthy eating patterns
- Increase the variety of foods eaten (no food deserts: social implications)
- Learn ways to eat without fear of pain, choking, allergies

30

Managing Initial Eating Disorder Management from the PCP

- Food diary: What they eat, when, how much, with whom and how are they feeling, can be easier with pictures
- Food pictures are also great when they are attempting to meet food goals
- Food intake lists (can be fun…or overwhelming) pictures for interest (“ugly fruit”)
- Setting food goals: 1 new food, bring back 1 safe food (put in chart,” contract”)
- Increasing intake (mechanical)Setting food goals: 3 extra sips, 3 extra bites of safe foods (need to increase stomach capacity)

31

Food chaining (works for ARFID and picky eaters)

- Taking child’s safe food and slowly introducing them to similar foods so they can start to increase their variety
- Only introduce one or two new foods at a time (it can be overwhelming and stressful for the patient AND family)
- Food chaining links between food profiles
- Uses sensory measures like similar textures, colors, smells, or flavors
- Ex. Rice, couscous, stelline, orzo, ditalini, orecchiette, farfalle, rotini
- Ex. Butter, olive oil, parmesan, blush sauce, marinara, salsa
- Slow combining!!! (Casseroles can be scary!!!)

32

Family Involvement in Treatment

- Be a role model. Support a variety of foods in family eating.
- Schedule regular meals and snacks. Every time is a new opportunity/exposure.
- Regular family meals in pleasant environment. Avoid battles!
- Encourage, support, do NOT force! (You cannot force feed your child…it is illegal ☺)
- Reward positive eating behaviors! (Your child may have equaled or surpassed the achievement of honor roll or sports win)
- Find innovative ways to manage anxiety and stress around food (or anything)!
- Stay calm, avoid criticizing your child, avoid blame on them…or yourself!

33

Managing Initial Eating Disorder Management from the PCP

- Consider treating the anxiety (weight can impact response)
- Anxiety based psychotherapy referrals
- Parents/Caregivers/Sibs need support too!
- Respite care (Families should go eat out! And …identify "safe" restaurants to re-introduce patient to that environment)
- Developmentally appropriate planning: birthday parties, sports team buses, school "pizza" parties, dating, COLLEGE (may need notes to prepare own food. Dining Hall is the goal!)

34

Medications that may be used in ARFID (very few studies to support ☹)

- Anxiety medications (Fluoxetine, Escitalopram): best option
- Cyproheptadine (off label)
- Mirtazapine (off label)
- Lorazepam (off label)
- Olanzapine (off label)
- Child may also be on additional medications: ADHD

35

Managing PCP visits for this complex eating disorder

- Usually an established patient
- Get 24 hour diet recall (weekday vs. weekend), duration, food refusals, % completed
- 99214 presenting problem(s) are of moderate to high severity
- Moderate level of medical decision-making
- 30-39 minutes of total spent day of encounter (caloric conversion)
- Problem focused history (4 items)
- Problem focused examination
- Moderate complexity decision-making

36

Managing ARFID and complex eating disorders

- Dietician
- Speech-language pathologist (swallowing and feeding evaluation)
- Cognitive-Behavioral Therapy (specialized)
- Family-based therapy
- Occupational therapy

37

Some interesting presentations in new patients

- A 10-year-old male patient in the 5th grade who heard about "good" food and "bad" food in health class.
- An 11-year-old male who saw his older brother "load on protein" to be a better "lifter" (decreased fruits, veggies and carbs)
- An 11-year-old female who gave up "sweets" for Lent…and went on to carbohydrates and grain-based foods
- A 15-year-old female who fixated on "healthy and organic" foods when the family food budget could not support that.

38

Our work in Eating Disorders at Oishei Children's Hospital in Buffalo, NY

39

My Favorite ARFID kiddo!

40