FAMILY MEALS FOCUS
Article 89

ARFID, Feeding Dynamics and sDOR

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Parents who have struggled long term with their child around eating are often relieved when their child is diagnosed with ARFID. It means to them that after years of reassurance, brush-offs, partial solutions, and ineffective advice, their concerns are being taken seriously. An ARFID diagnosis positions parents to get access to care and supports third-party payment for treatment. ARFID problems are far more serious and entrenched than the ordinary food refusal, choosiness, and over- and undereating displayed by up to half of children.[1] In practice, the ARFID diagnosis is generally reserved for the child who has a growth deficiency, relies on oral or tube-fed meal replacements, and/or whose restrictive eating has interfered with psychosocial functioning. What, then, is ARFID?

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What is ARFID?

Avoidant/Restrictive Food Intake Disorder (ARFID) is the American Psychiatric Association Diagnostic and Statistical Manual 5 (DSM-5) diagnosis of feeding disorder of infancy or early childhood.[2] In the words of DSM-5, ARFID is 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 weight faltering, significant nutritional deficiency, dependence on enteral feeding or oral supplements, and/or marked interference with psychosocial functioning.

fdSatter, sDOR, and ARFID

The Satter Division of Responsibility in Feeding (sDOR) is endorsed as best practice in feeding by prominent child pediatrics and nutrition agencies such as the American Academy of Pediatrics and the Academy of Nutrition and Dietetics. Building on that endorsement, a Satter Feeding Dynamics Model (fdSatter)-consistent team approach incorporating sDOR[3] is recommended as best practice in addressing ARFID. fdSatter and sDOR are family-focused and shape a positive feeding relationship. From the fdSatter perspective, the ARFID diagnosis, the same as any other feeding problem, exists not just in the child but in the whole parent-child feeding relationship.[4] ARFID presents as stress-ridden and long-standing struggles around feeding, resistant to multiple efforts at resolution, and likely accompanied by growth distortion.

Professionals trained in the fdSatter-based Ellyn Satter Institute Feeding with Love and Good Sense VISION workshop begin by doing a complete workup: A detailed assessment of medical, nutritional, developmental, psychosocial, and feeding-dynamics issues.[5] This comprehensive assessment reviews the child's clinical records from birth, re-plots growth, reviews the child's developmental and feeding history, assesses the child's food intake and nutritional status, examines the psychosocial context of feeding, and observes feeding dynamics. Based on that workup and within the context of a treatment team, ESI-trained professionals plan and carry out sDOR-grounded treatment integrated with skillful attention to complicating medical, nutritional, and oral-motor issues. That pressure-free feeding supports children in bringing themselves along with respect to eating to the best of their abilities.

sDOR can't stand alone

While sDOR forms the core of fdSatter-consistent ARFID treatment, parents can't simply be advised to follow sDOR. Feeding struggles are complex, deep-rooted, and long-standing, and parents are frightened for their child's well-being: They need to be able to trust the intervention. The assessment and treatment-planning process identify the components of the problem and allow parents to feel that they, their child, and their situation are fully understood. Without a detailed workup, advice to follow sDOR comes across as just one more of the many partial and piecemeal bits of instruction they have been given over the years. Parents need expert help to tailor the nuances of the what, when, and where of feeding to their own and their child's needs. Once sDOR is defined in individualized and achievable ways, parents need support for taking and maintaining the leap of faith necessary to let their child do the how much and whether of eating at the same time as they recognize the child's ways of gradually learning to eat.[5]

Understanding empowers change - and trust

fdSatter-trained professionals work with the parents of the child diagnosed with ARFID, not the child directly, and see the child as being innately competent with eating. This treatment approach identifies and corrects past and present feeding dynamics that interferes with the child's Eating Competence, helps parents establish what- when- and where-adjusted sDOR, and helps parents hold steady with feeding while children develop increased capabilities with eating.

This is in contrast to approaches that work directly with the child diagnosed with ARFID and that include parents only from the point of view of applying the treatment at home.[6] These approaches characterize the child's avoidant/restrictive food attitudes and behavior as based on a deficit in the child: as having a sensory processing disorder or being so eating-averse that they will go hungry rather than eat food beyond their comfort level. Interventions focus on getting the child to eat. Children may be offered special foods or have meals catered to them. Children are rewarded, enticed, or pressured to mouth, touch, lick, and/or smell food using selective attention, praise, games, cheering, tokens, and elaborate modeling. Children may be maneuvered into eating rejected food by blending it with preferred food or gradually modifying the taste and texture of preferred food. Extreme forcing methods include punishing children's not-eating by withholding privileges or attention, not letting children refuse food, or physically compelling them to eat. While pressuring, enticing, encouraging, and forcing tactics may increase the child's food intake in the short term, they are not sustainable. Parents typically have too little time and energy and too much empathy with the child to keep the intervention going and the feeding struggles re-emerge.

The course of treatment

Working with an AFRID-diagnosed family to establish and maintain a positive feeding relationship takes considerable skill, perseverance, and flexibility. Once sDOR is in place, the atmosphere at family meals quickly takes a positive turn and sets the stage for the resolution of ARFID, which can take years. Over that long term, parents have to remain consistent with sDOR and withstand outside interference as well as their own entirely natural, but counterproductive, impulses to speed the process along. Particularly cautious children and those who have pronounced oral-motor sensitivity take longer to bring themselves along with food acceptance and food regulation. Depending on their degree of involvement, children with neurological and developmental challenges take longer still and, indeed, may not be able to fully support themselves by eating. Those parents and children can still have a positive feeding relationship. Children can eat at family mealtime until it is no longer enjoyable, then satisfy the rest of their nutritional needs via supplemental feeding.

References

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ARFID: American Psychiatric Association DSM 5 Diagnostic and Statistical Manual.

Avoidant/Restrictive Food Intake Disorder replaces and extends the DSM-IV diagnosis of *f*eeding disorder of infancy or early childhood. ARFID is 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*:

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

In some individuals, food avoidance or restriction may be based on the sensory characteristics or qualities of food, such as extreme sensitivity to appearance, color, smell, texture, temperature, or taste. Such behavior has been described as 'restrictive eating,' 'selective eating,' 'choosy eating,' 'perseverant eating,' 'chronic food refusal,' and 'food neophobia' and may manifest as refusal to eat particular brands of foods or to tolerate the smell of food being eaten by others.

Intervening with Pediatric Feeding Disorders

More about understanding established feeding problems from the perspective of the Satter Feeding Dynamics Model.

Feeding with Love and Good Sense

To understand children's normal eating behavior and how to be successful with feeding, read "Feeding your toddler," in Ellyn Satter's Child of Mine: Feeding with Love and Good Sense.