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Understanding ARFID Part II: Responsive Feeding and Treatment Approaches

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Avoidant/Restrictive Food Intake Disorder (ARFID) captures individuals of all ages with limited food intake and/or range of foods; their eating behaviours, often accompanied by fear and revulsion of novel foods, result in impaired psychosocial function or development. In the previous *Bulletin* issue, we explored the diversity of ARFID presentations and the relationship between eating disturbances and early feeding experiences. We reviewed common pediatric feeding therapies many ARFID clients have experienced, and discussed the lack of theoretical basis or evidence to support one treatment approach over another.[1]

Considering the range of ARFID presentations, it is unlikely that one standardized intervention or protocol will emerge. This article discusses "responsive" approaches in ARFID treatment and the supporting rationale.

WHAT IS RESPONSIVE FEEDING?

Responsive parenting & feeding

Responsive parenting and feeding are considered best practice.[2,3,4] Within a responsive framework, parents: provide a routine, structure and emotional context; and interpret and respond to children's verbal and non-verbal communication.[3] This promotes a mutually satisfying reciprocal relationship, providing the basis for attachment between children and caregivers that is essential to healthy social-emotional and physical functioning.[3,5]

Responsive feeding (RF) is the application of these principles to feeding relationships. Parents establish mealtime routines, foster pleasant interactions with few distractions, model appropriate mealtime behaviours, allow children to attend to hunger and satiety, and respond in a "prompt, emotionally supportive, contingent and developmentally appropriate manner".[3] Throughout this article, "feeding" refers to everything that happens between parents and children around food, including the act of eating from infancy through maturity.

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Based on responsive parenting and feeding research, RF is predicted to "promote children's attentiveness and interest in feeding, attention to their internal cues of hunger and satiety, ability to communicate needs to their caregiver with distinct and meaningful signals, and successful progression to independent feeding".[3] The principles of RF are operationalized through Ellyn Satter's Division of Responsibility[3,4]; parents take leadership with *where*, *when*, and *what* children are fed, and children determine *whether* and *how much* to eat.[6]

Responsive feeding therapy

"Responsive feeding therapy" (RFT) is a term coined by Katja Rowell and Jenny McGlothlin[7] to describe an approach grounded in clinical experience and informed by research. RFT follows the premise that early childhood interventions should make every effort to follow typical development.[8]

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RFT includes various therapy tools informed by RF philosophy and literature, along with individualized goals and interventions. Treatment may include a speech pathologist, a mental health therapist, a dietitian, and/or an occupational therapist to assist with anxiety, oral-motor concerns, nutritional deficits, and/or non-coercive exposures. It is critical that clinicians partner with parents to identify and eliminate counterproductive feeding practices and establish RF.

RFT is "facilitating (re)discovery of internal cues, curiosity and strengths, while building skills (mastery)."[7] It is flexible and takes place within trusting relationships with caregivers and therapists.[7] While RF principles are considered best practice in family feeding, its application to feeding difficulties, particularly extreme presentations, remains contentious among professionals. There is often a belief that children will not progress without external incentives or pressure. However, clinical experience informs us, with responsive facilitation and therapies as needed, even children with severe challenges can be entrusted to gain feeding skills within a supportive feeding environment.[10] Of note, these interventions have primarily been used clinically for children. The guiding principles of structure, autonomy and decreasing anxiety, however, apply across the lifespan and are foundational to treatment for adolescents and adults.[11]

APPLYING RESPONSIVE FEEDING PRINCIPLES TO ARFID TREATMENT

Rationale

The development of feeding skills evolves from infancy through adolescence into adulthood. Each stage affects subsequent stages. Skills pertinent to ARFID include, but are not limited to, self-feeding, sensorimotor abilities, internal food regulation, and food acceptance. With ARFID, this development is usually disrupted by a complex constellation of interrelated factors.[1] Approaches that focus on 'correcting' behaviours without addressing underlying factors miss therapeutic opportunities and can backfire.[1] RF allows individuals to gain skills while maintaining agency (sense of control) and bodily autonomy.

Anxiety is commonly present with ARFID, more than with other eating disturbances.[12,13] "The main goal is to reduce anxiety associated with feeding/eating"[4] in both oral sensorimotor practice and feeding situations.[14] Alleviating distress supports healthy growth and internally-guided food regulation, as anxiety and elevated stress negatively impact gastrointestinal motility, nutrient absorption, growth hormones, and appetite.[15,16] As clinicians and caregivers enact RF principles, conflicts and stress decrease and children's sense of agency improves.

The impact of non-responsive pressured feeding is well documented (see last Bulletin).[1] If coercive feeding likely contributed to anxiety and reluctance to eat, replicating it in treatment could perpetuate and further complicate feeding disturbances. With RFT, replacing counterproductive feeding practices with responsive strategies reduces anxiety and resistance, allowing feeding skills to progress.

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Caregivers' role

A foundational tenet of RFT is that complex feeding challenges are best resolved within safe feeding environments and trusting relationships. This focus may be misinterpreted as 'blaming parents' for their child's difficulties. ARFID presentations are complex and cannot be attributed to any isolated factor. "Absolution", as suggested by Segal, is clinicians' initial task in reducing parental guilt.[17] Many caregivers express remorse when they learn that strategies they were told to follow or applied out of desperation may have been unhelpful. Clinicians support parents by acknowledging the complexity of the situation and affirming what parents know, which is "what we are doing isn't working". Empowering parents to shift towards RF decreases family conflict, builds trust, and strengthens relationships.

Nutrition & growth concerns

If a client is not meeting basic nutritional or energy needs, there is often an urgency to improve nutrition rapidly. This understandable sense of urgency increases the likelihood of using coercive strategies. A thorough assessment of weight, growth, and eating/feeding history is essential to determine if growth, energy intake, and/or nutrients are concerns.

When clients are allowed to eat accepted foods while establishing routine and addressing anxiety, intake usually increases quite quickly. Coaching on meal planning and incorporating accepted foods is often needed. Supplements to boost calories can be incorporated into a pressure-free

routine if inadequate caloric intake is an immediate concern. Treatment focused on calories and weight gain (at the expense of agency and autonomy) bypasses important therapeutic opportunities. Caloric or nutrient deficits can be addressed through nutrition interventions and should not preclude RF principles.

AN EXAMPLE OF A RESPONSIVE FEEDING THERAPY – STEPS+

Within a responsive treatment framework, it is critical to thoroughly assess individuals' history of feeding difficulties and past therapies, to inform etiology, subtypes and treatment.[1] A client with limited diet variety without significant anxiety might begin with implementing structure and increasing food acceptance skills. Another client eating inadequate volume due to aversive experiences and anxiety would initially focus on decreasing anxiety, allowing accepted foods at routine meals and snacks, optimizing appetite, and increasing attunement to hunger and appetite cues. Goals to increase variety can wait until progress is seen with intake and anxiety.

STEPS+ (Supportive Treatment of Eating in PartnershipS) was developed by Rowell and McGlothlin, integrating responsive feeding and skill-building. STEPS+ prioritizes caregivers and the home feeding environment as central to the healing process, augmented with therapy if necessary.[9]

	KEY COMPONENTS OF STEPS+	CORRESPONDING RFT PRINCIPLES	THERAPEUTIC IMPACT
STEP 1:	Decrease stress, anxiety and power struggles for children and parents	Recognize and respond to verbal/non-verbal cues, build trusting relationships, establish pleasant eating environment without pressure to eat	Reduce anxiety and aversive response during mealtimes, improve appetite
STEP 2:	Establish a routine	Establish predictable schedule that allows hunger and satiety cues to develop, set clear mealtime expectations	Optimize appetite, reduce anxiety through predictability
STEP 3:	Work towards pleasant family meals	Model eating behaviours and other expectations during mealtimes, introduce new foods in a neutral/non-pressured context	Increase exposures to non-preferred foods without pressure to eat, learn to follow mealtime expectations through observation and imitation
STEP 4:	Build skills in "what" and "how" to feed	Facilitate mealtimes in emotionally supportive ways, respond to cues promptly, provide appropriate foods while considering children's skills and sensory preferences	Reduce anxiety through non-pressured facilitation and provision of foods appropriate for current feeding and sensory skills, facilitate skill development with 'transition' foods
STEP 5:	Strengthen and support oral-motor and sensory skills	Provide opportunities to practice and develop mastery at children's pace, engage in responsive formal feeding therapy if necessary	Develop feeding skills (self-feeding, sensory, oral-motor or internal regulation etc.)

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Stages of progress

"The long-term goal [of RFT] is to raise a child who feels good about food and can eat a variety of foods based on internal cues of hunger and fullness".[9] Families usually reach less obvious yet important milestones before eating improves significantly. Initially parents tend to report that their children are calmer at mealtimes, even experiencing less anxiety overall. "The ability to 'let go' and avoid dealing with a child's food intake or feeding is also time dependent; as the child improves with feeding, the parental anxiety seems to decline".[17] Clinicians frequently must point out early progress, as parents may consider an increase in number of bites the only proof of effective treatment. Addressing parental anxiety is central to a successful transition to RF.[9,17] Over time, children show greater confidence – for example more comfort being around or trying new foods, trusting internal cues, or eating bigger portions. "Rushing the progress can be counterproductive".[9] Providing positive feedback, empathy and self-care support for children and parents and reviewing appropriate goals helps families to stay on track. Parents are then less likely to return to maladaptive strategies.

CASE STUDY

The following is a composite case based on recurring themes of our respective clients with ARFID diagnosis.

Michael is an eight-year-old boy. Per Mom, feeding has been "hard since day one". He mainly eats four foods: Goldfish crackers, dinner rolls, macaroni and cheese, and grilled cheese sandwiches. Michael lives with his parents and four-year-old sister. He is generally healthy with the exception of recently diagnosed iron deficiency. His doctor noted that he "is underweight."

Assessment

Michael has an unremarkable medical history, with no indications of gastrointestinal or physical problems, or oral-motor delays. He is "sensitive" overall, avoids loud noises, and only wears soft clothes. He is generally happy, sleeping well, and doing well in school and socially.

Michael was a "small" baby and parents were encouraged to "get him" to take more formula and to eat more. Feeding history indicates that coercion was used in an attempt to increase intake and variety since infancy. He remained around the 10th% weight-for-height. His growth is low and, while stable, may be below his natural trajectory, which is hard to determine as his feeding has always been challenging. His father described himself as a "beanpole" as a child.

Mealtimes grew more challenging when Michael was a toddler. Transition to solids was slow with only a few accepted foods. Throughout his childhood, mealtimes were filled with coaxing, crying, and tricks to sneak food in. Bribes, rewards, sticker charts, and punishment did not help. As mealtimes were unpleasant and the family became increasingly busy, they stopped eating together. Mom has "given up" and Michael is mostly offered his accepted foods.

Michael had six months of sensory-focused exposure therapy during preschool, which did not increase volume or variety but escalated battles as he resisted "homework" of kissing and licking foods. At that time an evaluation with a speech pathologist found no oral-motor concerns. Mom describes Michael as "strong willed" and cautious with new experiences.

Sometimes Michael eats right after school and is not hungry for dinner; other times he grazes on accepted foods throughout the day. He feels embarrassed by his eating and avoids social eating situations. He becomes tearful and agitated if asked to taste a new food or if it is placed on his plate.

Interventions

With the iron deficiency, increased anxiety around new foods, and social isolation, Michael qualified for an ARFID diagnosis. His presentation suggests a mix of subtypes – limited intake and limited variety using subtypes proposed by Norris et al.[18]

> After six months, with an established routine, he was less anxious and came to the table without coaxing.

Mom was provided with an overview of RFT, with recommendations for parents to 1) establish a consistent eating routine, 2) offer one to two accepted foods at every eating opportunity, and 3) discontinue pressuring cues during mealtimes. Parents implemented changes, but not consistently. We brainstormed ways for Michael to stay connected with friends and have non-pressured exposures to foods with cooking, shopping, samples, and buffets. Parents noticed within the first few weeks that Michael's appetite increased sometimes, eating a bit more than usual. After six months, with an established routine, he was less anxious and came to the table without coaxing. Family meals happened two to three times a week.

Parents had stopped confrontational tactics, but were still using subtle comments and positive prompts to encourage him to "try one bite", which he resisted. Interventions focused on reducing "positive pressure" (encouragement, prompts, and comments), setting up pleasant family meals, and meal planning to include accepted and novel foods. In the following months, Michael grew more relaxed at mealtimes, starting conversations and paying less attention to the foods. He ate bigger portions consistently. His doctor noted that his growth trajectory had increased a few percentile points. His diet variety increased only slightly with a few different types of crackers. Parents felt frustrated with the 'lack of progress' in diet variety, but were reassured with a review of Michael's progress. Eating had become more flexible, his anxiety was down, and intake and weight had increased. They were enjoying family meals for the first time.

Progress & outcomes

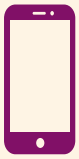
14 months into treatment, Michael occasionally tried different foods such as bites of strawberries and chicken nugget breading, indicating increased comfort with new foods. With repleted iron stores, his supplement dose was lowered. In the following months, he continued to experiment with foods including small bites of meatballs and hamburger. His regularly eaten foods expanded from four to over 15. While variety remained limited, parents felt good about the progress and terminated care, planning to continue with RF.

This case of a school-age child focused almost exclusively on parent support, with little direct work with Michael. In addition to parent education, adolescents may benefit from direct intervention with anxiety reduction techniques, cognitive behavioural therapy, exposures through cooking and eating explorations, app-based support for routines and self-care, and recognition of internal cues, all of which are modalities that help adults.[11]

CONCLUSION

Food provides us with physical nourishment, social connection, pleasure and more. Eating disturbances have pervasive implications for well-being impacting physical, mental, emotional and social health. In this two-part series, we discussed considerations fundamental to better understand ARFID and advance treatment options.

We encourage clinicians to consider the theoretical underpinning of treatment approaches: do we 'get' our clients to eat more or different foods, or provide a context for them to work autonomously towards eating competently?[19] One mother shared her experience of using a responsive approach (Murray K, email communication, July 2018): "Removing the pressure to eat was the key to my daughter's recovery from ARFID. Sit down meals and snacks with choices and no pressure allowed my child to finally relax around food, enjoy mealtime, and begin to eat more and try new things." RFT can effectively transform people's eating, nutrition, and physical and emotional wellbeing. Integrating a responsive approach offers largely untapped therapeutic potential and enhances effectiveness of therapy tools that are already available in ARFID treatment.



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