Behavioral Feeding Therapy

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Where the world comes for answers

Boston Children's

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Before we start…..

Behavioral therapy may help but it may not be "just behavioral"…

- Assess for GI condition
  - Vomiting not immediately after eating
  - Celiac, Crohn's, *Eosinophilic Esophagitis* (EoE), Severe Constipation that does not resolve with treatment…
- Child never transition to solids?
  - Assess for Motor Coordination or Delays
  - If you suspect feeding and swallowing difficulties, send to ORL
- Higher rates in neurodevelopmental disorders and ASD: Why?

Behavioral treatment takes time

Takes time to work and takes an investment of time.

- Is the child stable enough to start a program?
- Do the medical aspects of the child's care need to be addressed first?
- Is the "system" able to handle this type of change/intervention?
  - Family structure
  - "Psychological Mindedness" of the family system
  - Is this behavior at the top of the behavior management list? If not, what small goals can we work on to stabilize an individual medically until it is the right time.

Changing food related behaviors: Thinking in behavioral terms

Basics to using behavioral intervention in your practice

- Take time to understand the function of food refusal
- Examine the ABCs:
  - Antecedents: setting the stage- examine the who, what, where, when- look at the things that happen just before
  - Behaviors: What the behavior actually looks like, duration, frequency,
  - Consequences: What happens immediately after the behavior? May not be obvious and parents may not see the connection.
- Functions of Behavior: What is the function of behavior
  - food refusal, throwing, gagging and the list goes on!
- Plan: Game plan of how to change the antecedents and consequences to change food related behaviors.

Common behavioral problems

Understand the origins and functions of the behavior

- Food Refusal ➡ "Short Order Cooking" ➡ Reinforced Picky Eating
- The toddler "NO!" ➡ Parent cannot accept "NO!" ➡ Power Struggle
- Gagging and vomiting when foods are presented to eat
  - Form of refusal
  - Parents are often worried about medical concerns
  - Foods are removed
- Tantrums and other avoidance behaviors at mealtime
- Throwing Food
  - Fun to watch food fly and splatter
  - Form of refusal
  - Elicits negative reaction from parent ➡ Behavioral reinforcement of throwing

Behavioral Treatment Approaches

Not all therapies are the same.

- Types:
  - Parent training/Family Behavioral Therapy
  - Individual Therapy
  - ABA- ASD specific
- Treatment Modalities:
  - Reinforce behaviors that promote good food and feeding skill building.
  - Desensitization: (Food Game): aversions, fears and over-selectivity.
  - Cognitive Behavioral Therapy
  - Applied Behavioral Analysis (developed for treatment of ASD/ID).
  - Escape Extinction

Referral #1: Eve

Eve: 4-year-old girl seen for failure to thrive, born premature, at 30-weeks gestation. Outside of her growth and feeding concerns, generally in good health. Parents are highly concerned about her poor weight gain and growth. They have “tried everything” and she won’t eat unless she is forced to eat. Mealtimes have become a battle. Significant tantrums at mealtimes and refuses to come to the table. Parents often “sneak” food in. Eats a range of foods but just in very small quantities. Often refuse meals but want her sippy cup or different foods shortly after meals have stopped. Meals last 45-60 minutes.

Referral #1: Eve

Diagnosis: In the context of ASD, Avoidant Restrictive Food Disorder, subtype: “Infantile Anorexia”

- No or little interest in feeding
- Poor weight gain and growth
- Assess for depression in child and parent
- Assess for psychosocial stressors
- Associated with difficulty, irregularity, negativity, dependence, and unstoppable temperament ratings (1)

Chatoor M.D., Ganiban, J., Hirsch, R., Borman-Spurrell, E. Mrazek, D. (1999) Maternal Characteristics and Toddler Temperament in Infantile Anorexia. Journal of the American Academy of Child and Adolescent Psychiatry. Vol. 39. Issue 6, p.743-751

Behavioral guidance in your consultation

Advice you can offer as part of nutrition consultation

- Avoid wandering/getting up: Table or highchair
- Eliminating distractions at meals, fade electronics
- Keep meal lengths reasonable: Meals should last no more than 30 minutes
- All food at the table/during meals/snacks (NO GRAZING!)
- Family meals: Promote modeling BUT maybe too stressful or unrealistic
- Remove behavioral component in ending mealtimes
- Address maladaptive or disruptive mealtime behaviors
- Stop coercive feeding patterns if possible
- Make sure parents know what “typical intake” looks like

SPACE-ARFID: A pilot trial of a novel parent-based treatment for avoidant/restrictive food intake disorder

Authors: Shimshoni, Silverman and Lebowitz

- SPACE Program: Parent-focuses on reducing parent accommodations/Anxiety
- Manualized Parent-focused CBT-P: 12 weekly treatment sessions
- 6-14-year-olds: 17 eligible: 15 participate, 14 completed 12 sessions
- Symptom severity/impairment and parental accommodations reduced
- Increased food-related flexibility
- Parents and children rated highly satisfactory.

Shimshoni, Y, Silverman, WK, Lebowitz, ER. SPACE-ARFID: A pilot trial of a novel parent-based treatment for avoidant/restrictive food intake disorder. *Int J Eat Disord*. 2020; 53: 1623– 1635.

Cognitive-behavioral therapy for avoidant/restrictive food intake disorder: Feasibility, acceptability, and proof-of-concept for children and adolescents

Authors: Jennifer Thomas, et. Al.

- Manualized psychosocial treatment for ARFID: CBT-AR
- 20–30 sessions of CBT-AR delivered in a family-based or individual format.
- 25 eligible individuals, 20 initiated treatment, including 17 completers and 3 dropouts.
- Participants: 10-17-year-olds
- Clinician rated improvement, ARFID severity score reduction, Underweight group gained weight 16.7 (*SD* = 12.1) and moving from the 10th to the 20th percentile for body mass index. At post-treatment, 70% of patients no longer met criteria for ARFID.

Thomas, JJ, Becker, KR, Kuhnle, MC, et al. Cognitive-behavioral therapy for avoidant/restrictive food intake disorder: Feasibility, acceptability, and proof-of-concept for children and adolescents. *Int J Eat Disord*. 2020; 53: 1636– 1646.

Referral #2: Gabriel

Gabriel is a 6-year-old boy, diagnosed with failure to thrive. He has also recently been diagnosed with ASD. He is highly restrictive in his food choices and only eats foods that are brown/beige. He only eats chicken nuggets from McDonalds. If preferred foods are not available or changed in any way (grill marks on hotdogs), he will not eat, even when hungry.

Gabriel's Diagnosis

Avoidant Restrictive Food Disorder: Complex Diagnosis: Sensory Restrictive Eating and Ritualized Restrictive Eating

- Sensory Restrictive Eating:
  - Visual appearance
  - Texture
  - Smell
  - Taste
- Ritualized Restrictive Eating:
  - Child insists that food or drink presented in a particular manner/form
  - Deviation from routine results in distress and refusal
  - Child accepts foods out of certain containers or specific brands
- Note: If non-preferred foods are not presented, child typically will not eat.

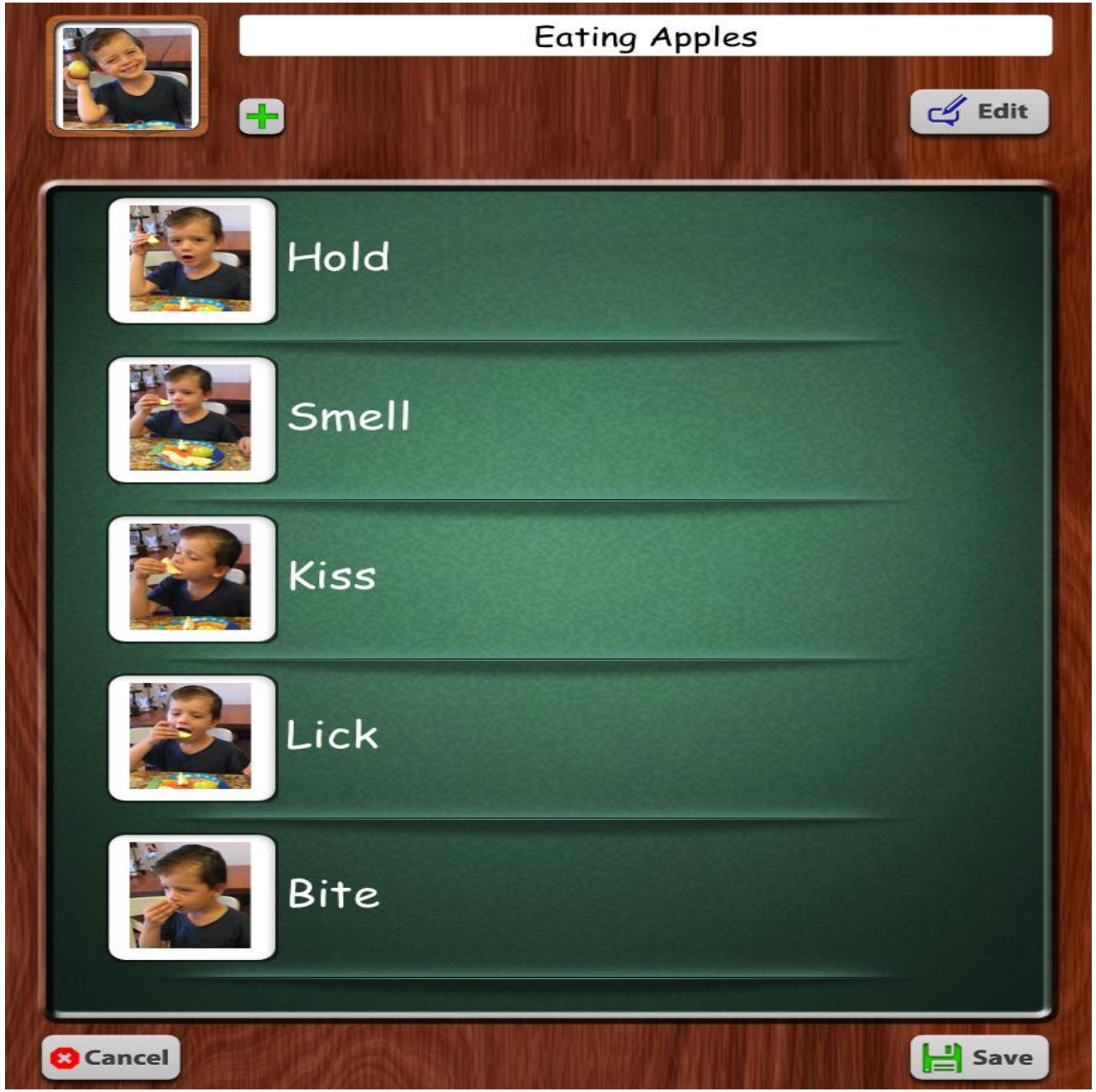
Treatment Plan

- General parent guidance: stop forcing and work on structure, diagnose health if possible
- Behaviorally reinforce deviations from the routine
- Intro new before getting rid of the old
  - Caution: Avoid “Cold Turkey” approaches
- Direct to community therapies:
  - EI
  - OT or SLP
  - Psychologist: CBT and desensitization/exposure directed by parent
  - ABA program implement food exposure trails

Systematic Desensitization:

“Food Game”

- Maintain fun, playful atmosphere- not at meals
- Introduce foods in a desensitization chain
- Introduce a small number of foods at a time
- After food is “mastered”, then focus on “generalization”
- Treatment is slow and gradual and manage anxiety
- Use play and rewards to increase motivation
- Always end on a positive note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	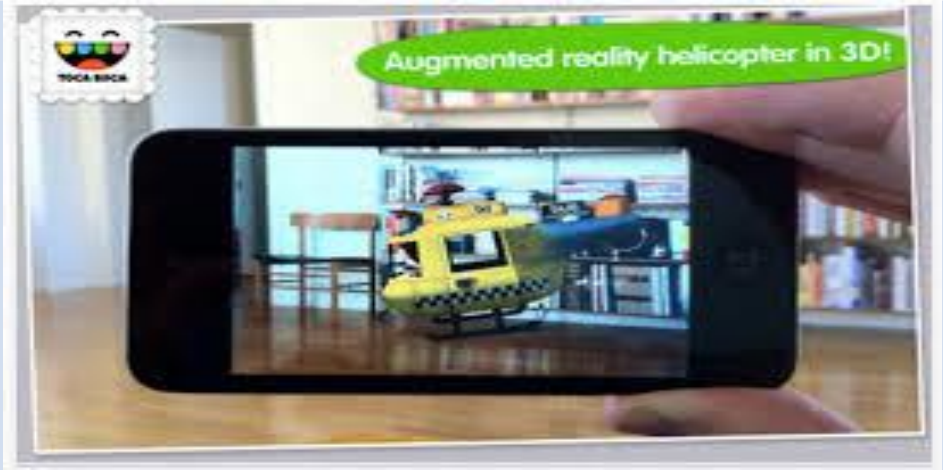

Referral #3: Alison

Alison is a 6-year-old girl that recently stopped accepting all food after a choking incident in the school cafeteria. She has not eaten for two weeks. Referral was made by the pediatric practice nurse requesting an urgent appointment with nutrition.

Alison's Diagnosis

Phobia: Food Refusal Related to Adverse Experience

"Food Phobia"

- Phobia is intense FEAR and AVOIDANCE of something.
- Occurs with a "punishing event" or repeated conditioning with negative stimulus.

Treatment: Cognitive Behavioral Therapy

- Educate and stabilize
- Correct cognitive distortions
- "Systematic Desensitization"
- Exposure in office and practice at home

Diagnosis

DSM-5:
Avoidant/Restrictive Food Intake Disorder

Published in 2012- other names used before include FTT and Feeding Disorder.

A. Eating or feeding disturbance 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/failure to gain weight or faltering growth
2. Significant nutritional deficiency
3. Dependence on enteral feeding
4. Marked interference with psychosocial functioning

All these criterion must be met:

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 eating disturbance occurs in context of a medical condition or another mental disorder, it is sufficiently severe to warrant independent clinical attention.

Subtypes of Feeding Disorders

Can be one or more of the following presentations:

- Infantile Anorexia: poor appetite/ limited interest in eating
- Sensory Restrictive Eating Disorders
- Ritualized Restrictive Eating Disorders
- Fear of negative consequences from eating
  - Post-traumatic Eating Disorders
  - Expect negative outcome (e.g., make me sick, choke, won't like)

How to refer to treatment

- Psychology and Behavioral Treatment Modalities:
  - Psychotherapy/Family Therapy for ARFID: CBT and “Exposure”
  - Community treatment clinics for ARFID: BCH ARFID clinic, MGH, Walden
  - Inpatient providers: Kennedy Krieger, Walden, other inpatient programs
  - ABA providers
- www.psychologytoday.com : Find a therapist
- www.services.abct.org: Find a therapist
- Boston area:

  William James Interface Referral Service

  888-244-6843

  www.interface.williamjames.edu

Speech and Occupational Therapies

- Speech Therapy: Specializing in oral motor dysphasia, chewing and swallowing problems
  - Necessary for individuals with suspected swallowing/risk of aspiration
- Occupational Therapy: Specializes in treating oral-motor coordination and sensory feeding difficulties.
- Referral Resources:

www.sosapproachtofeeding.com

www.Feedingmatters.org

Helpful Books and Resources

- **Feeding with Love and Good Sense: 18 Months through 6 Years** by Ellyn Satter
- **Food Chaining: The Proven 6-Step Plan to Stop Picky Eating, Solve Feeding Problems, and Expand Your Child s Diet** by Cheri Fraker and Mark Fishbien
- **Helping Your Child with Extreme Picky Eating: A Step-by-Step Guide for Overcoming Selective Eating, Food Aversion, and Feeding Disorders** by By Katja Rowell, Jenny McGlothin and Suzanne Evan Morris
- **Broccoli Boot Camp: Basic Training for Parents of Selective Eaters** by Keith Williams and Laura Seiverline
- **The Eating Handbook for Children with Autism, 2nd Edition: Comprehensive common sense strategies and tips to get your child to eat!** By Michelle Brown
- **Treating Eating Problems of Children w/ Autism Spectrum Disorders and Developmental Disabilities: Interventions for Professionals and Parents** by Keith E Williams
- **The Picky Eater's Recovery Book: Overcoming Avoidant/Restrictive Food Intake Disorder** by Jennifer J. Thomas, Kendra R. Becker and Kamryn T. Eddy
- **Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder** by Jennifer J. Thomas

Question and Answer