Supporting Families to Build Healthy Relationships with Food & the Body

Piper Caroll MD
UPMC Center for Eating Disorders

UPMC TiPS

Learning Objectives

1. Understand a primary care providers role in preventing the development of eating disorders.

2. Identify language that can be used to promote healthy and non-judgmental attitudes about eating and body weight/shape

3. Identify tips to give families to increase healthy eating related behaviors

UPMC TiPS

11-year-old Max comes in for his well child visit...

• You have known Max since birth, his BMI has consistently tracked in 95th %ile, in "obese" range.

• Dad expresses concern that he is unhealthy and asks how to help him lose weight.

Do you want any additional information before responding to the parent's concern? If so, what?

What recommendations do you make and what language do you use?

UPMC TiPS

Journal of Adolescent Health 63 (2018) 360–362

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH
www.jahonline.org

Adolescent health brief

Weight Labeling and Disordered Eating Among Adolescent Girls: Longitudinal Evidence From the National Heart, Lung, and Blood Institute Growth and Health Study

Jeffrey M. Hunger, Ph.D. *, and A. Janet Tomiyama, Ph.D.

Department of Psychology, University of California, Los Angeles, California

Article history: Received July 11, 2017; Accepted December 21, 2017
Keywords: Disordered eating; Weight stigma; Weight labeling; Unhealthy weight control

See Related Editorial on p. 267

A B S T R A C T

Purpose: Weight stigma is implicated in disordered eating, but much of this research focuses on forms of stigma such as weight-based teasing.
Methods: In a large cohort of adolescent girls (N = 2,036), we tested the hypothesis that being labeled as "too fat" by others predicts subsequent greater disordered eating cognitions and behaviors.
Results: Compared with girls who did not report weight labeling, girls who were labeled at age 14 showed an increase in unhealthy weight control behaviors and disordered eating cognitions over the subsequent 5 years. These effects were independent of objective body mass index, race, parental income and education, and initial levels of disordered eating.
Conclusions: Exploratory analyses suggest that weight labeling from family members is more strongly associated with disordered eating than labeling from nonfamily members. This study highlights how the long-term consequences of weight stigma can potentially begin when one is labeled as "too fat."

© 2018 Society for Adolescent Health and Medicine. All rights reserved.

IMPLICATIONS AND CONTRIBUTION

Whereas past research on weight stigma and disordered eating has focused on forms of stigma such as weight-based teasing, the current study shows that being labeled as "too fat" by others is prospectively associated with greater disordered eating cognitions and behaviors in a large cohort of adolescent girls.

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Preventing Obesity and Eating Disorders in Adolescents

Neville H. Golden, MD, FAAP, Marcie Schneider, MD, FAAP, Christine Wood, MD, FAAP,
COMMITTEE ON NUTRITION, COMMITTEE ON ADOLESCENCE, SECTION ON OBESITY

This Clinical Report was reaffirmed June 2022.

abstract

Obesity and eating disorders (EDs) are both prevalent in adolescents. There are concerns that obesity prevention efforts may lead to the development of an ED. Most adolescents who develop an ED did not have obesity previously, but some teenagers, in an attempt to lose weight, may develop an ED. This clinical report addresses the interaction between obesity prevention and EDs in teenagers, provides the pediatrician with evidence-informed tools to identify behaviors that predispose to both obesity and EDs, and provides guidance about obesity and ED prevention messages. The focus should be on a healthy lifestyle rather than on weight. Evidence suggests that obesity prevention and treatment, if conducted correctly, do not predispose to EDs.

FREE

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Clinical reports from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, clinical reports from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: 10.1542/peds.2016-1649

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2016 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The authors have indicated they do not have a financial relationship relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

To cite: Golden NH, Schneider M, Wood C, AAP COMMITTEE ON NUTRITION. Preventing Obesity and Eating Disorders in Adolescents. *Pediatrics*. 2016;138(3):e20161649

INTRODUCTION

The prevalence of childhood obesity has increased dramatically over the past few decades in the United States and other countries, and obesity during adolescence is associated with significant medical morbidity during adulthood.[1] Eating disorders (EDs) are the third most common chronic condition in adolescents, after obesity and asthma.[2] Most adolescents who develop an ED did not have obesity previously, but some adolescents may misinterpret what "healthy eating" is and engage in unhealthy behaviors, such as skipping meals or using fad diets in an attempt to "be healthier," the result of which could be the development of an ED.[3] Messages from pediatricians addressing obesity and reviewing constructive ways to manage weight can be safely and supportively incorporated into health care visits. Avoiding certain weight-based language and using motivational interviewing (MI) techniques may improve communication and promote successful outcomes when providing weight-management counseling.[4]

This clinical report complements existing American Academy of Pediatrics (AAP) reports on EDs[5] and obesity prevention.[6] The aim is to address the interaction between obesity prevention and EDs in teenagers and to stress that obesity prevention does not promote the development

Downloaded from http://publications.aap.org/pediatrics/article-pdf/138/3/e20161649/1703392/peds_20161649.pdf

FROM THE AMERICAN ACADEMY OF PEDIATRICS

UPMC TiPS

How do we (providers) *ask* about eating?

- Ask about *more* than just fruits, vegetables, and soda
- Ask about familial eating habits and attitudes
- Ask about physical activity habits

UPMC TiPS

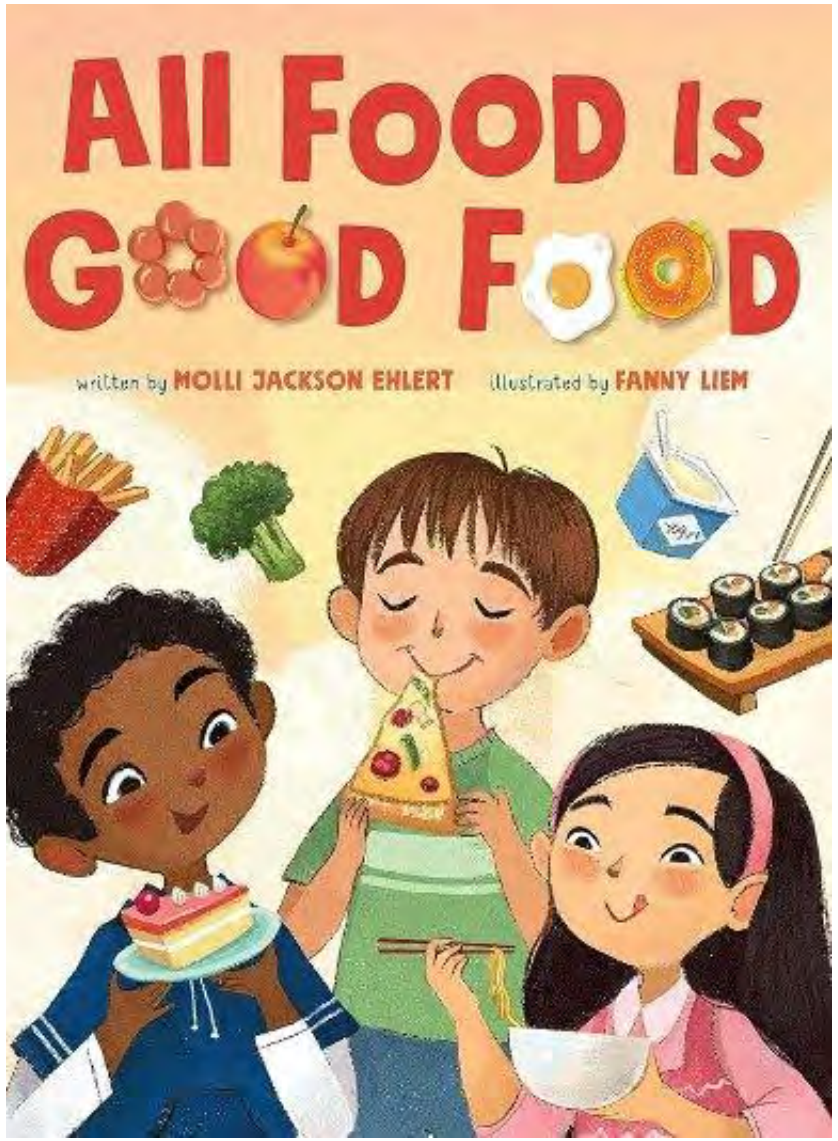
How do we (providers) *talk* about eating?

- Sustainable habits
- Family meals
- Emphasis on function
- Address weight stigma

UPMC TiPS

Discourage restrictive diets, meal skipping, and prolonged fasting focused on weight loss

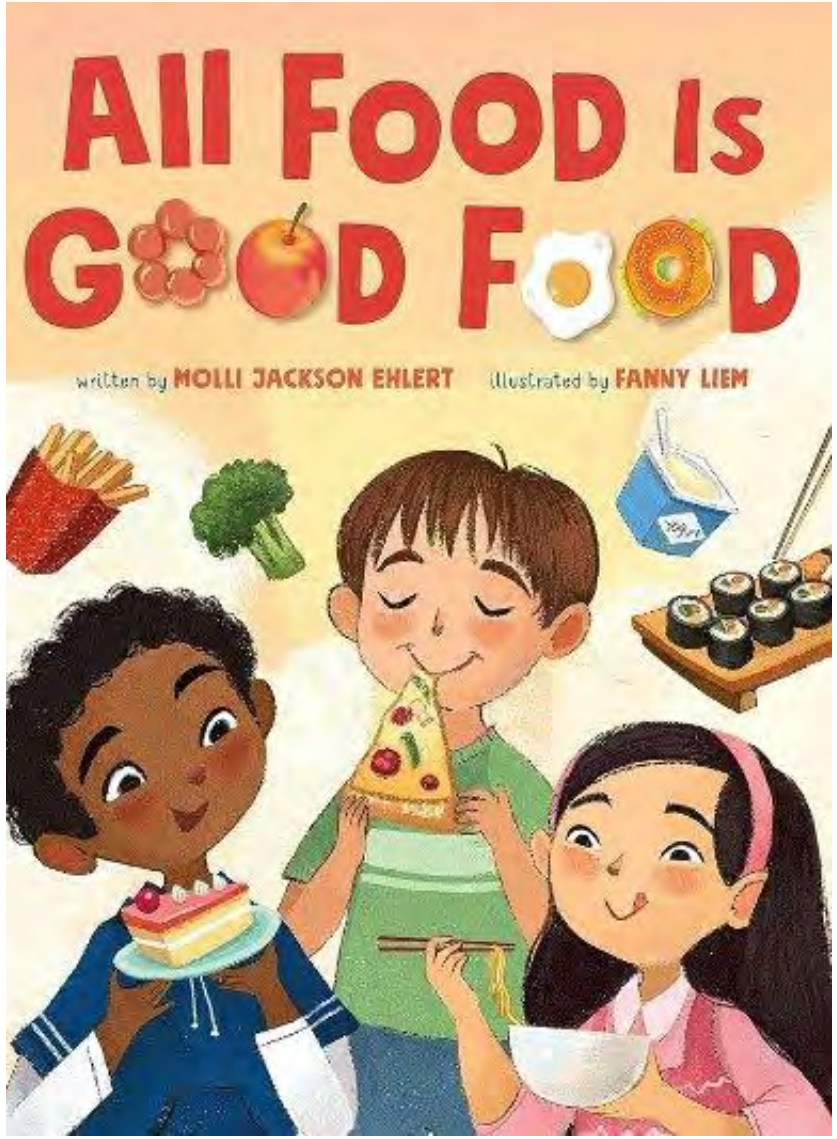
- Extreme caloric restriction is the main risk factor for development of eating disorders.
    - Very strict dieting is associated with 18x risk for an ED
    - Moderate dieting associated with 5x risk for an ED



UPMC TiPS

Discourage restrictive diets, meal skipping, and prolonged fasting focused on weight loss

- Avoid labeling foods good vs. bad or healthy vs. unhealthy
- Talk about food as fuel and nourishment
- Encourage sustainable diet patterns
- Focus on balanced nutrition and physical activity



UPMC TiPS

Refrain from discussing weight number

- Offer "blind" weights
- Avoid equating weight and health
- Utilize non-weight measures of health
- Focus on function instead of physical appearance
- Encourage families to talk less about weight
- Acknowledge weight stigma

UPMC TiPS

Encourage family meals

- Eating together allows for early detection of disordered eating
- Higher numbers of family meals are associated with improved diet quality
- Ask parents to think about their own dieting habits and remind them that their kids notice these

Discourage body focused teasing and negative comments on weight/shape

- Jokes and criticism about bodies within families are associated with unhealthy weight control behaviors *and* binge eating
- The teasing doesn't have to be towards the child to impact the child's feelings about their body
- Ask about negative messages coming from places outside of the family as well

UPMC TiPS

Promote positive or neutral body image & body acceptance

- Avoid reinforcing body dissatisfaction as reason for weight loss/change in habits
- In addition to eating disorders, body dissatisfaction is correlated with higher levels of depression in adolescents

UPMC TiPS

Monitor weight loss when it is necessary

- Sometimes weight loss and dietary change are indicated to support a child's health
- Focus on varied and flexible diet that is nourishing and balanced with level of physical activity
- Ensure you are monitoring weight loss closely
    - How a family is achieving weight loss
    - How rapidly the child is losing weight
- Avoid blindly praising weight loss

UPMC TiPS

Understanding ARFID:
What Every Pediatrician Needs to Know

Abigail Boden Schlesinger, MD

UPMC TIPS

Thank You for Your Collaboration

- Ken Tormey, PhD
- Amy Loughner, MOT, OTR/L
- Stephanie Persichetti, MOT, OTR/L

UPMC TiPS

Learning Objectives

- To differentiate the three types(IE DRIVERS) of ARFID
- To discuss the roles of the pediatrician when ARFID is a concern
- To review (anticipatory)guidance related to mealtime

UPMC TiPS

What do you think about when you hear

Picky Eating

ARFID

Eating is a Complex Learned Behavior

UPMC TiPS

The Tip of the Iceberg

Oral motor control
Sensory processing
Interoception
Fine motor skills

Emotional regulation
Cognitive flexibility
Mindfulness

Nutritional literacy
Meal structuring
Hydration management

Social modeling
Environment design
Cultural connection

UPMC TiPS

Physiological & Motor Skills

The foundational physical mechanics required to safely ingest food:

- **Oral motor control:** Coordinating the lips, tongue, and jaw to chew, move food inside the mouth, and swallow safely.
- **Sensory processing:** Managing how the body reacts to food textures, temperatures, smells, visual presentations, and tastes.
- **Interoception:** Recognizing and responding to internal bodily cues, specifically hunger signals and fullness (satiety).
- **Fine motor skills:** Developing the hand-eye coordination required to use utensils, hold cups, and bring food to the mouth.

UPMC TiPS

Psychological & Emotional Components

Our relationship with food is deeply tied to our mental state:

- **Emotional regulation:** Learning to separate the act of eating from emotional coping mechanisms (e.g., eating due to boredom, stress, or sadness).
- **Cognitive flexibility:** Being open to trying new foods and accepting variations in familiar meals without anxiety.
- **Mindfulness:** Paying active attention to the sensory experience of eating, which helps prevent overeating and improves digestion.

UPMC TiPS

Behavioral & Dietary Habits

The practical routines and structures that support long-term nutrition:

- **Nutritional literacy:** Building balanced meals
- **Meal structuring:** Establishing regular, predictable eating intervals throughout the day to stabilize blood sugar and energy levels.
- **Hydration management:** Integrating adequate fluid intake independently of solid food consumption.

UPMC TiPS

Social & Environmental Factors

The context in which we eat shapes our lifelong habits:

- **Social modeling:** Observing and mimicking the healthy eating behaviors of family members, peers, or mentors.
- **Environment design:** Creating a distraction-free eating space (e.g., turning off screens) to focus entirely on the meal.
- **Cultural connection:** Navigating family traditions, social gatherings, and cultural identities surrounding food in a healthy manner.

UPMC TiPS

Picky Eating

- Limited variety of foods
- Rejects familiar and unfamiliar foods, but will often eat preferred foods when hungry
- Strong preferences - certain types of foods, certain brands
- Mealtime stress
- Presents transiently in developmental phases
- Doesn’t impact growth or health

UPMC TiPS

Approach to Picky Eating

Mealtime

- Consistency
- Reduce physical distractions (adult and child screens)
- Make mealtime about connection and not just food
- Be clear about expectations & remember
- You don’t have to enjoy a food to eat it
- You don’t have to eat all of a food to try it
- It may take many presentations (5-15) for a young child to actually try (let alone accept) a new food

UPMC TiPS

Approach to Picky Eating

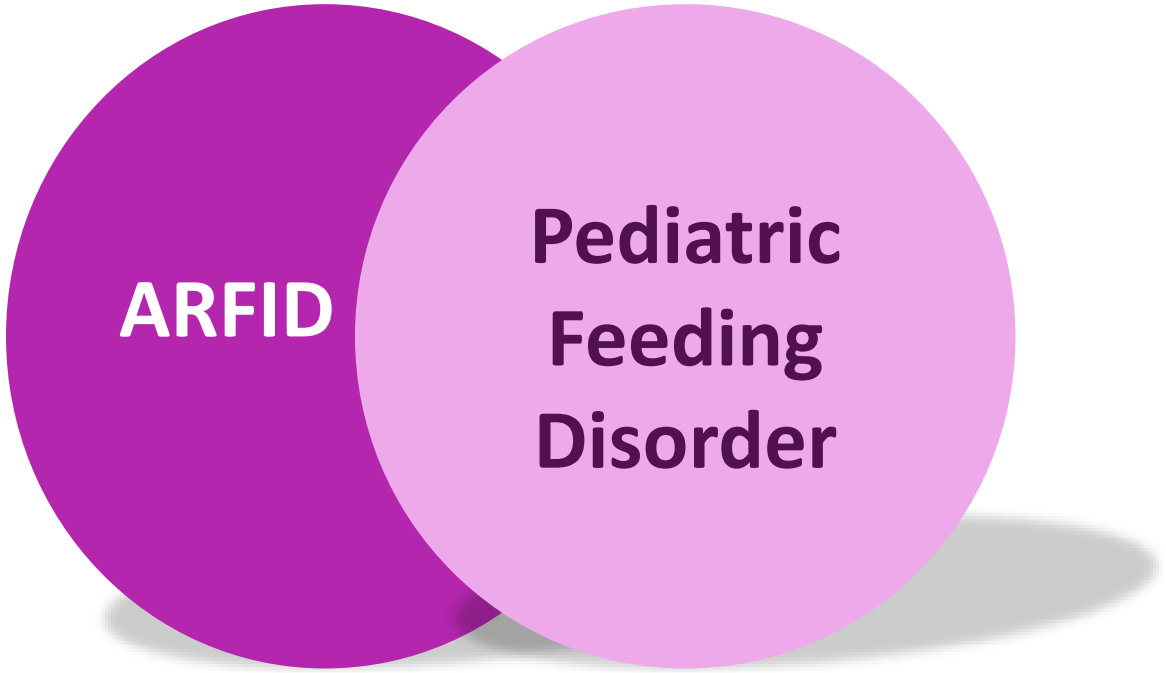
Between Mealtimes

- A child is less likely to eat if there are other options
- They have had too many snacks
- They have had meal supplementation
- Enforce natural consequences
- If you don’t eat much you might be hungry later

UPMC TiPS

Pediatric Feeding Disorder

- A medical (as opposed to psychiatric) diagnosis that focuses on physical health or feeding skill concern as source.



UPMC TiPS

What is ARFID?

- ARFID is characterized by restricted food intake leading to nutritional and/or psychosocial impairment
- Restriction is not related to body image distortion or weight concerns
- Included in DSM-5 feeding and eating disorders
- Frequently emerges during childhood but may persist into adulthood

UPMC TiPS

DSM-5 Diagnostic Features

- **Criterion A:** Eating or feeding disturbance resulting in persistent failure to meet nutritional or energy needs
    - Associated with one or more: significant weight loss/faltering growth, nutritional deficiency, dependence on enteral feeding/oral supplements, or marked psychosocial interference
- **Criterion B:** Disturbance is not due to lack of available food or culturally sanctioned practice

UPMC TiPS

DSM-5 Diagnostic Features

- **Criterion C:** Does not occur exclusively during anorexia nervosa or bulimia nervosa and no disturbance in body image perception

- **Criterion D:** Not better explained by another medical or psychiatric condition; if concurrent, severity exceeds what is routinely associated

UPMC TiPS

ARFID vs Picky Eating and Anorexia

ARFID	Picky Eating	Anorexia
Avoids eating	Avoids eating certain foods	Avoids eating
Uncomfortable in social settings centered on food	Indifferent in social settings centered on food	Uncomfortable in social settings centered on food
Interferes with growth, may cause malnourishment	Does not interfere with growth or nourishment	Interferes with growth, may cause malnourishment
Driven by sensory avoidance, fear of choking, dislike of sensation	Drive fueled by dislike of certain foods	Distorted body image/fear of gaining weight
Usually starts between ages 4-13	Usually peaks around 2-4 years	Usually starts around 11-12

UPMC TiPS

ARFID Epidemiology & Risk Factors

More common in pediatric populations

Frequently co-occurs with anxiety disorders, autism spectrum disorder, and ADHD

History of traumatic feeding experiences may contribute

Sensory processing differences are common

UPMC TiPS

Neurobiology of ARFID

- Sensory hyperreactivity may contribute to food avoidance
- Anxiety and fear circuitry may reinforce restrictive eating behaviors
- Neurodevelopmental and temperament factors likely contribute
- Research is growing but remains limited compared with other eating disorders

UPMC TiPS

Medical and Nutritional Complications

- Growth delay and pubertal delay
- Iron, vitamin, and micronutrient deficiencies
- Bradycardia, hypotension, electrolyte abnormalities
- Gastrointestinal complaints and fatigue
- Social and family impairment

UPMC TiPS

ARFID: Pediatric Primary Care Approach

Rule-out other conditions	• Distinguish ARFID from picky eating, typical developmental phase and other eating disorders • Rule out physical conditions that interfere with feeding • Mechanics of eating (motor skills, chewing, swallowing) • GI concerns (acid reflux or pain, constipation)
Recognize co-occurring conditions impacting care	Screen for anxiety disorders, OCD, autism spectrum disorder, ADHD, and depression Identify Likely Drivers
Identify likely drivers (consider NAIS)	Interview and/or NAIS
Treat and Monitor	• Monitor growth parameters and consider malnutrition panels • Provide short-term oral nutrition supplementation(ONS) if needed, treat nutritional deficiencies, and refer for treatment (behavioral health, OT, dietitian, or speech/swallowing) • Set clear expectations • Schedule follow-up • Escalate care when indicated

UPMC TiPS

TYPES OF ARFID

UPMC TIPS

Types of ARFID(DRIVERS)

1. **Fear of aversive consequences** such as choking or vomiting
2. **Sensory sensitivity** to food texture, smell, color, or temperature
3. Apparent **lack of interest** in food or eating

- Presentations may overlap in the same patient

UPMC TiPS

9 Item ARFID Screen (NAIS)

Nine Item Avoidant/Restrictive Food Intake disorder screen (NIAS) - Child

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	I am a picky eater	○	○	○	○	○	○
2	I dislike most of the foods that otherpeople eat	○	○	○	○	○	○
3	The list of foods that I like and will eat is shorter than the list of foods I won't eat	○	○	○	○	○	○
4	I am not very interested in eating; I seemto have a smaller appetite than other people	○	○	○	○	○	○
5	I have to push myself to eat regular mealsthroughout the day, or to eat a large enough amount of food at meals	○	○	○	○	○	○
6	Even when I am eating a food I really like, it is hard for me to eat a large enough volume at meals	○	○	○	○	○	○
7	I avoid or put off eating because I am afraid of GI discomfort, choking, or vomiting	○	○	○	○	○	○
8	I restrict myself to certain foods because Iam afraid that other foods will cause GI discomfort, choking, or vomiting	○	○	○	○	○	○
9	I eat small portions because I am afraid of GI discomfort, choking, or vomiting	○	○	○	○	○	○

Individuals respond to each question on a scale from 0 (*Strongly Disagree*) to 5 (*Strongly Agree*). Subscales are each scored on a scale from 0–15, with higher scores indicating higher levels of each metric (picky eating, lack of interest, and fear). All items may also be summed to calculate a total score, ranging from 0–45, with higher scores indicating higher levels of avoidant/restrictive eating broadly.

Zickgraf, Hana F., and Jordan M. Ellis. "Initial validation of the Nine Item Avoidant/Restrictive Food Intake disorder screen (NIAS): Ameasure of three restrictive eating patterns." *Appetite* 123 (2018): 32-42.

UPMC TiPS

Scoring NAIS

- Each question scored 0-5
  - total=45; over 23 indicative of ARFID
- Subscales over 12 indicative of primary concern - Note subscales don't match completely with Types of ARIFD
  - 1-3 – picky eating
  - 4-6- low appetite/lack of interest
  - 7-9 – fear of aversive consequences(which include sensory)

UPMC TiPS

Assessment & Evaluation

- Comprehensive medical and psychiatric assessment
- Dietary history and review of growth trajectory
- Screening for anxiety, OCD, autism spectrum disorder, and depression
- Laboratory assessment for malnutrition and deficiencies
- Multidisciplinary evaluation is recommended

UPMC TiPS

Treatment Approaches

- Nutritional rehabilitation and weight restoration when indicated
- Cognitive Behavioral Therapy for ARFID (CBT-AR)
- Exposure-based therapy to increase food flexibility
- Family-Based Treatment (FBT) for children/adolescents
- Occupational and speech therapy support for sensory/feeding concerns

UPMC TiPS

Hospitalization Considerations

- Severe malnutrition or dehydration
- Significant electrolyte abnormalities
- Cardiac instability
- Failure of outpatient treatment
- Need for supervised nutritional rehabilitation

UPMC TiPS

Prognosis & Future Directions

- Early intervention improves outcomes
- Many patients respond well to structured multidisciplinary treatment
- Long-term outcome research remains limited
- Greater clinician awareness and standardized treatment protocols are needed

UPMC TiPS

Fear of Aversive Consequences

ARFID Drivers

UPMC TiPS

Case Study

14-year-old adolescent boy with progressive weight loss after choking episode. He has lost ten pounds in a four months. He is distressed, anxious and irritable during meals, but no other time. No history of behavioral health concerns, or difficulty eating in the past other than being “a little picky” when he was younger.

Where do you refer this child Pick all that Apply:

a. Behavioral health
b. Occupational Therapy
c. Dietician

What to Expect Out of Treatment

- Psychoeducation and support to help family support child
- Development of skills to help tolerate exposures
- Graded Exposure
- Homework with family

UPMC TiPS

Referral Pearls

- Buy-in from (and practice with) family is key to success -> primary care physicians can really help with promoting buy-in.
- The treatment is not going to address weight change explicitly it's going to address behavior change.
- Amount of weight loss impacts needs for ONS or refeeding protocol more than type of BH,OT or dietary intervention

UPMC TiPS

When to Consider Oral Supplementation

- Consider ONS if a child has:
  - Weight gain below expected trajectory
  - BMI or weight-for-height below expected range
  - Crossing growth percentiles downward
  - Documented micronutrient deficiencies (e.g., iron, vitamin D)
  - Highly restricted intake that cannot meet nutritional needs
  - ARFID or severe feeding difficulties
  - Increased nutritional requirements due to medical illness

UPMC TiPS

How to Use ONS

Timing

- Offer after meals or snacks, not before.
- Avoid replacing meals with supplements.
- Use between meals when additional calories are needed.

Amount

- Mild nutritional risk: 1 serving daily
- Poor growth of significant nutritional deficiency: 1–2 servings daily

Duration

- Reassess every 1–3 months.
- Monitor weight gain, height velocity, dietary variety, and laboratory deficiencies if present.
- Reduce supplementation as intake and growth normalize.

As a general rule refer to parent/child to dietician, OT, and/or BH if prescribing ONS

UPMC TiPS

When NOT to Routinely Use ONS

- Avoid routine supplementation when:
  - Growth is normal
  - Diet variety is limited but caloric intake is adequate
  - The child uses supplements instead of meals
  - Supplements reinforce food refusal or selective eating
  - In these situations, ONS can actually reduce hunger and make expansion of the diet more difficult.

UPMC TiPS

Evidence for ONS in Picky Eating

- A 2025 systematic review found moderate evidence that ONS combined with dietary counseling improved weight-related growth outcomes in underweight picky eaters compared with counseling alone.

- Iwańska, LP, Agata S, Andrea H, Sonia S, Hania S. Effect of oral nutritional supplements administration on the management of children with picky eating and underweight: A systematic review and meta-analysis. Clinical Nutrition Volume 67,
- 2025: 257-264.

UPMC TiPS

Oral Nutritional Supplementation for Picky Eating & ARFID

Clinical Scenario	Recommendation
Normal growth, mild picky eating	No oral nutritional supplement (ONS); use behavioral feeding strategies and parent coaching
Normal growth, very limited dietary variety	Consider multivitamin and dietary counseling; avoid routine ONS
Weight percentile declining or slowed weight gain	Consider ONS plus dietitian involvement and feeding intervention
Underweight or faltering growth	ONS 1–2 servings/day in conjunction with feeding treatment and dietary counseling
ARFID with nutritional compromise	ONS often indicated **while** CBT-AR, FBT, or feeding treatment addresses underlying eating behaviors
Severe malnutrition or medical instability	Medical nutrition rehabilitation; ONS and/or enteral nutrition as clinically indicated

UPMC TiPS

Key Clinical Pearl

- For children with picky eating, ONS works best as a temporary adjunct to behavioral and nutritional treatment, not as a long-term substitute for food variety.

UPMC TiPS

Considerations for Referral to Occupational Therapy and Behavioral Health

- Behavioral Health
  - Previously eating a variety of foods
  - No history of sensory or physical issues interfering with eating
- Occupational Therapy
  - Provider should have training in developmentally and trauma-informed exposure treatment
- You might need both in a mixed presentation which is not uncommon in ARFID

UPMC TiPS

Sensory Sensitivities

ARFID DRIVERS

Types Senses

Exteroceptive

- **Vision (Sight):** Detects light and images through the eyes.
- **Auditory (Hearing):** Detects sound waves through the ears.
- **Olfactory (Smell):** Detects airborne chemical scents through the nose.
- **Gustatory (Taste):** Detects flavors via the tongue and mouth.
- **Tactile (Touch):** Detects pressure, vibration, and texture through the skin.
- **Thermoception:** Detects external heat and cold via skin receptors.
- **Nociception (Pain):** Detects harmful external stimuli that damage

Interoceptive

- **Heart Rate and Respiration:** Senses breathing pace and heartbeat during activity or rest.
- **Visceral Sensations:** Detects stomachaches, nausea, or digestive activity.
- **Temperature Regulation:** Monitors internal core temperature.
- **Elimination:** Signals a full bladder or bowels.

Proprioceptive - awareness of body in space

UPMC TIPS

ADHD, ASD, Anxiety, trauma all impact how we react to sensory input

Hypo or hyper- sensitivity can change the experience/desire to eat

EXPOSURE can help hypersensitivity – but the exposure can't occur so fast as to result in flooding and sensitization rather than desensitization

UPMC TiPS

Case Study

9-year-old boy with severe restriction to beige/crunchy foods only. Has been in the lower percentiles(19%) their entire life, but their BMI percentile is beginning to drop. They refuse food based on texture and smell. They have significant distress during lunch. Limited diet causing iron deficiency.

You refer to Occupational Therapy for treatment. Mom asks about giving ONS, how do you handle this?

Select all that Apply

A. Start oral supplementation now

B. Discuss risks of oral supplementation

C. Refer to BH

What to Expect from Treatment

- Graduated exposure
  - Exploring the food – explicitly exposing the food, not just the elements that they are avoiding.
  - Can be a longer process
  - They will need to work on foods that they can't currently tolerate, although they shouldn't start with the hardest food to tolerate
- Coping skills to tolerate exposures
- Evaluation needs to include consideration of comorbidities – since comorbidities(ASD, ADHD, Anxiety) which are frequent and the presence of comorbidities will impact treatment and outcomes

UPMC TiPS

When to Refer

- If a child is restricting the types of foods (based on textures, odor, color) and parents are having difficulty (re)introducing a variety of foods
- If the child is restricting # of foods
- Concern about weight loss, or ability to gain
- Caveats – is this a normal picky eating phase? Can the child sit thru treatment?

UPMC TiPS

Clinical Pearls

- Be worried about a child that eats only 10 foods and under

- Don't forget about comorbidities that might be a target for BH treatment
  - ASD, Depression, ADHD, Anxiety

UPMC TiPS

Lack of Interest in Food

ARFID Drivers

UPMC TIPS

Case Study

17-year-old with chronic low appetite and early satiety. Frequently forgets to eat. Significant nutritional deficiency and fatigue. Social impairment due to limited eating patterns. The child does not appear to need hospitalizaiton for refeeding

What would you do next?
Select all that apply

A. Nutritional Supplementation
B. BH referral
C. Dietician Referral
D. Occupational therapy referral

Treatment Approach

- Structured meal schedule
- Behavioral activation techniques
- Nutrition rehabilitation
- Monitoring of weight and labs

UPMC TiPS

What to Think About When Referring

- Comorbidities
  - Medication impact versus ADHD impact
  - Anxiety can reduce interest in eating
  - Don’t forget about anorexia nervosa/body image
- Has there been a change?
- Are they really at risk of health consequences?
- Have they ever gotten services before, if so what happened, if not why now and what’s different?

UPMC TiPS

ARFID Treatment

Clinical Treatment Pearls

- Identification of the goals that family/adolescent can engage in
  - For younger kids and those that can’t communicate you may need to individualize goals – it may be to teach the parent to safely increase variety at home so they feel in control.
- Exposure is always important, but you might need to start slowly
  - You might need to help the child and family develop behavioral regulation skills first
  - If the child can't sit they may not be able to participate in the exposure
- Cooking can be a part of treatment– to find something that helps the child be in control of food/taste

UPMC TiPS

Treatment Outcomes: Pediatric Patients

- Early intervention is associated with improved weight restoration and nutritional recovery
- Family-Based Treatment (FBT) and CBT-AR show improvement in food variety and reduced mealtime distress
- Many children demonstrate improved psychosocial functioning and school participation
- Outcomes are best when treatment includes caregiver involvement and multidisciplinary support

UPMC TiPS

Treatment Outcomes: Adolescents and Adults

- CBT-AR has demonstrated increases in dietary flexibility and reduced avoidance behaviors
  - Note this is not designed for younger children- best evidence for age 10 and up, but exposure therapy along with developing coping skills is a core feature of treatment of ARFID and other co-occuring anxiety disorders
- Anxiety symptoms often improve alongside improved nutritional intake
- Patients with co-occurring anxiety, ASD, or OCD may require longer treatment duration
- Some individuals continue to experience persistent sensory sensitivities despite nutritional improvement

UPMC TiPS

Factors Associated with Better Outcomes

- Earlier diagnosis and intervention
- Strong family engagement and meal support
- Consistent exposure-based interventions
- Close medical and nutritional monitoring
- Addressing co-occurring psychiatric or developmental conditions

UPMC TiPS

Lessons From Evidence-Based Treatments

- Role of Parent Vital
  - Parent must understand and buy-in to treatment
  - Parent as coach
    - Structures feeding, assures nutritional gaps are filled
    - Maintains calm environment
    - Implements behavioral strategies to encourage feeding
- Must understand food intake – often with diary
- Gradual Exposure and Anxiety Reduction
- Importance of Clear Achievable Goals

UPMC TiPS

Key Takeaways

- ARFID is a distinct eating disorder with medical, nutritional, and psychosocial consequences
- The DRIVERS of ARFID and comorbidities drive treatment decisions.
- Assessment requires careful evaluation of medical and psychiatric contributors
- Evidence supports multidisciplinary treatment approaches
- Ongoing research is needed to better understand neurobiology and long-term outcomes

UPMC TiPS

ARFID: Pediatric Primary Care Approach

Rule-out other conditions	• Distinguish ARFID from picky eating, typical developmental phase and other eating disorders • Rule out physical conditions that interfere with feeding • Mechanics of eating (motor skills, chewing, swallowing) • GI concerns (acid reflux or pain, constipation)
Recognize co-occurring conditions impacting care	Screen for anxiety disorders, autism spectrum disorder, ADHD, and depression Identify Likely Drivers
Identify likely drivers (consider NAIS)	Interview and/or NAIS
Treat and Monitor	• Monitor growth parameters and consider malnutrition panels • Provide short-term oral nutrition supplementation(ONS) if needed, treat nutritional deficiencies, and refer for treatment (behavioral health, OT, dietitian, or speech/swallowing) • Set clear expectations • Schedule follow-up • Escalate care when indicated

UPMC TiPS

Thank-you

References

- Zickgraf, H. F., & Ellis, J. M. (2018). Initial validation of the Nine Item Avoidant/Restrictive Food Intake disorder screen (NIAS): A measure of three restrictive eating patterns. Appetite, 123, 32–42.
- Burton Murray, H., Dreier, M. J., Zickgraf, H. F., Becker, K. R., Breithaupt, L., Eddy, K. T., Thomas, J. J. (2021). Validation of the nine item ARFID screen (NIAS) subscales for distinguishing ARFID presentations and screening for ARFID. International Journal of Eating Disorders, 54(10), 1782-1792.
- Hellner M, Cai K, Freestone D, Baker JH, Menzel J, Steinberg DM. Clinical Outcomes in a Large Sample of Youth and Adult Patients Receiving Virtual Evidence-Based Treatment for ARFID: A Naturalistic Study. Int J Eat Disord. 2025 Apr;58(4):680-689.
- Kambanis P, Tabri N, McPherson I, Micalia C, Lawson E Thomas J. Prospective 2-Year Course and Predictors of Outcome in Avoidant/Restrictive Food Intake Disorder. Journal of the American Academy of Child & Adolescent Psychiatry, 2024; 64, 262-275
- Fonseca NKO et al. Avoidant restrictive food intake disorder: recent advances in neurobiology and treatment. Journal of Eating Disorders. 2024.
- StatPearls: Avoidant Restrictive Food Intake Disorder. National Center for Biotechnology Information (NCBI Bookshelf).

UPMC TiPS