



*A quarterly broadcast  
of things helpful and  
interesting in local  
clinical psychology.*

### Literature Digest: The lesser-known paediatric eating disorder - ARFID

Avoidant Restrictive Food Intake Disorder (ARFID) is an eating or feeding disturbance that results in failure to meet nutritional or energy needs. ARFID most commonly presents in children. It is more than 'picky eating' and can develop into other psychosocial problems or into anorexia nervosa. There are three recognised subtypes: **fear of aversive consequences** (e.g. choking, nausea, reflux, pain); **sensory sensitivities** related to the colour, textures, temperature, smell, or tastes; and a **lack of interest** in food or eating. A diagnosis requires significant disturbance such as low weight for age, failure to grow, nutritional deficiency; and dependence on nutritional supplements. ARFID is different to other types of eating disorders, as food restriction does not occur as an attempt to influence one's body shape or weight.

### Treatment options

Medical assessment and monitoring is important to exclude differential diagnoses and monitor biological safety. There are three main psychosocial therapy approaches for ARFID at present, each summarised below.

**The Sequential Oral Sensory (SOS)** approach is a multidisciplinary approach incorporating psychologists, speech pathologists, OT's and dietitians. SOS uses a graded exposure approach to introduce a variety of foods while assisting the child to progress through the hierarchy of sensory and oral motor steps towards eating new foods. **Family Based Therapy** has been adapted for ARFID from its original version targeting anorexia nervosa. Parents are educated about ARFID and given responsibility for the child's eating by deciding what, when, and how much the child will eat. Parents are encouraged to be firm and persistent yet compassionate and to use a graded exposure approach along

with positive reinforcement to increase variety and quantity of intake. Families are assisted in problem solving how to prioritise goals e.g. weight gain, and/or nutritional needs. **Cognitive Behavioural Therapy** for ARFID (CBT-AR) can be employed for anyone above 10 years of age. In children and adolescents CBT-AR is delivered in a family supported format particularly if weight gain is required. CBT-AR begins with psychoeducation, regular eating, and renourishment. It then proceeds to address any fears of aversive consequences to eating, sensory sensitivities, and lack of interest in eating as relevant to the client.

If you have any queries about paediatric eating disorders, you can call the practice and ask to speak with Debbie Etienne-Ward or Chris Basten and we have free resources for GPs and parents on our website.



### Interview with a Clinical Psychologist

**DEBORAH ETIENNE-WARD** B.Sc.(Psych); PGDipPsych; M.Psych.(Clin)

B.Sc.(Psych); PGDipPsych; M.Psych.(Clin)

*Debbie is a clinical psychologist in Chatswood with experience in treating all types of eating disorders across the lifespan. Debbie also works with children and adolescents experiencing anxiety, OCD, depression, emotion dysregulation, and behavioural difficulties.*

### Q: Are eating disorders increasing in prevalence in young people?

**A:** Research suggests that the prevalence of eating disorders is increasing in adolescents (Gonzalez et al., 2007; Steinhausen & Jensen, 2015). Younger adolescents are more likely to present with Anorexia Nervosa while there is a later age of onset for Bulimia Nervosa. It is unclear whether this is due to true increase in incidence or due to improved awareness and thus earlier detection. Those diagnosed with ARFID are generally younger at age of onset than those with typical eating disorders including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, and Other Specified

Feeding and Eating Disorder.

### Q: What do you find rewarding about working with young people in distress?

**A:** I enjoy helping young people to understand the factors that contribute to their distress and to problem solve with them how the distress can be reduced or managed in more helpful ways. I also find it rewarding to assist young people by explaining to their parents the function of unhelpful behaviours used to manage distress and to assist parents to validate and coach their young person through their emotional experiences. Seeing parents feel empowered to help their young person and also for the young

person to feel supported by their parents is most rewarding.

### Q: Can you name one idea or issue for clinicians to use in their own self-care?

**A:** Reflective practice is very important particularly when working with children, adolescents and families. Being mindful of your own thoughts, emotions, and behaviour inside and outside of therapy sessions can help identify early warning signs for fatigue or burn out. Early identification of fatigue helps to facilitate scheduling time for additional self-care (over and above what is needed on a day to day basis). Self-care will look different for everyone, however, for me there is nothing better than some enjoyable physical activity outdoors with friends.

**Gonzalez, A., Kohn, M.R., & Clarke, S.D. (2007).** *Eating disorders in adolescents.* Australian Family Physician, 36(8), 614-619.

**Steinhausen, H.C., & Jensen, C.M. (2015).** *Time trends in lifetime incidence rates of first time diagnosed anorexia nervosa and bulimia nervosa across 16 years in a Danish nationwide psychiatric registry study.* International Journal of Eating Disorders, 48(7), 845-850.



*"The hunger for love is much more difficult to remove than the hunger from bread".*

- Mother Theresa

## Basten & Associates

Basten and Associates is a practice of clinical psychologists devoted to enhancing mental health in our community.

We have been providing psychological treatments since 1998 and have three locations in Sydney – Sydney CBD, Chatswood and Westmead.

We are passionate about making a special contribution to mental health and emotional wellbeing. We differ from other practices in several ways:

1. We are all clinical psychologists with post-graduate clinical training.
2. We have enough specialists for different conditions, so you will find the right psychologist to work with your patients.
3. Our clinicians are committed to staying up to date with research into the causes and treatments of common conditions.
4. We only use treatments that have a known basis of evidence showing them to be effective and then adapt and tailor these treatments to each individual after a thorough assessment.

## Motivating patients to change behaviour:

### Part 8: Motivating children and adolescents to improve their health behaviours

As health professionals, we try to help people improve their health and yet it can be hard to motivate patients to do potentially helpful treatments or lifestyle changes. This is a serialised account of numerous strategies to increase motivation for change in our patients.

What can you do to motivate children and younger adolescents to engage in better health behaviours?

1. Target the parents. If you get the chance, then some key questions might motivate the parents to do more. Firstly, ask the parents if they know what the risks are if they can't help their child to change their behaviours. Discuss to what degree they think that this is their responsibility; even 30% means they'll try to help and we may be able to get that closer to 100%. Then ask how things might be for years and years to come for their child if that child cannot make some changes very soon.
2. Change some contingencies so a change of behaviour is rewarded. Contingencies need to be personally meaningful, very short-term and 'natural'. For instance, if a child with Type 1 diabetes is not adhering to their regimen and they are sporty, it might make sense to declare them not fit for their preferred sport, which they could earn back within two weeks of better compliance. It matters to them (meaningful), it comes and goes quickly (short-term), and it is natural that they cannot push themselves if not healthy.

3. Align their behaviours with age-relevant values; and the strongest value often is being accepted and highly regarded by their peers. Take a few minutes to find out what is important to them and then ask whether they can find a way to honour that value (hang with friends) and still look after their health (say 'no' to cigarettes or find time for treatments).

4. What if the unwanted health behaviour is aligned with peer acceptance? Examples might be smoking tobacco with friends or not following their asthma plan so they feel 'normal'. Start by empathising with them: "that makes sense to me now". Then try 'The Best Friend Question': "If you knew your best friend was compromising their health just to be accepted by the group, what would you say to them and what you want them to do? You could also ask whether their health behaviours clashes with other things they value apart from peer acceptance – such as family values, being healthy, having money to do things.



## Basten & Associates

Westmead  
Sydney  
Chatswood

ph 9891 1766

## Resources:

The Basten and Associates website has plenty of resources for GPs interested in emotional wellbeing and there is a free downloadable page on "The Psychology of Motivation" to give to patients.

Email Chris if you are interested in one of our motivational interviewing or mindfulness training days for GPs in 2019.

[chris@bastenpsychology.com.au](mailto:chris@bastenpsychology.com.au)