BHN DPG Webinar: "Picky Eating or ARFID? Satter or FBT? When Clients Don't Fit Into the Boxes"
May 01, 2018

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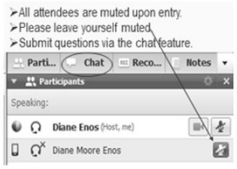

Picky Eating or ARFID? Satter or FBT? When Clients Don't Fit Into the Boxes

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BHN Webinar
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Lutz, Alexander & Associates Nutrition Therapy

Objectives

1. Explain the key concepts of the Satter Feeding Dynamics Model and list 3 references that support an RDN using this model.
2. Explain the key concepts of Family Based Treatment and list 3 references that support an RDN using concepts from this treatment model.
3. Identify key components of a case to determine which model (Satter Feeding Dynamics or FBT) is most appropriate to use as a foundation for a treatment plan.

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Real People are Complicated

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What is "Picky Eating"?

- "Layman's" term – each person defines this differently
- Being limited or selective in the types of foods an individual eats
- Possible contributing factors:
  - Increased sensitivity to taste, texture, temperature
  - Increased caution for new things
  - Having a lower disgust threshold
  - Not being offered or exposed to a variety of foods
  - Modeling of others' selective eating
  - Pressure has been put on the person to eat certain foods

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Childhood Eating/Feeding Concerns

Picky Eating
Failure to Thrive
Sports Nutrition
Rapid Weight Gain
Slow Weight Gain
ARFID
Anorexia Nervosa
Binge Eating
Bulimia Nervosa
Sneak Eating
Behavioral Concerns Related to Eating/Not Eating
Disordered Eating
Food Allergies
Medication Side Effects
ADHD and Nutrition
OCD related to Food
Beginning Solids

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What is an eating disorder?

A mental illness that involves marked disturbances in a person's eating behaviors.

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Eating Disorder
- ARFID

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ARFID - Avoidant Restrictive Food Intake Disorder

Diagnostic Criteria for ARFID (DSM-V)

1. 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 failure to achieve expected weight gain or faltering growth in children).
   - Significant nutritional deficiency.
   - Dependence on enteral feeding or oral nutritional supplements.
   - Marked interference with psychosocial functioning.
2. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
3. 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 in which one's body weight or shape is experienced body image.
4. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

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As RDN's what frameworks do we have for working with children and families with eating concerns?

1. Satter Feeding Dynamics Model
2. Family Based Treatment

...and we have clinical wisdom and experience

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Satter Feeding Dynamics Model

The Satter Feeding Dynamics Model (fdSatter) illustrates that when parents feed according to a developmentally appropriate **Division of Responsibility in Feeding (sDOR),** children gradually accumulate attitudes and behaviors that characterize adult **Eating Competence.**

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Scoring and Interpretation of the ecSatter Inventory 2.0

Factor descriptions

Eating attitude: Is positive about eating and about food.
Food acceptance skills: Is comfortable with preferred foods and has skills for learning to like unfamiliar foods
Internal regulation skills: Depends on internal regulators of hunger and appetite as well as feelings of fullness and satisfaction to determine how much to eat.
Contextual skills: Makes meals a priority and has skills and resources for managing food.

Items arranged by factors

Eating attitude
1. I am relaxed about eating.
2. I am comfortable about eating enough.
4. I feel it is okay to eat food that I like
8. I am comfortable with my enjoyment of food and eating.
14. I enjoy food and eating.

Food acceptance
5. I experiment with new food and learn to like it.
6. If the situation demands, I can "make do" by eating food I don't much care for.
7. I eat a wide variety of foods.

Food regulation
9. I trust myself to eat enough for me.
10. I eat as much as I am hungry for.
13. I eat until I feel satisfied

Contextual skills
3. I have regular meals.
11. I tune in to food and pay attention to eating.
12. I make time to eat.
15. I consider what is good for me when I eat.
16. I plan for feeding myself.

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Eating competent people…

- Have better quality diets
- Have better physical self acceptance
- Are more active
- Sleep better
- Have better medical and lab tests
- Do better with feeding their children

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Division of Responsibility in Feeding (sDOR)

The Division of Responsibility for infants:

- The parent is responsible for ***what***.
- The child is responsible for ***how much*** (and everything else).

The Division of Responsibility for toddlers through adolescents

- The parent is responsible for ***what, when, where***.
- The child is responsible for ***how much*** and ***whether***.

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Parenting Styles

Permissive — Authoritative — Authoritarian

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Parents' Job: The "What"

- Decide what food items are offered at structured meal and snacks.
- Parents put together a balanced meal: protein, starch, fruit/veg, high fat item
- Balanced snack: protein/dairy and fruit/starch
- No short order cooking
- Parents focus on balance and variety

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Parents' Job: The "When"

- Structured meal and snack times.
- Sit down snacks
- Example:
  - Breakfast
  - Snack
  - Lunch
  - Snack
  - Dinner
- No grazing or "panhandling"
- No drinking caloric beverages between eating times

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Parents' Job: The "Where"

- Sitting at the table, park bench, ground…
- Not running around the park
- Not in front of TV, or with other distractions

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Child's Job: The "How Much"

- Children are born with the ability to self regulate intake. (Fomon , 1993….and many others)
- Trust

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Child's Job: The "Whether"

- Child decides what he will eat of items offered
- Even if that means they get seconds of one thing, but not another

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Family Style

- Helps child with the ***how much*** and ***whether***

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What the sDOR is…

- Structure: set meal and snack times
- Family style meals
- Parents in charge of nutrition, presenting balanced meals and snacks
- Parents trusting children will learn and progress in regards to eating
- Parents trusting children's bodies to grow as they are intended
- Teaching children table manners and how to eat out "in the world"

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What the sDOR is not…

- Child deciding what he wants to eat
- "If the child is hungry, he will eat"
- Putting the same meal in front of a child over and over
- Prohibiting snacks between meals
- Grazing between meals
- No thank you bites
- Asking child to eat everything that is part of the meal before having seconds

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Conventional approach

- Having weight/BMI cutoffs
- Focus on food selection
  - Healthy vs. Unhealthy
- Focus on portion sizes
- Nutrition recommendations given to children
- Prescriptive exercise

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Satter Feeding Dynamics Model

- Genetically and historically appropriate growth
- Focus on the *how* of eating
- Children are born with the desire and ability learn and grow in regards to eating
- Nutrition recommendations given to parents of young children
- Focus on giving children opportunities to move

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The Research - Feeding Practices

- Children who have restricted access to palatable foods have increased intake of those foods. (Fisher JO, Birch LL., 1999)
- Maternal restrictive feeding predicted daughters' eating in the absence of hunger and increased change in BMI. (Birch LL, Davison 2003; Francis, Birch LL 2005)
- Parents' attitudes about overweight predict restrictive feeding practices (Musher-Eizenman et al., 2007)

The Research – Increased Risk of Weight Gain

- Girls at risk for overweight at age 5 had higher dietary restraint, disinhibited overeating, weight concern, and body dissatisfaction at age 9.
- Girls with "at risk status" at age 5, had greater increases in weight gain at ages 7 and 9.
- As dietary restraint increased, there were greater increases in BMI.

(Shuck and Birch, 2004)

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The Research – Adolescents and Dieting

Adolescents who dieted and used unhealthy weight control methods:

- Increased their BMI more than those that did not.
- Were 3 times more likely to be overweight at 5 year follow-up
- Were at increased risk for binge eating, self induced vomiting, laxative use, and diet pill use at 5 year follow-up

(Newmark – Sztainer, 2006.)

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The Research – Parents and Feeding

- Overweight parents of overweight teens are more likely to engage in restrictive feeding practices.
- When both the parents and the adolescent were not overweight, parents were more likely to pressure children to eat.

Berge et al., 2015

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The Research – "Overweight" Children Do Not Eat More

- Estimates of caloric intake and physical activity did not correlate with anthropometric measurements in infants and children (Shapiro, et al)
- Estimated kcal and CHO intake was found to be significantly lower in overweight students than in non-overweight students (Rocandio, et al)
- Hypophagic, euphagic, and hyperphagic individuals are found among both lean and obese groups (Huenemann, et al; Garrow et al; Creff et al)

Studies fail to show that overweight children and adolescents eat significantly more than their peers.

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The Research – Children Will Expand What They Eat

- Children are born with the ability to self regulate and get what they need (Fomon, Davis, 1928)
- Children will learn and grow with their eating
- When offered a variety of foods, without pressure, children will eat

(Birch, Marlin 1982; Birch, 1987, Hendy 2002)

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Possible Indications for Use In Clinical Practice

- Typical structure for feeding without any concerns
- Acceleration or Deceleration of expected weight gain in children/adolescents
- Picky Eating in children, toddlers – high school
- Erratic eating
- Parental concerns about eating without severe mental illness or emotional diagnosis that is interfering with child learning and growing with food (ie. Anorexia Nervosa)
- Assess for confounding problems, including other diagnoses and emotional issues – refer appropriately
- When maladaptive feeding practices is a piece of the picture

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Family Based Treatment (FBT)

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Family Based Treatment (FBT)

- A psychotherapy approach being used for the treatment of Anorexia Nervosa, Bulimia Nervosa and OSFED
- The initial research was with adolescents with Anorexia Nervosa
- FBT is recommended as the first line of treatment for adolescents with AN (prevent hospitalization)
- Originally developed at the Maudsley Hospital in the UK
- Research continued in the US and was manualized by Locke and LaGrange

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Family Based Treatment

"The Maudsley approach can mostly be construed as an intensive outpatient treatment where parents play an active and positive role in order to: Help restore their child's weight to normal levels expected given their adolescent's age and height; hand the control over eating back to the adolescent, and; encourage normal adolescent development through an in-depth discussion of these crucial developmental issues as they pertain to their child."

Locke and LaGrange

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Family Based Treatment

- Mental Heath Provider meets with the family for 15 – 20 sessions
- Sessions with a Registered Dietitian were not part of the research, nor are they part the manualized treatment
- RDN's are now both being used as an adjunct provider in manualized treatment as a support and RDN's are using "an FBT framework" in treatment
- Resource for RDN's:
  - Bryan et al. Adolescent Anorexia: Guiding Principles and Skills for the Dietetic Support of Family-Based Treatment. Journal of the Academy of Nutrition and Dietetics, Published online December 2017.

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FBT Principles

- The cause of anorexia nervosa is unknown, but parents are not to blame.
- Parents are the experts on their children, and parents have unique strengths and resources to help their child recover.
- Full nutrition is the essential first step in recovery from anorexia nervosa.
- Parents can – and must – require their malnourished child to eat the types and amounts of food that he or she needs to recover.

https://www.mirror-mirror.org/family-based-treatment-for-anorexia.htm

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FBT Phases

1. Phase 1: Weight Restoration
2. Phase 2: Returning control of eating back to the adolescent
3. Phase 3: Establishing Healthy Adolescent Identity (95% EBW)

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Treatment of AN

"Traditional" Treatment

- Clinician focus on individual
- Including parents – unnecessary or harmful
- "family problems" as part of the etiology

Family Based Treatment

- Clinician focused on the family
- Parents are part of the solution and essential for success
- No one is to blame for the eating disorder

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Evidence for FBT and AN

- 4 main studies demonstrate: 2/3 of adolescents with AN are recovered at the end of FBT while 75 - 90% are fully weight recovered at five-year follow-up.
- Studies included patients with 3 year or less duration of illness
- Research shows that adolescents need on average of 20 treatment sessions over 6-12 months and that about 80% of patients are weight restored with a start or resumption of menses at the conclusion of treatment

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FBT and BN

- Research is less definitive
- 3 main studies demonstrated that FBT with adolescents with BN may be useful
- Schmidt et al. found that family therapy compared favorably to CBT for adolescents with BN, but that more adolescents refused family treatment.
- Le Grange et al. found that manualized family-based treatment was superior to a nonspecific individual therapy, but improvement was small.

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FBT and ARFID

- Little to no research

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FBT – Indications for Use

- First line for treatment for Adolescent with Anorexia Nervosa and possibly Bulimia Nervosa, depending on the situation and severity
- Important to screen if model is appropriate for the client and the family being assessed (may be contraindicated with families that are are highly rigid)

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FBT – Clinical Lessons

- Families and support people can provide healing support
- When there is malnutrition, increased nutrition is the number 1 goal
- Families can in a supportive way interrupt the eating disorder pathology

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Case Studies –
When Clients Don't Fit Into the Boxes

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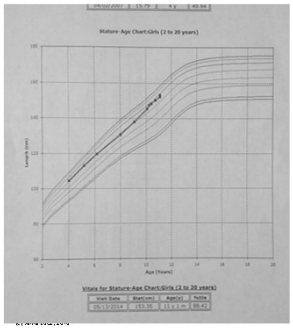
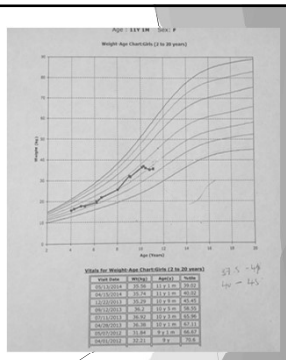
Case Study - Abigail

- 10 year old female
- Recent onset of fear of choking
- Seeing a therapist
- Diagnosed with OCD
- Not eating solids
- Catering to child
- Recent weight loss





Case Study – Abigail
Treatment/Intervention

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Case Study – Abigail
Treatment/Intervention

- "FBT-informed" model – ie. We need to get nutrition on board
- Provide structure and support to the child to increase intake
- Worked directly with parents, child saw therapist
- Coached parents with verbiage to coach child at meals in a supportive way
- Coached parents to not cater, may feed into anxiety
- Used liquid supplements between meals
- Eating Disorder Prevention Work
- Moved back towards DOR model towards end of treatment

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Case Study - Meredith

- 13 year old female
- 2-9 years old: 75th percentile weight-for-age; 25th percentile height-for-age
- Sneak eating, binge eating
- Very picky eater – eats few vegetables and little meat
- Rapid Weight Gain
- Different body type than mom
- Family history of severe mental illness
- Dieting/restrictive messages at home
- Concern from family about weight as a younger child
- Depression, impulsive behaviors –sees a therapist biweekly
- Recent Elevated Insulin levels

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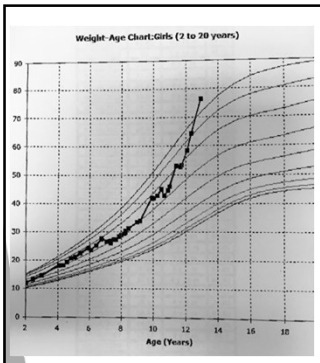

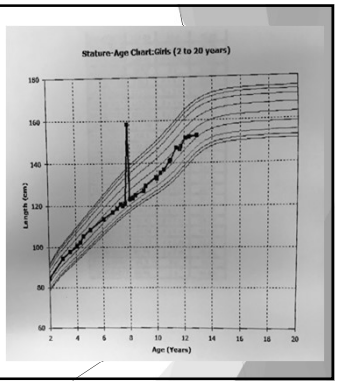

Case Study – Meredith Treatment/Intervention

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Case Study – Meredith Treatment/Intervention

- "fdSatter Informed" Treatment
- RDN worked directly with the mom
- Goal of Eliminating Restriction and Provide structure/support
- Initial Goal is eliminate disordered eating behaviors – sneak eating, binge eating
- Desserts
- Coached mom regarding nutrition education/talking about food – as a form of pressure
- Worked directly with mom

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YOU ARE WISE!

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Some Questions For the RDN to Consider After an Assessment

- Is malnutrition present? What is the % of EBW?
- Is there a severe psychological issue interfering with the clients ability to listen to hunger/fullness or progress in eating? (OCD, Anorexia Nervosa, etc.)
- Has there been a maladaptive feeding practice (pressure, coercion, restriction) along the way?
- What will assist the client to move back towards a DOR model?
- Is a higher level of care needed?

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Questions?

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FBT and BN

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