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Childhood Avoidant/Restrictive Food Intake Disorder: Review of Treatments and a Novel Parent-Based Approach

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Avoidant/Restrictive food intake disorder (ARFID) is characterized by dietary restrictions that are not based on weight or shape concerns but that result in marked interference in feeding, growth, or psychosocial functioning (American Psychiatric Association, 2013; Eddy et al., 2019). The aim of the current article was to review available reports of treatment for childhood ARFID published since its inclusion in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), and to introduce a novel parent-based treatment for child ARFID through a case presentation. Empirical support for psychosocial treatments for child ARFID currently stems from two small-scale pilot randomized control trials, one pilot open trial, case reports, case series, and retrospective chart reviews. Treatment approaches for outpatient care generally apply family-based therapy, child-centered cognitive behavioral therapy, or parent-based behavioral approaches. SPACE-ARFID is a novel outpatient parent-based treatment that focuses on parental responses to child problematic eating habits. SPACE-ARFID aims to promote flexibility and adjustment in food related situations. The treatment helps parents to systematically reduce family accommodation, or changes that they make to their own behavior to help their child avoid or alleviate distress related to the disorder, while increasing supportive responses to the child's symptoms.

Keywords: avoidant/restrictive food eating disorder; treatment; parents; accommodation

Avoidant/restrictive food intake disorder (ARFID) is characterized by dietary restrictions that are not based on weight or shape concerns but that result in marked interference in feeding, growth, or psychosocial functioning (American Psychiatric ASSOCIATION, 2013; Eddy et al., 2019). ARFID was introduced in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM)* as an expansion of the *DSM-IV* diagnosis of feeding and eating disorder of infancy and early childhood and is not limited in age.

PREVALENCE AND DEMOGRAPHICS

In a large community study ARFID was reported in 3.2% of children and adolescents (*N* = 1,444; ages 8–13 years; Kurz, van Dyck, Dremmel, Munsch, & Hilbert, 2015). Reports of ARFID prevalence in clinical samples of patients in adolescent tertiary care centers range between 5%–14%

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(Fisher et al., 2014; Norris et al., 2014), with the highest prevalence (22.5%) found in a pediatric partial hospitalization program (PHP) for eating disorders (Nicely, Lane-Loney, Masciulli, Hollenbeak, & Ornstein, 2014). In a sample of 2,231 consecutive referrals to pediatric gastrointestinal clinics (ages 8–18 years) the reported prevalence was 1.5% (Eddy et al., 2015). ARFID is present throughout development, from very young children (Sharp et al., 2016; Zucker et al., 2019), mid-childhood, and adolescents (Dumont, Jansen, Kroes, de Haan, & Mulkens, 2019; Lock, Sadeh-Sharvit, & L'Insalata, 2019; Ornstein, Essayli, Nicely, Masciulli, & Lane-Loney, 2017) to adults (Nakai, Nin, Noma, Teramukai, & Wonderlich, 2016). In clinical samples comparing children with ARFID to those with anorexia nervosa, children with ARFID were younger and a greater proportion were male (Nicely et al., 2014; Ornstein et al., 2017). ARFID has also been shown to co-occur with other disorders such as autism-spectrum disorder (Lucarelli, Pappas, Welchons, & Augustyn, 2017), anxiety disorders (Fisher et al., 2014; Norris et al., 2014), and gastrointestinal problems (Eddy et al., 2015).

Current research into the phenomenology of ARFID highlights its heterogeneity, with accumulating evidence supporting three distinct, but not mutually exclusive, presentations of restrictive eating: (a) selectivity of foods based on their sensory properties such as smell or texture (e.g., "picky eating" or food neophobia); (b) limited interest in eating or poor appetite; and (c) fear of aversive consequences from eating such as choking, vomiting, or gastrointestinal pain (Bryant-Waugh, Markham, Kreipe, & Walsh, 2010; Lock, Robinson, et al., 2019; Norris et al., 2018; Thomas, Lawson, et al., 2017; Zickgraf, Lane-Loney, Essayli, & Ornstein, 2019). Based on these phenomenological distinctions Thomas, Lawson, et al. (2017) proposed a three-dimensional model of the neurobiology of ARFID, rooting these phenomenological distinctions in neurobiological abnormalities in sensory perception, homeostatic appetite, and negative valence systems. A recent study of children and adolescents referred to a hospital based pediatric eating disorder service and diagnosed with ARFID (*N* = 102, ages 8–18 years) found differences in ARFID characteristics based on age, weight, and duration of illness. In this sample, adolescents (ages 12–18 years) presented with higher rates of depression compared with children (ages 8–11 years); those with chronic ARFID symptoms (≥12 months) presented with significantly lower weight than those with acute symptoms (<12 months); and those with acute symptoms endorsed significantly higher suicidal ideation and/or self- harm (Duncombe Lowe et al., 2019). The heterogeneity in ARFID presentation, suggesting distinct etiological and maintenance factors for different restrictive eating patterns, has led to calls for the development of interventions that consider variability in clinical symptoms, demographic characteristics, and appropriate levels of care (Eddy et al., 2019; Zickgraf, Lane-Loney, et al., 2019).

The aim of the current article is to review available reports of treatment for childhood ARFID published since its inclusion in the 5th edition of the *DSM*, and to introduce a novel parent-based treatment for child ARFID through a case presentation.

ASSESSMENT MEASURES

Several measures are available for evaluating ARFID, including self-report screening measures for assessing symptom severity and dimensions and clinician administered diagnostic interviews for establishing an ARFID diagnosis. Screening measures include the Eating Disorders in Youth-Questionnaire (EDY-Q; Kurz et al., 2015) for children and adolescents and the Nine Item ARFID Screen (NIAS; Zickgraf & Ellis, 2018) for adults/parents. Diagnostic interviews include the Pica, ARFID, Rumination Disorder Interview (PARDI; Bryant-Waugh et al., 2019), the Eating Disorder Assessment for *DSM-V* (EDA-5; Sysko et al., 2015), and the ARFID module of the Eating Disorder Examination (EDE-ARFID; Schmidt, Kirsten, Hiemisch, Kiess, & Hilbert, 2019). In addition to determining whether a child meets diagnostic criteria for the disorder, clinical assessment of

ARFID should include a focus on the degree and domains of psychosocial impairment associated with the symptoms. It is also recommended that medical and nutritional assessments be completed by a medical health professional. In complicated ARFID cases multidisciplinary input may be needed to assess additional problems, such as gastrointestinal problems, autoimmune diseases, and oral sensorimotor concerns (Bryant-Waugh, 2019; Eddy et al., 2019).

TREATMENT LITERATURE

As ARFID is a newly introduced diagnosis there is little research documenting treatment, and to date there are no well-established psychosocial treatments for child ARFID (Eddy et al., 2019; Sharp, Volkert, Scahill, McCracken, & McElhanon, 2017). Aside from two small-scale pilot (randomized controlled trials) RCTs and one pilot open trial, treatment approaches have been presented through case reports, case series, and retrospective chart reviews. The majority apply family-based treatment, child-centered cognitive behavioral therapy or a parent-based behavioral approach, with variability in intended age and setting. Table 1 summarizes interventions for childhood ARFID.

FAMILY-BASED TREATMENT

Family-based treatment (FBT) is one of the most documented treatments adapted for childhood ARFID. FBT for ARFID is usually carried out in an outpatient setting and empowers parents as the primary agents managing behavioral change. The treatment focuses not only on promoting increased volume of food intake (as in FBT for anorexia) but also on increasing the variety of foods eaten. Following an initial description of the application of FBT to ARFID with sensory sensitivity (Fitzpatrick, Forsberg, & Colborn, 2015), Lock, Robinson, et al. (2019) reported on an application of FBT (FBT-ARFID) to each of the three common ARFID presentations. A pilot RCT in children aged 5–12 compared FBT-ARFID ($n = 16$) to treatment as usual (TAU; $n = 12$). Participants in the TAU group were free to seek the treatments of their choice, excluding FBT-ARFID. Results showed improvement in weight and ARFID symptom severity for children in the FBT-ARFID condition compared with children in the TAU group. The authors highlighted significant changes in parental self-efficacy for parents in the FBT-ARFID group and that these changes were associated with improved clinical outcomes, implicating parental factors as one potential mechanism of therapeutic change. Applications of FBT for ARFID in combination with other approaches have been demonstrated in both outpatient settings, as in a case study of a 9-year-old girl describing the combination of FBT with the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children (UP-C; Eckhardt et al., 2019), and as part of more intensive treatment. For example, aspects of FBT have been incorporated in a broad family-centered treatment program therapy in a PHP for children with acute ARFID onset and low body weight (Ornstein et al., 2017), and Spettigue et al. (2018) reported on a case series ($N = 6$, ages 10–14 years) applying FBT for ARFID in combination with medication in an inpatient and outpatient setting.

COGNITIVE-BEHAVIORAL APPROACHES

Applications of cognitive behavioral approaches to childhood ARFID have been presented thus far through case examples, case series and retrospective chart reviews (Bryant-Waugh, 2013; Dumont et al., 2019; Fischer et al., 2015; Ornstein et al., 2017; Thomas, Brigham, et al., 2017) and have been applied in outpatient settings (e.g., Thomas, Brigham, et al., 2017) as well as integrated in PHPs (e.g., Dumont et al., 2019). These interventions commonly include cognitive restructuring,

TABLE 1. Psychosocial Interventions for Childhood ARFID

Approach	Intervention	Setting	Key Intervention Components	Who Is Involved in Treatment	Treatment Duration and Age	Empirical Support
Family-based	Family-based treatment for ARFID (FBT-ARFID) (Lock, Robinson, et al., 2019; Lock, Sadeh-Sharvit, et al., 2019; Norris, Spettigue, & Katzman, 2016)	Outpatient	Externalizing, agnosticism, parent-led behavioral changes, focus is on changing eating behavior rather than family process/dynamics	Child, parents, and siblings (optional)	Up to 22 sessions over 6 months Ages 5–12 year	Pilot RCT with treatment as usual as comparator (N = 28) Case reports
	FBT adapted for ARFID + medication (Spettigue, Norris, Santos, & Obeid, 2018)	Inpatient and outpatient	Medical monitoring, psychoeducation and support for parents, parent-led behavioral changes, relaxation techniques, medication,and CBT for co-morbid anxiety	Child and parents	4–6 months 10–14 years	Case series (N = 6)
	FBT + Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children (UP-C)(Eckhardt, Martell, Duncombe Lowe, Le Grange, & Ehrenreich-May, 2019)	Outpatient	Collaborative weighing, family engagement, externalizing, parent-led behavioral changes, cognitive restructuring, exposures, behavioral activation, mindfulness	Child and parents	29 sessions over 10 months Age 9	Case report

TABLE 1. Psychosocial Interventions for Childhood ARFID

Approach	Intervention	Setting	Key Intervention Components	Who Is Involved in Treatment	Treatment Duration and Age	Empirical Support
Cognitive-behavioral	Cognitive behavioral therapy for ARFID (CBT-AR) (Thomas, Brigham, Sally, Hazen, & Eddy, 2017)	Outpatient	Psychoeducation, monitoring of food intake, establishing regular eating routines, increasing volume of preferred foods or variety of foods, in vivo and interoceptive exposure	Individual or family-supported format depending on the patient's age	20–30 sessions Age 11 Treatment intended for ages 10 years and up	Case report
	Broad CBT approach (Bryant-Waugh, 2013)	Outpatient	Self-monitoring, behavioral experiments, cognitive restructuring, breathing, relaxation	Child and parents	Length of treatment not specified Age 13	Case report
	Cognitive and behavioral treatment (Fischer, Luiselli, & Dove, 2015)	Outpatient	Gradually increasing feeding demands and reinforcing consumption, cognitive restructuring breathing, relaxation, guided imagery	Child and parents	11 sessions Age 16	Case report
	Feeling and Body Investigators -ARFID Division (FBI-ARFID) (Zucker et al., 2019)	Outpatient	Interoceptive and exteroceptive inhibitory learning, exposure to aversive sensations, acceptance	Child and parents	11–15 sessions Age 4 Treatment intended for ages 4–10 years	Case report

(*continued*)

TABLE 1. Psychosocial Interventions for Childhood ARFID (*continued*)

Approach	Intervention	Setting	Key Intervention Components	Who Is Involved in Treatment	Treatment Duration and Age	Empirical Support
	Exposure-based CBT integrating inhibitory learning principles (Dumont et al., 2019)	Partial hospitalization program followed by outpatient treatment	Exposure, behavioral experiments, cognitive restructuring, relaxation	Individual, parent and child, and group sessions	4-week intensive day treatment (6–8 hours per day) followed by 4-week low intensity outpatient treatment Ages 10–18 years	Case series (*N* = 11)
	Family centered treatment (Bryson et al., 2018; Ornstein et al., 2017)	Partial hospitalization programChildren with acute onset, low body weight	Meal planning, exposure and response prevention, cognitive restructuring, hierarchical reintroduction of foods in program and at home, contingency management, medication when needed	Child and parent and/ or other family members	5 days per week for 8.5 hours per day including 2-hour school componentfor an average of 7 weeks Ages 7–17 years	Retrospective chart review (*N* = 130, *n* = 32 with ARFID)
Behavioral parent-training	Behavioral parent-only group treatment (Picky Eaters Clinic) (Dahlsgaard & Bodie, 2019)	Outpatient	Psychoeducation, improving mealtime hygiene, parents-facilitated exposures, habituation, differential reinforcement, contingency management	Parents	7 group sessions. Each group included parents of 2–4 children Ages 4–11	Pilot open trial (*N* = 21)

(*continued*)

TABLE 1. Psychosocial Interventions for Childhood ARFID (*continued*)

Approach	Intervention	Setting	Key Intervention Components	Who Is Involved in Treatment	Treatment Duration and Age	Empirical Support
	Behavioral parent-training intervention (Murphy & Zlomke, 2016)	Outpatient	Psychoeducation, in vivo parent coaching, parent modeling, differential reinforcement, gradual exposure, contingency management	Child and parents	18 sessions over 6 months Age 6	Case report
	Behavioral parent-training intervention through teleconsultation (Bloomfield, Fischer, Clark, & Dove, 2019)	Outpatient	Contingency management	Parents	Age 8	Case report
Hospital-based feeding programs	Integrated eating aversion treatment (iEAT) (Sharp et al., 2016)	Partial hospitalization program for children with chronic food refusal and dependence on enteral feeding or oral nutritional formula supplementation	Reinforcement, escape extinction, formulized meal structure	Child and parents	5 consecutive days with 14, 40-minute meals Ages 13–72 months	Pilot RCT with wait list as comparator (N = 20)

(*continued*)

TABLE 1. Psychosocial Interventions for Childhood ARFID (*continued*)

Approach	Intervention	Setting	Key Intervention Components	Who Is Involved in Treatment	Treatment Duration and Age	Empirical Support
	Nutritional rehabilitation program (Strandjord, Sieke, Richmond, & Rome, 2015)	Inpatient	Meal planning, nasogastric tube and nutritional supplements when needed.	Child	5–13 days Ages 5–25 years	Retrospective chart review (*N* = 318, *n* = 41 with ARFID)
	CHOP inpatient nutritional rehabilitation protocol (Peebles et al., 2017)	Inpatient	Rest, electrolyte monitoring, gradual increases in nutrition and weight gain, nasogastric tube and nutritional suppliants when needed, as well as psychotherapeutic support and nutritional education.	Child, parents as part of treatment team	3–40 days Ages 5–23 years	Retrospective chart review (*N* = 215, *n* = 9 with ARFID)
	Nutritional rehabilitation + pharmacotherapy augmentation (Sharp, Allen, et al., 2017)	PHP	D-cycloserine (DCS), escape extinction, reinforcement procedures	Child and parents	5 days Ages 20–58 months	Double-blind pilot RCT with placebo as comparator (*N* = 15)

Note. ARFID = avoidant/restrictive food intake disorder; CBT = cognitive behavior therapy; CHOP = Children's Hospital of Philadelphia; FBT = family-based treatment; RCT = randomized controlled trial.

systematic exposures to increased volume and/or variety of foods, self-monitoring, and relaxation techniques. An on-going open trial is currently examining the application of a manualized cognitive-behavioral treatment for ARFID (CBT-AR) in 20 participants (ages 10–22 years) in an outpatient setting (Thomas & Eddy, 2019). CBT-AR leans on the three-dimensional model of the neurobiology of ARFID, which posits distinct neurobiological predispositions to sensory sensitivity, lack of interest in food or eating, and/or fear of negative consequences (Thomas, Lawson, et al., 2017). A case report of an 11-year-old girl with acute onset of ARFID following a choking incident demonstrated the application of this approach. Improvement following treatment included weight gain, greater variety of foods eaten, reduced anxiety, and improved psychosocial functioning (Thomas, Brigham, et al., 2017). In a retrospective chart review, Ornstein et al. (2017) reported on the integration of cognitive behavior therapy (CBT) in an intensive family-centered treatment in a PHP (*N* = 32, ages 7–17, average treatment length was 7 weeks) and showed post-treatment gains in weight and reductions in eating disorder and anxiety symptoms. Another report of CBT in a PHP was described through a case series (*N* = 11, ages 10–18 years) that applied a 4-week intensive CBT with a focus on inhibitory learning principles (Dumont et al., 2019). This study reported remission in 10 out of 11 patients, with healthy body weight and age-adequate nutritional intake following treatment. Additional gains were reductions in patients' dysfunctional beliefs and anxiety levels.

A recent article described an application of the Feeling and Body Investigators-ARFID Division (FBI-ARFID) for a 4-year-old girl with ARFID (Zucker et al., 2019). This exposure-based interoceptive treatment focused on exploring and experiencing aversive sensations rather than terminating them, in an acceptance-based framework.

BEHAVIORAL PARENT TRAINING

A single pilot open trial examined the acceptability, feasibility, and initial outcomes of a parent-only outpatient group behavioral treatment for childhood ARFID (Picky Eaters Clinic; *N* = 21, ages 4–11 years). In this study, seven groups of parents (2–4 families in each group) participated in seven sessions focused on teaching parents to facilitate daily in-home exposures, differential reinforcement, contingency management procedures, and elements of parent management training. Results showed significant reductions in picky eating symptoms after treatment and gains were maintained at 3-month follow-up (Dahlsgaard & Bodie, 2019). Other accounts of treatments with high parental involvement include a case of a 6-year-old girl who received a behavioral parent-training intervention which was successful in increasing her food intake variety (Murphy & Zlomke, 2016) and a case of an 8-year-old boy who increased intake volume of non-preferred foods during a behavioral parent-training intervention delivered via teleconsultation (Bloomfield et al., 2019).

HOSPITAL-BASED FEEDING PROGRAMS

One prospective pilot RCT trial compared an intensive multidisciplinary behavioral feeding therapy to a waitlist condition in a 5-day PHP for young children with chronic food refusal and dependence on enteral feeding or oral nutritional formula supplementation (*N* = 20, ages 13–72 months; Sharp et al., 2016). Compared with waitlist, children receiving therapy consumed more food and had fewer mealtime disruptions. Inpatient programs have also described the use of nasogastric tube feeding as part of feeding programs through retrospective chart reviews (Peebles et al., 2017; Strandjord et al., 2015) and case reports (Pitt & Middleman, 2018; Schermbrucker, Kimber, Johnson, Kearney, & Couturier, 2017). The benefits and negative effects of such procedures remain a contested issue in the field (Dovey, Wilken, Martin, & Meyer, 2018). In PHPs and inpatient settings, the use of pharmacotherapy (olanzapine, fluoxetine, and/or cyproheptadine) for ARFID has also been examined in addition to other treatment modalities and reported mainly through retrospective chart reviews and case series (e.g., Brewerton & D'Agostino, 2017; Gray, Chen, Menzel, Schwartz, & Kaye, 2018; Spettigue et al., 2018). A single small-scale double-blind RCT for very young children with ARFID (*N* = 15, ages 20–58 months) compared intensive extinction-based feeding intervention and D-cycloserine (DCS) to the same intensive feeding intervention and placebo (Sharp, Allen, et al., 2017). Compared with the feeding intervention and placebo group, children in the feeding intervention and DCS group showed increased food acceptance and decreased problem behavior during meals. To date, there are no established guidelines for the use of pharmacological treatments for ARFID, though it has been recommended that they be used in addition to other treating approaches and not as a first-line treatment intervention (Bryant-Waugh, 2019; Naviaux, 2019).

In sum, current empirical support for psychosocial treatments for child ARFID stems mainly from case reports, case series, and retrospective chart reviews, with the exception of two pilot RCTs, one of FBT-ARFID (Lock, Sadeh-Sharvit, et al., 2019) and one of an intensive feeding therapy for very young children (Sharp et al., 2016), and one pilot open trial documenting a parent-only behavioral group treatment (Dahlsgaard & Bodie, 2019). Most outpatient treatment approaches include FBT or child-centered cognitive behavioral interventions. These approaches acknowledge the importance of parental involvement both for maintaining the eating disorder and for facilitating change, and most include parents in treatment to varying degrees. Yet, even when the parental role in treatment is significant (as in the case of FBT-ARFID) these approaches require the active participation of the child in sessions. A single pilot open trial documents the application of a completely parent-based approach that trained parents in a variety of behavioral techniques and did not require active participation by the child to facilitate positive change (Dahlsgaard & Bodie, 2019).

Large-scale RCTs are further required to establish the efficacy of these approaches. As research into the clinical phenomenology and underlying neurobiological mechanisms of ARFID continues to expand and to highlight the heterogeneity in ARFID presentations, greater specification of treatments for these presentations may be warranted (Bryant-Waugh, 2019; Eddy et al., 2019). Future research should also continue to clarify and operationalize the *DSM-5* criteria for ARFID as well as the benchmarks for remission. A recently published article summarizing a convention of multi-disciplinary international eating and feeding disorders experts underscores the need to better determine what is meant by "significant weight loss" (criterion A1), "significant nutritional deficiency" (criterion A2), and "dependence on enteral feeding or oral nutritional supplements" (criterion A3) (Eddy et al., 2019).

THEORETICAL MODEL OF FAMILY ACCOMMODATION IN ARFID

One way parents may inadvertently contribute to the maintenance of ARFID symptoms is through the process of family accommodation. Family accommodation refers to the ways in which parents and other family members change their own behavior to help their relative with a psychiatric illness avoid or alleviate distress related to the illness. Family accommodation has been extensively studied in pediatric anxiety and obsessive-compulsive disorder (OCD), where it has been repeatedly shown to be highly prevalent and associated with symptom severity, functional impairment, and poor treatment outcomes (Lebowitz, Panza, & Bloch, 2016; Shimshoni, Shrinivasa, Cherian, & Lebowitz, 2019). Family accommodation has been identified as a maintaining factor in eating disorders other than ARFID, such as anorexia nervosa and bulimia (Fox & Whittlesea, 2017; Treasure & Schmidt, 2013) where it has been associated with greater symptom severity (Salerno et al., 2016) and caregiver burden (Anastasiadou, Medina-Pradas, Sepulveda, & Treasure, 2014; Sepulveda, Kyriacou, & Treasure, 2009).

Research into family accommodation in ARFID is lacking, though clinical experience suggests that it is highly prevalent in this eating disorder as well. One recently published retrospective chart review of 22 outpatients (ages 4–25 years) diagnosed with ARFID based on sensory characteristics reported the presence of accommodation in 100% of the cases (Zickgraf, Murray, Kratz, & Franklin, 2019). Accommodation by parents of children with ARFID involves active participation in symptom-driven behaviors as well as modifications to the family's routines and schedules. Examples of active participation in symptom-driven behaviors are buying and preparing only preferred foods or bringing special food for a child to social situations. Examples of modifications to family routines and schedules include planning trips and vacations based on availability of preferred foods, always hosting (rather than attending) play dates so a child won't have to eat at friends' houses, or only going to restaurants that serve a child's preferred foods.

Conceptually, family accommodation may maintain the disorder by promoting avoidance and reinforcing pathological beliefs. For example, a child who fears that trying new foods will cause a severe stomach ache and possible diarrhea and insists on being served only preferred "safe" foods, may feel relieved when parents agree to only present those foods, but is likely to remain anxious and avoidant of new foods. The child may also view the parent's accommodating behavior as confirmation of their belief that indeed, new foods are not safe to eat. Given the strong emphasis cognitive behavioral therapies place on practicing exposure and reducing avoidance, it is not surprising that high levels of family accommodation are associated with poorer treatment outcomes in anxiety and OCD. Figure 1 demonstrates the theoretical model by which accommodation contributes to the maintenance of symptom severity and impairment.

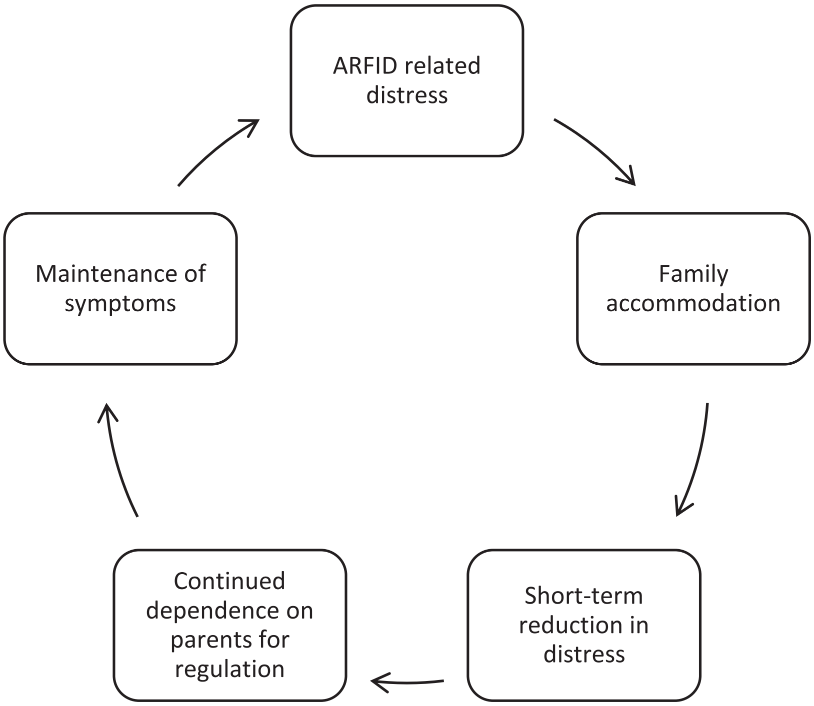

Figure 1. Accommodation cycle.

Family accommodation may also lower the child's motivation to engage in therapy. Parents who provide high levels of accommodations may be inadvertently "helping" the child to cope with the restricted eating without need for treatment. To take the same example of the child who fears that new foods will cause stomachaches and diarrhea, though the parents may be burdened by the extensive accommodations, being heavily accommodated may limit the level of distress the child experiences.

Although increasingly understood as a maintaining factor in eating disorders, and addressed to some extent in some child and family centered interventions (e.g., Anastasiadou et al., 2014; Goddard et al., 2011; Lock, Robinson, et al., 2019; Pepin & King, 2013), reducing family accommodation has not been emphasized as a central treatment goal for these problems. In OCD and anxiety however, reducing family accommodation is increasingly recognized as an important treatment goal and is incorporated into treatments for these disorders (Comer et al., 2014; Freeman et al., 2014; Gomes et al., 2016; Thompson-Hollands, Abramovitch, Tompson, & Barlow, 2015). SPACE (Supportive Parenting for Anxious Childhood Emotions) is a manualized parent-based treatment for childhood anxiety and OCD that places accommodation reduction at the core of its theoretical foundation and treatment objectives. SPACE also includes a set of practical tools that help parents identify the various forms of provided accommodation, formulate and implement detailed plans for reducing family accommodation, and equips parents with strategies for coping with the range of difficult responses sometimes exhibited by children when accommodation is not provided (Lebowitz, 2013; Lebowitz, Omer, Hermes, & Scahill, 2014). A recent RCT (*N* = 124, ages 6–14 years), found SPACE to be as efficacious as CBT for treating childhood anxiety disorders (Lebowitz, Marin, Martino, Shimshoni, & Silverman, 2019).

SPACE-ARFID is an adaptation of SPACE for parents of children with ARFID in an outpatient setting. The foundation for this adaptation of SPACE rests on commonly observed shared features between pediatric anxiety and ARFID. These include elevated levels and anxiety and avoidance behaviors (Fisher et al., 2014; Norris et al., 2014; Pallister & Waller, 2008; Swinbourne & Touyz, 2007; Zucker et al., 2019) and the presence of family accommodation (Brigham, Manzo, Eddy, & Thomas, 2018; Eddy et al., 2019; Zickgraf, Murray, et al., 2019). Although family accommodation has not been extensively studied in ARFID, reports of parent behaviors in pediatric picky eating (e.g., providing special meals; replacing non-preferred food with preferred ones) underscore the role of family accommodation (Carruth, Ziegler, Gordon, & Barr, 2004; Dahlsgaard & Bodie, 2019; Dubois, Farmer, Girard, & Peterson, 2007; Mascola, Bryson, & Agras, 2010).

SPACE-ARFID: TREATMENT DESCRIPTION

SPACE-ARFID consists of 12–16 weekly 60-minute sessions conducted with parents in an outpatient setting. SPACE-ARFID focuses on parents' responses to the child's ARFID symptoms and strives to promote greater flexibility and adjustment in food related situations. To achieve this goal SPACE-ARFID helps parents to reduce their accommodating behaviors, reduce food related stress, and increase their supportive responses to the child's symptoms. Similar to SPACE, SPACE-ARFID was developed specifically to be implementable without direct child involvement, when necessary. Throughout the SPACE-ARFID treatment process parents are not instructed to directly modify their child's behavior and treatment is not contingent on the child's agreement. Instead, SPACE-ARFID focuses on the parents' own behavior, and in particular on their responses to the child's symptoms. The focus on modification of the parents' behaviors, and not the child's, reduces the risk of parent-child conflict as there is no need for parents to impose demands on the child.

SPACE-ARFID follows a manualized set of seven parts with optional modules that can be implemented when needed (see Table 2 for an outline of treatment steps). In brief, the initial sessions review the child's presenting problem, provide psychoeducation on ARFID, explain the treatment rationale and its underlying principles, and address any misgivings or concerns parents may have about treatment. Next, parents are introduced to the overarching treatment goal of increasing flexibility and adjustment in situations involving food and to the three key concepts and processes that are the focus of SPACE-ARFID: family accommodation, food related stress, and supportive responses. Supportive responses to the child's symptoms are defined in SPACE-ARFID as any parental response that conveys to the child both acceptance of the child's genuine distress, and confidence in the child's ability to cope with and tolerate the distress. An example of a supportive response to a child distressed by the presence of non-preferred food is, "I see you are uncomfortable about this food being on the table, and I am sure you can handle it."

The second part of SPACE-ARFID focuses on understanding parents' attitudes and behaviors regarding the child's eating habits and completing Food ladders. Food Ladders are hierarchies filled out with the child if possible, which represent how difficult the child thinks it would be to eat different foods. The information gained in this step serves to guide the therapist and the parents in formulating specific plans for parental behavior modification later in treatment. Once parents understand their role in the conflict and stress surrounding food-related situations (e.g., by commenting on the child's eating habits, asking the child to finish what is on their plate, counting bites, or making unhelpful comparisons with other children), they are guided in reducing these behaviors and replacing them with supportive responses. The goal in the third part of treatment is to formulate a detailed and specific plan for parental change. This plan involves reducing a specific target accommodation while continuing to promote a low-stress food environment and increasing supportive responses when the child is distressed. In the fourth part of treatment parents implement the plan and begin to reduce their accommodation. Parents are instructed on how to communicate the plan to the child in an open, transparent, and supportive manner. Treatment then focuses on implementation and trouble-shooting and parents monitor their accommodating behavior and supportive responses between sessions. The fifth part of treatment teaches parents additional tools aimed at increasing the child's exposure to non-preferred foods or food related situations in a "game-like" manner, while parents continue to implement their plan. For example, parents can increase exposure to non-preferred foods by involving the child in food preparation and other food-related games and activities. Many of the tools taught in this part of treatment do rely on child participation and cooperation, and therefore are implemented only with the child's agreement. When the accommodation reduction plan is successfully implemented, and gains are apparent and stable, parents proceed to the sixth part in which a second target accommodation is selected and reduced in similar manner. The seventh part focuses on relapse prevention and treatment termination. Therapist and parents assess treatment processes and gains and discuss additional goals and future directions. SPACE-ARFID includes optional modules for problem-solving possible difficulties relating to the reduced accommodation. These modules include recruiting and engaging supporters from outside the nuclear family, dealing with severe disruptive behaviors, dealing with threats of self-harm, and improving collaboration between parents.

CASE ILLUSTRATION

Max was a 7-year-old, White, English-speaking boy, who lived with both his parents, Joe and Carla. Max was referred for treatment by his primary care physician who was concerned about longstanding rigid eating habits and an increasingly restricted list of consumed foods. Following a non-eventful developmental history, around age 3 Max started to show strong food preferences, gradually eliminating more foods from his diet. These preferences persisted over time. Max had been eating the same foods, and in the same order, every day since he was 4. For breakfast, he ate only waffles or cheerios with milk. For lunch he ate homemade turkey loaf, goldfish crackers, and fruit gummies. After-school he snacked on goldfish crackers, and for dinner he ate turkey

TABLE 2. SPACE-ARFID Treatment Parts

Part	Key interventions
Part 1 Introduction and setting the stage for parent work 1–2 sessions	Psychoeducation on ARFID Introducing the rational for parent work Introducing the main treatment goals and concepts: increasing flexibility and adjustment in food related situations by reducing family accommodation, reducing food related stress, and increasing supportive responses
Part 2 Monitoring parent behavior 2–3 sessions	Discussing family food habits and attitudes Discussing parent-child food related interactions Parents start to work on reducing conflict and increasing support Charting accommodation Completing Food Ladders
Part 3 Picking a target and formulating a plan 1–2 sessions	Picking a target and formulating a detailed plan for: Reducing conflict and stress in food related situations Reducing accommodation of the ARFID symptoms Increasing supportive responses to the child's distress
Part 4 Implementation 3–5 sessions	Informing the child of the parents' plan Implementing the plan Monitoring implementation and troubleshooting
Part 5 Additional tools Alongside implementation	Incorporating additional tools aimed at increasing the child's exposure to non-preferred foods or food related situations in a "game-like" manner (e.g., food chaining, increasing the child's knowledge of food and involvement in food preparation, food-related games)
Part 6 Additional targets 3–5 sessions	Charting accommodation Formulating a second plan Informing the child Implementing a second plan Monitoring implementation and troubleshooting
Part 7 Relapse prevention and termination 1 session	Assessing treatment gains Discussing additional goals Treatment termination
Modules (optional) Alongside implementation	Recruiting and engaging supporters Dealing with extreme disruptive behavior Dealing with threats of self-injury or suicide Improving collaboration between parents

loaf again. After dinner, Max had another snack of goldfish, butter cookies, and fruit gummies. Sometimes he ate crackers with peanut butter and rarely, applesauce.

Over time, Max's parents became engaged in many forms of family accommodation. The fear that Max would not eat at all or that he would respond with distress or anger led Max' parents to gradually stop serving him any foods other than his preferred ones. For dinner, Joe and Carla prepared two separate meals, one for Max and one for themselves. When Max continuously complained that his parents' food "smelled and looked funny" and showed signs of anxiety when certain foods were placed on the table near him, Joe and Carla agreed to eat later in the evening or allowed Max to eat separately while watching television. The family stopped dining at restaurants and limited their travels and vacations because it was hard to handle the food situations. When they did travel or were invited to friends or family, they made sure to always bring special food for Max, including enough turkey loaf in a cooler. Max became angry and anxious at birthday parties because he was worried that he would be asked to eat cake or pizza and eventually opted not to attend most parties. On rare occasions when his parents asked him to try a new food Max cried and begged them not to "make him." Sometimes the parents offered Max toys or money in exchange for trying a new food, but Max usually declined their offers. If he did agree to take a bite of a non-preferred food, he would gag or hold the food in his cheeks with a distinct look of distress on his face. In these situations, Joe tried to encourage Max to swallow, but he rarely did.

As Max became more restricted and rigid, anxious and resistant to new foods, his parents' own anxiety rose. They felt stressed and anxious at mealtimes, especially when offering new foods. They continuously checked their pantry to make sure there was enough of Max' preferred foods and would make special trips to the store if they ran out. On one occasion, their usual supermarket chain went on a 2-week strike, making it exceptionally hard to find ground turkey. This triggered heightened levels of parental anxiety, as they found themselves driving for hours in search of ground turkey. It was this experience, combined with the pediatrician's concern at Max's 7-year wellness visit that led them seek help.

Joe and Carla had previously enrolled Max in occupational therapy to gradually expose him to new foods. Although Max initially agreed to participate in treatment, when the treatment grew more challenging he refused to participate in sessions or to practice at home. After a few weeks of hiding under the table during sessions and not engaging with the therapist, treatment was terminated. In addition to Max' low motivation, the high level of family accommodation and the likelihood that the accommodation was maintaining his restricted eating and reducing Max' willingness to engage in therapy all pointed to the need for parent-based treatment. Although Max was adamant about not going to therapy or making changes to his eating habits, his parents were not ready to give up and wanted to help him and to get help for themselves. Thus, a parent-based approach was recommended by the therapist, with the option of engaging Max in treatment later, if his attitude changed.

Assessment

The assessment was based on reports from Max and his parents. The parents and Max were separately administered a diagnostic interview following *DSM-V* ARFID criteria (American Psychiatric Association, 2013), the Anxiety Disorders Interview Schedule (ADIS C/P; Silverman, Saavedra, & Pina, 2001) to assess for other problems, a number of rating scales and an ARFID screening measure (NIAS; Zickgraf & Ellis, 2018). Max and his parents provided a list of the foods he regularly ate. Max' height and weight were within the normal range (his expected body weight percentage was 101.4). Per the parents' report, Max' recent bloodwork did not show evidence of nutritional deficiencies, yet his primary care physician was contemplating the introduction of multi-vitamins to his daily diet. Based on the descriptions provided by the family, the primary care physician's concern for an eating disorder was confirmed and Max was diagnosed with ARFID. His selectivity of foods was based primarily on sensory properties such as smells or textures as well as fear of eating any unfamiliar foods. Additionally, Max and his parents reported symptoms of separation anxiety at a subclinical level.

Treatment

Introduction to SPACE-ARFID. Joe and Carla responded well to the introduction to SPACE-ARFID, feeling that the treatment would provide them with a way to help their son despite his resistance and lack of motivation. Joe and Carla felt guilty for allowing Max' eating habits to become so restricted and rigid and they felt helpless and frustrated about not being able to make changes. After endless failed attempts to directly make Max eat more foods, parents accepted the limits of their control over his behavior and were open to shifting their focus to examining and changing their own behavior. Discussion of the interference caused by the ARFID revealed psychosocial interference in several domains. This interference included not being able to eat together as a family, not being able to talk about food with Max, Max' distress or avoidance of social events, complications relating to school trips and participation in camps, difficulty traveling, and conflict between the parents and Max and between the two parents. This exercise in reviewing the impairment caused by the ARFID made it clear that the limited variety of foods Max ate, though easy to count and measure, was merely one aspect of the ARFID and much of the impairment related to his psychosocial functioning. The therapist explained that focusing only on expanding the variety of foods would not be a sufficient treatment outcome without change in other aspects. Instead, the therapist suggested that treatment would aim to increase Max' flexibility in food situations, something that would enable Max to take part in aspects of his life he now avoided, and in the longer run could promote experimentation with trying new foods. Joe and Carla agreed with this perspective, as they felt that Max' rigidity, which manifested in all aspects of his eating—the food items he ate, the brands, the amounts and the sequencing—was a source of significant stress and burden for the whole family. Next, the therapist introduced the Food Ladders and asked parents to fill these out at home with Max for later use in treatment.

Reducing Food Related Conflict and Stress. The therapist discussed with the parents the ways in which their behavior contributed to the high levels of stress surrounding food. Carla said that she closely monitored how much Max ate, to make sure he consumes enough calories. She also would tell him to finish what's on his plate and ask him repeatedly "do you want more?" or "do you want to try this?' Aside from Carla's concern for Max' wellbeing, Carla also didn't like to see food going to waste and tried to ensure prepared food was eaten. Joe shared that sometimes he would put new foods on Max' plate to try to get him to eat them. This usually resulted in Max getting very upset and running away from the table. Joe would get angry when Max wouldn't eat, especially in social situations, where it embarrassed him, and as a result he sometimes scolded Max in front of other people and later felt guilty and ashamed. Joe and Carla agreed to stop commenting on Max' eating and not to pressure him to try new foods. They also agreed to allow Max to decide how much food to eat and not to say anything about food being wasted, for the time being.

Increasing Supportive Responses. The therapist introduced the parents to the two elements of support: acceptance and confidence. Carla described herself higher on acceptance than on confidence. She felt sorry for Max when he showed signs of distress around food and was worried when he refused to eat. Joe thought he was better at conveying confidence than acceptance. He was sure that Max was capable of eating a greater variety of foods and viewed his pickiness as controlling and being spoiled. He wanted to encourage Max and told him things like "you got this buddy; I know you can do it!" He felt that Carla's gentle approach during mealtimes was not helping and found himself getting frustrated with her and angry with Max, saying things like "just eat the damn burger! If you would only *try* it, you'd like it!" These differences in the parents' approaches led to frequent arguments between them.

The therapist suggested to the parents that they each expressed messages that were very important for Max to hear. Max needed to know that his parents acknowledged his distress and struggle (*acceptance*, expressed mostly by Carla). But he also needed to know that his parents believed that he could handle his distress, overcome this problem and adjust better to eating situations (*confidence*, expressed mostly by Joe). By combining these two perspectives of acceptance

TABLE 3. Chart of Family Accommodation

	Joe	Carla
Morning	Prepares Max’s lunch. Packs the same things every day.	Makes Max’s Breakfast. If in a hurry will sometimes spoon-feed him.
Afternoon	Prepares Max’s snack. Provides the same snacks every day in the same order and quantity.	
Dinner	Prepares Max’s dinner. Serves the same foods every night.	
	Agree not to eat together as a family: either sit with him at the table without eating other foods or sit separately.Cook other foods only after Max has left the kitchen.	
Evening	Makes sure there is enough of Max’s preferred foods for the following day. If there isn’t will make special trips to the store. Will make sure there is enough turkey loaf and cook more if needed.	Makes sure Max has enough time to eat all of his snacks in the order he prefers before he goes to bed.
School field trips	If food cannot be refrigerated will stay home with Max or join the trip at lunch time with Max’s food.	
Family social events, restaurants, and trips	Will take a cooler with turkey loaf and a bag of snacks for Max. Avoid going on long trips when it is difficult to take turkey loaf.	
Play dates and birthdays		Will make sure that Max eats before he goes and will pick him up before he gets hungry again.Will stay at birthday parties to make sure Max doesn’t become distressed around the food and to help him calm down if needed.
Summer	Carefully choose summer camps that will have refrigerators for the turkey loaf.	

and confidence into one message, the parents would be united in a supportive stance. Joe and Carla practiced in session how to change unsupportive statements into supportive ones and the therapist encouraged them to practice saying supportive statements to Max at home.

Charting Accommodation. The therapist next devoted one session to mapping the parents’ accommodating behavior. Table 3 is the initial accommodation chart that was completed in the session, and later was added to as additional accommodations were identified.

Picking a Target, Formulating a Plan and Informing Max Reviewing the accommodation table, parents identified several behaviors they wanted to change and after discussing the possible options they chose the accommodation of eating separately from Max as their first target. The therapist worked with Joe and Carla on a detailed plan for resuming family meals and not accommodating Max's avoidance of being near non-preferred foods. Joe and Carla planned to serve dinner to all family members at the same time and at the dining room table. They decided to serve at least one thing they knew Max liked but to also serve other foods that they liked but had been avoiding because Max objected to seeing or smelling them. They decided to place all food items at the center of the table and not predetermine what Max would eat by placing food in his plate. They also agreed to not provide snacks for 2 hours before dinner, to increase Max's appetite at dinner.

The therapist and Max's parents drafted a written message for the parents to read and give to Max. This message conveyed the details of the plan in a supportive and loving way:

> *Dear Max,*
>
> *We both love you so much and are so proud of the sweet and thoughtful boy you have become - we could not ask for anything more in a son. We also understand how difficult it is for you to try new foods because they make you so nervous. We realize now, that when we agree to make sure to only give you your preferred foods, we are not helping you with your problem, we are actually making it harder for you. We are also sorry for making you feel bad about not trying new foods.*
>
> *This is why we have decided to make some changes to our behavior that we believe will help. This is our plan:*

- *We will start eating dinner together as a family: We will all sit at the table at the same time and eat. We will serve the food to the center of the table and we can each take what we want onto our plates. We will not put food on your plate anymore.*
- *There will always be at least one thing that we know you generally eat, but there will also be other foods and you are welcome to take anything you like.*
- *If you try something and don't like it, you can spit it out (yes, we mean it!)*
- *There will be no replacements for dinner. Whatever is served is dinner.*
- *Also, there will be no snacking up to two hours before dinner.*

> *This might sound hard at first, but we are 100% sure that you can handle it! We are not trying to hurt you or punish you in any way. We are your parents and our job is to help you in any way that we can.*
>
> *Love, Mom and Dad*

Implementation and Troubleshooting. Joe and Carla reported that when they first approached Max with the letter he thought he was in trouble and started to cry. Parents hugged him and read him the letter once he calmed down. Max wiped his tears and said, "I don't like this letter! But can you read me again the part where it says I'm sweet?" That week the family had three meals together. The parents reported that the first time they sat down to eat together Max was visibly anxious and hesitant. His face was red, and he was breathing fast, his eyes scanning the table. Joe provided support by saying "I know this is new and I see you are nervous, but I know you will be ok." Max was surprised by the empty plate in front of him and asked in a panicked voice for his turkey loaf. Joe decided to let Max cut a piece and serve himself. Max was happy that he was allowed to use a "grownup knife" and helped himself to a thick slice. After eating it, and without another glance at the other foods on the table, Max excused himself and went to watch TV in the living room, taking his after-meal snacks with him.

Over the first few dinners, Max' anxiety decreased, and he willingly joined his parents at the table. Carla shared that there were moments when she almost asked him to try other foods but remembered the plan and didn't. Although Max was still only eating turkey loaf, his parents felt they had made a meaningful change. They were happy to be eating together and to finally have started addressing Max' problem.

The therapist praised the parents for implementing their plan and began to address the issue of Max' after-meal snacks. It became apparent that having three substantial snacks (equivalent to ~450 calories) directly after dinner did not encourage Max to eat other foods at dinner and the parents decided to limit Max to only one snack. They predicted that Max would find the change to his rigid routine of eating three snacks in a specific order to be challenging. Yet, encouraged by their initial success in restoring family dinners, they felt that they could now withstand his reactions. They added a bullet to the written message:

- *After dinner you can eat one snack of your choice.*

To their surprise, Max was not very upset. For a few nights he asked for the other snacks, but the parents were able to deny his request with consistent supportive messages "We see that you are a little upset about having to choose only one snack, but we know that you can handle it just fine."

An unexpected challenge was Max' complaints about not being able to snack *before* dinner, something he was not limited in before treatment. During the first week, Max frequently demanded food before dinner. He would walk grumpily around the house pouting, "you're starving me!!" "this is mean!" and "I'm so hungry!" After discussing this issue in session, Max' parents introduced "anytime snacks." Anytime snacks were new foods, fruits and vegetables and "once eaten" foods, that Max could eat at any moment, even right before dinner. Max refused these foods and continued to ask for his regular snacks, but parents showed consistency over time, and continued to offer only the anytime snacks. Joe noticed that excessive suggestions of snack options made Max very angry. In line with the goal of reducing conflict and stress around food, it was suggested that Joe stop presenting all the snack options and instead, put a few options on the table with a note saying, "you can snack on these." Joe deliberately chose foods that were relatively low on Max' Food Ladders and foods he used to eat a few years prior. Whenever Max would complain about being hungry before dinner Joe would point to the snacks on the counter and leave the room. To Joe' surprise, after a few days Max tried strawberry yogurt, something he used to eat every day when he was 3 years old. This quickly became a regular snack. That weekend Max went to a birthday party with Joe. They made pizza together during the party and for the first time ever, Max tried it. He gave it a "thumbs up" and ate a few more bites. After that, Joe and Carla made sure to serve pizza at least twice a week, in addition to the turkey loaf, and twice Max had some.

As Joe and Carla gained confidence in Max' ability to cope with his food related distress they found opportunities to further challenge Max. In one incident Max' school had a field trip to the zoo. The school provided chicken nuggets for all the children on the trip and Joe decided to send Max to school without turkey loaf—a first for Max. As he expected, Max did not eat lunch at the zoo, but when the children returned to school, he ate his snacks and at home he ate a whole sandwich and a strawberry yogurt. When Joe saw Max that evening he said, "I'm so proud of you for handling the trip without turkey loaf." Max said, "It was horrible. I was hungry and sad" and Joe said, "yes, but you coped and you're ok." This experience was a turning point in Joe's and Carla's perception of Max' ability to navigate food related situations without special accommodations. In session Carla said, "I learned that he won't die if he is hungry for a few hours, he'll find a solution." For the next trip, 2 weeks later, the parents sent Max with sandwiches and a juice box, prepared for him to stay hungry again. They cried when the teacher sent them a video of Max eating a sandwich.

Additional Tools. Now that Joe and Carla felt that stress levels and conflict relating to food were down, and that Max accepted the new dinner routine, they were able to incorporate new tools to increase Max' exposure to foods in a fun and engaging manner. The therapist explained "food chaining" as the practice of making gradual variations in preferred foods that can ultimately result in the child accepting a very different food. In session, Joe and Carla made plans for a hamburger food chain, and for expanding the brands of snacks Max ate by purchasing slightly different flavors of goldfish or a different brand of fruit gummies. Joe and Carla played a game with Max in which he had to pick a fruit or vegetable from a bag and guess what it is without looking. In another game Max competed against Carla in a food challenge tasting game. The family also visited farms and orchards and started going together to the grocery store where Max became the "produce helper," picking and bagging different items.

Additional Accommodation Target. Max was now less anxious around food, had expanded his food list to include occasional pizza, peanut butter sandwiches, baby carrots and strawberry yogurt, and was more flexible about trying new foods and different brands of his preferred foods. The family had dinner together 4–5 times a week and Max was an integral part of preparing and eating the meal. Joe and Carla felt it was time to revisit their original target accommodation of providing turkey loaf every night. They told Max how proud they were of his hard work and of how well he handled the changes they had made around food. They also told him that they now know that he can be ok even when he doesn't have his preferred foods and that they decided to not always serve turkey loaf. Max accepted this but asked that they always have it for dinner. The parents said that they will prepare turkey loaf once a week and he can have it for dinner until it runs out. The first night without turkey loaf Joe and Carla were very nervous. When Max asked for his turkey loaf Carla looked away and Joe said, "We're out. You can have mac & cheese or pancakes." Expecting an epic meltdown, they were amazed to hear, "hmm ··· I'll try the mac & cheese then."

Treatment Termination. During the last weeks of treatment, Joe and Carla continued to provide Max with ample opportunities to try new foods. They went out to restaurants (without checking the menu in advance or bringing turkey loaf) and read Max the whole menu, without assuming ahead of time what he would choose. They went to the cinema and bought popcorn, which Max tried and loved. Most importantly, they continued to be mindful about creating optimal circumstances for Max to experiment with foods while accepting the limitations of their control over what he actually chose to eat. One instance which highlights the change Max and his parents made over the course of treatment was a trip they took the museum. It was only after being there for an hour that they all realized that they forgot to bring food for Max. After an initial panic they had lunch at the museum restaurant.

Treatment Outcomes. Treatment occurred over 12 weekly sessions. Following the last session, a post-treatment evaluation was conducted. Max and his parents were interviewed separately, and both interviews indicated no clinically impairing diagnoses. Max said, "I'm not a picky eater anymore because I can try new foods." He was especially excited to share how these changes have made it easy for him to go to summer camp and to be with his friends.

DISCUSSION AND SUMMARY

Max' case illustrates how the psychosocial impairment of ARFID can cut across domains and cause interference in many aspects of a child's and family's lives, even when there is little concern for weight and growth. Parents can become entangled in their children's ARIFD symptoms through the process of family accommodation. Parents may feel compelled to accommodate to ensure the child will eat, but the accommodation may actually contribute to maintaining the symptoms over time.

Max' case also highlights how important it is for parents to have systematic and practical guidance when working on changing their responses to the child's symptoms. Joe and Carla understood that their accommodations were not helping Max become less restricted in his eating, yet they struggled to find ways to change. Reducing family accommodation, providing a low-stress food environment, and increasing supportive responses require systematic plans and practical tools.

It is not known whether high levels of family accommodation predict poor treatment outcomes for CBT and medication for ARFID, as they do for pediatric anxiety and OCD (Kagan, Peterman, Carper, & Kendall, 2016; Piacentini et al., 2011; Turner, O'Gorman, Nair, & O'Kearney, 2018). If so, then even when a child is directly involved in treatment, the therapist should consider the issue of family accommodation and coach parents in reducing accommodation in a supportive manner. When a child is not directly engaged in therapy, or when the child's therapy is not proving effective, the need to address accommodation is even more prominent. Measures for assessing family accommodation in childhood ARFID are needed to systematically explore the magnitude, characteristics and impact of this phenomena.

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