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Summary

Behavioural assessment and treatment in disordered eating

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This presentation describes the spectrum from adaptive dietary restriction to ARFID in gastrointestinal patients, emphasizing that avoidance driven by fear of GI symptoms is evolutionarily normal but becomes problematic when it causes functional impairment, and outlining behavioral assessment tools and CBT-based treatment approaches.

KEY POINTS

- The speaker stated that 90% of gastroparesis patients with ARFID symptoms report fear of gastrointestinal symptoms as the reason for restriction, and about 13% report severe food avoidance associated with greater symptom severity and poorer quality of life.
- The nine-item ARFID screen measures eating behaviour only and cannot diagnose ARFID because it cannot assess whether restriction exceeds what the GI condition usually causes, and it has not been validated in GI patient samples.
- Risk factors for ARFID symptoms include high anxiety, depressive symptoms, trauma or medical PTSD, high GI symptom severity, significant weight loss at low BMI, and co-occurring autoimmune or celiac disease.
- CBT for food avoidance, applying exposure to avoided foods, is the best available psychological intervention at phase two evidence level according to the ORBIT model, with reduction in food avoidance driving symptom improvement.
- The speaker recommends screening for disordered eating before starting elimination diets, keeping the strict elimination phase short and time-limited, planning structured reintroduction in advance, and maintaining gastroenterologist involvement even when referring to mental health professionals.

– CBT is incompatible with elimination-type dietary interventions, and the speaker calls for applying DSM-5 ARFID criteria carefully, noting ARFID should not be diagnosed when the GI condition fully accounts for the behaviour and impairment.

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