



When 911 Is Called for Multiple Medical Complications, Child Psychiatry's Systems Approach Comes to the Rescue



No conflicts of interest

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LEARNING OBJECTIVES

To explore how a systems of care approach was crucial to a successful outcome in a child with Avoidant/Restrictive Food Intake Disorder

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

- New diagnosis in DSM-5
- Prevalence in healthcare settings is estimated 7.2-17.4%
- Associated features: selective eating since early childhood, generalized anxiety, GI symptoms, fear of choking or vomiting, texture/sensory issues pertaining to food, food allergies

ARFID

- No body image preoccupation or fear of gaining weight
- More common in females, with higher % of males compared to AN/BN
- Presents at a younger age
- Median % body weight in between those with AN and BN
- More likely to have a medical condition, which may have preceded ARFID
- More likely to have an anxiety disorder
- Can lead to severe medical sequelae similar to AN: amenorrhea, bradycardia, electrolyte abnormalities, prolonged QT, vitamin deficiencies

Anorexia Nervosa/ Bulimia Nervosa

- Preoccupation with body weight or shape and fear of gaining weight
- More common in females, with lower % of males compared to ARFID
- Typically presents during mid-adolescence in eating disorder programs
- More likely to have a mood disorder
- Anorexia nervosa can lead to severe medical sequelae due to malnutrition

CASE DESCRIPTION

While working in a pediatric tertiary care hospital, I evaluated a 12-year-old boy for intense food aversion who was admitted for severe dehydration and malnourishment. He was also found to have significant vitamin A deficiency resulting in optic nerve damage, poor dentition, significant osteopenia, and anemia due to chronic malnutrition. Our child psychiatry team soon discovered that his food aversion had originated from a traumatic choking incident when this child was 3 years old; since that time he has refused to eat solid foods. The diagnosis of Avoidant/Restrictive Food Intake Disorder was established.

We then began exploring strengths and weaknesses of each system that this child had interfaced with to develop a more cohesive and robust treatment plan. We began empowering the child's family as well as his medical teams at the hospital through psychoeducation about his diagnosis. Since his parents often demonstrated poor understanding of medical recommendations, our team also served as a liaison between the parents and medical team to facilitate their consent to critical procedures and treatment. We also worked closely with speech therapy to carve out a diet plan for this child. We reached out to his pediatrician not only to obtain more detailed past history and to communicate patient's hospital course but also to ensure continuity of care. We realized that his parents had a long drawn past and ongoing struggle to adhere consistently to the treatment recommendations, so we collaborated with the child welfare system to temporarily support this child in a medical foster home while the parents agreed to seek help for themselves.

While in the hospital, this child began making noticeable progress with decreased medical complexity and increased eating of more varied food items. Lastly, we connected him with another child psychiatrist in training from our program who would treat him in an outpatient clinic. Our cross collaboration with multiple providers and systems proved successful—eight months post discharge this child continues to make steady weight gain and improved eating through weekly exposure and feeding therapy while in kinship care of his grandmother.

DISCUSSION

Challenges in this case:

- 1) Poor recognition in the outpatient setting that a psychiatric disorder (ARFID) was the root cause for restricted diet and poor weight gain, thus failure to aggressively pursue psychiatric referral
- 2) Lack of collaboration among outpatient providers and specialists as medical complications arose from the child's chronic malnutrition
- 3) Parents' own psychiatric illness and limitations perpetuating child's severe food avoidance, poor follow up with providers, and poor nutrition knowledge

Applying Systems of Care Approach to Successful Outcome:

- 1) Empowering family and all medical providers through educating them about ARFID
- 2) Interdisciplinary team meetings in the hospital setting to understand all medical, psychological, and social dynamics and identify barriers to feeding progression in the hospital
- 3) Identifying strengths and limitations of family system to facilitate a successful outcome. Involving child welfare system to help family system (support parents to seek psychiatric treatment for themselves; in the interim find a suitable placement for child to thrive) and school for individualized education plan
- 4) Linking child to various service systems as part of discharge planning
- 5) Creating a mechanism for regular communication among outpatient psychiatrist, feeding therapist, pediatrician, and child protective services such that treatment planning is not disjointed



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