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The (Extremely) Picky Eaters Clinic: A Pilot Trial of a Seven-Session Group Behavioral Intervention for Parents of Children With Avoidant/Restrictive Food Intake Disorder

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Excessive and impairing picky eating is a common problem among children for which there is little published research on efficacious psychosocial treatment. Extant research largely concerns single-case studies, or small samples of very young children, who are typically treated in hospital settings. This paper reports on outcomes of 21 children (ages 4–11) described by their parents as extremely picky eaters who met criteria for avoidant/restrictive food intake disorder not associated with a developmental disorder, other eating disorder, or other eating-related anxiety disorder (e.g., specific phobia of vomiting or choking). Seven cohorts of two to four families each took part in a seven-session manualized parent-only group treatment in an outpatient setting. This group treatment focused on training parents to serve as effective coaches for daily in-home exposures to nonpreferred foods, as well as in components of parent management training to reduce problematic mealtime behaviors. Parents completed standardized feeding measures to assess picky eating and associated problem mealtime behaviors at pretreatment, posttreatment, and at 3-month follow-up, as well as a satisfaction measure at posttreatment. Results showed excellent feasibility and adherence by parents and high parent satisfaction with treatment. Paired t *tests to measure within-group change showed significant pre–post treatment reductions in picky eating scales with moderate to large effect sizes. Gains were maintained at 3-month follow-up. Findings indicate that a relatively brief group treatment that focuses specifically on training parents to facilitate and carry out food exposures and contingency management procedures in their homes is associated with reductions in functionally impairing picky eating and related negative mealtime behaviors in elementary school-age children.*

PICKY eating is prevalent among children and adolescents and elicits considerable concern and distress from caregivers (Garro, Thurman, Kerwin, & Ducette, 2005; Jones & Bryant-Waugh, 2012; Mascola, Bryson, & Agras, 2010; Zucker et al., 2015). Hallmarks of picky eating include food neophobia (avoidance of new foods), rejection of foods based on various characteristics, and consumption of a limited variety of foods (Dovey, Aldridge, Martin, Wilken, & Meyer, 2016; Norris, Spettigue, & Katzman, 2016). When picky eating manifests in a persistent failure to meet appropriate nutritional and/or energy needs and impairs healthy weight gain or growth, results in nutritional deficiencies, necessitates enteral feeding or nutritional supplements, or interferes with psychosocial functioning (e.g., family strain, difficulty eating outside the home), a diagnosis of avoidant/restrictive food intake disorder (ARFID) may be made according to the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013).

When presented with a new or nonpreferred food, children with ARFID typically rely on a host of negative behaviors (e.g., whining, refusing, negotiating, crying, gagging) to avoid or escape the expectation that they consume the food (Morawska, Adamson, Hinchliffe, & Adams, 2014). Parents often respond by increasing attention (e.g., coaxing, negotiating, feeding the food directly), reducing the demand (e.g., requiring a smaller portion or removing the food altogether), or changing the types of foods offered (Carruth, Ziegler, Gordon, & Barr, 2004). These parent behaviors inadvertently reinforce food neophobia and refusal behaviors (Babbitt et al., 1994; Piazza et al., 2003; Sharp, Jaquess, Morton, & Herzinger, 2010; Williams, Field, & Seiverling, 2010). Parents typically report a narrowing list of preferred foods as their child ages and an increasing alarm about adequate nutrition (Cardona Cano, Hoek, & Bryant-Waugh, 2015; Davies et al., 2006). They also report psychosocial impairment, such as stressful mealtimes and high child distress whenever new or nonpreferred foods are presented, difficulty traveling or attending social events unless they have brought along their child's

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preferred foods, and a sense of helplessness, hopelessness, and lack of self-efficacy regarding properly feeding their own child.

Aside from a school-based study from Switzerland, in which 3.2% of children ages 8–13 met criteria for ARFID via self-report (Kurz, van Dyck, Dremmel, Munsch, & Hilbert, 2016), no full-scale epidemiological studies to date have examined the prevalence of ARFID in the general population (Pinhas et al., 2017). Between 12 and 22% of children and adolescents presenting to specialty eating disorder clinics meet DSM-5 criteria for ARFID, suggesting that it is a very common and serious eating disorder worthy of clinical attention and effective treatments (Fisher et al., 2014; Forman et al., 2014; Nicely, Lane-Loney, Masciulli, Hollenbeak, & Ornstein, 2014).

Reviews of treatment research involving children with feeding difficulties provide robust evidence that behavioral interventions are effective in altering interactions that reinforce food avoidance and improving feeding outcomes, such as acceptance of bites, weight gain, and reduced reliance on enteral feeding (Lukens & Silverman, 2014; Sharp, Volkert, Scahill, McCracken, & McElhanon, 2017; Williams et al., 2010). Such interventions typically employ evidence-based behavioral strategies targeting the antecedents and consequences of mealtime behaviors. Key tenets of such behavioral feeding interventions include the following: contingency management (i.e., positive reinforcement for approaching and swallowing food and consequences for avoidance), differential reinforcement (i.e., praising eating behaviors while giving less attention to inappropriate mealtime behaviors), consideration of mealtime hygiene (i.e., appetite manipulation via a structured meal schedule and timed beverage consumption), systematic desensitization (i.e., repeated exposure to new or nonpreferred foods), escape prevention, and stimulus fading (e.g., slowly increasing portion sizes; Babbitt et al., 1994; Linscheid, 2006; Williams et al., 2010). It has been demonstrated that behavioral intervention is superior to nutritional advice and meal scheduling alone (Benoit, Wang, & Zlotkin, 2000), as well as sensory integration therapy (Addison et al., 2012).

There are a number of factors that limit the generalizability of previous research to older, typically developing children who are nonreliant on supplements or enteral feeding but who nonetheless present with picky eating of such severity and duration that they qualify for a diagnosis of ARFID. All published randomized controlled trials (RCTs) to date involve participants with developmental disorders or complex medical histories, reflecting the high rates of feeding difficulties among such populations (Sharp, Burrell, & Jaquess, 2014; Sharp et al., 2010, 2017). Additionally, many larger-scale studies examine very young children and measure successful outcomes as the percentage of patients successfully weaned from enteral feeding (Benoit et al., 2000; Hartdorff et al., 2015; Lukens & Silverman, 2014; Williams et al., 2010). Although weaning is an important aspect of feeding treatment for many patients, the assessment of outcomes such as food acceptance and flexibility, improved mealtime behaviors, and parental factors may be particularly relevant for otherwise typically developing picky eaters with ARFID. Much remains to be learned about the optimal treatments for such families.

Documented treatments for picky eaters largely take place in day hospitals or inpatient settings, but most picky eating takes place in the home. Dissemination of interventions to parents for use at home remains limited (Fischer, Luiselli, & Dove, 2015; Sharp et al., 2016). Parents, when taught with methods such as verbal or written instructions, modeling, rehearsal, and constructive feedback, have been shown to deliver feeding treatments with high fidelity (Mueller et al., 2003; Najdowski et al., 2010). Further, though some studies have implemented behavioral strategies in naturalistic or home environments with positive feeding outcomes (Anderson & McMillan, 2001; Cosbey & Muldoon, 2017; Gentry & Luiselli, 2008; Najdowski et al., 2010; Werle, Murphy, & Budd, 1993), most have used very small sample sizes and included children with developmental delays, limiting generalizability to typically developing children. However, in a nonrandomized study, Dovey and Martin (2012), using a sample of 24 young children (*M* = 4.23 years) without medical or mental health diagnoses and deemed as having extremely limited diets, found decreases in problematic feeding on a standardized feeding measure and increases in dietary variety after a four-session individual intervention spanning 16 weeks that focused on parental psychoeducation and behavioral modeling. In another nonrandomized study of 75 mostly very young problem eaters (85% were age 5 or younger) without known medical histories, Fraser, Wallis, and St. John (2004) found reductions in problematic eating and mealtime behaviors on a standardized measure after a single 2.5-hour parent education session. Two published case studies have examined feeding interventions in older children with diagnoses of ARFID due to picky eating without developmental disabilities. In one, a “motivated” 16-year-old boy showed increased food acceptance after an 11-session treatment, although no standardized measures were used to assess outcome (Fischer et al., 2015); in the other, a 6-year-old girl showed improvement on a standardized parent-report measure of food acceptance and mealtime behaviors after an 18-session treatment (Murphy & Zlomke, 2016).

In addition to the paucity of large-scale randomized studies of ARFID interventions and dissemination of these treatments to providers and families, there are a number of barriers that parents encounter as they seek treatment for their children with functionally impairing picky eating. For the patient with ARFID, local treatment options are often woefully scarce (Johnson, Foldes, DeMand, & Brooks, 2015; Sharp et al., 2010). Providers who treat eating disorders, such as anorexia and bulimia, may be less informed about appropriate approaches to ARFID treatment and the frequency or duration of sessions needed to achieve goals (Forman et al., 2014). In sum, there is a clear need for brief and effective behavioral treatment protocols that can be readily provided at a low cost to patients and their families.

The Picky Eaters Clinic

This paper reports on the acceptability, feasibility, and initial outcomes of the Picky Eaters Clinic, a seven-session parent-only group-based intervention to train parents of children exhibiting moderately-to-severely picky eating with a primary diagnosis of ARFID. Parents were taught to act as behavioral interventionists who can effectively promote and generalize long-term improvements in food acceptance and positive mealtime behaviors in the home environment and other social settings. Parent-only treatment, rather than parent–child or child-only interventions, was chosen as the preferred mode of intervention for several reasons. First, picky eaters engage in highly disruptive behaviors when presented with non-preferred foods and are typically unmotivated to engage in treatment. These particular challenges suggest that parent management training (PMT) approaches are appropriate, as they have shown to be highly effective with children with behavior problems (see Chorpita et al., 2011; Michelson, Davenport, Dretzke, Barlow, & Day, 2013). Second, there is evidence that parents can be trained as effective exposure coaches who can carry out exposures with their children in real-world settings outside of the therapy office, which may enhance generalization of target behaviors to real-world settings (Forehand, Jones, & Parent, 2013; Taboas, McKay, Whiteside, & Storch, 2015). Third, parents, when specifically trained as the primary behavioral interventionists, have greater access to administer differential reinforcement promptly, which improves generalization and acquisition of new foods spurred by child-driven interest (e.g., if a child spontaneously asks to try a new food, a parent can instantly praise and reinforce that flexible, approach-based behavior).

A group-based—rather than individual—intervention also has a number of potential benefits. Most importantly, a group intervention improves access to treatment, with more families receiving timely treatment and fewer families on lengthy wait-lists. Given the potential for severe picky eating to influence a child's growth, nutrition, and development, ready access to intervention is imperative. Second, the group context provides ample opportunities for parents to benefit from social reinforcement and support (i.e., enhanced parental motivation to enact interventions at home because others are simultaneously engaged in the process). Though not often explicitly integrated into behavioral feeding interventions, parental support and social reinforcement may be particularly beneficial given high levels of stress reported among parents of children with feeding difficulties (Garro et al., 2005; Jones & Bryant-Waugh, 2012; Mascola et al., 2010; Zucker et al., 2015).

Method

Participants

Participants were 21 children and their parents who were specifically referred to K.K.D., the clinical director of an outpatient anxiety specialty clinic for evaluation and treatment of extremely picky eating. Twenty-five families were initially evaluated and referred to the treatment groups. Two of those families dropped out of treatment after Session 4, both citing difficulties adhering to the protocol of nightly food challenges. One family dropped out after Session 5, due to complications from an accidental injury unrelated to participation in this study that required ongoing medical care. Two of these families also failed to complete pretreatment feeding assessment measures and one did not complete posttreatment or follow-up measures. One family that did attend the first six sessions did not complete posttreatment or follow-up measures. Hence, data analyses were limited to the 21 families that completed feeding measures at all three assessments.

Families, including the child, attended an evaluation appointment for 1–2 hours for diagnostic evaluation and to assess appropriateness for treatment. Inclusion criteria were an age range of 4–12 years, a diagnosis of ARFID due to excessive picky eating and associated functional impairment, and if another psychiatric disorder or medical problem (e.g., food allergy) was present, parental report that this was well controlled and their primary concern was their child's picky eating. There was no standardized structured diagnostic interview for ARFID at this time—hence, children were diagnosed via a clinical interview based on DSM-5 criteria as well as information on symptom severity and functional impairment gathered from the battery of standardized parent-report questionnaires (described below). Exclusion criteria included contraindications for oral feeding or swallowing at the time of participation, other medical complications that would interfere with the ability to take part in the treatment protocol, and an existing diagnosis of a developmental disorder (e.g., autism, cognitive impairment). Child weight and body mass index (BMI) were recorded prior to the start of treatment. Table 1 shows the demographic characteristics as well as relevant medical and psychiatric histories for all participants.

Measures

Behavioral Pediatric Feeding Assessment Scale (BPFAS)

The BPFAS is a 35-item caregiver-report questionnaire that assesses frequency and problems of various child and caregiver mealtime behaviors (Crist et al., 1994; Crist & Napier-Phillips, 2001). Sample items include "My child tantrums at mealtimes," and "I get frustrated and/or anxious when feeding my child." The BPFAS yields four domain scores: Child Frequency, Parent Frequency, Child Problems, and Parent Problems. The BPFAS was originally validated using samples of children ages 9 months to 8 years, but has been used to assess problematic mealtime behaviors with older children (e.g., Davis, Canter, Stough, Gillette, & Patton, 2013; Martins, Young, & Robson, 2008; Wu, Franciosi, Rothenberg, & Hommel, 2012). Though there is no "gold standard" measure for ARFID assessment, the BPFAS is considered a reliable and valid tool to assess food avoidance and associated problems in multiple contexts, and has demonstrated adequate sensitivity and specificity in differentiating children with ARFID from the general population and the ability to identify changes that occur during an intervention (Dovey et al., 2016; Dovey, Jordan, Aldridge, & Martin, 2013).

Child Eating Behaviors Questionnaire (CEBQ)

The CEBQ is a 35-item caregiver-report questionnaire that broadly assesses children's food approach and food avoidance behaviors (Wardle, Guthrie, Sanderson, & Rapoport, 2001). The CEBQ yields four food approach and four food avoidance subscales—however, the current analyses examined CEBQ subscale scores considered most relevant to assessing behaviors associated with excessive food neophobia and pickiness, specifically, Enjoyment of Food, and all four avoidance subscales of Satiety Responsiveness, Slowness of Eating, Emotional Undereating, and Food Fussiness. The CEBQ was originally validated with children ages 2–7 years, but has been used to assess food approach and avoidance behaviors in a sample of older children up to age 11 (Ashcroft, Semmler, Carnell, van Jaarsveld, & Wardle, 2008), with the Food Fussiness subscale, in particular, identifying severity levels of picky eating with acceptable sensitivity and specificity (Steinsbekk, Sveen, Fildes, Llewellyn, & Wichstrøm, 2017).

Child Behavior Checklist (CBCL)

The parent-reported CBCL (Achenbach & Rescorla, 2000, 2001) was completed only at the intake evaluation and provided ratings of behavioral, emotional, and social problems. The CBCL has excellent psychometric properties. Standardized *T* scores are reported here for two broad groupings of problem behaviors: internalizing problems and externalizing problems.

Table 1
Demographic Characteristics and Comorbid Medical and Psychiatric Problems of the Sample at Pretreatment ($N = 21$)

Variables	*M* (*SD*)	% (*n*)
Age, years	7.66 (2.02)	
Gender, female		10% (2)
Race, White		90% (19)
BMI [a]	37.75 (33.00)	
Underweight: <15th percentile		38% (8)
Overweight: >85th percentile		14% (3)
History feeding problems other than picky eating [b]		38% (8)
History food allergies [c]		29% (6)
History other psychiatric diagnoses		
Anxiety disorder		38% (8)
OCD or tic disorder		14% (3)
ADHD or behavior disorder		14% (3)
Elevated internalizing problems on CBCL [d]		37% (7 [e])
Elevated externalizing problems on CBCL [d]		0% (0 [e])

Note. BMI = body mass index, OCD = obsessive-compulsive disorder, ADHD = attention-deficit/hyperactivity disorder, CBCL = Child Behavior Checklist.

[a] Median BMI = 31.42.

[b] Includes reflux and other gastrointestinal concerns.

[c] Includes one child with celiac disease.

[d] Elevated *T* scores on the CBCL = ≥65.

[e] Two families did not complete the CBCL at pretreatment and percentage was therefore calculated from a total *n* of 19.

Parent satisfaction with treatment. At the end of active treatment, each family was asked to complete a parent satisfaction questionnaire that was designed specifically for the Picky Eaters Clinic to generate information for quality improvement. Parents rated their satisfaction via a Likert scale from 1 (*not helpful*) to 5 (*extremely helpful*) for a series of 11 questions. The first six questions asked for rating of helpfulness of each of the six sessions of active treatment; the final five questions asked for ratings regarding organization of sessions, information provided during sessions, opportunities for group sharing, group leader role plays, and between-session homework assignments. Parents were then asked to answer two open-ended questions regarding what aspect of the treatment was most helpful to them and what other suggestions they had.

Intervention Procedure

The Picky Eaters Clinic protocol was intended to treat mild-to-severe levels of picky eating among school-age children not dependent on supplements or tube feedings. Although DSM-5 does not provide severity classifiers for children with ARFID, the children in the current sample showed moderate to severe levels of picky eating. For example, Steinsbekk et al. (2017) identified a cutoff score of 3.33 on the CEBQ Food Fussiness subscale to designate "severe" cases of pickiness; our sample at intake had a mean Food Fussiness score of 4.76 (*SD* = 0.32; range = 3.67–5.00). BPFAS scores were similar to those reported for other clinical samples of children with feeding problems, including those dependent on nutritional liquid supplements and those with autism spectrum disorder (ASD; Allen et al., 2015; Crist & Napier-Phillips, 2001; Dovey et al., 2013, 2016; Marshall, Raatz, Ward, & Dodrill, 2015). All families reported considerable impairment and stress caused by the picky eating, including their child eating less than 20 foods; their child refusing entire groups of foods (typically vegetables, meats, or fruits); routinely having to make the child a separate meal; difficulty traveling, socializing, or going to restaurants; high child distress and refusal to eat when presented with a new or nonpreferred food; and lack of child motivation to change or engage in treatment.

The Picky Eaters Clinic intervention followed a protocol developed by the first author and informed by a decade of clinical work providing evidence-based cognitive-behavioral therapy to youth with primary anxiety disorders as well as several years' experience providing family-based behavioral therapy to individual children with clinically impairing picky eating in an outpatient setting of a psychiatry clinic at a children's hospital (Dahlsgaard, 2014). The group treatment protocol described here was intended as a quality improvement project to increase patient access to care and was delivered at the same outpatient setting. All measures were collected as part of standard treatment procedures in the clinic and parent responses and other demographic and background information were later recorded in a de-identified data set; accordingly, IRB approval was not required. Data were collapsed across seven waves of parent groups (two to four families per cohort; *M* = 3.42).

All seven sessions lasted 90 minutes each. The first four sessions were spaced 1 week apart; Sessions 5 and 6 were each spaced 3–4 weeks apart to allow families time to practice the assigned behavioral strategies and to solidify gains. Posttreatment feeding measures and a parent satisfaction measure were administered at the sixth "graduation" session. An optional "reunion" session (Session 7) was conducted 3 months after the end of active treatment, during which feeding measures were again administered ("follow-up").

The initial session included psychoeducation about ARFID, improving mealtime hygiene and appetite optimization, and an introduction to the core behavioral principles of the program, such as exposure, habituation, differential reinforcement, limit setting, and contingency management. Group sharing and support was also encouraged. Parents were introduced to a daily exposure procedure at Session 2, in which the child is challenged at home to chew and swallow a portion of a new or nonpreferred food ("challenge food") in a limited time frame in order to access a reward following the meal. Parents were coached to choose a reward they believed would be the most motivating for their child and feasible to administer over the long term; the majority of parents chose screen time (i.e., access to a tablet, computer, television, or video game). Parents eliminated access to the reward during all other times of the day, and the reward was given contingent upon challenge food consumption. Parents received verbal instruction, participated in role plays, and had the opportunity to ask questions and problem solve regarding enacting daily challenge food exposures. Later sessions followed a similar structure and focused on improving parent compliance and skill with differential reinforcement and contingency management techniques during food exposures and at regular mealtimes, as well as increasing portion sizes of challenge foods and eventually fading them into regular meal rotation. The optional booster reunion Session 7 focused on relapse prevention and maintaining gains over the long term. A summary of individual sessions and their intended active ingredients may be found in Table 2.

Outcomes

Treatment Feasibility and Adherence

Attendance was uniformly high, with 95% (20/21) of families having at least one parent attend all six active sessions. The majority of children had two parents attend treatment sessions (71% or 15/21). Although the seventh reunion session was optional, 81% (17/21) of families chose to attend. The four families that could not attend completed the follow-up assessment questionnaires. Parent adherence to the protocol of daily food exposures was monitored via in-session review of the previous week's exposure and reward recording sheets, and all families presented challenge food exposures at least 5 days of the week throughout active treatment (with the vast majority adhering to challenge food exposures 7 days a week).

Feeding Measures

Table 3 displays changes in mean scores on the BPFAS and CEBQ subscales at pretreatment, posttreatment, and 3-month follow-up, as well as comparisons from pretreatment to posttreatment and pretreatment to follow-up. Associated effect sizes (Cohen's *d*) were calculated using the following equation, which accounts for the correlation between pretest and posttest values in a within-group comparison: $d_{\mathrm{RM}} = \mathrm{tc}[2(1-r)/n]1/2$ (Dunlap, Cortina, Vaslow, & Burke, 1996).

Paired-sample *t* tests indicated a significant change in almost all BPFAS and CEBQ mean scores at each point of

Table 2

Content of the “Picky Eaters Clinic” Group Treatment and Intended Component Purpose

Session 1

- Introductions; purpose and format of group sessions
- Psychoeducation and brief review of treatment literature on ARFID (PE)
- Introduce evidence-based components of treatment (PE, EX, DR, CM):
    1. Improved mealtime hygiene
    2. Daily exposure to “challenge foods”
    3. Differential reinforcement
    4. Contingency management
- Homework:
    1. Improve mealtime hygiene per recommendations
    2. Preparations regarding daily reinforcer

Session 2

- Review homework: collaboratively reinforce parent efforts to set foundation for successful food exposures and problem solve regarding difficulties (M, RG, PS)
- Provide instructions for daily, timed food exposures (PE, EX)
- Role-play successful and unsuccessful food exposures modeling differential reinforcement (EX, DR, RP)
- Collaborative cognitive identification and modification regarding parental predictions and beliefs regarding food exposures (CT, EX)
- Establish token economy and rewards for target behaviors (CM)
- Demonstrate completion of weekly exposure and reward sheets (M, GS)
- Homework:
    1. Enact daily food exposures with new/nonpreferred foods
    2. Enact token economy and associated rewards

Session 3

- Review homework: group review of weekly exposure and reward sheets (M, RG)
- Group reinforcement of successes (child behaviors and parent behaviors) (RG)
- Collaborative problem solving and role-play regarding difficulties encountered during exposures and regular mealtimes (EX, PS, RP)
- Collaborative identification/role-play of additional positive mealtime behaviors to reinforce with labeled praise, tokens, and rewards (DR, CM, RP)
- Homework:
    1. Continue daily exposures
    2. Parent self-correction of identified difficulties with DR or CM
    3. Additions to token economy

Session 4

- Review homework: group review of weekly exposure and reward sheets (M, RG)
- Group reinforcement of successes/problem solving regarding difficulties (RG, EX, RP, PS)
- Introduction of “streak rewards” to motivate child progress by rewarding successive days of successful food exposures (PE, CM)
- Collaborative development goals for each family for multiweek break until next session (GS)
- Homework:
    1. Continue daily exposures
    2. Parent self-correction of identified difficulties with DR or CM
    3. Enact streak rewards

Session 5

- Review homework: group review of weekly exposure and reward sheets (M, RG)
- Group reinforcement of successes and problem solving regarding difficulties (RG, EX, RP, PS)
- Discussion/role-play of behavioral techniques for encouraging generalization of gains to other mealtimes or social settings (M, EX, DR, CM, GS, PS)
- Collaborative development of goals for each family for multiweek break until next session (graduation) (GS)
- Homework:
    1. Continue daily exposures
    2. Parent self-correction of identified difficulties with DR or CM
    3. Enact behavioral strategies for generalization of gains

Session 6—Graduation Session

- Review homework: group review of weekly exposure and reward sheets (M, RG)
- Review overall progress and mastery of effective techniques that led to child success as more flexible eaters and parent success

(continued on next page)

Table 1 (*continued*)

as exposure coaches (EX, DR, CM, RG)
- Discussion and recommendations regarding relapse prevention and continuing exposures and contingency management over the long term and during difficult times (e.g., sickness, holidays, vacations, plateauing of progress) (PE, PS, RPv)
- Collaborative development of goals for multimonth break until reunion (GS)
- Homework:
  1. Continue daily exposures
  2. Parent self-correction of identified difficulties with DR or CM

Session 7—Optional Reunion Booster Session
- Review progress over last several months (M, RG)
- Collaborative problem solving and role-play regarding remaining difficulties encountered during exposures and regular mealtimes (PS, GS, PE, RP)
- Review relapse prevention strategies (PE, EX, DR, CM, PS, RPv)
- Recommendations and discussion of when and how to fade exposures and contingency management procedures with goal setting (PE, GS)

Note. ARFID = avoidant/restrictive food intake disorder, CM = contingency management, CT = cognitive techniques, DR = differential reinforcement, EX = exposure, GS = goal setting, M = monitoring, PE = psychoeducation, PS = problem solving, RG = reinforcement of gains, RP = role-playing and skill rehearsal, RPv = relapse prevention.

comparison. On the BPFAS, there were significant reductions across all four subscales from pretreatment to posttreatment (*p* values < .01) with large within-group effect sizes at posttreatment (*d* range = 1.00–1.28). Results also showed significant reductions on all BPFAS subscales from pretreatment to 3-month follow-up (*p* values < .01) and similarly large within-group effect sizes (*d* range = 0.98–1.23). There were no significant changes on any of these outcome measures from posttreatment to follow-up, indicating that gains were maintained at 3 months. Reliable Change Indexes (RCIs) were calculated for each participant at posttreatment and follow-up via the method described by Jacobson and Truax (1991), using normative data on the BPFAS reported by Dovey et al. (2013; T. Dovey, personal communication, May 31, 2018). The proportion of the sample that achieved significantly reliable change in symptom reports at posttreatment ranged from 29% (Child Frequency) to 70% (Parent Problems). At follow-up, the proportion that achieved significantly reliable change ranged from 38% (Child

Table 3
Descriptive Statistics and Pairwise Comparisons at Pretreatment to Posttreatment and Pretreatment to Follow-Up (*N* = 21)

	Pretreatment	Posttreatment	Follow-up	Pretreatment to posttreatment comparison			Pretreatment to follow-up comparison[a]		
Variables	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*t* ratio	*SE*	*ES*	*t* ratio	*SE*	*ES*
BPFAS									
Child Frequency	69.00 (11.92)	57.43 (11.08)	54.67 (12.54)	4.87***	2.38	1.00	5.48***	2.61	1.17
Parent Frequency	30.38 (5.75)	23.19 (5.47)	22.24 (7.20)	5.59***	1.29	1.28	6.37***	1.28	1.23
Child Problems[b]	10.50 (4.47)	6.33 (4.60)	6.19 (5.43)	3.63**	1.24	1.01	3.73**	1.27	0.98
Parent Problems[b]	5.95 (2.42)	3.24 (2.17)	3.14 (2.69)	4.32***	0.64	1.19	5.72***	0.52	1.15
CEBQ									
Enjoyment of Food[c]	2.38 (0.70)	2.85 (0.58)	2.89 (0.77)	-3.41**	0.14	-0.72	-3.54**	0.14	-0.69
Satiety Responsiveness	3.17 (0.80)	2.74 (0.65)	2.79 (0.81)	2.72*	0.16	0.58	2.35*	0.16	0.47
Slowness in Eating	2.85 (0.97)	2.24 (0.99)	2.25 (0.83)	3.10**	0.20	0.62	2.81*	0.21	0.66
Emotional Undereating	2.81 (1.29)	2.70 (1.11)	2.21 (1.04)	0.36	0.31	0.09	2.24*	0.27	0.51
Food Fussiness	4.74 (0.32)	4.05 (0.70)	3.88 (0.78)	4.24***	0.16	1.26	5.15***	0.17	1.36

Note. BPFAS = Behavioral Pediatric Feeding Assessment Scale, CEBQ = Child Eating Behavior Questionnaire, *SE* = standard error, *ES* = effect size in Cohen's *d*, adjusted due to the correlated nature of the dependent sample per Dunlap, Cortina, Vaslow, and Burke (1996).

* $p < .05$, ** $p < .01$, *** $p < .001$.

[a] Within-group *t* tests for posttreatment to follow-up were nonsignificant across outcomes.

[b] One family did not complete the "Problems" sections of BPFAS at pretreatment; *n* = 20 for calculations on these variables.

[c] Higher scores indicate greater enjoyment of food.

Frequency) to 70% (on both Child Problems and Parent Problems).[1]

On the CEBQ, results showed significant increases in Enjoyment of Food and significant decreases in Satiety Responsiveness, Slowness in Eating, and Food Fussiness from pretreatment to posttreatment (all p values < .05), with large within-group effect sizes at posttreatment (d range = 0.58–1.26). The CEBQ score on Emotional Undereating did not show significant improvements. Results further showed significant increases in Enjoyment of Food and significant decreases in Satiety Responsiveness, Slowness in Eating, Emotional Undereating, and Food Fussiness pretreatment to follow-up (all p values < .05) and moderate to large within-group effect sizes (d range = 0.47–1.36). There were no significant changes on any CEBQ subscales from posttreatment to follow-up, indicating that gains were maintained at 3 months. RCIs calculated using normative data from Wardle et al. (2001) showed the proportion of the sample that achieved significantly reliable change on the subscales ranged from 29% (Emotional Undereating) to 43% (Food Fussiness) at posttreatment and 29% (Satiety Responsiveness and Emotional Undereating) to 62% (Food Fussiness) at follow-up.[2]

Parent Treatment Satisfaction

One or both parents of 71% of the participants (15/21) completed a treatment satisfaction questionnaire at posttreatment, for a total of 25 completed questionnaires. For the questions regarding how helpful parents found specific aspects of the Picky Eaters Clinic, mean scores ranged from 4.32 to 4.72 (SD range = 0.46–0.85), with 96% of parent responses falling into the Very Helpful or Extremely Helpful categories. Parents' responses to open-ended questions about treatment were extremely positive, with group support and parent training in exposures and contingency management procedures frequently mentioned as the most beneficial aspects. Some transcribed responses to the question "What was most helpful?" include the following: "It was great being in a group setting to learn from the other families and hear about different situations. I feel like every variable was covered, and it was a great experience"; "Learning to increase the portion sizes, advice on how to manage setbacks, learning that his reaction is distress and overcoming it is one of the goals—that he has the ability to eat anything with enough exposures"; "Utilizing the program philosophy in other areas of parenting; the method has been working across the board." Other parents reported: "I liked that you taught the parents and not the kids"; "The program is effective and very user-friendly for working parents"; "I can't believe my son is eating the foods that he is; he has come a long way in 12 weeks."

Case Example 1

Michael (pseudonym) was an 11-year-old who attended fifth grade at his local public school. He and his family presented at the initial evaluation with an explicit parental goal: "We would like him to eat more than 20 foods." Michael had an unremarkable early feeding history: He was breastfed and weaned at 14 months with no reported problems. Strained foods were introduced at 4–6 months and table foods were introduced at 12 months with no reported oral–motor problems or excessive food neophobia or pickiness. Parents first became concerned about his pickiness at age 2 because they had required their older children at this age to eat nonpreferred foods before they left the table, but with Michael these same limits were unsuccessful—he would merely lick the foods or refuse them entirely and was "very loud and persistent" in his distress. Parents found that when they did coax him to eat nonpreferred foods, he would frequently gag and vomit. His range of accepted foods initially expanded when he entered school, but declined again in third grade with no identifiable trigger. Over the course of his childhood, parents had tried the following to address the problem: sneaking food into his mouth, sneaking new foods into preferred foods, "letting him be the decision maker," yelling, punishments (such as time-outs), and rewards—none had been successful. At the intake evaluation, parents wearily reported they had "given up" because it was their perception that efforts to expand Michael's palate were compromising their relationship with their son.

At the time of his intake evaluation, Michael's BMI was at the 74th percentile. He showed a good appetite for preferred foods and ate scheduled meals and snacks enthusiastically. Michael and his family denied excessive fears of choking or vomiting, as well as restriction due to concerns about body shape or size. Michael had some mild clothing sensitivities (he did not like tight clothes but could be coaxed to wear them when necessary), but otherwise met all developmental milestones on time, and the parents had no other concerns. He was a star athlete,

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[1] These percentages of participants who achieved reliable change were calculated for the 21 for whom complete data were available. If the dropouts and those who failed to complete feeding measures (N = 4) were included and counted as failing to achieve reliable change, recalculated percentages would range from 24% (Child Frequency) to 58% (Parent Problems) at posttreatment and 32% (Child Frequency) to 58% (Child Problems and Parent Problems) at follow-up.

[2] If dropouts and those who failed to complete feeding measures (N = 4) were included and counted as failures, recalculated percentages would range from 24% (Emotional Undereating) to 36% (Food Fussiness) at posttreatment and 24% (Satiety Responsiveness and Emotional Undereating) to 52% (Food Fussiness) at follow-up.

enjoyed and did well at school, and made and kept friends easily. There was a reported family history of anorexia (aunt) but no other significant psychiatric history. Due to the severity of his picky eating and associated impairment, Michael met criteria for ARFID but no other psychological or developmental disorders. Problem scores on the CBCL were uniformly in the average range. He had never before received treatment for his picky eating.

At the start of the Picky Eaters Clinic, Michael was highly picky and neophobic and ate the same limited foods at virtually all meals. For breakfast he ate brand-specific muffins or waffles along with chocolate or strawberry milk. Lunch at school consisted each day of a brand-specific and sugary yogurt, as well as pretzels and chips with water. His after-school snack consisted of the same crunchy junk foods that he ate at lunch, along with flavored milk. Dinner consisted of several slices of a specific brand of frozen pizza that he had “only recently” deigned to accept regardless of the shape into which the slices were cut, but that he would still frequently reject if “it didn’t look exactly right.” He would also eat a particular brand and size of buttered noodles. His after-dinner snack consisted of more snack foods or a milkshake. He ate no meats, no vegetables, and no fruits. Michael was also rigid in other ways with regard to food: He refused to eat the edges of his breakfast waffles; he would clear family plates from the table but not scrape them such that he did not have to touch nonpreferred foods.

Michael’s parents were both employed, had divorced, and neither had remarried. Both parents attended all Picky Eaters Clinic sessions and participated actively, though they acknowledged at the first session that they did not think the program would work. They chose access to screen time as the nightly reinforcer for passing the challenge food exposures and chose initial challenge foods of various fruits, vegetables, and chicken. To his parents’ amazement, Michael swallowed three of five food challenges in the first week exposures were introduced (Session 2). His parents would provide challenge foods at dinner during weekdays and a breakfast or lunch on weekends. They both enacted the protocol with good fidelity. At Session 4, he had passed four of seven challenge foods, and his parents independently realized that his afternoon snack was too big and reported to the group that they had decided to limit it such that he was hungrier when he came to the dinner table for challenge food exposures. After the 3-week break between Sessions 4 and 5, Michael’s parents reported that he had swallowed all challenge foods each day and that they had increased portion sizes. He was also increasing his speed in swallowing the challenge foods. He showed pride when he passed food challenges and was earning streak rewards consistently. They had moved grapes to regular rotation in meals but, after several failures and group problem solving, planned to move them back to a challenge food so that Michael would have more exposures before they tried to fade it again. They had added watermelon to the challenge food list and he was eating this easily. After the 3-week break at Session 6 (graduation), parents reported he had only failed a challenge food once, and that they had successfully faded grapes to regular rotation in meals. They reported that Michael was still reluctant to eat corn, but would now chew it and swallow it rather than swallowing it whole.

After a 3-month break, parents reported at Session 7 (reunion) that they had faded only one more food to regular rotation, but that Michael had not failed eating a challenge food in over a month, including when they were presented at restaurants. They had by that point dispensed with the timer for challenge foods, as Michael ate all of them very quickly. He would attend sleepaway camp soon, and parents and therapist were confident he would make additional gains there via peer social reinforcement. Parents reported that despite their initial trepidations, they were very pleased with progress and were confident they could continue the program on their own in the future with the expectation of further gains. At intake, BPFAS scores were uniformly above clinical cutoff (Child Frequency = 77, Parent Frequency = 32, Child Problems = 13, Parent Problems = 6). At posttreament Session 6, most were below clinical cutoff (Child Frequency = 53, Parent Frequency = 26, Child Problems = 4, Parent Problems = 3).[3] In addition, these differences all demonstrated statistically reliable change. BPFAS scores were unchanged or lower at 3-month follow-up (reunion Session 7).

Case Example 2

Ernest was a 6-year-old who attended first grade at his local public school. His food selectivity and disruptive mealtime behaviors were such that his parents had initially sought a full evaluation at the local hospital’s feeding and swallowing center, which found no organic or oral–motor causes for his eating difficulties and referred him for treatment at the Picky Eaters Clinic. In infancy, Ernest had difficulty latching during nursing, lost weight, and was switched to formula with success. He initially showed some pickiness with foods prior to age 2, but could self-feed. Feeding issues and selectivity became severe around 2 years of age, seemingly coinciding after he broke his leg and was confined to a cast. Since that

[3] Previous research has suggested that BPFAS scores above the following levels differentiate a clinical sample with ARFID from a nonclinical sample: 59 for Child Frequency, 22 for Parent Frequency, 6 for Child Problems, and 3 for Parent Problems, with the Child Problem domain score deemed best able to discriminate those with a clinical diagnosis of ARFID (Dovey et al., 2016).

time, he "just does not eat well." He had strong, negative reactions to smells and textures of food. When he would not eat, his parents would sit with him and spoon feed him. Ernest's parents reported that getting him to eat—even foods he liked—was a "constant battle" and that they had tried coaxing, involving him in food preparation, and rewards. He frequently complained about stomach pain and constipation and was followed by the Gastrointestinal (GI) Department.

Ernest had experienced some delayed milestones, including language, had an individualized education plan (IEP), and received speech therapy at school where he was otherwise reported to be doing well with no behavioral difficulties. He had long received occupational therapy for his picky eating without improvement. ASD had been assessed for and ruled out when he was younger, but he still presented with some social skills difficulties, fears, rigidities, and emotional dysregulation.

When presented with a new or nonpreferred food at home, Ernest would refuse to eat; refuse to touch it and push it away; try to get out of his seat; cry and scream; gag, cough, and spit out food; and complain about the food and how it would make him feel. He would not sit at the family table because the smell of foods bothered him, he would not self-feed with utensils because he perceived them as "dirty," and he would only eat a single yogurt at school lunch due to the smells of the cafeteria and his dislike of sitting at a messy table with crumbs on it. With preferred foods, he would appear not to be hungry, but once his mother began to feed him, he would eat but then consistently negotiate what "finishing" a meal entailed.

At the time of the intake evaluation for the Picky Eaters Clinic, Ernest's BMI fell in the 36th percentile. His stomach pains and constipation were better and he tended to complain about GI distress only when presented with nonpreferred foods. He ate around 20 foods, including a few fruits; a few vegetables (asparagus, carrots, and string beans); plain hamburger, chicken, and hot dogs; string cheese and yogurt; a few breakfast cereals; plain pasta; and several crunchy salty snack foods. He ate three meals and two snacks a day.

There was a family history of obsessive-compulsive disorder (OCD) and a paternal history of picky eating. At intake, Ernest did not meet criteria for OCD, and his contamination fears appeared secondary to excessively picky eating. However, he did present with enough additional fears to meet criteria for a diagnosis of other specified anxiety disorder as well as ARFID. Problem scores on the CBCL fell uniformly in the average range.

Ernest was an only child, and his parents were married and employed. Both parents attended all sessions and initially expressed trepidation that he would feed himself, much less increase his willingness to try new foods. They chose access to screen time as the daily reinforcer for challenge food exposures and were shocked to find that he passed every challenge food the first week they were introduced. However, they revealed they were serving them on a separate plate in order to reduce his distress and refusal and resolved with group support to place challenge foods on his regular plate during the second week of exposures. By Session 4, parents reported there was only one night that Ernest did not swallow the challenge food—a cherry tomato. He spit it out, and "due to the rules, that was that." Parents reported he was "devastated" not to pass and earn screen time, and "he vowed to never let that happen again." After the 3-week break at Session 5, parents reported that "we are seeing that he will just about try anything! The child that would never try anything new and scoffed at anything that wasn't a noodle or hot dog! He eats the challenge foods, including that darn tomato, quicker than it takes to even start the timer!" They reported a greatly increased quality of life: "His overall anxiety level has lessened considerably. He has not freaked out about smells of food or others eating near him. We have been going to the houses of friends and family and not having to bring a cooler for Ernest's special foods." They also reported that he was feeding himself, sitting at the table, and they were increasing portion sizes of the challenge foods. They had faded three foods to regular rotation (lunch meats and cheese) and were having success in restaurants. After the 3-week break at Session 6 (graduation), parents had moved several other foods to regular rotation and were giving Ernest multiple challenge food exposures a day. At 3-month follow-up Session 7 (reunion), parents reported continued progress and confidence they could continue the program at home. Ernest's parents concluded, "We are seeing that, although Ernest's food issues were not created by us, by placating him, we allowed the issues to continue." At intake, BPFAS scores were uniformly above clinical cutoff (Child Frequency = 80, Parent Frequency = 35, Child Problems = 8, Parent Problems = 8). At posttreatment Session 6, all were below clinical cutoff (Child Frequency = 43, Parent Frequency = 14, Child Problems = 0, Parent Problems = 1). These differences all demonstrated statistically reliable change. BPFAS scores were unchanged or lower at 3-month follow-up (reunion Session 7).

Discussion

The aim of the current study was to assess the initial effects, acceptability, and feasibility of a seven-session behaviorally based parent-only group intervention for children described by their parents as extremely picky eaters who met criteria for ARFID based on psychosocial impairment due to their selectivity. Parents, rather than children, were chosen as the recipients of treatment due to the strong component of PMT required to address entrenched and disruptive mealtime behaviors and groups were the chosen mode of treatment to improve access to care as part of a quality improvement initiative. Parents completed standardized measures that assessed picky eating as well as other associated problematic child and caregiver mealtime behaviors before, immediately after the sixth session, and 3 months following the intervention at an optional seventh booster session. Immediately following active treatment (Session 6), challenging child and parent mealtime behaviors, including food avoidance, were significantly less frequent and less problematic. Specifically, parents reported that children were less picky and fussy about food, ate more quickly, and were less likely to express early satiety. Of particular note, despite the daily exposure to nonpreferred foods required by the treatment protocol, parents also reported at posttreatment that their children enjoyed eating more. Effect sizes were moderate to large and 29–70% of the sample achieved significantly reliable change depending on outcome measure. Moreover, these gains were maintained from the end of active treatment to a 3-month follow-up booster session.

In addition to improvements on standardized measures, the intervention yielded high levels of parent satisfaction as reported on a quantitative and qualitative parent satisfaction feedback measure. Parents overwhelmingly rated every measured aspect of the program as "very helpful" or "extremely helpful." Attendance was high and parents engaged their children in the daily food exposures with exceptional fidelity. These findings, particularly when combined with qualitative reports of parent appreciation for the program ("No more peeling hot dogs!"), suggest that the treatment is acceptable and feasible and that the brief group format resonates with parents as an effective intervention medium. The focus on parent-only training appears to have been another feasible aspect of the treatment approach: Only 2 of the original 25 families referred to the intervention dropped out citing difficulties engaging in the protocol, suggesting that the vast majority of parents were willing and able to serve as their children's exposure coaches. The total 12% dropout rate is impressive, given that the dropout rate in group behavioral parent training for children with disruptive behavior disorders is 26%, according to a recent review (Chacko et al., 2016). Moreover, results on the feeding measures showed that parents were effective as exposure coaches, and qualitative data suggest they felt empowered by this aspect of the treatment.

Taken together, results indicate that moderate to severe picky eating, a vexing—not uncommonly, heartbreaking—eating disorder, can be well treated in children in a relatively short time frame with high parent engagement, satisfaction, and effectiveness. To our knowledge, this is the first published study employing a brief outpatient, parent-only, behaviorally based group intervention for a large clinical sample of typically developing, school-age children with a primary diagnosis of the picky eating subtype of ARFID. Extant literature has suggested the disorder is generally difficult to treat (Strandjord, Sieke, Richmond, & Rome, 2015), especially in outpatient settings (Hartdorff et al., 2015; Sharp et al., 2014). However, the moderate to large effect sizes found after the six-session group intervention and maintained at a follow-up booster session challenge these assumptions and demonstrate that a brief outpatient intervention can be highly impactful for children with excessive and impairing picky eating.

The protocol used in the present study has a number of strengths. First, the treatment is manualized and therefore prime for dissemination to clinicians and trainees (Dahlsgaard, 2014). Second, the protocol is informed by evidence-based techniques of anxiety treatment, such as exposure, as well as key elements of PMT for behavior problems, including differential reinforcement and contingency management. Third, the treatment can be administered in an outpatient context, which for many families made it reimbursable via insurance, a factor reported to be very important to caregivers of children with eating disorders (Cifra, Morley, Kreipe, Teelin, & Stewart, 2017). Fourth, the brief length of active treatment (six sessions spaced over approximately 3 months) and evening timing made it feasible for working parents to attend. Fifth, the protocol explicitly trained parents to implement daily food exposures in the child's natural home environment and community, allowing for generalization of gains beyond a hospital or therapy office that could be maintained after "official" treatment led by a therapist ceased. Sixth, the parent response to the intervention was tremendously positive, to the extent that many parents reported successfully utilizing the behavioral techniques taught in sessions with their other children who displayed milder picky eating and for problematic behaviors beyond feeding. Seventh, this approach allows increased treatment access for multiple families at once and frees up providers' time in comparison to the individual model of therapy.

The present study included several limitations. First, this was not an RCT, and comparisons cannot be made regarding progress that could have occurred in a wait-list control group over the same time period. However, given the persistent nature of untreated ARFID (Forman et al., 2014), the tendency toward narrowing of food preferences over time (Cardona Cano, Tiemeier, et al., 2015; Davies et al., 2006), and the long duration of symptoms prior to diagnosis documented in previous studies (Fisher et al., 2014; Forman et al., 2014), it seems unlikely that significant gains in a wait-list control group would have occurred during the same 3-month time period. The study relied on clinical data that were collected as part of standard clinical procedures within an outpatient clinic and as part of quality improvement to inform future treatment groups. Clinical data are typically less reliable and complete than those collected during planned research protocols. In addition, children were diagnosed with ARFID via clinical interview, rather than a standardized structured interview, as one did not exist for ARFID at the time of these treatment groups. However, given that standardized measures of problematic feeding behaviors were used to assess change, the results are readily interpretable and replicable.

Although the sample is rather heterogeneous in terms of previous medical diagnoses, comorbid psychiatric diagnoses, food allergies, and age, this can also be viewed as a strength, as it offers a higher likelihood that these data will be relevant and generalizable to many children with ARFID, a group already recognized as very heterogeneous (Cardona, Hoek, et al., 2015). Though large for a clinical sample, the sample size was too small to permit reliable secondary analyses of moderating or mediating variables on treatment outcome (e.g., age, gender, presence of other psychiatric or medical symptoms). These and other limitations, such as the brevity of the follow-up period (3 months) and the lack of posttreatment BMI or CBCL data could be addressed in future studies that apply this manualized treatment. A randomized trial examining the efficacy of the intervention would be a beneficial next step, particularly against another active treatment that focused on individual treatment, treatment with children included, or treatments that focused on other theorized ingredients of change. Additional applications could involve parents of mild picky eaters (aimed at preventing the onset of ARFID), parents of children with ASD and rigid eating, or parents of inpatients with ARFID in eating disorder units to prepare for maintenance of feeding gains postdischarge.

Common Challenges and Recommendations

Altogether, the current study demonstrates the clinical utility of a brief, parent-only behavioral intervention that leads to significant ARFID symptom reduction among typically developing children. Though the treatment protocol is straightforward and lean, it accommodated several common challenges presented during treatment. For example, some parents, perhaps accustomed to a lay understanding of "therapy" as individual and focused on the identified patient, expressed initial confusion as to why they were the focus of treatment and not their child. This was ameliorated by reminding parents that many had already sought individual, often lengthy treatment for their children, but described it as ultimately unhelpful, with the near universal refrain that "the therapist could get my child to eat in their office, but our child wouldn't do it for us at home." Parents were also reminded that the parent-as-agents-of-change model would address the frequent refrain that, even if they were present in individual sessions of previous treatment, this did not result in increased compliance by their children once at home, nor a confidence among themselves that they could successfully navigate challenging exposures or negative mealtime behaviors. Families with multiple siblings frequently raised concerns about focusing exposures with rewards on just one child; via group discussion of problem solving and pros/cons, parents typically opted to impose a system of nightly food challenges for all their children (and some husbands). Parents who worried about delaying the reward of screen time on weekends were encouraged to hold food challenges on weekend mornings at breakfast. Groups were held in the fall and winter (during the school year) rather than during the summer, such that nightly routines and access to screen time were more tightly controlled while the families were learning the skills.

Another common concern raised by parents was that daily food exposures would "create a negative atmosphere at the meal," result in their child "dreading" mealtimes, or potentially cause an eating disorder. In these cases, parents were quite receptive to feedback that their child already dragged his or her feet to the table and, in fact, already met criteria for an eating disorder—this is why they were seeking treatment in the first place. These concerns were also addressed via psychoeducation in the first session regarding the strong evidence base for exposure as well as sensitive explanation of the rationale for temporarily increased distress as a step toward habituation, inhibitory learning, and improved distress tolerance. Also helpful was Socratic questioning about other instances where parents felt like good parents when setting clear expectations/limits and delivering appropriate consequences, even if much to their child's temporary distress (e.g., bedtimes, chores, vaccinations).

Indeed, no adverse events were reported during the course of this treatment, and qualitative feedback suggests that parents felt renewed self-efficacy and enthusiasm toward feeding their children. The findings are promising, but highlight a need for more RCTs related to ARFID to ultimately advance the dissemination of empirically supported interventions to an underserved patient population.

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