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Research Article

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Emotional and Feeding Aspects of Avoidant/Restrictive Food Intake Disorder (Arfid): A Case Report

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Abstract

Purpose: *To describe the nutritional, psychological and family aspects involved in the treatment of a patient with Avoidant/Restrictive Food Intake Disorder (ARFID).*

Methods: *Descriptive, exploratory, quali-quantitative case report. A semi-structured questionnaire, a 24-hour Dietary Recall, Body Mass Index Percentiles and the Eating Attitudes Test-26 were used to assess the dietary variables and nutritional status. Both patient's and mother's psychological aspects were investigated by means of semi-structured interviews with descriptive analysis.*

Results: *At the age of 12, patient did not eat fruits, salad and vegetables. Over two years of treatment, he was able to try food items from those groups and also a hypercaloric supplement. EAT-26 scored negative at the beginning and end of the treatment, however with a drop in the score. Nutritional status showed entropy in both occasions, but the final curve was closer to Percentile 50. The mother's initial difficulties in respecting her son's attempts towards autonomy were managed in psychological group meetings, which helped her to lower her anxieties and to stop overloading her son's emotional development, which contributed to improve his relationship with food.*

Conclusion: *Improvement in the relationship with food showed that the treatment was effective, and that family has an important role in (re)building healthy eating habits.*

Keywords: Feeding and Eating Disorders of Childhood; Feeding Behavior; Patient Care Team; Family Relations.

Introduction

Eating is essential to human survival and is an act described in mankind's cultural origin since the earliest records of civilization. It is considered a form of human relationship and communication that pervades religion, anthropology, psychology, science and politics and is continuously and intimately deep-rooted in human life [1].

Eating habits start to build up during pregnancy, by means of the contact of the fetus with the amniotic fluid, that in influenced by the mother's feeding pattern. After birth, breastfeeding also provides several flavor experiences to the baby, again, experiences that reflect the food intake of the breastfeeding mother. Throughout life, such established habits will influence a number of factors of genetic, cultural, familiar, ethnical, religious, social and economic order, to name a few [2,3].

The first years of life are marked by fast development and changes in a child's food intake. Infants move from exclusive milk-sourced feeding to general feeding that includes all types of food. During this period, what infants learn about food and eating has an important role in the construction of their future feeding choices, diet quality and body weight, all of them fundamental aspects for the promotion of the individual's health [4].

Family plays an important role in their children's food education, and may have either a positive or negative impact, depending on the attitudes and behaviors of family members towards feeding. Although

there is a genetic predisposition to liking more sweet rather than savory flavors, it is known, for instance, that the environment and an individual's experiences may modify such interests. Therefore, family has a crucial role in developing children's and adolescent's food preferences. They do so by encouraging an environment that enables them to develop healthy feeding behaviors and moreover, by being themselves an example to be followed [5].
In this context, eating disorders (ED) may arise as a result of, but not limited to, disturbed eating environments. ED are characterized by distress in the feeding pattern, behavior and attitudes that result in impaired physical health and psychosocial functioning of an individual. They may appear at any point in life, but are more frequent during childhood and adolescence, as the etiology of ED is multifactorial and covers personal, environmental and familiar aspects [6-8].

About 25 to 45% of children with appropriate development and up to 80% of those who present a delay in development will have some kind of feeding issue. However, ED incidence and prevalence rates in this group may be impaired by the variety of definitions used [9]. After the amendments of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) of the American Psychiatric Association, the old chapter First Childhood Eating Disorder, that presented inaccurate descriptions and low practical application, was replaced by the term Avoidant/Restrictive Food Intake Disorder (ARFID) [8,10].

ARFID is characterized by atypical reactions towards food or feeding, such as apparent lack of interest in eating, avoidance based on the sensory characteristics of food, all that demonstrated by failure to adjust one's nutritional and/or energy needs. Patients with ARFID do not refer body image distortion or fear of weight gain. Those behaviors may be associated with one or more of the aspects as follows: significant weight loss, malnutrition (or impact related to the health), dependence on oral nutritional supplementation or significant interference in the psychosocial functioning [8].

In spite of being more frequent during childhood, ARFID may emerge or remain during adult life. Aversion to certain food items may arise after episodes of chocking or suffocation and may take place at any phase of life. However, during the first years of life, avoidances are more associated with the sensory characteristics of food such as appearance, smell, color, texture or flavor. There are descriptions in literature such as "restrictive eating", "selective eating ", "picky eating", "chronic food refusal", "perseverant eating " and "food neophobia"[8]. In childhood, symptoms are associated with traits of irritability, lethargy and anxiety, and parents and caregivers usually find it difficult to offer appropriate and enjoyable meals to children [11]. Symptoms such as depression, attention deficit hyperactivity disorder have already been associated with it, noting that symptoms worsen according to the severity of the ARFID [12].

The World Health Organization considers EDs as psychiatric disorders that must be primarily cared for during childhood and adolescence [13]. Generally, due to their multifactorial etiology, ED should be treated by a multidisciplinary team, usually comprised of psychiatrists, general practitioners or neurologists, nutritionists and psychologists. Different therapeutic techniques should be used, not only to address feeding issues, but also other factors related to the disorder. However, to our knowledge, there is no first line treatment for ARFID. Health assistance services have been testing different clinical management possibilities to better address the needs specific to this psychopathology [14].

Nutritional treatment aims at promoting healthy eating habits and a better relationship with food, facilitating exposure to rejected food items and expanding the variety of food eaten, with focus on the frequency of contact with food, rather than the quantity of food ingested. Nutritional supplementation may act as an important resource to address nutritional needs, especially at the beginning of treatment, and contributes to weight recovery and maintenance [15]. On the other hand, the psychological follow-up aims at enabling patients and family members to develop a broader and deeper understanding of external aspects (social and cultural environment and familiar dynamics) as well as of internal aspects (emotional conflicts and personality traits) involved in the emergence and maintenance of the ED [16]. It is believed that such understanding may lessen the unconscious defenses of patients and family members, improve their engagement in treatment and, consequently, improve the psychological and pathological condition.

Studies addressing the results of assisted ARFID patients, especially under the perspective of a multiprofessional assistance approach, are incipient. ARFID has only recently been recognized as a clinical entity distinguished from other types of ED, with revised nomenclature and diagnostic criteria, which highlights the need for more studies that characterize its clinical presentation and evolution [17].

Infant feeding has been a recurrent topic nowadays that arises interest in several fields of knowledge as it involves issues other than just mere nutritional-related ones [18]. For professionals who are not specialists in eating behaviour it can be challenging to differentiate a picky eating behaviour from an ED, which reinforces the need for more studies in this field, aiming to elucidate these behaviours and offer new clinical resources for treatment [19,20].
Considering the above, the aim of this paper is to describe the nutritional, psychological and family aspects involved in the treatment of a patient with ARFID.

Method

It was adopted as the strategic methodology a descriptive and exploratory case report with a quali-quantitative outline. The study was conducted by the Assistance Group on Eating Disorders from Hospital das Clínicas Ribeirão Preto Medical School, University of São Paulo (GRATA-HCRP-USP). The subjects of the research is a 12-year old male patient being treated for ARFID and his mother.

Patient data related to his weight, height, background and food intake was collected using a semi-structured food frequency questionnaire and a 24-hour dietary Recall [21]. In addition to this, he was assessed as per eating disorders risky attitudes (Eating Attitudes Test-26/ EAT-26), both at the beginning and at the end of treatment [22].

Regarding the psychological aspects, mother and son participated in semi-structured interviews, individually applied at the beginning of the treatment. Those interviews addressed questions regarding psychological, social and familiar functioning before and after the disorder being diagnosed, any stressful events that could be associated with the first symptoms, history of any previous psychological,

psychiatric and/or neurological treatment, evolution of symptoms and motivations to undergo a treatment. The mother was also asked questions about her pregnancy, breastfeeding experience and marital relationship.

The psychological and familiar aspects of this case were also investigated during the psychological support groups offered separately to patients and family members. Participating in these group meetings is mandatory to both patient and family member on days of outpatient follow-up visits. Topics are not defined beforehand – groups usually work with harrowing content brought up by participants themselves. More information about the psychological support group offered to family members can be accessed in Santos, Leonidas and Costa (2017) [23].

Description of the specialized service

The specialized literature on ED suggests that a multi/interdisciplinary approach is essential to treat the conditions efficiently, especially when provided in an institutional context [24,25]. Therefore, assistance groups should be comprised of professionals from different specializations, who should work based on therapeutic strategies jointly planned and agreed upon in a conversed and structured manner.

GRATA was founded in 1982 and is a pioneer service specialized in treating EDs in Brazil. GRATA is connected with the Nutrology Outpatient Unit of HC-FMRP-USP [26]. Its team currently comprises

professionals of the following areas:

1. Psychology: two coordinating psychologists, two supervising psychologists and four trainees of the Psychology undergraduate program;
2. Nutrition: one coordinating nutritionist, three supervising nutritionists and four trainees of the Nutrition undergraduate program;
3. Psychiatry: a coordinating psychiatrist and two resident physicians in Psychiatry;
4. Nutrology: a coordinating nutrologist and two resident physicians in Nutrology;
5. One occupational therapist.

GRATA operates on Fridays, on an outpatient basis. Assistance includes: weekly meetings with the multi/interdisciplinary team; individualized outpatient visits with which specialization (nutrition, nutrology, psychology, psychiatry and occupational therapy); individual psychotherapy of psychoanalytic orientation to patients and caregivers, held at the Center of Applied Psychology of the Ribeirão Preto School of Philosophy, Sciences and Letters of the University of São Paulo (FFCLRP-USP), offered by the trainees of the Psychology program on days and times other than Fridays and supervised by the psychology professionals of the team; nutritional support groups, occupational therapy and psychological support for patients and family members/caregivers (separately).

Data Analysis

Anthropometric data was used to calculate the Body Mass Index (BMI) Percentile, which was analyzed according to the reference of the National Health and Nutrition Examination Survey [27]. The 24-hour Dietary Recall was analyzed using Avanutri® software, while the semi-structured questionnaire was analyzed according to the frequency of answers provided by the patient. EAT-26 was analyzed according to the score, which establishes 21 or over as the cutoff score for a positive test [28].

Psychological and familiar aspects involved in the case were analyzed in a qualitative and descriptive fashion, from the psychodynamic perspective in the context of ED. Such reference suggests that, ED has been currently observed with less focus on the patient-food relationship, and more focus on the body and on the relationship with others. Therefore, they are psychopathological conditions that evidence elements inherent to the construction of identity, thus emphasizing the complexity of this hardly managed cases [29].

Results and Discussion

In order to maintain data confidentiality, all the names used in the description of the case are fictitious.

João, a patient diagnosed with ARFID, male, 12 years old, was treated for two years (February 2016 to March 2018), together with his mother (Maria) who accompanied him during his return visits. During the psychological interviews at the beginning of the treatment, João seemed rather shy, spoke little, but reported lack of willingness to lose weight and was not bothered by his body image. He simply said he could not put certain kinds of food in his mouth, especially fruits and any food that "would come from the earth" Apparently he had a satisfactory social life: had friends in school, enjoyed playing soccer (although he sometimes felt physically enfeebled) and had been dating for a year. He said he used to meet his girlfriend at school and sometimes she would go to his house to watch TV.

The mother, in her turn, reported to have had an unruffled pregnancy and that she had always hoped to have a male child. Satisfied with her son, Maria did not feel the need to have more children. Regarding breastfeeding, Maria reported "to have always had plenty of milk", and attributes that to the fact that she breastfed her son until he was seven. She said that "if she'd allowed, he would be breastfed until today". In order to stop breastfeeding, him Maria used to put a drop of dipyrone on her breast so he would taste the unpleasant flavor. Despite the apparent desire to separate from her son through the active interruption of breastfeeding, the time the mother took to effectively put this idea into action shows possible ambivalence in her experience to tolerate her son´s separation/individuation process.

Such ambivalence was also presented by the difficulties Maria showed in accepting that her son had social relationships – that is, a close relationship with people other than herself or other nuclear family member –, mainly when those relationships could inflict any kind of suffering, even if transient, on João. Different from how her son behaved, Maria mentioned to be really concerned about João's social life: she believed he felt inferior to his friends, and as an anxious attempt to protect him, she would take him and pick him up from school every day. After her son's complaining about feeling embarrassed for being taken and picked up from school, the mother stopped doing so, at the expense of lots of suffering which increased her levels of anxiety. In addition to this, when the son

started having interest in going to parties at night with his friends the mother seldom allowed him to do so. When she did, she would repeatedly drive past the place where he was to observe what her son was up to.

In this context, right at the beginning of João's treatment, it was noticeable the existence of a rather symbiotic relationship between mother and son. This type of relationship suggests a desire for a mutualistic and parasitic illusory unconscious bond, that transforms the son into a narcissistic extension of the mother and hinders him from his chances of developing individuation and autonomy [30]. Considering ED as manifestations of psychic suffering and of an unstable sense of self and difficulty to articulate efficient defenses, the first interviews with João and Maria rose questions to the multiprofessional team regarding the function of the feeding symptom in the psychic life of patient and his family.

João and Maria almost never referred to João´s father and he had never participated in the treatment, which reinforced the idea of symbiosis between mother and son. Maria and João´s father were married, they lived together, but he was never mentioned but neither, as if he did not existed. Despite the recurring requests from the multidisciplinary team for the father to accompany João on outpatient visits and to participate in the psychological support group for family members, such requests came to fruition only at the end of the treatment, when João's father lost his job and started to perform sporadic services as a truck driver. This job had more flexible hours, which allowed the father to appear sometimes at outpatient visits. In addition, João also started to accompany his father on some of his truck trips, and he seemed quite satisfied with this new routine. The multidisciplinary team realized that João admired his father and mirrored some of his habits, for example: "I like popcorn with pepper, just like my father".

Although the symbiosis between mother and child is extremely necessary and important in the baby's first months of life, the role of the father figure is crucial during the child's separation / individuation process [31]. It is the father who – under ideal conditions – has psychic abilities to bring the mother back to the outside world, beyond the relationship with the baby. In this way, mother and son begin to perceive themselves as separate from each other, and the principle of reality begins to be established [30,32,33]. By excluding the father figure from the treatment and from the speech itself, João and Maria demonstrated the existence of a type of triangular relationship, in which mother and son remained united against a third – the father – who, in turn, is not able to fit into the pair and exercise his father's separation function. In this sense, it is considered that the creation of a new routine that allowed the father to get closer to the son has contributed significantly to the improvement of the psychopathological condition.

João's maternal grandmother accompanied Maria in the group, showing an active participation in raising her grandson, which often involved disagreements and conflicts between mother and daughter. It is noted, therefore, that the roles of mother, daughter, grandmother, son and grandson were not well defined, indicating a family with diffuse borders [34].

João's follow-up at the service happened frequently, at first, on a fortnight basis and, subsequently, on a monthly basis. During this period, João was assisted individually by professionals of the team. On outpatient return visit days, João also participated in groups of nutritional orientation, occupational therapy and psychological support provided to patients. His mother participated in psychological support group provided to family members.

In the initial nutritional assessment, João was interviewed so that the team of professionals could investigate about his food intake, feeding habits and behaviors using the tools mentioned previously. Maria accompanied the interview and helped João by reminding him of situations involving his feeding. At this point, it was found out that he did not have his meals with his family. He usually ate breakfast in bed while other meals were eaten in the living room while he watched TV. In addition to this, João avoids eating during the period he is at school.

During feeding anamnesis, João points out he does not eat any kind of food that comes from earth (salad, fruits and vegetables) and says he is not even able to hold them with his hands, because he feels disgusted and sick. As for the protein group, he consumes only yogurt and red meat, as long as it is coal grilled (barbecue) and purchased from a restaurant. As for the carbohydrates group, ingestion comes from some specific types of industrialized products, such as sandwich cookies and instant noodles, in small portions. Fat is consumed in the form of meat and yogurt, in addition to industrialized food. In the last months, he mentioned he accepted to take 250ml of food supplement powder, enriched with calories, vitamins and minerals, once a day.

Follow-up with the nutritionist totaled 15 visits. In the beginning, João requested the presence of his mother during the service, but throughout the treatment he felt comfortable to be alone, and Maria's presence was requested by the professional only at the end of the visit, to let her know about the conduct and goals for the next visit.

João's main difficulty was with the food group that includes fruits, salad and vegetables. He reported to feel aversion to this food items because he did not know their origin and could not understand how a seed would turn into food. In order to work this issue, João was invited to look up in his school's science book how the process took place, from the moment the seed in planted in the soil to the moment food is ready for consumption. After that research, he came back to the visits more involved and telling the professional what he had learned from the book, but still showing lack of confidence to try such food items. When it was noticed that João was excited to be the protagonist of new knowledge, the team adopted a playful approach as the strategy of nutritional education, which used cutouts of food images, drawings made and colored by him, all that to complete the task of building a food pyramid, a three-dimensional one, as suggested by João himself. On each return visit, a food group was addressed and the nutritionist explained the importance of that food for the body's functioning, while João would be cutting out, coloring and gluing the images. After four visits, all food groups had been described and the pyramid was complete, which brought a great satisfaction to João.

Throughout the follow-up, John was encouraged to try new food

items, slowly and gradually, always respecting his difficulties. On each visit, it was suggested that he held the food with his hands and felt its texture, since he also felt uneasy to manipulate those foods. Then, he was encouraged to smell it, put it in his month, chew it and finally, swallow it. He was instructed to complete each of these steps whenever and taking as much as time as he needed to feel comfortable. To encourage even more João's participation, at the end of each visit it was presented to him the seasonality wheel of fruits, salad and vegetables and therefore, among the foods in season, João was invited to choose one of them to try by the time of his next return visit.

Maria was also instructed on how to help João in this process, considering that families of children with ED have less positive interactions during the meals [35]. Therefore, he was encouraged to participate in the simplest cooking preparation, and to have his meal with the family, always in contact, even if indirectly, with refused items There are evidences that the more one is exposed to foods that cause aversion, the more familiar they become, leading to a significant improvement in acceptance them, especially if they are offered in different preparations, forms, textures and temperatures [36].

One of the first tasting attempts suggested by the nutritionist was banana. João said he could even get close to the fruit, however, he could not hold it in his hands, as he thought he was about to throw up. Given this difficulty, João asked whether he could try orange instead, and in the next return visit, he came back pleased saying he had orange juice and liked it.

With the purpose of helping João to express his thoughts, feelings and sensations regarding a new food item, the nutritionist developed a tasting assessment form (Figure 1). That tool was useful to identify if João's discomfort was related to the appearance, smell, texture, flavor and/or any other sensation or feeling caused by the food. From that moment on, new alternatives could be suggested to improve acceptance.

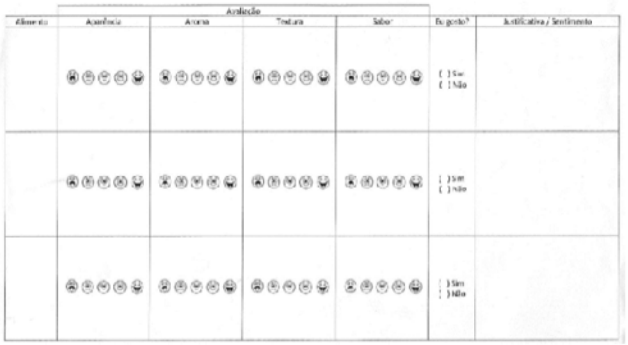

Figure 1: Food tasting assessment form, 2016.

Throughout the treatment, João tried some food items which were not part of his diet before, such as: acerola cherry, apple, pineapple, strawberry, passion fruit, arugula, lettuce, tomato, cassava, okra, heart of palm, olive and cucumber. Although the number of food items seems derisory, it is import to value each and every accomplishment made by the patient and constantly encourage him to try new food items and incorporate them to his daily meals. João also accepted to change the food supplement to another kind, more appropriate to meet his nutritional needs. Therefore, he started consuming 250ml twice a day, with a dilution of one calorie per milliliter.

Other aspects that show a satisfactory progress of João's feeding behaviors were the fact the he agreed to eat lunch on Sundays at his grandparents' house, at the table. There was an improvement in his accepting to reduce the frequency he took sandwich cookies to school as snacks, no longer every day as it used to be. However, he refused the meals served in school, as well as any other options of snacks other than industrialized sandwich cookies.

The progress of the qualitative aspects of patient's food pattern was also followed by the quantitative improvement, noticed on.

Table 1: Calorie and nutrient composition of the participant's food intake according to the moment of treatment. Ribeirão Preto, 2018.

Diet Composition	Initial	Final	Reference Values*
Calories	1931	1533	2323
Carbohydrates (%)	39.2	51.5	45 to 65
Proteins (%)	18.1	14.5	10 to 35
Lipids (%)	42.7	34	20 to 35
Fibers (g)**	5.6	3.9	25
Calcium (mg)	235	400	1300
Iron (mg)	10	11.2	8

*Dietary Reference Intake, 2005
** World Health Organization, 2003.

Despite the fact there was a reduction in the intake of calories a day, it was observed a better distribution of macronutrients. It was noticed improvement in the intake of iron and calcium, despite the latter being still below the recommended levels. Progressive acceptance of fruits, vegetables and salad my raise the content of fiber in the mid-term. Although the 24-hour Dietary Recall used to obtain these results present advantages such as a quick and easy application, it is important to consider that it depends on the memory of the interviewee, who may under or overestimate the size of the portions, and the fact that the specific day may not represent the patient's most frequent and typical feeding day.

Nutritional status showed entropy at the beginning and at the end of follow-up, however the BMI percentile moved closer to the median value (Percentile 50), represented in Figure 2. It is noteworthy that the specialized service that attended João had a waiting list for new cases with estimated time to start treatment between six months and

one year, depending on the severity of the case. While waiting for the start of treatment, João was accompanied by a doctor from the Basic Health Unit, and during this period, he accepted a nutritional supplement, which contributed to the recovery and maintenance of weight.

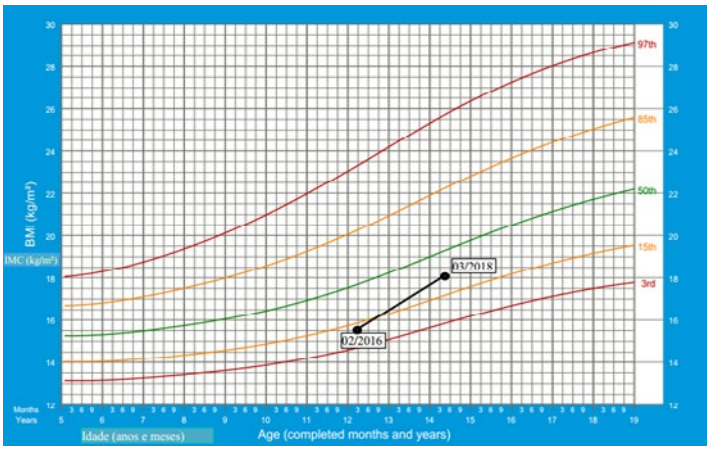

Figure 2: Patient's Body Mass Index Percentiles, according to the age, at the beginning and end of treatment (World Health Organization, 2007).

Feeding behaviors typical of ED, assessed by EAT-26, showed negative results at both moments of treatment, with a drop of the score (from ten to four points) which suggests an improvement in the dysfunctional behavior and eating attitudes. Lafraire et. al consider the perception, mental representations, emotions and feelings related to food, are important elements to be worked with during treatment [37].

In all outpatient visits, João was also evaluated by a psychiatrist. At the beginning of the treatment, it was noted that João had anxious conditions referred mainly when eating and in some social situations. He used medications prescribed by other professionals in order to alleviate the symptoms, such as olanzapine (5mg) and escitalopram (10mg). When João started treatment at GRATA, he accepted nutritional supplementation and gradually started to recover weight, which led the psychiatrist to withdraw olanzapine. João maintained the use of escitalopram throughout the treatment and was instructed to keep the medication even after discharge from the service.

As to João's emotional aspects, his diligent participation in the psychological support group evidenced his growing desire to be emancipated, both from his social and familiar life and from treatment itself. He did not relate to the accounts of other patients, as he was not dissatisfied with his own body image and did not want to lose weight. On the contrary, he wanted to recover soon to be able to play soccer and have a "normal" life, just like his friends. Moving closer to the end of the treatment, João was 14 years old and expressed he wanted to go to parties and study in a better school, in a city close to where he lived. Therefore, he would need to commute on a bus on his own, to his mother's distress, who openly said: "I hope he is not approved in the test". João, on the other hand said: "I know my mother does not want me to be approved in the test, but I'm going to". In fact, João was approved.

During several months, the work with the mother in the psychological support group provided to family members consisted of helping her deal with the difficulty to cope with her son's maturing, which she experienced as a rejection, as if she no longer was important to him. The mother complained that her son was becoming "sassy", adjective that received new meanings throughout the group psychotherapy process and became an expression of a healthy teenager impulse, which indicated João's desire "to take the reins" of his own life and leave behind his childlike traits.

It is worth mentioning that the psychological consultations carried out with João were offered in a group format, together with other patients. The groups were coordinated by a psychologist linked to the outpatient clinic and two interns from the Psychology undergraduate course. João had weekly individual psychotherapy sessions with a professional not linked to GRATA, since he lived in another city. GRATA´s multiprofessional team maintained contact with João's psychologist throughout the treatment, with whom he maintained a positive relationship and demonstrated progress.

Maria suffered a great deal when she learned about the hospital discharge. It is believed that, besides the uncertainties related to her son's recovery and her fearing potential relapses, Maria also perceived the discharge as a threat of separation from her son, whose condition made him remain dependant on her. Therefore, it is worthy emphasizing that hospital discharges in cases of EDs may give rise to feelings of abandonment that may be acknowledged and embraced by the team. In the case of João and Maria, it was a long process during which several contents related to the natural reorganization of the mother-son relationship during adolescence had to be dealt with, so that the discharge, as well as the emancipation moves made by João, could be perceived by the mother as something positive.

Final Considerations

The aim of the present study was to describe a case of ARFID and to outline its evolution in nutritional and emotional aspects, as well as the patient's mother's perceptions about the disorder and treatment. In general, it was evident how the symbiotic relationship between mother and child, as well as the absence of the father figure, influenced the precipitation and maintenance of the symptoms of ED, since they kept the child in an extremely infantile situation and dependent on the mother. Numerous psychological group meetings were necessary over the two years of treatment, coordinated by the Psychology team of the outpatient service, so that João's mother could approach, become familiar and emotionally elaborate her own feelings of helplessness with the possibility of psychic separation from her child. João, in turn, had a desire for separation and psychic differentiation from the maternal figure, which demonstrated the existence of powerful internal resources that were worked on during the group therapeutic process and that favored recovery from the ED.

The evolution of the presented clinical case suggests the importance of the multidisciplinary treatment. It is reflected by the progressive

improvement of the relationship and acceptance of food items, and consequent progress of the nutritional status. It is evident the importance of family to (re)construct healthy feeding habits and the role of environments that favor behavioral change towards previously rejected food items.

Although this study addressed relevant aspects of the treatment of ARFID and the importance of the active role of the family to obtain significant results, it investigated a single case, which suggests that such results should not be generalized. We emphasize the need for future research to address a greater number of patients with ARFID to validate the therapeutic measures adopted in this study and to collaborate for the adequate training of professionals who attend these cases, increasing chances of success in treatment.

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institutional and National Research Committee of the School of Nursing of Ribeirão Preto – São Paulo University (Certificate of Presentation for Ethical Consideration CAAE Protocol: 69377317.6.0000.5393) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Conflict of Interest

The authors declare that they have no conflict of interest.

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