JOURNAL
OF THE CANADIAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY / DE L'ACADÉMIE CANADIENNE DE PSYCHIATRIE DE L'ENFANT ET DE L'ADOLESCENT

CLINICAL CASE ROUNDS

Avoidant/Restrictive Food Intake Disorder in an 11-Year Old South American Boy: Medical and Cultural Challenges

Jonah Schermbrucker BSc[1]; Melissa Kimber PhD[1]; Natasha Johnson MD[1]; Sarah Kearney MD[1]; Jennifer Couturier MD[1]

Abstract

Avoidant/Restrictive Food Intake Disorder (ARFID) is new in the DSM-5, replacing the DSM-IV-TR diagnosis of Feeding Disorder of Infancy or Early Childhood. ARFID has no age criterion, and therefore addresses eating disturbances across the lifespan. This report illustrates the case of an 11-year-old boy of Colombian ancestry with ARFID and explores the role of culture in the diagnosis of ARFID. To date, literature describing this disorder is limited. ARFID is often seen in the child and adolescent population and can have significant medical consequences, including weight loss, hemodynamic instability, and growth retardation. Studies examining the potential cultural challenges of diagnosing and treating ARFID would benefit patients, as well as health professionals working in primary care, pediatrics, and psychiatry. This paper is intended to inform the reader about this multifaceted disorder, and to generate interest for future research.

Key Words: *Avoidant/restrictive food intake disorder, treatment, cultural competencies*

Résumé

Le trouble d'alimentation sélective et/ou d'évitement (TASE) est nouveau dans le DSM-5, et remplace le diagnostic du trouble de l'alimentation de la première ou de la deuxième enfance du DSM-IV-TR. Le TASE n'a pas de critères d'âge et englobe donc les troubles d'alimentation de durée de vie. Cet article illustre le cas d'un garçon de 11 ans d'origine colombienne souffrant du TASE et explore le rôle de la culture dans le diagnostic du TASE. À ce jour, la littérature décrivant ce trouble est limitée. Le TASE est fréquent dans la population des enfants et des adolescents et peut avoir des conséquences médicales significatives, notamment la perte de poids, l'instabilité hémodynamique, et un retard de croissance. Des études qui examineraient les problèmes culturels potentiels du diagnostic et du traitement du TASE seraient bénéfiques pour les parents et pour les professionnels de la santé des soins de première ligne, de la pédiatrie et de la psychiatrie. Cet article vise à éclairer le lecteur sur ce trouble multi dimensionnel, et à susciter un intérêt pour une future recherche.

Mots clés: *trouble d'alimentation sélective et/ou d'évitement, traitement, compétences culturelles*

Introduction

Recent studies suggest that the prevalence, age of onset and persistence of eating related psychopathology in South America are similar to estimates in North America and the United Kingdom (Ferreira, de Souza, da Costa, Sichieri, & da Veiga, 2013; Herscovici, Bay, & Kovalskys, 2005; Kessler et al., 2013; Power, Power, & Canadas, 2008; Vicente et al., 2012). Furthermore, South American children living in immigrant families in North America may be at increased risk for eating disordered behaviors compared to their non-immigrant peers (Kimber, Georgiades, Couturier, Jack, & Wahoush, 2015; Magtoto, Cox, & Saewyc, 2013). One possible explanation is that the stressors resulting from immigration may compound those stressors commonly

[1]McMaster University, Hamilton Health Sciences Centre, Hamilton, Ontario
Submitted: August 10, 2016; Accepted: January 11, 2017
Corresponding E-Mail: couturie@HHSC.CA

associated with adolescence (e.g. identity formation, puberty, social acceptance), thus potentially exacerbating immigrant youth's risk for disordered eating (Magtoto et al., 2013).

Avoidant/Restrictive Food Intake Disorder (ARFID) is a new diagnosis in the DSM-5. Currently, the prevalence of Avoidant/Restrictive Food Intake Disorder (ARFID) among South American youth is not known. There are unique socio-cultural factors facing South American populations that can create barriers for mental health intervention, including eating disorder treatment (Ahmedani et al., 2013; Mascayayano et al., 2016). This paper examines the treatment challenges of a South American boy with ARFID, and discusses socio-cultural factors that may have contributed to his family's reluctance to accept a psychological diagnosis.

Case

An 11-year-old boy of Colombian descent was referred by his family physician to the emergency department at an academic pediatric hospital for acute food refusal and medical instability. The boy had recently returned to Canada after visiting family in Colombia, including an uncle with terminal throat cancer. In Colombia, the patient had complained of epigastric pain, constipation and dysphagia. He was obtaining all of his nutrition from liquid meal supplements. He denied body image concerns, but did endorse a fear of choking. The patient also reported concerns about his parents' health, as well as other generalized worries. The patient was described as shy, with significant performance anxiety. His mother noted that the patient would become distressed when separated from his parents. The patient's parents were born in Colombia and the patient was born in the United States. His maternal extended family lived in Colombia, and the parents and patient identified strongly with the culture and visited those relatives often.

At the time of assessment, the patient's height was 148.9 centimeters (75th percentile for age) and weight was 33.1 kilograms (10th percentile for age). His ideal body weight was estimated to be 41 kilograms, putting him at approximately 80% of his target weight. At presentation, he was bradycardic with a resting heart rate of 56 beats per minute. The patient was diagnosed with generalized anxiety disorder, separation anxiety disorder, and ARFID. He was admitted to the pediatric eating disorder unit for weight restoration. Prior to admission, he had undergone several investigations at a community hospital, including swallowing studies, laryngoscopy, and esophagoscopy. All were unremarkable. The psychological nature of ARFID was explained to the patient and his family, yet they were adamant that there must be a physical explanation for his food refusal. Following discussions with the family, abdominal x-rays and repeat esophagoscopy and laryngoscopy were completed, all with normal results. The patient was offered food exposure therapy, but did not engage in the exposure tasks due to insistence that he could not eat because of a physical aberrancy in his throat. He declined to participate in group therapy. The patient and his parents also declined a trial of fluoxetine to manage the patient's anxiety.

Because of ongoing food refusal, the patient experienced no weight gain after one month of hospitalization, and given this information, nasogastric tube feeding was initiated. At this time, the family agreed to begin fluoxetine to target his anxiety symptoms, but continued to seek a physical etiology of his food refusal.

During the patient's admission, his family suggested that his needs were not being met by the Canadian health system. After six weeks in hospital, the patient and his family returned to Colombia to seek other medical opinions. The patient was discharged with outpatient follow-up at a weight of 39.8 kilograms, placing him at 97 per cent of his ideal body weight. His nutritional intake at the time of discharge was 3000 kilocalories per day.

Two months following the patient's discharge, the patient's parents attended a follow-up appointment at our clinic. They explained that the patient, who remained in Columbia, had seen a physician there who diagnosed him with "globus". The patient also discontinued the fluoxetine. The family understood "globus" as a physical, mobile lump in the throat, which impeded the passage of food and therefore explained the patient's food refusal. The parents reported that the patient's eating had improved and that they planned to permanently relocate to Columbia, where they felt the patient's health concerns were better addressed.

Discussion

The prevalence of ARFID among adolescents presenting to an eating disorder service has been reported to range from 5 to 13.8 per cent (Fisher et al., 2014; Norris et al., 2014). Children meeting diagnostic criteria for ARFID are more likely to be male, experience comorbid anxiety disorders, and experience or witness a previous choking event or life-threatening allergic reaction (American Psychiatric Association, 2013). Many of these features were applicable in the case described.

A common challenge in medicine, as in this case, is to ensure accurate communication between a patient and a treatment team with differing cultural backgrounds. As Good (1977) points out, "medical language, whatever its source, acquires meaning specific to a particular social and cultural context and in turn integrates illness and cure deeply into that context" (p. 31). Despite the efforts of the Canadian medical team, it is possible that the language used to convey the psychology of ARFID did not resonate with the family's understanding of the etiology of their son's illness. This hypothesis is supported by the ultimate success of the team in South America, who perhaps better aligned

with the family's cultural understanding of the patient's illness by using the term "globus" to encapsulate the patient's condition.

Relatedly, in the case of South American culture, literature highlights the pervasive stigma plaguing the acceptance of mental health diagnoses and the pursuit of mental health services (Andrade et al., 2014; Caldas de Almeida, & Horvitz-Lennon, 2010; de Toledo Piza Peluso, & Blay, 2004). Cultural values shared by those with South American heritage may contribute to individuals' hesitation to accept a mental health diagnosis and to seek treatment (Abdullah, & Brown, 2011; Mascayayano et al., 2016). These values include *familismo*, *machismo*, *compadrazgo* and *dignidad y respeto*. *Familismo* refers to a strong attachment to one's family, with a commitment to reciprocal financial and emotional support between family members. *Machismo* confers the belief that males should provide for and protect their family. The latter two values correspond to the veneration of warm relationships within and outside professional circumstances (*compadrazgo*), as well as the acceptance that parents and elders are afforded more respect than youth (*dignidad y respeto*).

Characteristics described in this case could relate to these socio-cultural values. Research with South American populations has shown negative biases toward individuals with mental illness, with the misperception that they will be chronically unwell and unable to work (Mascayayano et al., 2016). Perhaps in the present case, the patient's family feared being stigmatized due to their child's disorder, and that he would not grow up to be able to provide for his family. Furthermore, they may have had fears that he could be a burden to the family and fail to fulfill the respected elder position. Finally, it is possible that the socio-cultural mismatch between the treatment team and the patient's family created a sense of mistrust. This is supported by the fact that the patient's condition did not improve until he returned to Colombia to receive treatment.

These socio-cultural considerations may have contributed to the family's acceptance of the diagnosis of "globus" in their country of origin over a psychological explanation. Importantly, one cannot generalize the hypotheses here to all children, adolescents and their families who are of South American origins and who present to eating disorder treatment services in the North American context. A critical component to working with families of differing cultural origins and beliefs is a comprehensive history-taking and exploration of the patients and families understanding of the etiology of the child's illness. Clinicians should attempt to understand the socio-cultural pressures that may inform families' understanding and acceptance of eating-related psychopathology and be attuned to and respectful of these understandings and beliefs throughout the diagnostic and treatment process. Thus, a strengths-based approach that demonstrates socio-cultural competency and challenges negative misperceptions concerning those living with mental illness is an important part of this process.

Conclusion

This paper describes the case of a boy of Colombian descent with ARFID. This case illustrates that a comprehensive and culturally competent treatment approach is essential. It is important to explore — but not presume — the socio-cultural values of individual families. Although cultural differences between the patient and medical team in this case may have contributed to the failure of treatment in Canada, a patient's illness experience is determined by multiple factors that are beyond the scope of this paper. Studies investigating ARFID and its potential cultural implications are warranted, as are studies charged with identifying evidence-based treatments for the disorder.

Acknowledgments / Conflicts of Interest

The authors have no conflicts of interest to disclose.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31*, 934-948.

Ahmedani, B. K., Kubiak, S. P., Kessler, R. C., de Graaf, R., Alonso, J., Bruffaerts, R.,…Anthony, J. C. (2013). Embarrassment when illness strikes a close relative: A world mental health survey consortium multi-site study. *Psychological Medicine, 43*, 2191-2202.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition. Arlington, VA: American Psychiatric Association.

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G.,… Kessler, R. C. (2014). Barriers to mental health treatment: Results from the WHO World Mental Health Surveys. *Psychological Medicine, 44*, 1303-1317.

Caldas de Almeida, & J. M., Horvitz-Lennon, M. (2010). Mental health care reforms in Latin America: An overview of mental health care reforms in Latin America and the Caribbean. *Psychiatric Services, 61*, 218-221.

de Toledo Piza Peluso, E., & Blay, L. (2004). Community perception of mental disorders: A systematic review of Latin American and Caribbean studies. *Social Psychiatry and Psychiatric Epidemiology, 39*, 955-961.

Ferreira, J. E., de Souza, P. R. Jr., da Costa, R. S., Sichieri, R., & da Veiga, G. V. (2013). Disordered eating behaviors in adolescents and adults living in the same household in metropolitan area of Rio de Janeiro, Brazil. *Psychiatry Research, 210*, 612-617.

Fisher, M. M., Rosen, D. S., Ornstein, R. M., Mammel, K. A., Katzman, D. K., Rome, E. S.,…Walsh, B. T. (2014). Characteristics of avoidant/restrictive food intake disorder in children and adolescents: A "new disorder" in DSM-5. *Journal of Adolescent Health, 55*(1), 49-52. doi: 10.1016/j.jadohealth.2013.11.013

Good, B. J. (1977). The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine, and Psychiatry, 1*(1), 25-58.

Herscovici, C. R., Bay, L., & Kovalskys, I. (2005). Prevalence of eating disorders in Argentine boys and girls, aged 10 to 19, who are in primary care: A two-stage community-based survey. *Eating Disorders, 13*, 467-478.

Power, Y., Power, L., & Canadas, M. B. (2008). Low socioeconomic status predicts abnormal eating attitudes in Latin American female adolescents. *Eating Disorders, 16*, 136-145.

Kessler, R. C., Berglund, P. A., Chiu, W. T., Deitz, A. C., Hudson, J. I., Shahly, V.,…Xavier, M. (2013). The prevalence and correlates of binge eating disorder in the World Health Organization World Mental Health Surveys. *Biological Psychiatry, 73,* 904-914.

Kimber, M., Georgiades, K., Couturier, J., Jack, S. M., & Wahoush, O. (2015). Adolescent body image distortion: A consideration of immigrant generational status, immigrant concentration, sex and body dissatisfaction. *Journal of Youth and Adolescents, 44*, 2154-2171.

Magtoto, J., Cox, D., & Saewyc, E. (2013). Body satisfaction and eating disorder behaviors among immigrant adolescents in North America. *International Journal of School & Educational Psychology, 1*, 13-19.

Mascayayano, F., Tapia, T., Schilling, S., Alvarado, R., Tapia, E., Lips, W., & Yang, L. H. (2016). Stigma toward mental illness in Latin America and the Caribbean: A systematic review. *Revista Brasileira de Psiquiatria, 38*, 73-85.

Norris, M. L., Robinson, A., Obeid, N., Harrison, M., Spettigue, W., & Henderson, K. (2014). Exploring avoidant/restrictive food intake disorder in eating disordered patients: A descriptive study. *International Journal of Eating Disorders, 47*, 495-499. doi: 10.1002/eat.22217

Vicente, B., Saldivia, S., de la Barra, F., Kohn, R., Pihan, R., Valdivia, M.,…Melipillan, R. (2012). Prevalence of child and adolescent mental disorders in Chile: A community epidemiological study. *Journal of Child Psychology and Psychiatry, 53*, 1026-1035.