



“It's always on the safe list”: Investigating experiential accounts of picky eating adults



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ABSTRACT

Previous research into severely restricted eating for reasons which are not cultural, medical, due to a lack of food or due to concerns about body image has focused predominantly on “picky/fussy eating” in children. Despite evidence that picky eating does continue into adulthood and recognition in the new diagnostic category Avoidant Restrictive Food Intake Disorder (ARFID) that problematically avoidant and restrictive patterns of eating affect people across the lifespan, relatively little is known about the challenges and consequences faced by older adolescents and adults. This research employs qualitative methods to explore the experience of living as an adult with picky eating behaviours. Semi-structured interviews were undertaken with thirteen adults who identify as picky eaters and eat a highly limited diet, as determined by a checklist food questionnaire. Data were analysed using interpretative phenomenological analysis (IPA). Two themes are presented in this paper: “Constructions of food” and “Motivators for and barriers to change”. These themes show the importance of how individuals perceive food, their diet and themselves, and implications for clinical practice and future research in light of these findings are considered.

1. Introduction

Picky eating is a widely used descriptive term which refers to a diet characterised by food refusal and food neophobia (Cardona Cano, Hoek, & Bryant-Waugh, 2015). Whilst it is important to recognise that the two terms are not interchangeable (Cardona Cano et al., 2015), it has been suggested that picky eating may reflect a subclinical manifestation of some presentations of Avoidant Restrictive Food Intake Disorder (Kauer, Pelchat, Rozin, & Zickgraf, 2015). Avoidant Restrictive Food Intake Disorder (ARFID) is a new diagnostic category in the DSM 5, replacing the DSM IV category of ‘feeding disorder of infancy or early childhood’ (American Psychiatric Association, 2013). An individual with this disorder substantially restricts their food intake, and presents with associated physiological and/or psychosocial problems (APA, 2013). In order to meet the diagnostic criteria for ARFID, the restrictive eating behaviours must not be culturally sanctioned or due to either a lack of available food or a medical problem (e.g. allergy), the restrictions must not occur exclusively during the course of another eating disorder (either anorexia nervosa or bulimia nervosa), and there must be no evidence of disturbances of the individual's perception of their body weight or shape (APA, 2013). Several aspects of research and theory in this area are both complex and contested (Taylor, Wernimont, Northstone, & Emmett, 2015). Pliner and Hobden (1992) suggest that food neophobia is one end of a neophobia-neophilia continuum, and it may well be the case that picky eating can also be conceptualised in this way. There are generally two separate constructs that research in this

area has focused on: food neophobia and ‘picky/fussy’ eating. Food neophobia refers to avoidance of novel foods and is a normal development trend seen in children from about 18 months e.g. Pliner, 2008. Alternatively ‘picky/fussy’ eating refers to rejection of foods that are familiar and/or unfamiliar to the individual (Dovey, Staples, Gibson, & Halford, 2008). As ‘picky/fussy’ eating is not a clinical label, this type of eating behaviour is sometimes referred to as food faddyness/refusal (e.g. Gravestock, 2000), restrictive eating, selective eating, choosy eating, food avoidance emotional disorder, chronic food refusal, or sensory food aversions (Bryant Waugh, Markham, Kreipe, & Walsh, 2010). The label “picky eating” has been used throughout this paper, as this reflects both the label used in other research in the area (e.g. Thomson, Cummins, Brown & Kyle, 2015) and the way that participants in this study chose to identify themselves.

A severely restricted diet can have a number of effects on the individual. Physiologically, there is a risk of malnutrition: a study comparing picky and non-picky nine year old girls found that the picky eaters consumed significantly less fibre, vitamin E and folate than their non-picky counterparts, and were at higher risk of inadequate intake of vitamins C and E (Galloway, Fioritio, Lee & Birch, 2005). This could lead to lethargy, concentration problems, stunted growth, changes in weight, cell damage, a weakened immune system, and/or digestive problems (Bryant Waugh et al., 2010; Dovey et al., 2008); the latter is particularly problematic as it may cause the individual to associate a recently eaten food with abdominal pains caused by constipation, which may then lead to them cutting out that food and further

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restricting their diet (Dovey et al., 2008; Taylor, Northstone, Wernimont, & Emmett, 2016). In addition to these potential physiological consequences, studies of picky children have shown a link between picky eating and anxiety (Farrow & Coulthard, 2012) and suggest that some picky children may face difficulties in peer relationships due to teasing about their eating habits (Bryant-Waugh, 2013). Adult picky eaters report more symptoms of depression and OCD than non-picky peers and are more likely to score within the clinical range for these disorders (Kauer et al., 2015; Wildes, Zucker, & Marcus, 2012). The direction of the relationship between picky eating and OCD and/or depression remain unclear: as outlined by Kauer et al. (2015) it may be the case that the picky eating is a manifestation of OCD/depressive traits, or it may be that there are underlying personality risk factors for both OCD/depression and picky eating. In addition adult picky eaters show higher disgust sensitivity than normal eaters (Kauer et al., 2015), and previous studies have shown that disgust is closely linked to food rejection (Martins & Pliner, 2005, 2006). Research into picky eating in children has shown a link between picky eating and anxiety, sensory sensitivity, and more problem behaviours than non-picky peers (Farrow & Coulthard, 2012; Jacobi, Schmitz, & Agras, 2008).

Although we have some understanding of the nutritional and developmental consequences of restricted eating it is apparent that there is limited research exploring the social and psychological consequences, although there is a recent move towards this (e.g. Ellis, Galloway, Webb, & Martz, 2017). Previous research into this type of eating behaviour has focused predominantly on “picky/fussy eating” in children (Wildes et al., 2012), as this type of eating behaviour was categorised as ‘feeding disorders in infancy and early childhood’ in the DSM IV (APA, 2013). Existing literature suggests that there are potential physiological and psycho-social consequences amongst children (Galloway, Fiorito, Lee, & Birch, 2005; Farrow & Coulthard, 2012; Bryant-Waugh, 2013), but little is known about the challenges and consequences that adults face. There is to date only one qualitative study examining the experiences of picky eating adults (Thompson, Cummins, Brown, & Kyle, 2015) which highlights the specificities of a picky eater’s diet, such as the importance of sensory properties of the foods or the physical disgust response that participants reported in response to a food they do not eat. They also discuss the impact this restricted diet can have on the individual, from their perception of themselves to the impact on eating socially. However there were some methodological limitations with regard to this paper as the participants were a mix of self-identified picky eaters and accounts of parents who identified their adult children as picky eaters (Thompson et al., 2015). Thompson et al. (2015) identify a need for further research into the specific practices of picky eating adults and the impact this has on their lives: the present study aims to expand on this initial work by exploring the lived first-hand experience of adults with picky eating behaviours. This sample have been selected as this is a population of individuals who for a variety of reasons appear to be accessing and receiving very limited support for their eating problems and for whom interventions are arguably rather under-developed (Kauer et al., 2015), and so a better understanding of their perceptions and conceptualisations could begin to inform future interventions for those whose restricted diets are causing them significant concern.

2. Method

2.1. Participants

Participants were recruited through purposive sampling via an online support group for adult picky eaters which is used by people from several countries. An advert briefly detailing the purpose of the study and what participation would involve was posted onto this group, with contact details for the primary researcher and an invitation to contact the researcher for further information if they were interested in participation. The advert stated that the researcher was a PhD student

interested in selective eating in adulthood, and continued as follows: “As you may know, Avoidant Restrictive Food Intake Disorder (ARFID) is a newly recognised eating disorder which is characterised by a very restricted diet for reasons that are not cultural, religious, moral or relating to concerns around body weight and/or shape. However little is known about how having such a restricted diet affects the lives of adults. I am looking to interview people over the age of 16 who have a restricted diet (eating less than 20 types of food), to learn more about living with selective/picky eating as an adult. Please note that you do not have to have a diagnosis of ARFID in order to take part in this research.”

In total, thirteen individuals participated. Eleven participants were women (aged 18–67 years) and two were men (aged 22–32 years). Inclusion criteria were: self-identifying as a picky eater; eating a diet of twenty foods or fewer; aged sixteen or over; and able to speak English fluently. A formal diagnosis of ARFID was not a requirement, as ARFID is a newly recognised condition and it has been deemed unlikely that many adults who meet the diagnostic criteria will have an official diagnosis. We were also interested in understanding the difficulty of those who have significant difficulties but who may not reach the threshold of a clinical diagnosis. All participants who volunteered to take part met these inclusion criteria. Details of participants are included in Table 1 below.

2.2. Materials and procedure

Prior to beginning the interview, participants were required to provide a free recall list of the foods that they eat, in order to ensure that those participating had a suitably restricted diet, identified for the purpose of this study as up to twenty different foods. Participants were advised on what was meant by different foods, for example that specific brands or flavours of the same foods (e.g. crisps) were not considered to be different foods. The decision to use a maximum of twenty foods to reflect a limited diet was made as there is not yet a single agreed-upon measure for what constitutes picky eating (Kauer et al., 2015), but recent research has used a maximum of either ten or twenty types of food to indicate a narrow range of foods in the diet (e.g. Kauer et al., 2015; Zickgraf, Franklin, & Rozin, 2016). A semi-structured interview schedule was developed and piloted by the research team which comprised experts in eating disorders research and qualitative research methods. The interview schedule was composed of a series of open-ended questions relating to a range of relevant topics, with prompts used only as necessary. Questions covered areas such as participant’s food preferences and choices, the impact of their eating behaviour on various areas of their lives, and their views on treatment and recovery. A copy of the interview schedule is available from the first author on request. Upon completing the interview, participants were given a debrief sheet, which contained contact details for the research team and some additional online support forums.

The study was advertised to potential participants on social media in a post containing brief details about the aim of the research, inclusion criteria, what participation would involve and contact details for the researchers. Those who wished for further information or wished to participate were invited to contact the lead researcher for a copy of the detailed information sheet and to arrange an interview where appropriate. The interview schedule was used to guide the interviews in a flexible and participant-driven fashion, in keeping with the inductive approach used (Smith & Eatough, 2007). Interviews lasted for approximately 1 h, and were recorded and carried out in person at the participants’ homes (N = 1) or via voice over internet protocol (VOIP) software (N = 12). Data were transcribed using basic Jefferson notation. Semi-structured interviews are typically considered to be the most appropriate form of data collection for Interpretative Phenomenological Analysis (IPA), as they allow the researcher to address a comprehensive range of aspects of the phenomenon under scrutiny whilst also exploring ample opportunity to discuss additional areas that arise (Smith

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