FAMILY MEALS FOCUS
Article 91

# Extreme Food Selectivity in Adults: How to Help

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From the Satter Eating Competence Model (ecSatter) perspective, suffering from extreme food selectivity has little to do with what individuals do or don't eat and everything to do with their *feelings* and *attitudes* about food and eating. Everyone has food preferences. However, people become handicapped with food acceptance when they experience a lot of conflict and anxiety about eating the food they eat and are immobilized with respect to being able to explore unfamiliar food. Such extreme food selectivity can be part of the constellation of food behaviors and coexisting conditions the American Psychiatric Association (APA) Diagnostic and Statistical Manual (DSM 5) describes as Avoidant Restrictive Food Intake Disorder (ARFID). However, addressing ARFID is outside the scope of this article. Here, we discuss adults with extreme food selectivity who do not qualify for the ARFID diagnosis.

***Effectively working with extreme food selectivity draws on a solid knowledge of and practice with the Satter Eating Competence Model.***

## Consider attitudes and feelings

Extreme food selectivity is painful and life-limiting. Your client is likely to experience considerable stress around food selection and eating, react strongly and negatively to certain smells and textures, feel that if they take it they have to eat it all, and be ashamed of their inability to eat from more than their short list of acceptable food.[1] Some fear choking and have a lack of interest in eating[2] although those characteristics may bring them into the realm of ARFID. Their extreme food selectivity may limit their social life If they are not comfortable eating with others for fear that their inability to eat the available food will attract attention and even ridicule.

Effectively working with extreme food selectivity draws on a solid knowledge of and practice with the Satter Eating Competence Model. Professionals trained in the ecSatter-based Ellyn Satter Institute *Treating the Dieting Casualty VISION* workshop consider the history and context of extreme food selectivity by doing a complete workup: A detailed assessment of medical, nutritional, developmental, psychosocial, and eating-competence issues. This comprehensive assessment reviews their past and present eating milieu including efforts by others to get them to eat, tests eating attitudes and behaviors with ecSI 2.0 and EAT-26, reviews their current relationship with food, examines current lists of acceptable foods, and examines their broader food context.

### Think in terms of Eating Competence, not increasing their food variety

EC adults achieve nutrition and wellness goals[3] by eating based on their own positive and receptive eating attitudes and behaviors[4] as described in the bullet list below. Rather than trying directly to get your client to eat certain amounts or types of food, help them to gain Eating Competence (EC). That positive stance toward food and eating frees them to grow and develop with food acceptance to the extent that they are able to, drawing on their own innate capability and drive toward growth and development. ecSatter-informed care involves supporting positive eating attitudes and feelings, therefore initially allowing the client to gain comfort with eating their accepted foods. Having gained that comfort, they can explore whether they have an inclination to expand their food repertory.

- **They feel good about eating**: They enjoy food and enjoy the times they get to eat.
- **They can eat as much or as little as they need**. Even if they eat a limited assortment of food, their bodies "count the calories:" Their sensations of hunger and fullness still effectively guide food regulation.
- **They behave well at mealtime**: They know the social niceties and can relax and enjoy being included.
- **They can be comfortable with their limited food acceptance.** They can tactfully ignore and defend themselves against unwanted food, get by with less-preferred food, and be prepared to quietly not eat if nothing appeals.

### Consider history and context

Considering history and context supports the realization that the Satter Feeding Dynamics Model (fdSatter) and the Satter Division of Responsibility in Feeding (sDOR) are protective against extreme food selectivity. Or, more specifically, fdSatter and sDOR protect against *conflict and anxiety* about food selectivity. Some people are perfectly comfortable with eating a limited variety of food and only need help protecting themselves from interference. Others are distressed by their extreme food selectivity and willing to explore the origin of their conflict and anxiety about eating. Here is a common scenario: The same as all other children, the child is born with the drive to eat and with overall positive feelings about eating. But the child doesn't eat what the parent wants them to eat, perhaps because they have a child's skepticism about new food or because they are particularly sensitive to smell, texture, or taste. Perhaps they were traumatized by choking. Parents are desperate to get their child to eat and are likely to have exerted continual and considerable pressure. Parents had their reasons. The child may have been particularly small, ill, prematurely born, or have a medical or developmental diagnosis. Health professionals may have urged parents to get their child to eat. Whatever the origin, the child reacts to the parents' pressure and *can't* eat. Shame enters: The child who can't do and be what the parent wants is ashamed. As the child grows up, outside pressure on eating morphs into internal pressure: They do to themselves what parents did to them. That internal pressure combined with their ongoing conflict and anxiety about eating interferes with their eating all but the least challenging, most familiar food.

### Treat the feelings and attitudes; don't try to get them to eat

Above all, do not use direct or indirect means of trying to get the client to eat more foods. Enticing, rewarding, or pressuring them to increase their food variety is likely to replicate the conditions that caused the extreme food selectivity in the first place. Instead, begin by helping your client reconnect with their eating. The person with extreme food selectivity eats from a limited and often-detailed list of foods they can tolerate: certain brands, certain colors and textures. They cater exquisitely to their own tastes, but at the same time they are harshly self-critical ("It's bad to eat this /I should eat that/I have to eat it all"). To get past this conflict and anxiety they are likely to eat without eating, putting themselves on automatic pilot when they eat, perhaps using TV, reading, or game-playing for distraction. Incorporating elements of the *How to Eat* intervention taught in the *Treating the Dieting Casualty VISION Workshop* into Eating-Competence-focused intervention helps neutralize this conflict and anxiety with in-session food exposure and discussion and progressive take-home assignments. This experiential process gradually frees them to eat with comfort and joy.

### Eating in public

Eating in public might come next, or it might not. They don't have to eat in front of others if they don't want to. But if and when they are ready, they benefit from coaching in what is and isn't okay with respect to mealtime behavior. They can pick and choose from what is at the meal, eat only one or two food items, and leave unwanted food. However, they can't draw attention to food refusal, ask for food that is not on the menu, or eat someone else's share.

### Increasing food variety

Increasing food variety will come last if it comes at all. Does your client want to eat new food, or do they *want to* want to? In gaining peace and comfort with their eating *as it is* they have essentially provided themselves with food security, and the principles of the Satter Hierarchy of Food Needs[5] say that establishing food security allows learning and growth. This natural developmental process can take years and may lead the recovering extremely selective eater to ever-so-gradually become more flexible and experimental with exploring unfamiliar food, or simply being in the *presence* of unfamiliar food: not necessarily *eating* it, just looking, seeing what others eat, reading recipes, smelling. Or they might learn to eat new food, perhaps at the rate of a food or two foods a year. A word of warning: Trying to speed up the process will slow it down.

### Food selectivity in context

Not every food-selective adult requires the detailed assessment and treatment described in this article. Some are simply picky. They are stuck because what they are trying to do is unrealistic, not because they have so much conflict and anxiety that they *can't* do it. You can help bring those folks along with a one- or two-session intervention such as the one I describe in *Family Meals Focus #44: The Adult Picky Eater.*

## References


1. Wildes JE, Zucker NL, Marcus MD. Picky eating in adults: results of a web-based survey. *Int J Eat Disord*. 2012;45:575-582.
2. Lucarelli J, Pappas D, Welchons L, et al. Autism Spectrum Disorder and Avoidant/Restrictive Food Intake Disorder. *J Dev Behav Pediatr*. Jan 2017;38(1):79-80.
3. Satter E. The Satter Eating Competence Model: the Satter approach to eating Ellyn Satter Institute. Accessed February 2, 2022. https://www.ellynsatterinstitute.org/satter-eating-competence-model/
4. Satter E. Eating Competence: definition and evidence for the Satter Eating Competence Model. *J Nutr Educ Behav*. 2007;39:S142-S153.
5. Satter E. Hierarchy of food needs. *J Nutr Educ Behav*. 2007;39:S187-S188.


### *Secrets of Feeding a Healthy Family*

Ellyn Satter's *Secrets of Feeding a Healthy Family* says the secret of raising a healthy eater is to love good food, enjoy eating, and share that love and enjoyment with your child. When the joy goes out of eating, nutrition suffers.