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Cognitive-behavioral treatment of food neophobia in adults

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Abstract

Food neophobia is an eating disturbance defined as the fear of trying new foods. In its extreme, the disorder can lead to malnutrition, limited social functioning, and psychological difficulties. Successful treatment of food neophobia in children has been reported, but if those children are not provided with treatment, it stands to reason that the disorder may follow them into adulthood. To date, adult cases have not been described in the literature and the prevalence in adults is unknown. Our paper will review the methods used to treat children with the disorder then delineate how the procedures were modified for an adult population, giving two case examples.

Keywords: Food neophobia; Adult; Cognitive-behavioral approach

1. Introduction

It is estimated that 25% of infants and children are afflicted with some type of feeding problem (Babbitt et al., 1994). Severe dietary restriction due to refusal to try new foods has been addressed by the literature almost entirely in regard to infants and young children with significant medical illnesses or developmental

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disabilities that contributed greatly to feeding difficulties. However, a distinct food neophobia appears to exist in some children who have developed normal feeding patterns as infants. These children become comfortable with eating only a limited number of foods and develop a cognitive aversion as well as behavioral avoidance of new foods (Singer, Ambuel, Wade, & Jaffe, 1992). This type of food neophobia, which occurs after normal feeding development as an infant, is the focus of our paper.

Treatment of food neophobia has received only brief attention in the child literature and no adult cases have been described. Prevalence of the disorder, in either children or adults, is unknown. Although food neophobia shares some symptoms and features with eating disorders, choking phobia, and social phobia, its sufferers normally do not qualify for diagnosis of these other disorders. In children, temperamental characteristics such as shyness, emotionality, and negativity toward novel foods have been linked to increased levels of food neophobia (Pliner & Loewen, 1997). Expected disliking and perceived danger of a new food has also been associated with increased food neophobia (Pliner, Pelchat, & Grabski, 1993).

With respect to treatment of food neophobia in children with developmental disabilities, behavioral programs using contingent reinforcement have been successfully implemented on an individual and familial basis (Luiselli, 1994; Werle, Murphy, & Budd, 1993). An effective, multidimensional program incorporating behavioral, psychodynamic, and family systems concepts applied at a systemic level in one case has also been reported (Archer & Szatmari, 1990). In this case, the child was approximately $3\frac{1}{2}$ years old at presentation and exhibited delays in speech, language development, and fine motor skills. There was also some evidence of pervasive developmental disorder. Treatment consisted of educating the parents about general childhood development, childhood feeding habits, and their child's particular feeding problems. The parents were also taught behavior management techniques and basic parenting skills. The child's self-feeding and food acceptance was increased through behavioral methods in graduated steps. Finally, cognitive restructuring and anxiety management was conducted with the mother to increase positive parent–child interactions and to reduce the mother's anxiety level during mealtime, which functioned to decrease the child's anxiety.

Successful treatment of food neophobia in children without a medical or developmental disorder was reported by Singer et al. (1992). A phobic conceptualization of the disorder and an individualized inpatient program of cognitive-behavioral techniques were utilized with three malnourished children. Specifically, a combination of desensitization, relaxation training, contingency management, shaping, and extinction was applied. In addition, cognitive restructuring, education, and family therapy with a cognitive-behavioral component were implemented. The children improved, and no medical or pharmacological treatments were needed. As with the above example, the limited literature on children with food neophobia has resulted primarily from those children who