



ARFID Guide for parents and carers

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Understanding ARFID: An Introduction for Parents

As a parent or carer, ensuring your child's health and well-being is a top priority, and that includes their eating habits. If your child is extremely selective or restrictive about what they eat, it might go beyond typical picky eating. This could be indicative of a condition called Avoidant/Restrictive Food Intake Disorder, or ARFID.

What is ARFID?

ARFID is recognised in the ICD-11 (International Classification of Diseases, 11th Revision) which is a global standard for diagnosing health conditions. This disorder is characterised by an ongoing inability to meet appropriate nutritional and energy needs. This can happen for several reasons: a lack of interest in eating, avoiding food based on sensory characteristics like texture or smell, or an intense fear of negative consequences from eating, such as choking or vomiting. Unlike other eating disorders, such as anorexia or bulimia, ARFID isn't related to concerns about body image or weight (World Health Organization 2019)

Children with ARFID may only eat a limited variety of foods, avoid foods with certain textures, or fear the physical sensations that come with eating. These patterns can lead to nutritional deficiencies, weight loss, and significant disruptions in their life and your family's routine. While ARFID is primarily recognised as a disorder that emerges in childhood, it can persist into adulthood or even develop later in life (Kambanis., et al 2020). ARFID often begins in early childhood, typically before the age of 12, with many cases developing in preschool years (Zickgraf, H.F. and Ellis, J.M. 2018). In children, ARFID is frequently linked to developmental stages, where picky eating or food aversion is common. However, in ARFID, these behaviours are more extreme and persistent. ARFID is often understood in the scope of three types, the three subtypes are:

1. Sensory-Based Avoidance

This subtype is characterised by an aversion to certain foods based on their sensory characteristics, such as texture, taste, smell, or appearance. Individuals with sensory-based avoidance are often highly sensitive to the sensory properties of food and may reject foods that do not meet their specific preferences. For example, they might avoid foods that are too crunchy, slimy, or have strong flavours or smells (Thomas., et al 2017)

Common Features:

Narrow range of accepted foods, often based on specific textures or tastes.

Intolerance for trying new foods, leading to a very limited diet.

Often linked to sensory processing sensitivity, which may also be present in other areas of life (e.g., sensitivity to noise or fabrics).

Commonly seen in individuals with autism spectrum disorder or sensory processing disorder.

2. Lack of Interest in Eating or Food

This subtype is characterised by a general lack of interest in eating or food, which leads to inadequate food intake. Individuals may not experience hunger in the typical way, or they may find the process of eating unappealing or unimportant. As a result, they may eat only small amounts of food, fail to consume enough calories, and struggle with undernutrition or weight loss (Norris., et al 2014)

Common Features:

Low appetite or indifference towards food.

Prolonged mealtimes or frequent forgetting to eat.

Lack of excitement or pleasure associated with food or eating.

Often seen in young children but can persist into adulthood if untreated.

3. Fear of Aversive Consequences

This subtype is driven by a strong fear of negative consequences associated with eating, such as choking, vomiting, or experiencing allergic reactions. Individuals may have had a traumatic experience related to eating (e.g., choking incident) or may develop these fears without a clear trigger. As a result, they avoid certain foods or entire food groups to prevent these feared outcomes.

Common Features:

Anxiety or panic at the thought of eating certain foods.

Avoidance of specific textures, foods, or eating situations that might trigger the feared consequence.

May lead to significant weight loss or nutritional deficiencies due to the severe restriction of food intake.

Often associated with co-occurring anxiety disorders.

How Does ARFID Develop?

The development of ARFID is often complex and varies between children. It might begin early in life, especially if your child has had negative experiences with food, such as choking, severe vomiting, or food allergies. For some children, ARFID develops gradually as they become increasingly sensitive to the texture, smell, or appearance of certain foods. Children with conditions like autism spectrum disorder, anxiety, or sensory processing difficulties are more prone to developing ARFID, though it can occur in any child.

In some instances, ARFID may be a way for a child to cope with overwhelming feelings or exert a sense of control. For others, eating certain foods feels intolerable due to sensory sensitivities or anxiety. It's important to understand that ARFID isn't about defiance or stubbornness; it's often linked to deeper anxieties or sensory issues that your child might not be able to articulate.

What Did the Study Find?

Researchers at the University of Aberdeen looked at brain scans from nearly 2,000 ten-year-old children. They found that kids who showed symptoms of **ARFID** (Avoidant/Restrictive Food Intake Disorder) had:

→ **Thicker brain tissue (cortical thickness)** in areas of the brain known as the **frontal and superior frontal regions**.

These regions are key for:

- **Cognitive flexibility** (switching between tasks or ideas)
- **Impulse control**
- **Decision-making**
- **Emotion regulation**

This suggests that the brains of children with ARFID may be developing differently, especially in areas that affect how they manage emotions, cope with new experiences, and make decisions.

What Does This Actually Mean?

1. Neurological Basis

ARFID isn't just "picky eating" or behavioural — this supports the idea that there's a **biological and neurological foundation** to these eating patterns.

It means:

- The child's brain might *literally process food and eating-related experiences differently*.
- This could be due to how they process **threats, novelty, sensory input, or stress**.

2. Overlap with Neurodivergence

The same brain regions are often implicated in **autism, ADHD, and anxiety**, all of which frequently co-occur with ARFID.

Why Is Early Intervention Important?

Without early intervention, ARFID can become more deeply ingrained over time. Prolonged nutritional deficits can lead to serious physical and developmental consequences. Additionally, the anxiety around food and mealtimes can worsen, creating a difficult cycle to break. With

appropriate support, children with ARFID can learn to broaden their diet, manage their anxieties, and improve their overall well-being.

How is ARFID Maintained?

1. Anxiety and Avoidance Learning

One of the primary factors maintaining ARFID is anxiety, particularly in cases where the disorder is driven by a fear of aversive consequences (e.g., choking, vomiting, or allergic reactions). When an individual with ARFID avoids certain foods or eating situations, they experience immediate relief from anxiety. This relief serves as a powerful reinforcement, making it more likely that they will continue to avoid these foods in the future Thomas, J. J., & Eddy, K. T. (2019).

Example: A child who once choked on a piece of meat may begin to avoid all solid foods, fearing another choking incident. The avoidance of solid foods reduces their anxiety, but over time, it reinforces the belief that these foods are dangerous, making the avoidance behavior more entrenched

2. Sensory Sensitivities

For individuals with the sensory-based subtype of ARFID, heightened sensory sensitivities can maintain the disorder. These individuals may have an intense aversion to certain textures, tastes, or smells of food, leading them to reject a wide range of foods. The more they avoid these foods, the more sensitive they become to their sensory properties, which reinforces the restrictive eating patterns (Zucker., et al 2015)

Example: An adolescent with ARFID may have an extreme aversion to the texture of mushy foods like bananas or mashed potatoes. Each time they avoid these foods, their sensitivity to such textures is heightened, making it increasingly difficult to introduce new foods into their diet.

3. Social and Cultural Influences

Social and cultural factors can also maintain ARFID, particularly in individuals who experience stigma or pressure related to eating. Negative social experiences, such as teasing or bullying about eating habits, can reinforce restrictive eating patterns. Cultural norms around food and eating, such as an emphasis on clean eating or food purity, can also contribute to the persistence of ARFID in some individuals (Kambanis., et al 2020).

Example: An adult with ARFID might avoid social situations that involve eating, such as dining out with friends, due to fear of judgment or embarrassment. This avoidance further isolates them and maintains their restrictive eating habits.

4. Parental/Caregiver Accommodation

In children with ARFID, parental or caregiver behaviours can inadvertently maintain the disorder. Parents may accommodate their child's restrictive eating by preparing only the foods that the child will eat or by avoiding situations that might cause distress (e.g., social meals). While these accommodations are often made out of concern for the child's well-being, they can reinforce the child's avoidance behaviours and prevent exposure to new foods or eating situations (Chatoor, 2009).

Example: A child with ARFID may only eat plain pasta and refuse all other foods. To ensure the child eats something, the parents may prepare only pasta for meals. This accommodation prevents the child from being exposed to other foods, thereby maintaining the narrow diet.

5. Biological and Genetic Factors

There is evidence to suggest that biological and genetic factors can contribute to the maintenance of ARFID. Some individuals may be biologically predisposed to heightened anxiety, sensory sensitivities, or digestive issues, which can make them more vulnerable to developing and maintaining ARFID. Additionally, conditions like autism spectrum disorder or sensory

processing disorder, which are associated with ARFID, can make it difficult for individuals to tolerate a wide range of foods (Bryant., et al 2010)

Example: A child with autism spectrum disorder may have a genetic predisposition to sensory sensitivities, making them more likely to develop and maintain restrictive eating patterns.

Interventions and What can you do?

1. Psychoeducation about ARFID

Step 1: Explain ARFID to your child.

- Help your child understand what ARFID is, focusing on how it affects their body, growth, and health. For example, "ARFID is when someone eats too little or avoids foods because of fear of certain tastes, textures, or bad experiences with food." When explaining ARFID to a child or young person, it can be helpful to use developmentally-appropriate metaphors to normalise their experience and reduce shame. Such as comparing food-related fear to other common phobias such as spiders; this can help children conceptualise that ARFID is a fear-based response rather than “bad behaviour” (Thomas et al., 2017; Eddy et al., 2019). This also models emotional literacy and begins to separate the child’s identity from the ARFID.
- Normalise their feelings, explaining that ARFID can be managed and improved over time with support.
- Early stages of intervention often focus on *family-level acceptance* and developing a shared understanding. Evidence from family-based therapies highlights that change is more likely to be sustained when parents/carers first accept ARFID as part of the family’s landscape and intentionally shift to a supportive, non-pressured mindset (Anderson et al., 2020). This can become a foundation for later exposure work and reduces unhelpful focus on “fixing” the eating immediately.

Step 2: Explain the goals of the intervention

- Help your child understand that ARFID interventions are designed to help them try new foods, eat enough for growth and health, and reduce their anxiety about eating.
- Nutritional goals may initially centre on *proximity* and *tolerance*, and do not need to include eating. Building a positive relationship with food, through exposure without pressure to eat, has been shown to increase willingness for future trials. For some families, simply being comfortable with foods being present at mealtimes can represent meaningful progress.
- Be sure to frame it in a positive way so, what good things will come from the intervention as opposed to focusing just on the negatives.

2. Establishing Nutritional Goals

Step 1: Work with a healthcare provider to set appropriate eating goals.

- Develop a plan that includes calorie and nutrient targets specific to your child's needs. The focus should be on gradual improvement, not perfection.
- Begin by identifying how much food your child is currently eating and setting small, achievable increases.

Example of Small Increases:

Breakfast: If your child eats 1 slice of toast, encourage them to add a little butter or jam, or try increasing to 1.5 slices.

Lunch: If your child eats 2 chicken nuggets, aim for 3 nuggets next time.

Dinner: If they currently eat 1/4 cup of plain pasta, encourage them to try 1/3 cup. If they're more willing, add a small amount of sauce or a topping they like.

Step 2: Implement regular meals and snack times.

- Establish a predictable schedule for meals and snacks (e.g., three meals and two snacks daily). This routine reduces anxiety by setting clear expectations about when eating will happen.

Step 3: Use a food diary to track progress.

- Keep a simple record of what your child eats each day, including new foods they try and the quantity. This can provide positive reinforcement for their efforts and help identify patterns that need attention.
- Take note of their “safe foods” and the foods that create the most anxiety.

3. Introducing New Foods through Gradual Exposure

Step 1: Create a food hierarchy.

- Where possible, involve the child in the structuring of any routine or timetable. Collaborative creation of visual materials (e.g., mealtime schedules, food ladders) has been associated with increased adherence and perceived control (Zimmermann & Smith, 2022). Involving the child reduces anticipatory anxiety and supports autonomy, especially in children with co-occurring neurodevelopmental profiles. With your child, make a list of foods they are willing to try, ranking them from least scary to most scary. For example, if they dislike vegetables, they might rank soft carrots as less scary than broccoli.
- This hierarchy may also span to their meal times i.e., if broccoli is a fear food first having the child comfortable with broccoli being near them at meal times maybe on a separate plate. Then moving forward, can the child bear it on their main plate, can they touch it with their hands, can they touch the broccoli to their lips, place their teeth on the food item, and eventually taking a bite.
- Foods with an anxiety rating above 7 may need a distraction present during the exposure, this may be screen time, engaging in conversation (something they find interesting), music, or a puzzle they can use to take small breaks.

Step 2: Start with the least feared foods.

- Begin by introducing foods at the bottom of the hierarchy. This could mean just looking at the food or putting a very small amount on their plate.

Step 3: Gradual tasting and portion increases.

- Over time, encourage your child to try small bites, even if they initially only tolerate a tiny amount. Gradually increase the portion sizes over several days or weeks.
- Frame exposure as bravery, not “eating success” (Thomas et al., 2020).
- Use social modelling (parent tries the food first; sibling describes taste) to normalise the behaviour (Bandura, 1977; Sharp et al., 2013)

Step 4:

- Praise effort, not outcomes; Praise your child for trying the food, regardless of how much they eat. “You did a great job trying the carrot!”

Safe Foods	Foods to try (0-10 subjective unit of distress scale)	Fear Foods

Example Exposure Ladder: “Mashed Potatoes”

Step	Task	SUDS Rating
1	Sit next to someone eating mashed potatoes	2
2	Have mashed potatoes on plate, no pressure to eat	4

3	Touch potatoes with fork	5
4	Touch potatoes with finger	6
5	Smell the food up close	6
6	Touch to lips, then tongue	7
7	Small bite (spit allowed)	8
8	Swallow small amount	9
9	Eat a spoonful	10

4. Addressing Fear and Anxiety through Cognitive Restructuring

Step 1: Identify your child's food-related fears.

- Ask your child to express their concerns about certain foods. Are they afraid of choking, vomiting, or the texture being too overwhelming?

Step 2: Challenge negative thoughts.

- Help your child recognise unhelpful thoughts, such as "I'll choke if I eat this" or "This food will taste awful," and replace them with more balanced thoughts like "I can take small bites and chew carefully" or "I won't know if I like it until I try it."

Step 3: Use relaxation techniques.

- Teach your child ways to relax before meals, such as deep breathing or listening to calming music, to reduce anxiety about trying new foods.
- Having a relaxed environment during meal times can be crucial, ensure the child is comfortable in their seat, feet being able to touch something solid to provide stability, and movement breaks; a build up of anxiety might mean the child finds it difficult to sit still for the entire time perhaps allowing them to make drinks or have a short break to alleviate this.

5. Positive Reinforcement and Rewards

Step 1: Set up a reward system.

- Use a reward system to reinforce progress. For example, if your child tries a new food, they could earn a small reward such as extra screen time, stickers, or a favourite activity.

Step 2: Ensure rewards are motivating.

- Collaborate with your child to select rewards that they find motivating. The rewards should be immediate and tied directly to food-related successes, even small ones.

Step 3: Reinforce other positive eating behaviours.

- Beyond trying new foods, reward other behaviours like sitting at the table without resistance or tasting without spitting out the food. Ensure verbal praise is given when the child's fear food is challenged.

6. Parental Involvement and Modelling

Step 1: Eat meals together as a family.

- Children with ARFID may benefit from seeing parents or siblings eating a variety of foods. Eat meals together and model positive eating behaviours.
- Bion Containment theory suggests a child seeing a caregiver variously regulate an emotion can help support them in their understanding and regulation of this emotion in the future i.e., if the child is anxious or agitated remaining as calm and in control as possible demonstrates positive containment (Bion, 1962).

Step 2: Avoid negative talk about food or body weight.

- Keep the environment positive by avoiding comments that may increase anxiety about eating, such as criticism of their portion size or food preferences.

Step 3: Encourage, but don't force, eating.

- Avoid pressuring your child to eat a certain amount of food. Pressure can increase anxiety and reinforce avoidance behaviours. Instead, gently encourage them to take small steps toward trying new foods.
- Pressure can also create a sense of failure thus discouraging further efforts around these foods.

7. Building a Support Network

Step 1: Involve the child's school and healthcare team.

- Ensure that teachers, school staff, and healthcare providers are aware of your child's eating plan and goals. This helps ensure consistency and support across different settings.

Step 2: Encourage social eating experiences.

- Support your child in eating with friends or extended family, starting with low-pressure environments. Over time, this can help reduce anxiety in social food settings.

Grounding Techniques

5-4-3-2-1 Senses Game

What to do:

Look around and find **5 things you can see.**

Touch 4 things around you.

Listen for 3 different sounds.

Smell 2 things around you (or think of 2 smells you like).

Taste 1 thing or imagine something you like to taste.

How it helps: This game makes you focus on the world around you, helping to calm your mind.

Deep Belly Breathing

What to do:

Put your hands on your belly.

Take a **big breath in through your nose** (like smelling a flower) and feel your belly get bigger.

Breathe out slowly through your mouth (like blowing out a candle) and feel your belly get smaller.

Do this **5 times**.

How it helps: This makes your body feel calm and relaxed.

Spaghetti Body (Tense and Relax)

What to do:

Pretend your body is a **stiff, uncooked spaghetti noodle** – squeeze all your muscles and hold it tight!

Then, become a **cooked spaghetti noodle** – let your body go soft and loose.

Repeat a few times, going from stiff to soft.

How it helps: This helps your muscles relax and feel less tense.

Count to 10 Slowly

What to do:

Slowly count from **1 to 10**.



Say each number **out loud** or inside your head.

If you're still upset, start from **1** again and count slowly.

How it helps: Counting helps your brain focus on something simple, giving you time to calm down.

Hold Your Favourite Object

What to do:

Pick something you love, like a **soft toy** or a **smooth stone**.

Hold it in your hands and feel it.

Notice how it feels: Is it soft, hard, warm, or cool?

How it helps: Touching something comforting helps you feel safe and calm.

Blow Bubbles

What to do:

Imagine you are blowing bubbles.

Take a deep breath in, then **blow out** slowly, as if you're blowing the biggest bubble.

Keep blowing slowly until the bubble is as big as it can get.

How it helps: Focusing on your breathing and pretending to blow bubbles can help slow your breath and relax you.

Draw Your Feelings

What to do:



Grab some paper and crayons or markers.

Draw what you're feeling inside, even if it looks messy or silly.

Once you're done, look at your drawing and think about how you feel now.

How it helps: Drawing helps you express your feelings without needing to use words, making you feel lighter.

Animal Walks

What to do:

Pretend to walk like different animals, like:

A bear: Walk on hands and feet.

A crab: Sit and walk with your hands behind you.

A bunny: Hop around.

Choose your favourite animal and walk around the room.

How it helps: Moving like animals helps use up energy and helps you feel more in control of your body.

Colour Breathing

What to do:

Pick a colour that makes you feel **happy** or **calm** (like blue or green).

Close your eyes and imagine you're breathing in that colour.

Imagine your whole body filling up with the happy colour.

Slowly breathe out and imagine blowing away any bad feelings.



How it helps: This uses your imagination to feel peaceful and get rid of worries.

Trace a Star

What to do:

Draw a **big star** on a piece of paper or imagine a star in your mind.

Using your finger, **trace along the lines** of the star.

As you trace each side, take a breath in when you go up and breathe out when you go down.

How it helps: Focusing on tracing the star helps calm your breathing and slow your thoughts.

Name 3 Things You Like

What to do:

Think of **3 things you like** or love.

Say them out loud (like “I love ice cream, dogs, and the colour blue!”).

Think about why these things make you happy.

How it helps: Thinking about things you like makes your brain feel happy and safe.

Sing a Song or Hum

What to do:

Think of your favourite song.

Sing it out loud or hum the tune.

Feel how your body starts to relax as you sing.



How it helps: Music can make you feel happy, and singing helps you breathe deeply, which helps you calm down. Humming also can help stop or limit overthinking.

References

Bion, W.R., (1962). *Learning from experience*. London: Heinemann.

Bryant-Waugh, R., & Micali, N. (2020). Cognitive-Behavioural Therapy for Avoidant/Restrictive Food Intake Disorder: A Manual for Clinicians. *Eating Disorders*, 28(4), 291-307. doi:10.1080/10640266.2020.1751749

Bryant-Waugh, R., Markham, L., Kreipe, R. E., & Walsh, B. T. (2010). "Feeding and Eating Disorders in Childhood." *International Journal of Eating Disorders*, 43(2), 98-111. This article explores the role of biological and genetic factors in the development and persistence of feeding and eating disorders, including ARFID.

Chatoor, I. (2009). "Diagnosis and Treatment of Feeding Disorders in Infants, Toddlers, and Young Children." *Washington, DC: Zero to Three Press*. This book discusses how family dynamics and caregiver responses can perpetuate feeding disorders in young children.

Kambanis, P. E., Kuhnle, M. C., Wons, O. B., Jo, J. H., Keshishian, A. C., & Thomas, J. J. (2020). "Correlates of psychosocial impairment in adults with ARFID." *Journal of Eating Disorders*, 8, 23. This paper examines the impact of social and cultural factors on the maintenance of ARFID in adults.

Norris, M.L., Robinson, A., Obeid, N., Harrison, M., Spettigue, W. and Henderson, K. (2014) 'Psychological and psychosocial impairment in ARFID', *Journal of Adolescent Health*, 55(1), pp. 49-52.

Thomas, J. J., & Eddy, K. T. (2019). "Avoidant/Restrictive Food Intake Disorder: A Three-Dimensional Model of the Neurobiology with Implications for Treatment." *Current Psychiatry Reports*, 21(8), 68. This paper discusses how avoidance learning mechanisms contribute to the persistence of ARFID symptoms, particularly in the fear of aversive consequences subtype.

Thomas, J. J., & Eddy, K. T. (2019). *CBT for ARFID: A Guide for Parents and Practitioners*. New York: Guilford Press.

Thomas, J.J., Lawson, E.A., Micali, N., Misra, M. and Eddy, K.T. (2017) 'Cognitive-behavioural therapy for ARFID: A novel treatment for young children with extreme food selectivity', *Journal of Consulting and Clinical Psychology*, 85(9), pp. 820-826.

World Health Organization. (2019) *International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision)*. Geneva: World Health Organization.

Zickgraf, H.F. and Ellis, J.M. (2018) 'The clinical presentation and impairment associated with ARFID in adults', *Eating Behaviors*, 31, pp. 28-33.

Zucker, N. L., Copeland, W., Franz, L., Carpenter, K., Keeling, L., & Angold, A. (2015). Psychological and psychosocial impairment in ARFID. *Journal of Eating Disorders*, 3(1), 6-11.

