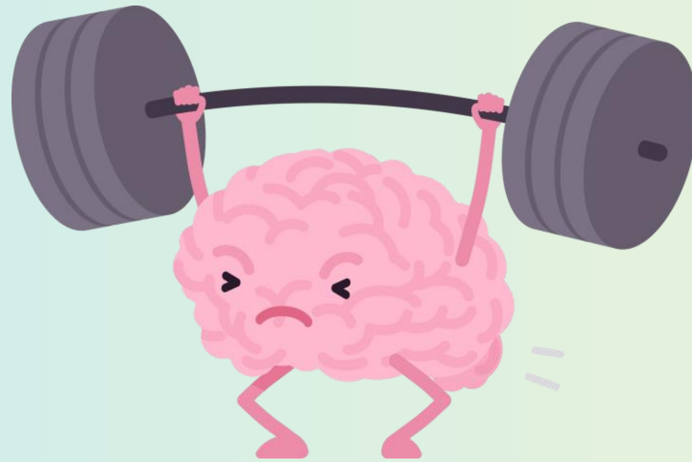
The Glenrose Complex Feeding Therapy Team & ARFID.

A discussion of what we know and what is still to learn



A Presentation to the PEAS COP by Terra Ward, SLP

ARFID

DEFINE **ARFID** AND ITS PRESENTATIONS

UNDERSTAND THE **IMPORTANCE OF COMPREHENSIVE ASSESSMENT**

IDENTIFY **EVIDENCE-BASED AND EMERGING TREATMENT APPROACHES**

CFT – COMPLEX FEEDING THERAPY AT THE GLENROSE. WHAT **WE** DO.

EXCITING THINGS THAT **OTHERS** ARE DOING.

ARFID is a feeding and eating disorder

- characterized by **persistent failure to meet nutritional and/or energy needs** not attributable to a concurrent medical condition or mental disorder

- **Not** driven by body image concerns or weight/shape fears

- **Associated** consequences may include
  - Weight loss or faltering growth
  - Nutritional deficiencies
  - Dependence on supplements or enteral feeding
  - Marked psychosocial interference

- ARFID is defined by **functional impact**, not food preferences alone.

- Not better explained by lack of available food or associated culturally sanctioned practice.

Substance Abuse and Mental Health Services Administration. DSM-5 Changes: Implications for Child Serious Emotional Disturbance [Internet]. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2016 Jun. Table 22, DSM-IV to DSM-5 Avoidant/Restrictive Food Intake Disorder Comparison. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519712/table/ch3.t18/

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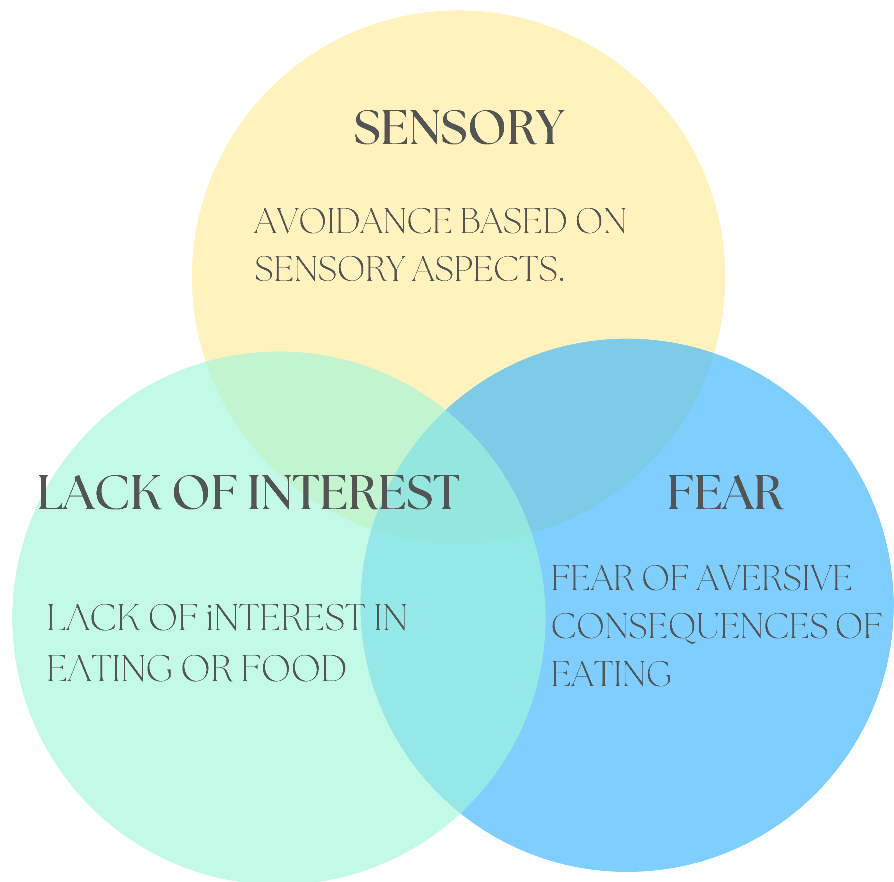
ARFID DRIVERS



- LOW HUNGER DRIVE
- POOR INTEROCEPTIVE AWARENESS
- EASILY DISTRACTED

- BRAND SPECIFICITY
- TEMPERATURE
- SMELL
- TACTILE
- TASTE

- NEOPHOBIA
- TRAUMATIC ASSOCIATIONS
- SPECIFIC FEAR OF VOMITING /CHOKING

Core features
•Avoidance due to fear of negative outcomes:
•Choking
•Vomiting
•Allergic reaction
•Abdominal pain

Often follows:
•A specific traumatic feeding or medical event
•Onset may be sudden

ARFID with fear of aversive consequences

ARFID with lack of interest in eating or food

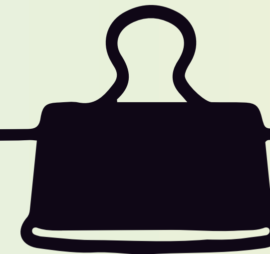
Core features:

- Low appetite or reduced interoceptive awareness
- Minimal hunger cues
- Eating feels like a chore

Common presentations:

- Early satiety
- Distractibility
- Forgetting to eat

ARFID with sensory based avoidance



Core features:

•Avoidance driven by sensory properties of food:

•Texture - •Taste -•Smell

•Temperature

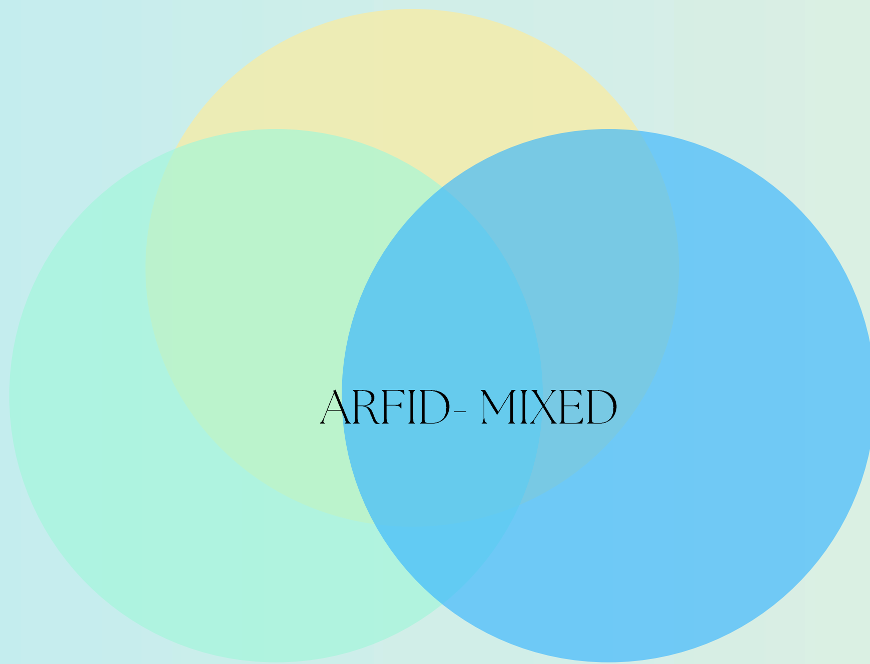
•Visual appearance

Common characteristics:

•Very limited food repertoire

•Strong gag responses

•Preference for sameness/brand specificity



ARFID- Plus

- co-occuring conditions
  - medical
  - mental health
  - neurodevelopmental

ARFID- Considerations

- overlapping domains of impact
- severity
- level of risk
- age

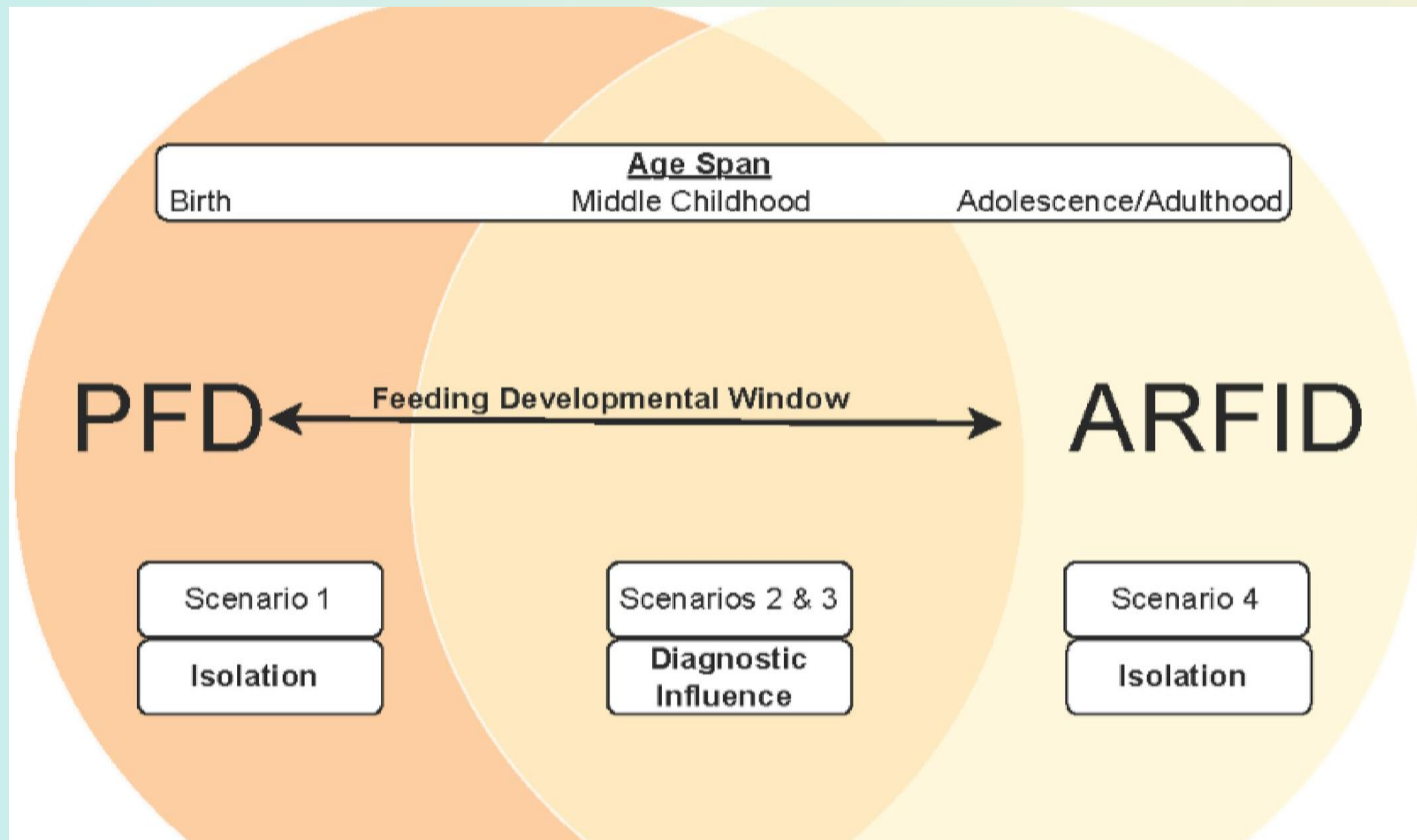
Have you been confused between PFD and ARFID… You are not alone

SUMMARY OF PFD-ARFID CONSENSUS STATEMENTS

1. ARFID is the only feeding and eating disorder that explicitly mentions feeding in this section of disorders in the DSM-5, but the manual should provide guidance about what distinguishes a feeding disorder from an eating disorder.
2. There is clear diagnostic overlap between PFD and ARFID, but both definitions would benefit from further clarity regarding how to navigate this overlap.
3. The relationship between PFD and ARFID is such that they can influence one another, criteria can be met for both conditions, or they can exist in isolation. The panel discussed four different scenarios outlining this relationship.
4. A multidisciplinary lens is beneficial for evaluating and treating both PFD and ARFID; however, the involvement and relative contribution of disciplines differs by treatment setting.
5. In determining the best diagnostic fit, medical screening and feeding skill assessment should be part of assessment protocols for both ARFID and PFD providers.
6. The feeding development period (birth through infancy and toddler period, early and middle childhood) needs to be considered when determining diagnosis and planning treatment for both ARFID and PFD.
7. PFD that transitions into ARFID likely involves a different etiological pathway than ARFID in isolation. Age of onset, learning history with food and eating, disorder course (among other developmental and learning histories) are important considerations in diagnosis. Both pathways involve a negative association with food.
8. Age of onset is an important consideration; both ARFID and unresolved PFD may be present in adulthood, but only ARFID may emerge in adulthood.
9. The proposed phenotypes of ARFID (i.e., sensory sensitivity, fear of aversive consequences, lack of interest in eating or food) apply throughout the lifespan; however, the presentation of symptoms may vary by age and developmental status.
10. Because of the overlap and influential nature between PFD and ARFID, it is vital that both fields partner to refine and share terminology, identify common outcome measures, and continue to pursue open communication to inform future research options.

Estrem, H.H., Pederson, J.L., Dodrill, P., Romeo, C., Thompson, K., Thomas, J.J., Zucker, N., Noel, R., Zickgraf, H., Menzel, J., Lukens, C.T., Goday, P.S., MacLaughlin, S. and Sharp, W.G. (2025), A US-Based Consensus on Diagnostic Overlap and Distinction for Pediatric Feeding Disorder and Avoidant/Restrictive Food Intake Disorder. Int J Eat Disord, 58: 489-499. https://doi.org/10.1002/eat.24349

Is it PFD ? ARFID Or Both?



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THE ASSESSMENT MATTERS

01 Dietary Analaysis

02 Oral Motor Evaluation

03 Sensory Analysis Profile

04 Mealtime Routines/Environment

05 Medical and Developmentlal Hiistory

Identifies drivers of avoidance not just symptoms
Guides ethical treatment -
Prevents mislabelling ARFID as “behavioural” or non-compliant

ARFID – SCREENS

ARFID specific (NAIS, ARFID-BS, SAS),

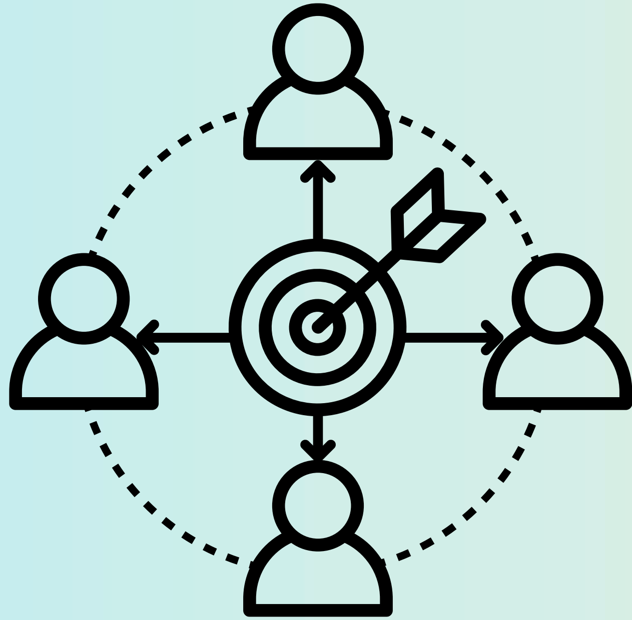
- Nine-Item ARFID screen (NAIS;)focus on the core drivers
- ARFID-Brief Screener (ARFID-BS) focus on the clinical implications
- Short ARFID (SAS) focus on the clinical implications

Some include other Eating Disorders

- PARDI-AR-Q
- Eating Disorders in Youth Questionnaire (EDY-Q;)
- Stanford Washington University Eating Disorder Screen (SWED

Some measures are:

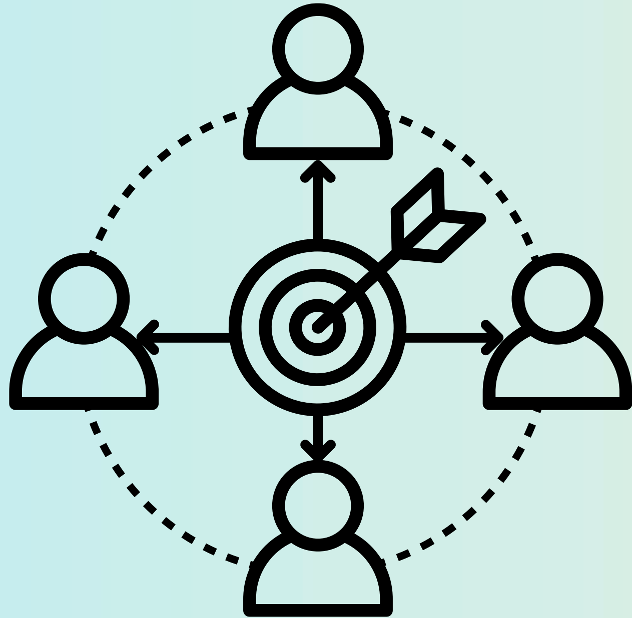
- Self-report,
- Parent/carer reported,
- Some are clinically administered,
- Some are currently validated for use in community populations but not in clinical settings.



ARFID TREATMENT BY CFT at the GLENROSE

ARFID TREATMENT BY CFT at the GLENROSE

is:



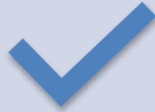
Individual treatment (...for now)

Collaborative

8 weeks = 1 block

Multi-disciplinary

Referral Process



1. Intake Call

Accept, Defer, Refer

Introduces team, process and next steps

2. Email +

Obtain more information and outline next steps

- Food Preference Sheet
- BFPAS
- Consent

Contact Information

3. Goal Setting Session

Zoom session – to determine area of focus for 8 weeks

Family + RD+ Psych+ OT+ SLP and + TA

Food Preference Sheet

1. Preferred foods

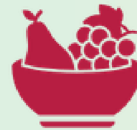
Gives outline of foods that are regularly accepted, helps identify sensory patterns/preferences

2. Sometimes

Helps identify rules around foods and mealtimes

Highlights environmental stressors and supports

Can often be used earlier in therapy as target food



3. . Dropped Foods

Provides information about avoidance patterns and reason for why?

Often used early in therapy to build confidence

4. Family Foods

Provides valuable information about what type of foods family regularly has access to

Highlights family and mealtime cultural practices

BFPAS

Child Mealtime Behaviours

- Questions related to both skill based factors and behavioural factors in food selection
- Length of time per meal
- Enjoyment of eating
- Problems chewing food

Parent Feelings

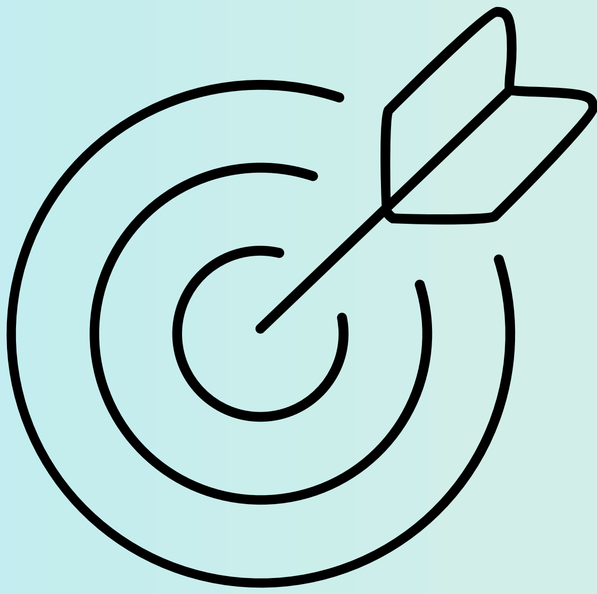
- Confidence
- Concern
- Frustration
- Anger
- Anxiety

Considerations

Age

Communication Profile

Other Diagnosis



Goal Setting
Session

Emotional regulation
Interoception
Thinking traps and helpful thoughts
Learning about Foods
Food targets
Mealtime Routines
Home practice
Triggers
Strategies & Resources

Goal Session Debrief

1. Ready to begin or defer until...
2. Who will be involved and when
3. What needs to be monitored and by whom
4. Who will take what role: lead, note taker/communication with family
5. What resources/will be required pre-tx

Session 1 — Introduction to room, routine and regulation strategies. And how does our brain work.

Session 2 — Review Regulation & Start NOTICING with familiar foods

Session 3

Session 4

Session 5

Session 6

Session 7

Full sequence with preferred and choose one food to target

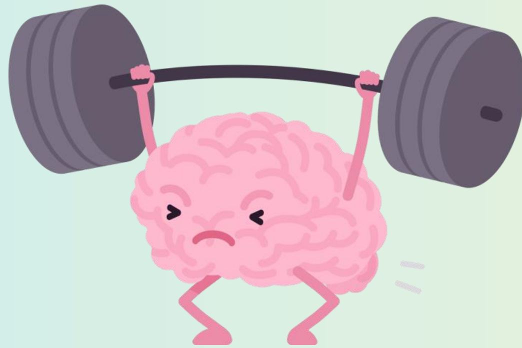
Review/refine strategies
Gradually introduce target foods and exposure protocol
coached opportunities for noticing
coached regulation.

Session 8 — Treatment summary and progress to date

Communication with parents includes:

Copies of all visuals
Weekly E-mail: summary highlights, new information /resources
Home practice
What to bring next session
Treatment Summary and Maintenance plan

Rethinking “Success” in Feeding Therapy

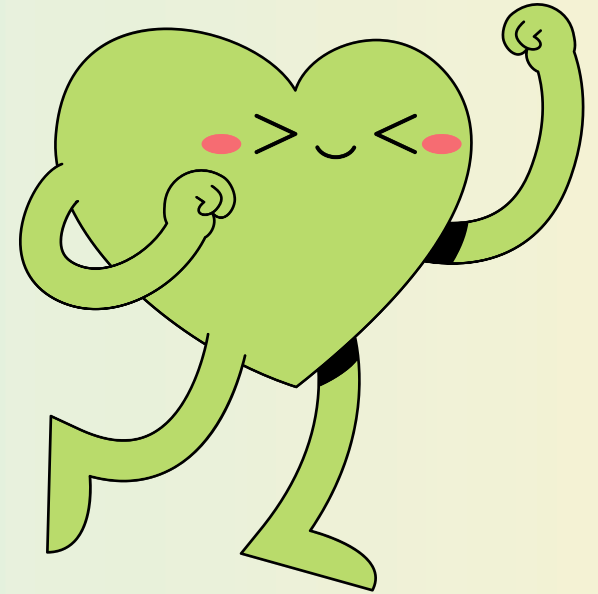


- Less anxiety at meals
- Increased nutritional adequacy
- Increase participation in shared meals
- More medical stability
- Increased sense of control and safety

Not everyone will:

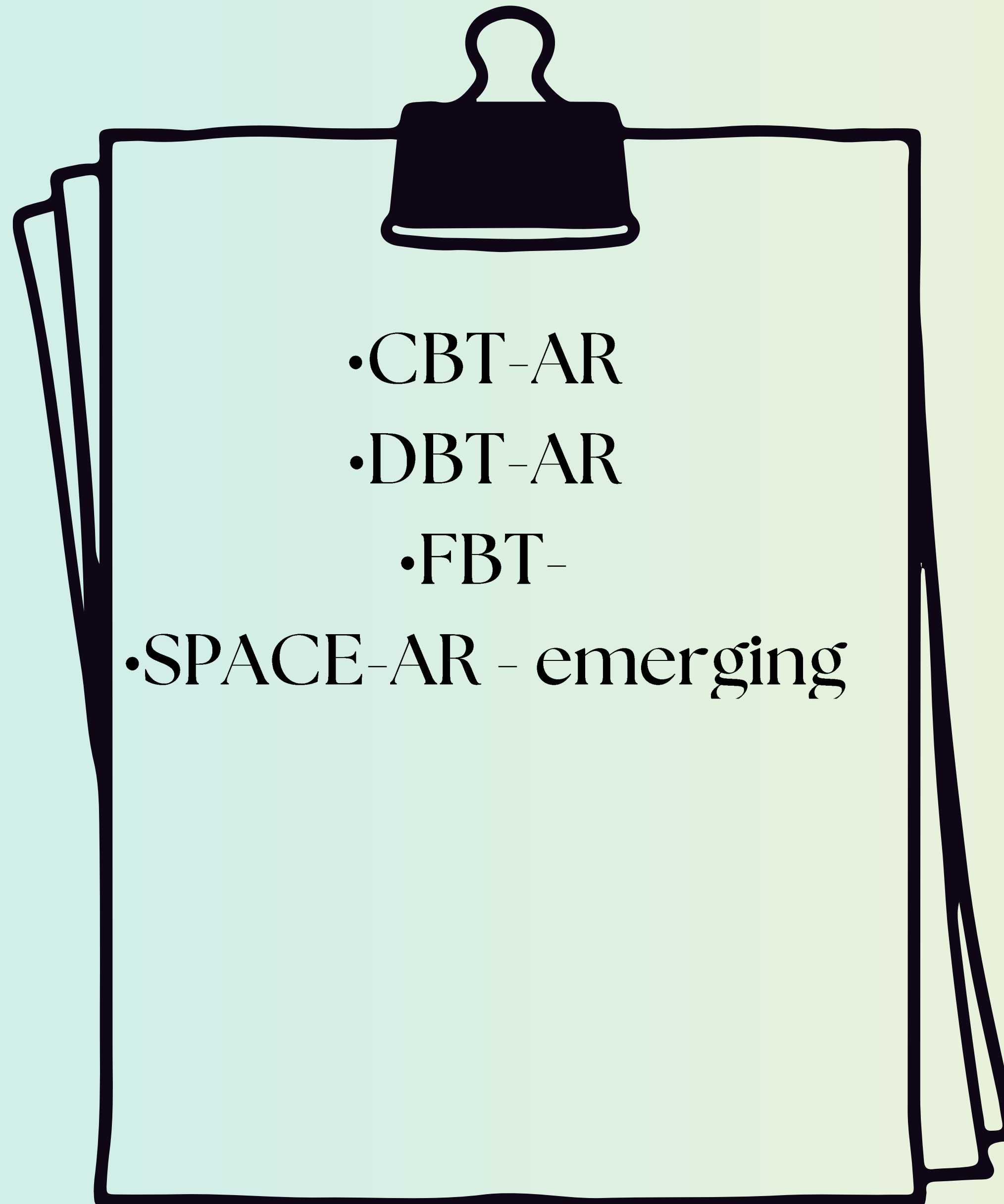
- Eat everything
- Eat socially expected foods
- Eat without accommodations
- And that is not failure.

Exciting Programs & Resources



- WHARAURAU – New Zealand
- Feeding Matters
- The Feeding Therapist – T. Foley
- The First Steps A Parent's Guide to ARFID
- Parent Education Program for PFD– L. Herschfield, PhD

Evidence Based Approaches to ARFID

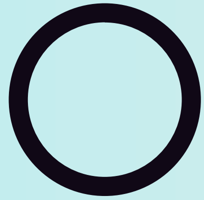


Possible Intervention Components could include:

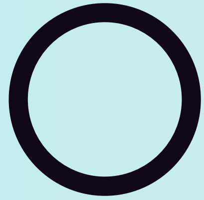
- CBT-AR
- DBT-AR
- FBT- AR
- Feeling and Body Investigators
- Sensory Desensitization
- Interoception
- Behavioral and environmental modifications
- Parent-mediated or caregiver-based interventions
  - SPACE
  - Food Challenge
- Nutrition counseling with flexibility
- Medical and pharmacologic support (when indicated)

ARFID - Service Delivery

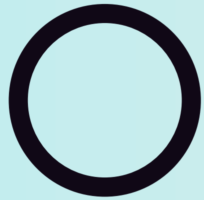
To do List



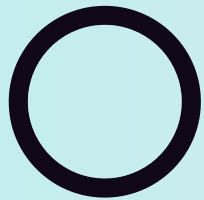
networks of providers across clinical settings



contributing to a shared ARFID care pathway



Continued data sharing to guide service development and configuration,



Support to develop EB and consistent patient care in all settings.

THANK YOU!

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