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FAMILY GUIDE SERIES

BEYOND PICKY EATING

Strategies for Navigating **ARFID** (Avoidant/Restrictive Food Intake Disorder) and Supporting Your Loved One

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Families Empowered and Supporting
Treatment of Eating Disorders

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Beyond Picky Eating:
Strategies for Navigating ARFID (Avoidant/Restrictive Food Intake Disorder) and Supporting Your Loved
Part Of The F.E.A.S.T. Family Guide Series

IMPORTANT NOTICE TO READERS

This guide is intended as a resource for families and caregivers. It should not be used as a substitute for professional medical advice, diagnosis, or treatment. Always seek the guidance of qualified healthcare providers with any questions regarding your loved one's medical condition. F.E.A.S.T. assumes no responsibility for any outcome relating to the information contained in this guide.

ABOUT THIS GUIDE
This guide was written for caregivers supporting a loved one with ARFID (Avoidant/Restrictive Food Intake Disorder). It offers practical strategies for understanding the condition, reducing mealtime conflict, and supporting food exploration at home, whether you're working with a treatment team or navigating this journey on your own.

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First Edition
Published by F.E.A.S.T.
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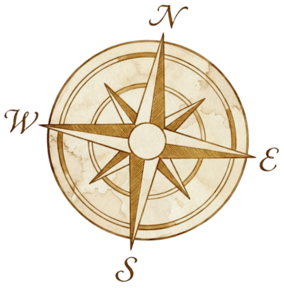
Beyond
Picky Eating

A GUIDE TO NAVIGATING **ARFID**
(AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER)
AND SUPPORTING YOUR LOVED ONE

NAVIGATING ARFID



First Things First

If your child has been diagnosed with ARFID, you may be feeling confused, relieved, or both. Maybe you've spent years being told your child is “a super picky eater” or that they will “just grow out of it.” Maybe you've watched mealtimes become battlegrounds, or felt the judgment of well-meaning relatives. You might have even quietly worried whether your child is getting enough to grow and thrive.

If any of this sounds familiar, you're not alone.

ARFID (Avoidant/Restrictive Food Intake Disorder) is a real, diagnosable condition. It's not a phase, and it's not a parenting failure. It is also not something your child is choosing. Understanding this is the first step toward helping them.

The good news is that ARFID is treatable. With the right approach, children and adolescents can learn to feel safer around food, expand what they're willing to eat, and participate more fully in the social world of meals. This guide will help you understand what ARFID is, how treatment works, and what you can do at home to support your loved one's progress.

This journey requires patience (sometimes a lot of it) but families who have walked this path before have reported that small steps add up, and change is possible.

> “ARFID is not a **phase**,
> and it's not a
> parenting **failure**.
> It is also not something
> your child is **choosing**.”

What is ARFID?

People with ARFID avoid food for reasons that go beyond typical pickiness. Generally, avoidance falls into three categories:

- **Sensory sensitivities** – certain textures, smells, or temperatures feel genuinely intolerable. Not just unpleasant, but *impossible to get past*.
- **Fear of aversive consequences** – a deep fear that eating will lead to choking, gagging, or vomiting.
- **Low interest in eating** – reduced appetite cues or a lack of enjoyment around food. Food just doesn't register as important or appealing.

Many people with ARFID have features of more than one type. And because ARFID is a brain-based condition, it can overlap with other eating disorders, anxiety disorders, sensory processing challenges, and medical trauma.

ARFID not a choice, or a behavior problem, or something that willpower alone can fix.

Understanding this reality is the first step; this guide is here to help show a way forward.

Avoidance is Key

There is one thing that every major ARFID treatment approach agrees on: avoidance is what keeps the problem going. Every time your child avoids a feared food or situation, the anxiety doesn't go away; it actually gets ***reinforced***. The brain learns that avoidance "worked," and the list of safe foods gets a little smaller.

The good news is that exposure and food exploration—done safely and appropriately—can improve this pattern. It reduces avoidance and builds confidence over time.

Key Insight:
Avoidance maintains anxiety. Exposure, done safely and at the right pace, is how avoidance loses its grip.

What Treatment Aims To Do

Effective ARFID treatment isn't just about getting your child to eat more foods—though that's often part of it. The goals are broader.

Treatment goals generally include helping your loved one to eat enough for growth and development, feel safer around food and mealtimes, and slowly expand what they're willing and able to eat.

The full list of treatment goals may include:

- Eating enough for growth and development
- Feeling safer around foods and mealtimes
- Slowly expanding food variety and flexibility
- Tolerating uncomfortable sensations (fullness, textures, nerves)
- Reducing fear-based avoidance
- Improving day-to-day functioning
- Reducing reliance on liquid nutrition or supplements
- Joining in with social meals more comfortably

Core Things Caregivers Should Know

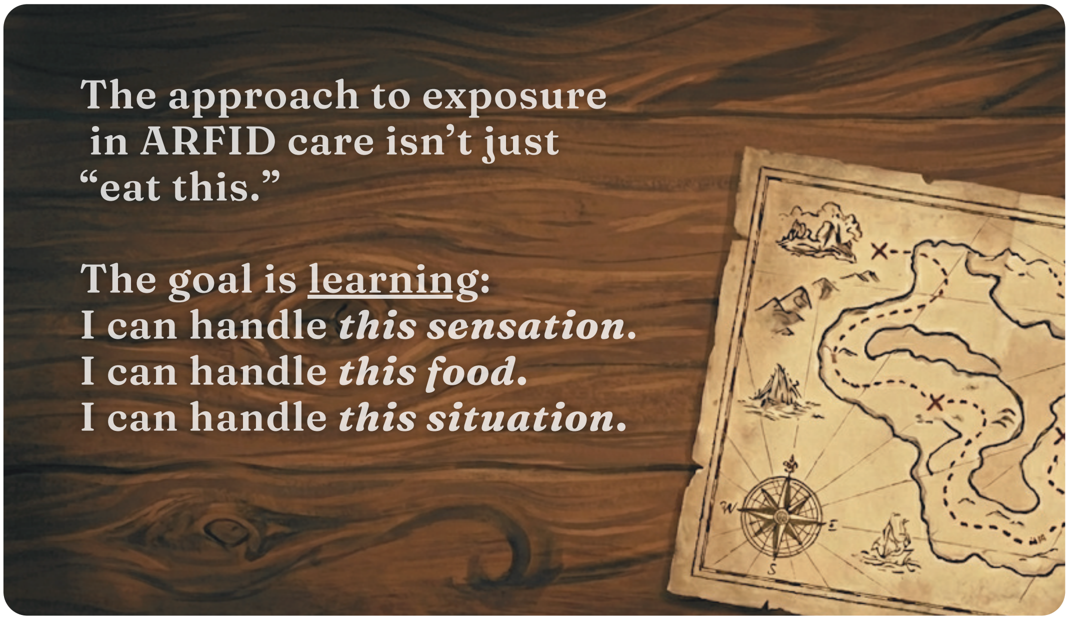
1. Safety Comes First

Before you focus on expanding foods, make sure your loved one is eating enough to gain weight and grow well. It’s okay to rely on safe foods to get there. Start with ones that have caloric density, and use liquid nutrition if needed.

This foundation usually needs to be in place before food exploration work can be successful. You can’t build flexibility on an empty tank.

2. Exposure Is Essential, But Must Be Done Thoughtfully

Exposure is the main mechanism of recovery. But exposure does not mean forcing bites. It is systematic and measured, often using comfort ratings. It is also generalized across settings (home, school, restaurants) and designed to target your loved one’s specific ARFID profile.



The approach to exposure in ARFID care isn’t just “eat this.”

The goal is learning:
I can handle *this sensation.*
I can handle *this food.*
I can handle *this situation.*

3. Reducing Pressure Avoids Power Struggles

When your child isn’t eating, every instinct says push harder. But pressure increases anxiety, and anxiety reduces willingness to try food. Here are some common approaches that ***feel*** helpful but tend to make things worse:

- “Just one bite”
- Sticker charts for eating
- Bribes or threats
- Commenting on how much was eaten
- Sneaking foods in or forcing tastes

Instead, try these approaches:

- Modeling calm enjoyment
- Offering variety without expectation
- Celebrating curiosity, not consumption

That shift might counterintuitive, but reducing pressure often opens more doors than pushing!

4. Caregivers Are Coaches, Not Enforcers

You play a huge role in your child’s progress—but not the role you might expect. You are not there to “make them” eat. You are there to support the process.

What does that look like **in practice**?

- Providing structure and routine
- Supporting exposures at home 5 to 7 days a week
- Coaching bravery, not compliance
- Reducing accommodations that reinforce avoidance
- Encouraging small steps while maintaining safety

Your steady, calm presence is one of the most powerful tools your child has.

Types of ARFID

Not all ARFID looks the same. Understanding which presentation best describes your loved one helps you—and their treatment team—tailor the approach. Keep in mind that many people have features of more than one type.

Sensory-Sensitive ARFID

For some people with ARFID, certain textures, smells, or temperatures feel genuinely intolerable. This isn't pickiness; their nervous system responds to these sensory experiences with real distress.

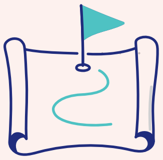
Helpful approaches include:

- Food play and gradual texture exploration
- Tiny, predictable exposures
- Sensory accommodations early on (reduced later)
- Trying foods through smell, touch, and sight first

What to **avoid**:

- Overwhelm (such as mixed textures too early)
- Pressure to swallow new foods

With sensory-sensitive ARFID, the goal is gradual desensitization rather than forced compliance. Let the nervous system learn at its own pace.



Making Incremental Progress

For sensory-sensitive ARFID, progress isn't just "more foods eaten." It might look like touching or smelling a new food without panic, tolerating a food on the plate, or trying something through sight and smell before taste.
Every step counts.

Fear-of-Aversive-Consequences ARFID

Some people with ARFID avoid eating because they’re afraid something bad will happen—choking, gagging, or vomiting. The fear is very real to them, even when the actual risk is low.

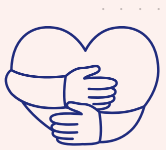
Helpful approaches include:

- Validate fears directly ("I believe you're scared, and you're safe")
- Interoceptive exposures (small increases in bite size, tolerating mild gag)
- Practicing predictability

What to **avoid**:

- Surprise exposures
- "You'll be fine" reassurance loops
- Forcing bites

With fear-based ARFID, trust is everything. Pushing too hard can backfire and deepen avoidance.



Why Validation Matters

When your child says they’re afraid, believe them.

Saying things like “I can see you’re scared, and you’re also safe” does more than “You’ll be fine.” Validation builds trust, and trust is the foundation for progress.

Lack Of Interest ARFID

For some people with ARFID, food simply doesn’t hold much interest. They may have reduced appetite cues or a lack of enjoyment around eating. Food just doesn’t register as important or appealing in the way it would for others.

Lack Of Interest ARFID (cont’d)

Helpful approaches include:

- Structured eating (regular meals and snacks)
- Exposure to food cues
- Gradually increasing caloric density
- Combining exposure with appetite awareness

What to **avoid**:

- Expecting hunger to lead on its own
- Allowing long gaps between meals

With lack-of-interest ARFID, external structure often needs to replace the internal cues that aren’t working reliably.

Schedules Are Helpful

With lack-of-interest ARFID, waiting for hunger to show up usually doesn’t work because the internal cues just aren’t loud enough. Regular, scheduled meals and snacks provide the external structure that replaces what the body isn’t signaling on its own.

It is important to understand the different types of ARFID and how approaches differ. The next section offers some practical tools you can use at home.

Practical Guidance For Caregivers

The principles matter, but so does ***knowing what to do***. This section offers concrete tools and strategies you can use at home to support your loved one’s progress.

1. Use Neutral, Supportive Language

The words you use at mealtimes carry more weight than you might think. Pressure (and even well-intentioned encouragement) can increase anxiety and shut down willingness to engage. Neutral, supportive language keeps the door open.

Helpful phrases:

- "You're doing something brave."
- "You don't have to like it; you're just learning."
- "A little step is still a step."
- "It's okay to feel nervous. I'm right here."

Phrases to <u>**avoid**</u>:

- "Just try it."
- "You liked this before."
- "Take a bite, or no dessert."

You're looking to support them and give a voice to their courage, not manage their behavior.

Key Insight:
The goal is to acknowledge the difficulty **without** adding pressure.

2. Structure The Family Meals

Predictability helps anxious eaters feel safer. Structure isn't about rigidity; it's about creating a reliable container so your child knows what to expect.

Key elements:

- Predictable meal and snack times
- Family-style serving when possible
- Include one safe food at every meal
- Adults model trying foods calmly

When meals follow a rhythm and everyone eats together without fanfare, food becomes less charged. Your calm presence at the table matters more than any technique.

3. Keep Exposure Logs

Tracking exposures helps you see patterns, celebrate progress, and communicate with your treatment team. It doesn't have to be complicated.

For each exposure, note:

- What food was explored
- The steps involved (look, smell, touch, lick, bite)
- How anxious they felt (a simple 1-10 rating works)
- What they learned or noticed

Over time, the log becomes evidence that **small steps can add up**—even when progress feels invisible day to day.

4. Build a “Food Inventory”

Before you can build an exposure plan, it helps to know where you’re starting. A food inventory maps your child’s current relationship with different foods.

Useful categories:

- **Safe foods** — no anxiety, eaten reliably
- **Sometimes foods** — low to moderate anxiety, eaten inconsistently
- **Learning foods** — highest fear, currently avoided

This inventory gives you and your treatment team a starting point. Exposure work typically begins at the edges of the “sometimes” category (foods that are challenging but not overwhelming).

5. Gradually Reduce Safety Behaviors

Many children with ARFID develop habits that help them feel safer but reinforce avoidance over time—things like excessively small bites, over-reliance on water to wash food down, cutting food into tiny pieces, only eating one specific brand, or refusing all mixed foods.

These behaviors make sense as coping mechanisms, but they can become barriers to progress. The goal is to **reduce them gradually** and collaboratively, not to rip them away.

Work with your child (and treatment team, if you have one) to identify which safety behaviors are most limiting, and fade them slowly over time.

> “The process isn’t about taking away comfort. It’s about expanding what’s possible.”

What Progress Looks Like

It can be tempting to measure progress by counting new foods. But if that’s your only yardstick, you’ll miss a lot! You might lose heart when the list isn’t growing as fast as you hoped.

Real progress in ARFID often looks quieter than that:

- Eating enough for weight gain, growth, and development
- Sitting at the table with less distress
- Touching or smelling new foods without panic
- More flexibility with brands or presentations
- Trying foods even when nervous
- Reduced conflict at meals
- Joining social meals more comfortably

Sometimes progress just looks like **you handling things differently**: less conflict at dinner, fewer battles, a little more ease in a space that used to be filled with tension.

None of these moments will show up on a “foods my child eats” list, but they matter. They are evidence that something is shifting: avoidance is loosening its grip, one brave moment at a time.

When To Seek Professional Support

This guide is meant to help, but it’s not a replacement for professional care. ARFID can be serious, and some situations call for more support than any guide can offer.

If your child is losing weight, not gaining appropriately, or falling off their growth curve, that's a signal. If they’re down to fewer than 20 foods and the list is shrinking, that's a signal. If entire food groups have disappeared from their diet, or if bloodwork is showing nutritional deficiencies, those are signals too.

But it’s not only about the medical markers. If mealtimes have become so distressing that they’re affecting your family’s ability to function—if every dinner is a crisis, if siblings are suffering, if you’re exhausted and out of ideas—that’s also a reason to reach out.

You don’t have to wait until things are dire. A consultation with an ARFID-informed provider can help you figure out whether what you’re doing at home is enough, or whether your child needs more structured intervention. Sometimes the answer is “keep going, you’re on the right track.” Sometimes it’s “let’s add some support.” Either way, you’ll have a clearer picture.

A treatment team might include a therapist trained in exposure-based work, a dietitian who understands ARFID, a pediatrician or adolescent medicine doctor monitoring growth, an occupational therapist for sensory issues, or a speech-language pathologist if swallowing is part of the picture. Not every child needs all of these—but the right combination can make a significant difference.

Final Thoughts

If you’ve made it this far, you’re already doing something important: you’re trying to understand. That matters more than you might realize.

ARFID can be isolating; other parents don’t always get it, and relatives offer well-meaning advice that doesn’t help. Even doctors sometimes dismiss it as “just a phase.” Meanwhile, you’re at the table every night, trying to stay calm while your child struggles.

ARFID can also be exhausting. If you’re feeling that exhaustion, you’re not failing—**you’re just in the middle of something genuinely hard**.

We’ve been there!

Recovery from ARFID is absolutely possible. What makes the difference? Patience. Consistency. A willingness to let small steps be enough for now. Repeated opportunities without repeated pressure. And perhaps most of all, a caregiver who stays steady—not perfect, not calm every single time, but present and committed and willing to keep showing up.

You don't have to have all the answers. You don’t have to get it right at every meal. You just have to keep going, one plate at a time, trusting that your presence matters even when progress feels invisible.

With safety, structure, and support, your child can develop confidence, flexibility, and a more joyful relationship with food.

About The Author

Nathalia Trees, MS, RD, CEDS-C, is a certified eating disorder Registered Dietitian and consultant specializing in the treatment of adults and adolescents with eating disorders. She was granted a Bachelor of Science from the University of Colorado and a Master of Science in clinical nutrition from Tufts University. She completed her dietetics internship at Tufts Medical Center in Boston, MA. Her experience spans over 13 years in medical nutrition therapy, nutrition education, public speaking, and eating disorder related research. Her passion is advocacy, training, and education for current and future dietitians.

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