"I CAN'T EAT THAT": ADDRESSING AVOIDANCE IN AVOIDANT RESTRICTIVE FOOD INTAKE DISORDER

Laura McLain (she/her), PsyD, BC-TMH
Director of Training
The Renfrew Center

The Renfrew Center
FIRST IN EATING DISORDERS
CELEBRATING 40 YEARS

AGENDA

Participants will be able to differentiate 2 ARFID symptoms from other eating disorder diagnoses using DSM-5 criteria.

Participants will be able to utilize 3 evidence-based strategies with ARFID clients to reduce avoidance behaviors.

Participants will be able to implement 2 exposure principles to increase interoceptive awareness and tolerance.

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

Food avoidance or restriction leading to persistent failure to meet nutritional needs, causing >1 of the following:

- Significant weight loss
- Significant nutritional deficiency
- Dependence on tube feeding or oral supplements
- Psychosocial impairment

Not due to lack of available food or cultural practice

No fear of weight gain or body image disturbance

Not accounted for by another medical or psychiatric condition

American Psychiatric Association, 2013

ARFID SUBTYPES

SENSORY SENSITIVITY

Avoidance based on sensory characteristics of food (i.e. texture, smell)

Feel safer eating foods that they know

FEAR OF AVERSIVE CONSEQUENCES

Associated with food intake (i.e. choking, vomiting)

May stop eating foods that made them sick or eating altogether

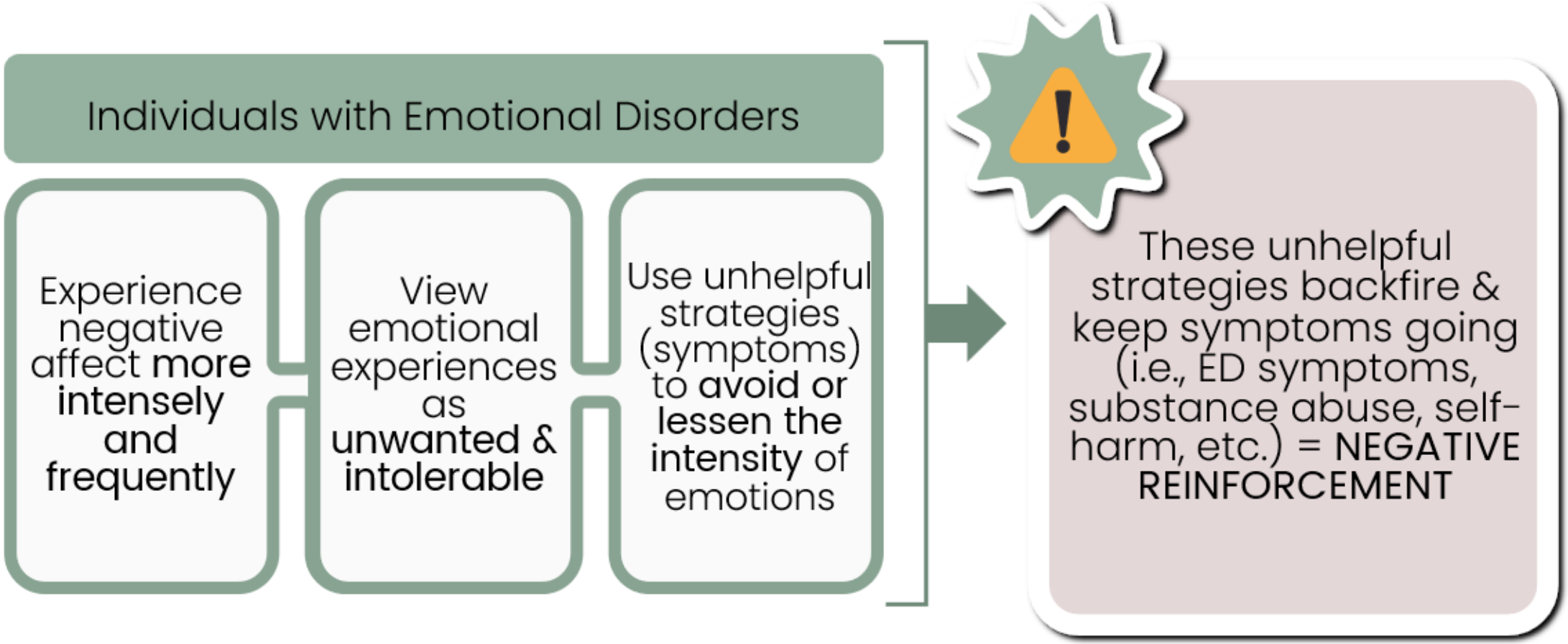
LACK OF INTEREST

Low interest in food or eating

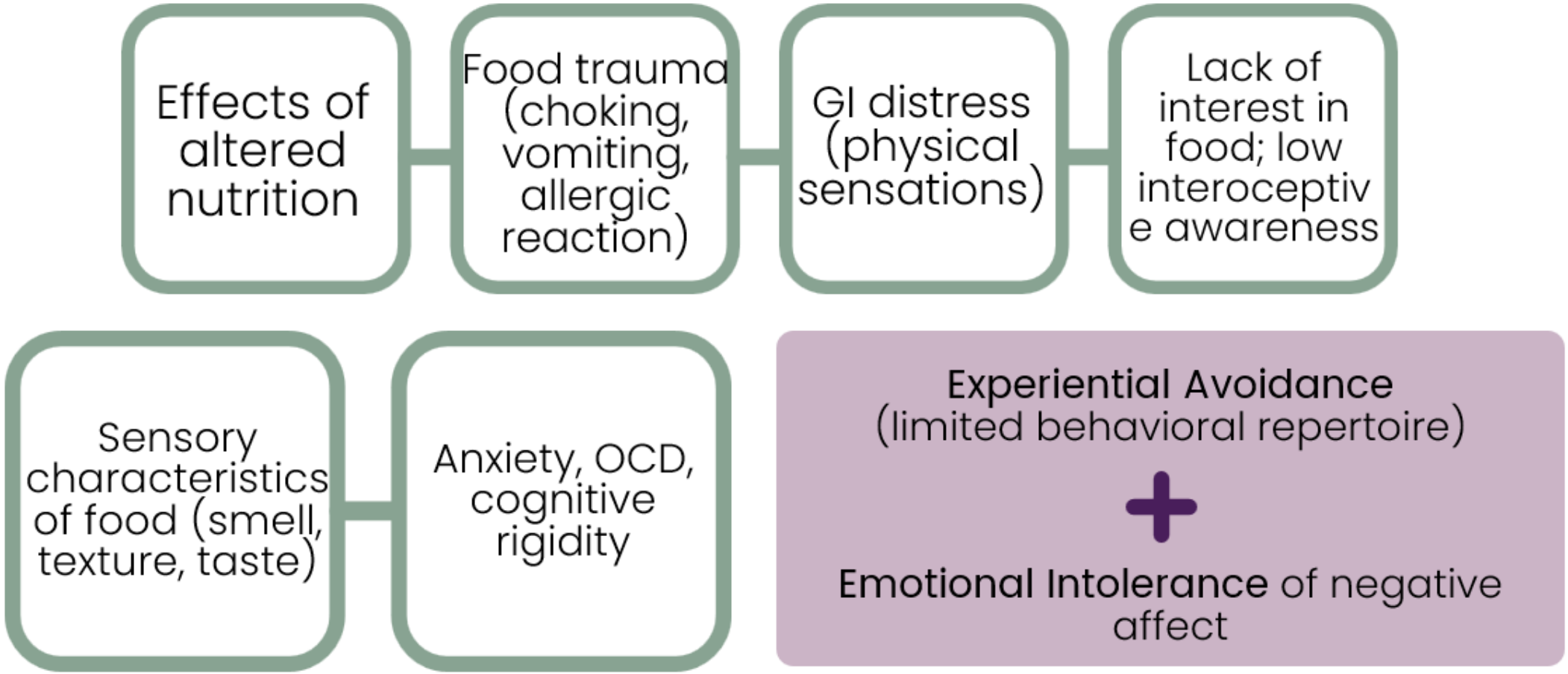
Don't feel hungry often, look at food as a chore, or get full very quickly

American Psychiatric Association, 2013

ARFID AS AN EMOTIONAL DISORDER



MAINTENANCE FACTORS



Nitsch et al., 2023

AWARENESS OF OUR OWN BIASES & ASSUMPTIONS

Are we asking the questions?

Tool vs Toy?

Encouraging patients to identify if something is a tool or toy by doing a 3-point check

"You've mentioned that drawing can be both a tool to engage and an avoidance strategy. I'm wondering if you could do a 3-point check in this moment and check in about the function of drawing in group this morning. What are you noticing?"

ASSESSMENT & SCREENING

Comparison Snapshot:

Tool	Primary Focus	Format	ARFID-Specific?	Key Themes Covered
EDY-Q	ARFID in youth	Self-report	Yes	ARFID profiles, body image neutrality
EDA-5	Diagnostic assessment	Interview	Yes	DSM-5 criteria for all EDs, including ARFID
NIAS	ARFID symptom screening	Self-report	Yes	Three ARFID drivers (interest, sensory, fear)
PARDI	ARFID, pica, rumination	Structured interview	Yes	Symptoms, functional impact, context
EPSI	General ED symptoms	Self-report	No	Restriction, bingeing, purging, body dissatisfaction

Open AI, 2025, Zickgraf & Ellis, 2018

RISK FACTORS

DIGESTIVE ISSUES

Nausea, bloating, reflux, rumination
Involuntary vomiting
Functional abdominal pain (FAP)
Exclusion diets

Food allergies
Neophobia (fear of trying new foods)

CO-OCCURRING ISSUES

AUTISM SPECTRUM DISORDER

Hyperfocus (may forget to eat when focused on special interest)

Sensory integration issues

Misinterpret or lack of awareness around interoceptive cues (hunger, thirst, satiety)

ADHD

Executive function (decisions about food)

Hyperfocus (forget to eat)

Low dopamine (crave easily accessible and highly palatable foods)

Stimulant medications can impact appetite and interoceptive awareness

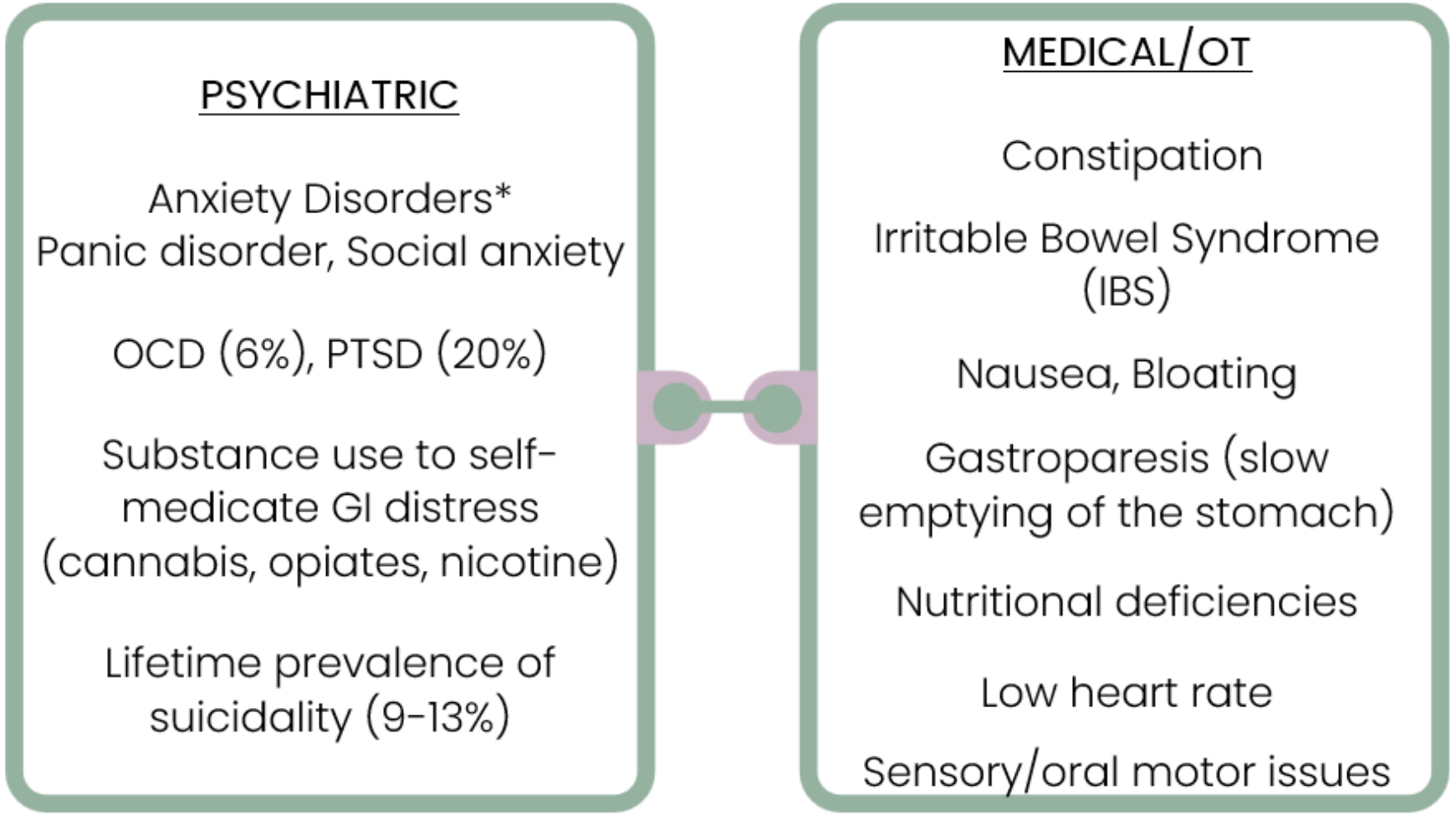
SENSORY SENSITIVITY

Severity of **sensory sensitivity** associated with neurodevelopmental disorders

Sensory Processing Disorders (hypo/hyper oral, tactile, visual, and olfactory channels impacted)
90% prevalence in ASD

Galiana-Simal, Munoz-Martinez, Beato-Fernandez, 2017; Kambanis et al., 2020; Nitsch et al., 2023

CO-OCCURRING ISSUES

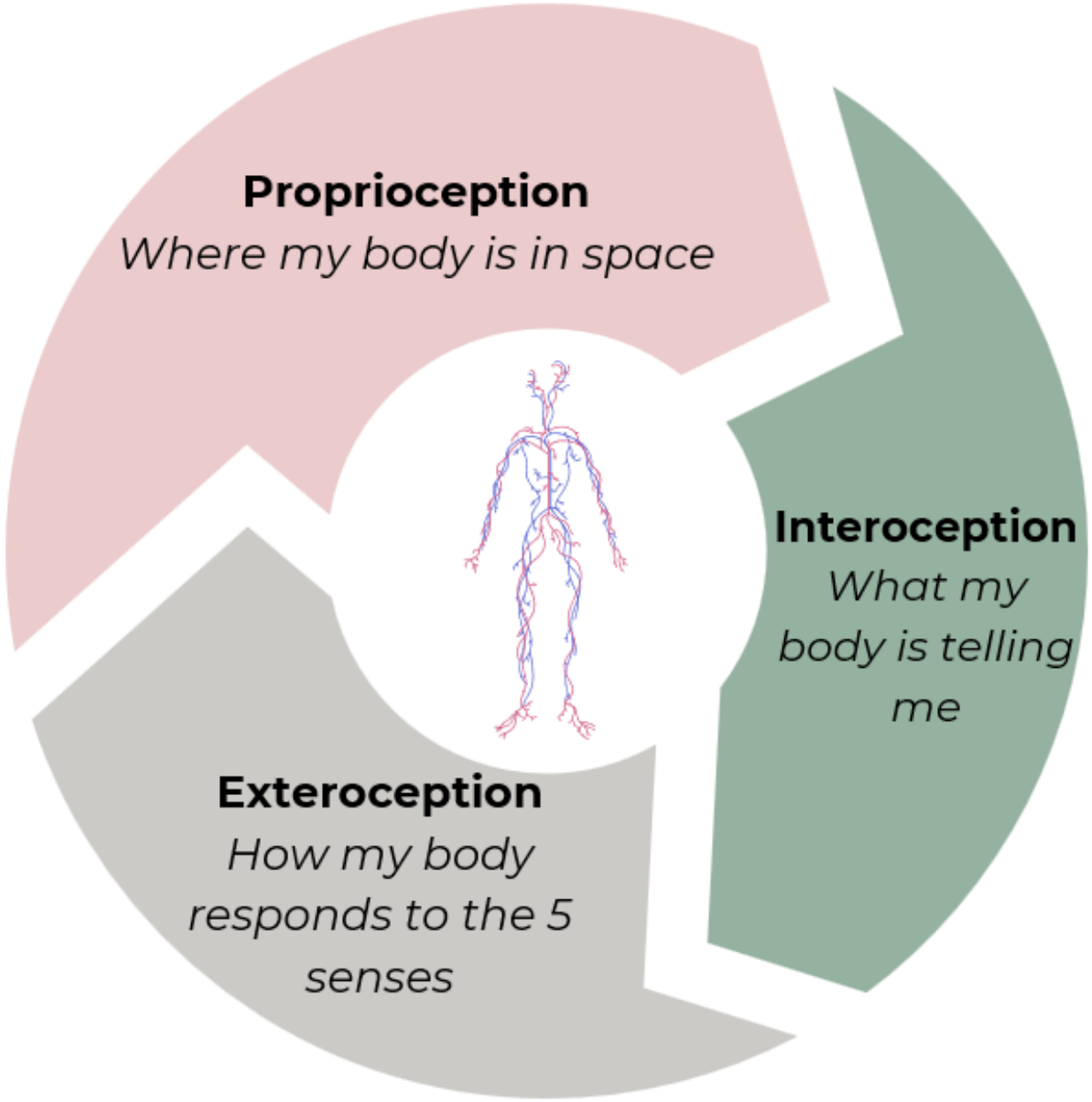


Galiana-Simal, Munoz-Martinez, Beato-Fernandez, 2017; Kambanis et al., 2020; Nitsch et al., 2023

SENSORY PROCESSING

All systems work together to guide action

Disruptions look like:
Lack of body trust
Lack of hunger/thirst cues
Hyperaware of surroundings
Aversions to taste/texture/smell
Overwhelmed by physical sensations



HOW DOES THIS SHOW UP?

HYPERSENSITIVITY

Seeking quiet spots in groups/meals

Startled by sudden/loud noises

Strong reactions to foods (e.g. slimy or sour)

Refusing to try new foods

HYPOSENSITIVITY

Sensory seeking through taste/texture (e.g. spicy tastes, crunchy textures)

Seeking physical contact and/or pressure

AVOIDANCE STRATEGIES

Avoiding meal times or dining area (anxiety)

Difficulties engaging in group discussions

Using distractions during exposures

Completing tasters very quickly vs. mindfully

SENSORY NEED OR FOOD RITUAL

Sensory needs enhance the eating experience, personal preference

Examples: noise canceling headphones, reducing clutter, wearing comfortable clothing, incorporating preferred foods, minimizing conversations at meals, seating preference in sessions

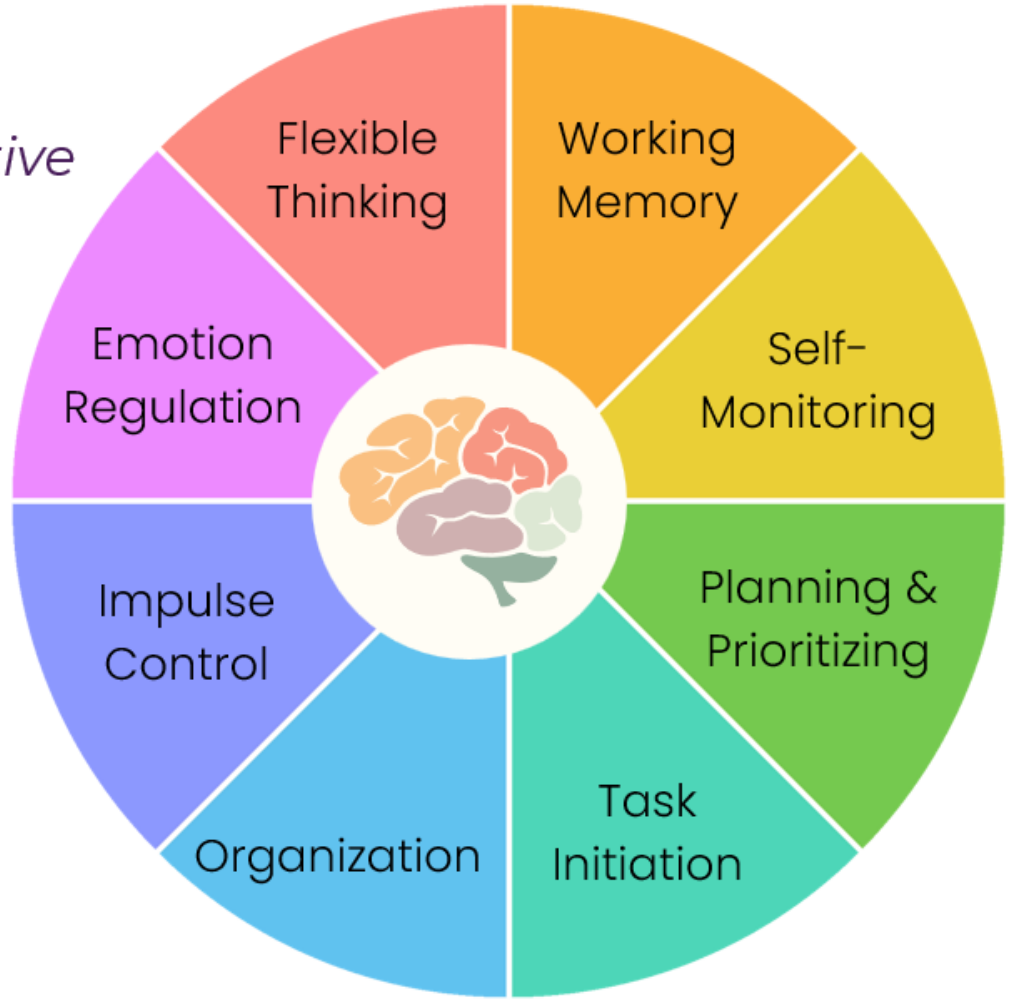
Food rituals are used to avoid the emotional experience of eating; they are about control and negative beliefs around food and eating

Explore short & long-term outcomes of rituals/sensory needs with the client

COMPROMISED EXECUTIVE FUNCTION

Nourishment impacts executive function

Iversen & Lewis (2021)



HOW DOES THIS SHOW UP?

Impulsivity:
- Can lead to restriction, purging, or binge eating
- Completing tasters mindlessly

Inattention:
- Forgetting to eat
- Difficulties focusing on food prep
- Forgetting tasters
- Not completing FEJs

Unreliable Hunger Cues:
- Body mistrust
- Bored with food choices
- Engaging in tasks while eating

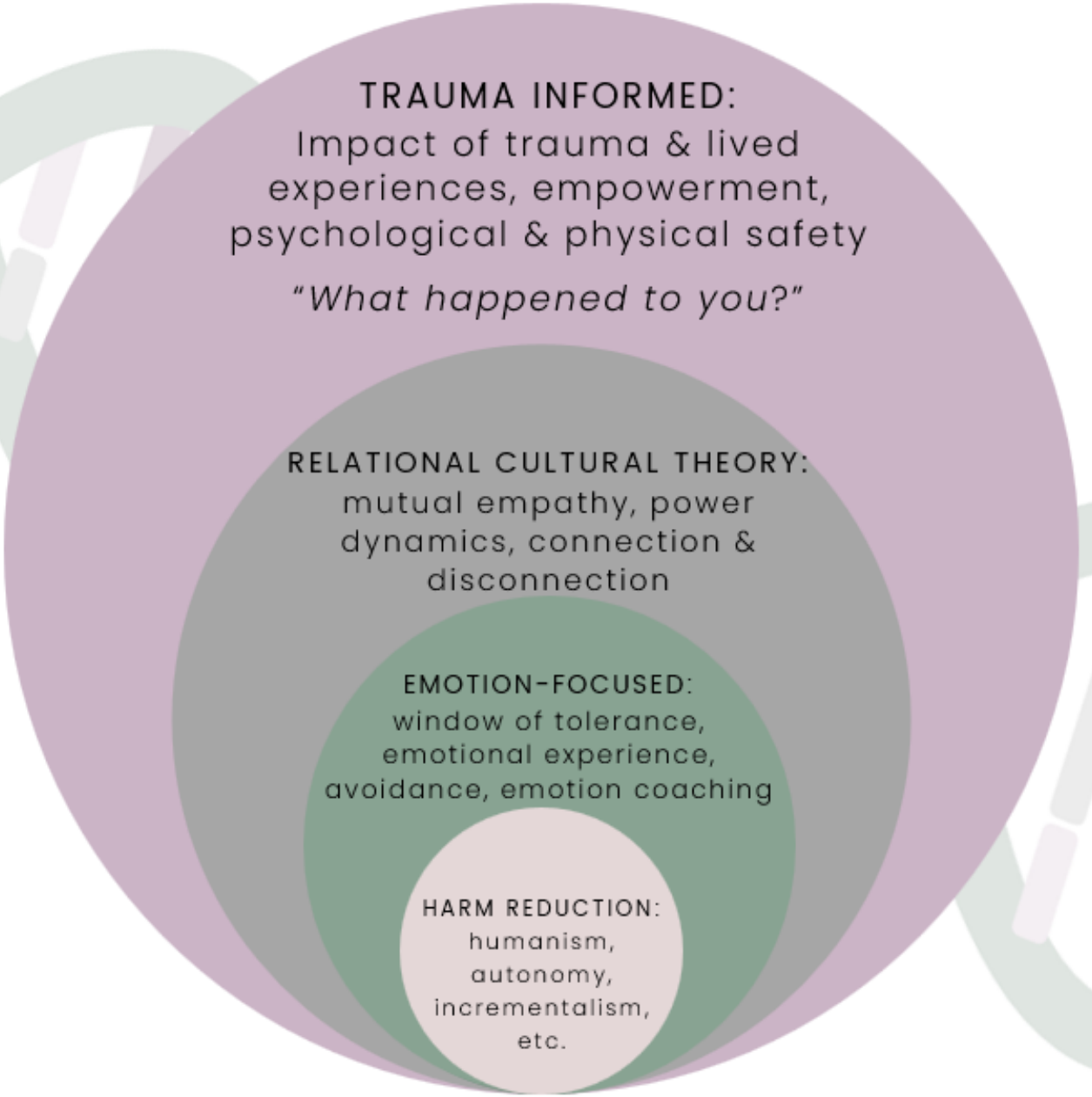
Interoceptive Awareness:
- Difficulties identifying hunger, thirst, satiety, fatigue, etc.
- Difficulties tolerating fullness

Impaired Executive Function:
- Difficulties meal planning & preparing food
- Overwhelmed by food choices

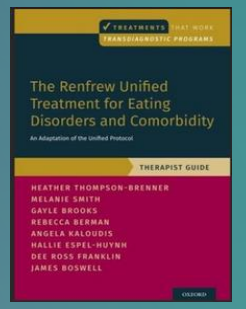
Emotion Dysregulation:
- Overwhelm/fear/anxiety impacts ability to adequately nourish
- ARFID behaviors mitigate emotions

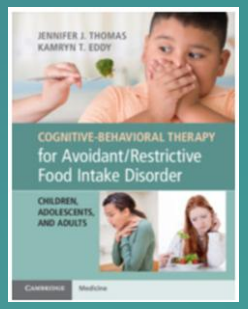
RENFREW'S TREATMENT APPROACH TO ARFID

The Renfrew Center
FIRST IN EATING DISORDERS
CELEBRATING 40 YEARS



RENFREW'S UNIFIED TREATMENT & CBT-AR





Conceptually aligned (targeting emotions & countering avoidance)

Cognitive based (challenging automatic appraisals around the eating experience)

+

Exposure principles, leaning into discomfort, interoceptive awareness & tolerance

WHY DO WE EMPHASIZE TRYING NEW THINGS?

Neuroplasticity

Our brain's ability to **adapt, rewire & learn** (i.e. recovery)

Trying new things creates new neural pathways

Dopamine

Novelty activities the **reward system (tied to motivation, curiosity & pleasure)**

Builds confidence & emotional competence

Cognitive Flexibility

We **gain new perspective, engage in creative problem solving, & increase tolerance to uncertainty** (maintenance factor for ARFID)

Emotional Tolerance & Growth

Doing something new increases discomfort, which **motivates value-driven change** (i.e. exposure work)

TREATMENT TARGETS

Treatment Goals

- Eating a larger range of foods
- Becoming less fearful of choking or vomiting
- Learning skills to approach new foods neutrally
- Increasing interest towards food
- Follow regulated eating schedule
- Build interoceptive awareness
- Building tolerance and increase comfort to eating in front of others
- Tolerating anxiety surrounding eating
- Correcting growth deficiencies and micronutrient status
- Increase family/support awareness and understanding of ARFID

Maintenance Factors

- Emotional avoidance
- Interoceptive awareness
- Non-sustaining emotion driven behaviors
- Negative beliefs about emotions
- Stage approach
- Utilizing food exposure hierarchy
- Evaluate feared outcomes
- Facing fears in a systematic way (repetition)
- Interoceptive exposure

Thomas & Eddy, 2019; Thompson-Brenner et al., 2021

VOLUME THEN VARIETY

For ARFID clients that require weight restoration and are very limited in their food choices, **prioritizing volume over variety may be necessary** at the beginning of treatment.

Increasing volume of safe/preferred foods and those lowest on their hierarchy

Including safe/preferred foods in all meals & snacks at the start of treatment

Pairing safe/preferred foods with oral supplements

Slowly incorporating new foods during snacks & meals

COMMONLY USED SKILLS

Mindfulness
Automatic Appraisals & Reappraisals
Leaning-In to Discomfort
Identifying Physical Sensations
Interoceptive Awareness
Expectancies
Using SUDs

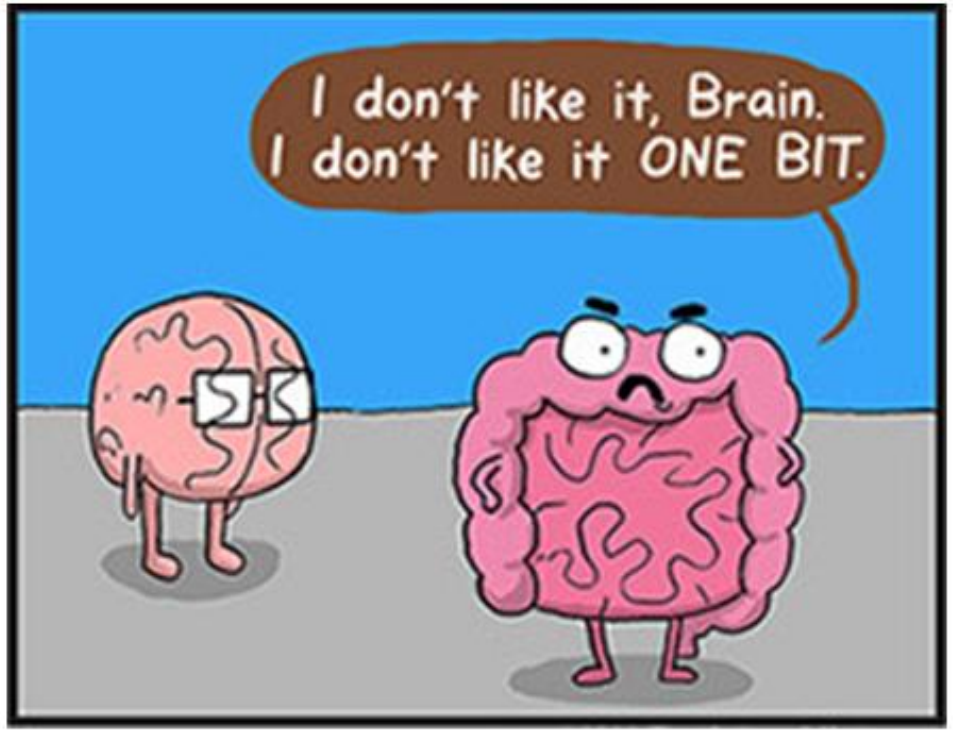


Image Credit: The Awkward Yeti, 2020

FUNCTION OF EMOTIONS

ANGER

- Defend a boundary
- Something is important to you
- Right an injustice

FEAR

- Escape/ Leave situation
- Fight

SADNESS

- Withdraw
- Slow down
- Process a major life transition

JOY

- Continue behavior
- Know what feels good for you

DISGUST

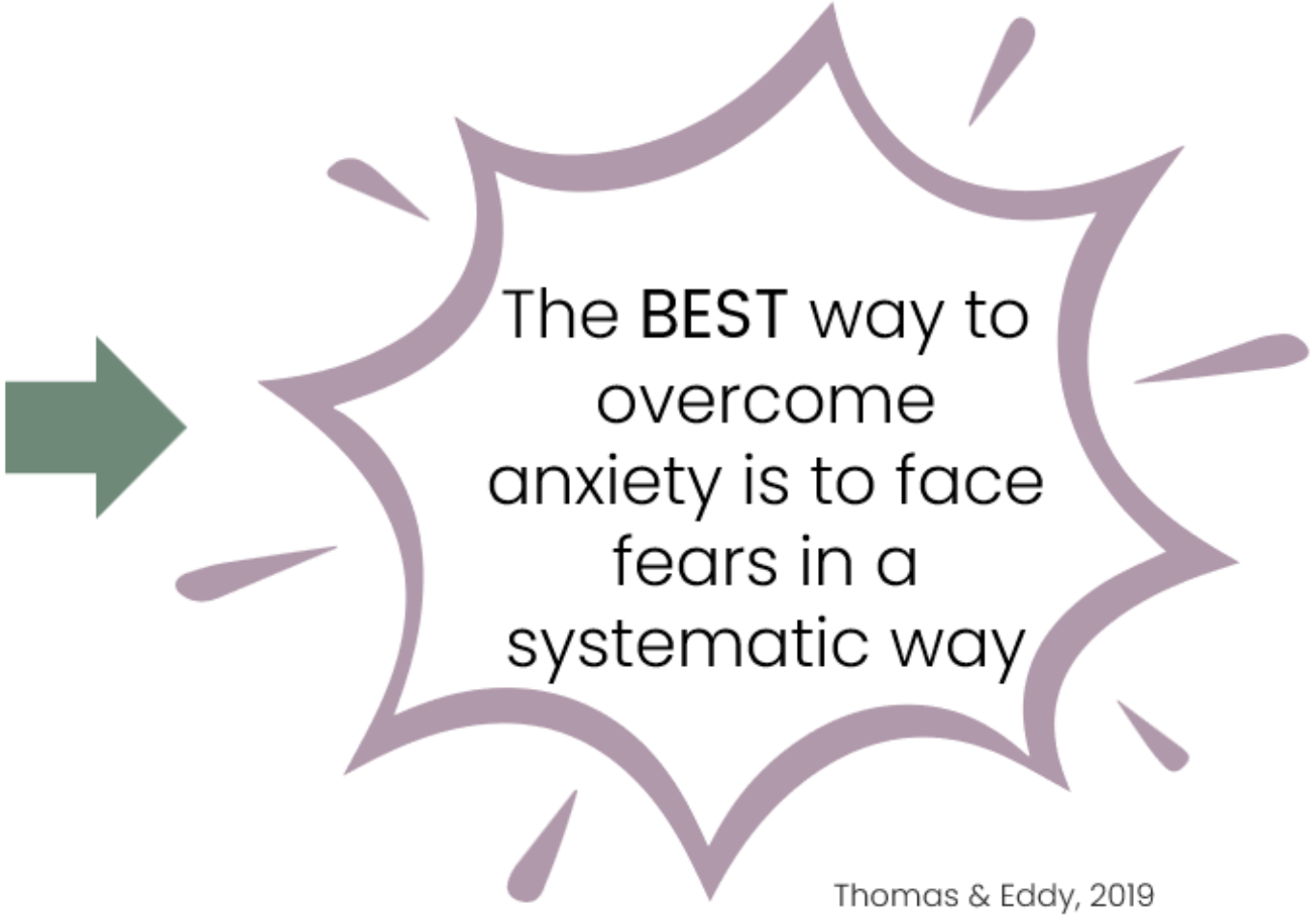
- Back away
- Avoid something that isn't good for you (ex: poison)
- Protect

ANXIETY

- Prepare
- Increase vigilance
- Focus

WHY EXPOSURE WORK?

Avoidance is a **SHORT-TERM** solution to anxiety



Thomas & Eddy, 2019

It's not about the stimulus...it's about the **RESPONSE**

Exposure facilitates corrective learning through:

- Building emotional tolerance
- Disconfirmation of expected negative outcomes
  - Ex: "I must do X to avoid Y"
  - Ex: Expectation of not being able to cope

All exposures are EMOTION exposures

Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014

MECHANISMS OF CHANGE

WHY DOES DISGUST NOT HABITUATE?

Evolution gave us disgust **to protect us**. We actually DO NOT want that response to go away universally.

Therefore, new learning that allows **APPROACH** behavior toward non-dangerous stimuli is necessary (not "unlearning")

DISGUST RESEARCH

Risk Factors	Treatment
• Disgust is a vulnerability factor • Predicts anxiety symptoms • Physiological manifestation (gag reflex, nausea)	• Imaginal exposures • Interoceptive exposures • Mindful acceptance • Building distress tolerance

Inncocenti et al., 2021

DISGUST AS AVOIDANCE MECHANISM

Urge to **distance oneself** from repulsive object

Such **avoidance halts learning** of new (safe) associations

Learned disgust responses are **highly persistent, resistant to extinction**, and insensitive to corrective information

Rozin et al., 2000; Bozman et al., 2016; Borg et al., 2016

DISGUST & ARFID

Sensory Food Avoidance

- Textures (slimy, soggy, crunchy, multi textures)
- Temperature of foods
- Color of foods

Interoceptive Sensitivity

- High sensitivity & distress around GI functions
- Bodily anxiety responses
- Visceral disgust response

Fear or Anxiety Food Avoidance

- Emotional disturbances related to food trauma
  - Choking
  - Vomiting/gagging
  - Feces

TYPES OF EXPOSURE

NATURALISTIC

- Eating in the dining room
- Social eating
- Hearing others eat
- Smelling food
- Talking about food and emotions

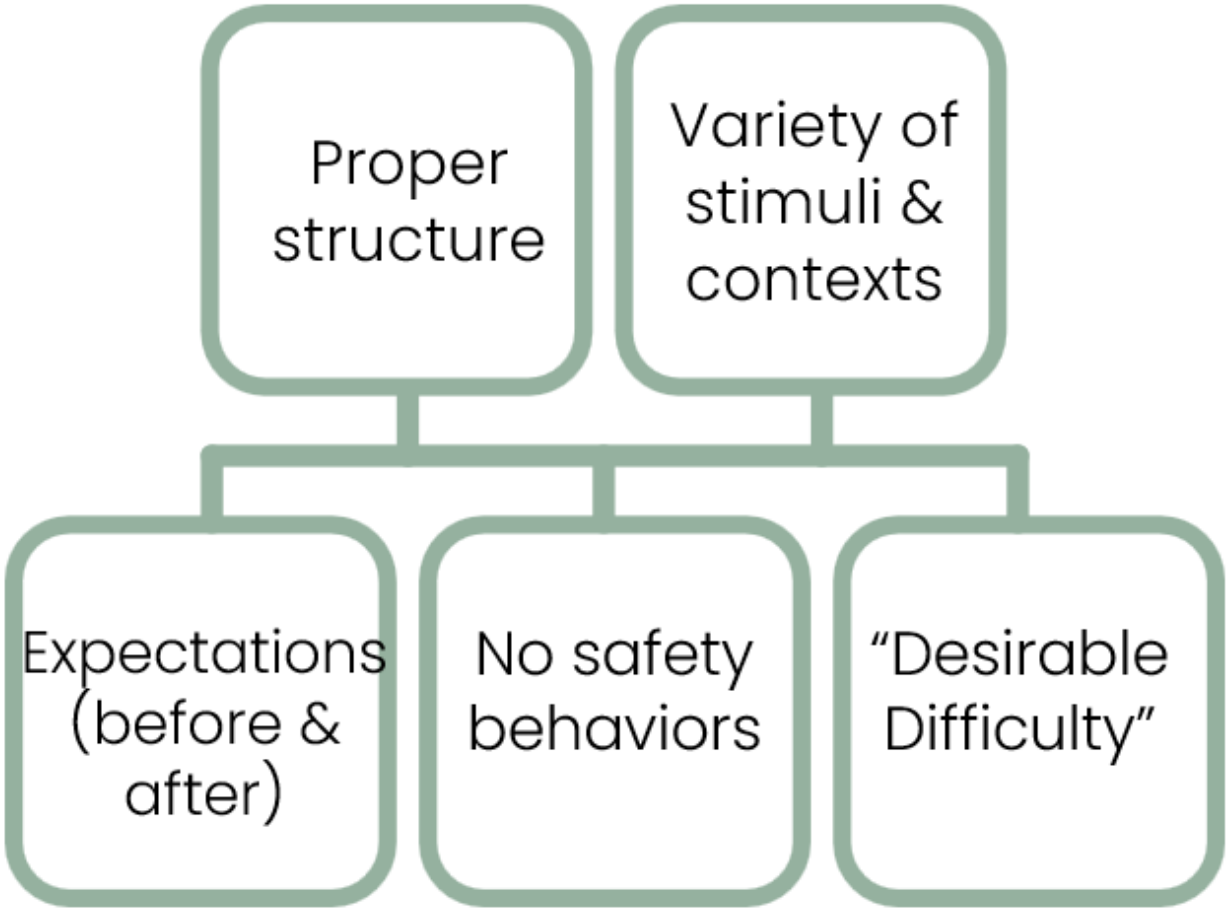
IMAGINAL

- Talking through a taster/exposure in nutrition/individual session
- Use the ARC to reflect on feared outcomes
- Identify automatic appraisals

IN VIVO/DESIGNED SITUATIONAL

- Completed food list & hierarchy
- Collaboration with patient to identify tasters
- NOT using avoidance strategies (as much as possible)
- Use of regulating skills

CONDUCTING EMOTION EXPOSURES



Repetition, repetition, repetition

SETTING THE STAGE FOR SUCCESS: BUILDING A HIERARCHY

Do Not Avoid		Hesitate To Enter But Rarely Avoid		Sometimes Avoid		Usually Avoid		Always Avoid
0	1	2	3	4	5	6	7	8
No Distress		Slight Distress		Definite Distress		Strong Distress		Extreme Distress

Individualized

What gets in the way of life & recovery (food, physical sensation, social)?

Rate experiences based on **level of distress and level of avoidance**

Be Specific

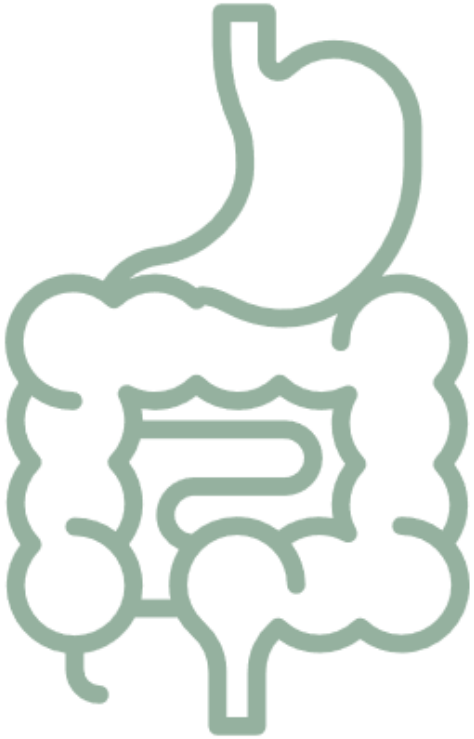
What food? How many bites? In what context/setting?

No Flooding

Start low to middle to build confidence, emotional tolerance & trust in the process

Thompson-Brenner et al., 2021

INTEROCEPTIVE EXPOSURES



Designed to **build tolerance** to physical sensations & **increase IA**

Targeting physical sensations that are **connected to emotional experiences**

Sensations may be **uncomfortable but not dangerous,** thus reducing avoidance behaviors

Becoming **"body investigators"** (curious)

Boswell et al., 2015

DECISIONAL BALANCE

Decisional Balance: **Motivation Worksheet**

The major reason people want to change is they don't want to keep feeling this way and continue to be limited in their lives. Think about all the ways your symptoms have gotten in the way of living the life you want to be living. Do you have values, goals, or qualities that have been compromised by the eating disorder, depression, or anxiety? If things stay the same, how will things look a year from now? What wouldn't you like about that? Do you see this getting better or getting worse? How has your life changed since you became impacted by the eating disorder way? What about your old life would you want back?

Why don't you want to change? Reasons not to try new foods.	**Why do you want to change? Reasons to try new foods.**

26

Thompson-Brenner et al., 2021

ARFID Self-Monitoring Record

Date	Food/Beverage	SUDs 0-8 Before	Thoughts	Physical Sensations	Urges/Behaviors	SUDs 0-8 After

Thomas & Eddy, 2019

Clinician Session Tracker

Name: _____

Date	Food	SUDS Before (0-8)	Temperature	Texture	SUDS During (0-8)	Taste	SUDS After (0-8)	Plan
1/27	Apple Cashews Sunflower seeds	1-2	Apple: Cold, room temp Nuts/seeds: room temp	Apple: crunchy, wet, grainy Seeds/Nuts: crunchy but turns soft	1-2	Apple: sweet Seeds/Nuts: salty	0-1	Integrate into meals at home
1/30	Apple w/ bruise	2	Apple: Cold, room temp	Apple: crunchy, wet, grainy	2	Apple: sweet	1	Ate around bruise, completed, repeat
1/30	Olives	3	Cold	Squishy, soft, wet		Salty but sweet, mixed flavor		Disliked – will retry spicy variety before ruling out completely
1/30	Bell pepper: green & red	2-3	Cold	Crunchy, wet, a bit slimy	2-3		1	Will try green again in dip; preferred green to red
2/13	Hummus & chocolate whipped yogurt	2-3	Both cold Wanted hummus to be the same temperature as the pretzels	Hummus- "muddy", "grainy" Yogurt-smooth	2-3	Yogurt-bitter with "typical yogurt taste". Hummus-not surprised by taste, same as chickpeas.	1-2	Will try spicy hummus. Preferred eating hummus with pretzels over peppers. Will try another flavored whipped yogurt.

Record of ARFID Food Exposure Practice Form

Food/drink exposure:_____

Prior to the exposure:

SUDs (0-8):____

Expectancies:_____

_____

Goal for exposure:_____

After completing the exposure:

Thoughts, Physical Sensations, Urges/Behaviors:

_____

_____

_____

SUDs (0-8):____

Any avoidance strategies used during the exposure?_____

_____

Looking back at your expectancies, did your feared outcomes occur? If so, how were you able to cope with them?_____

_____

What did you take away / learn from this exposure?_____

_____

What is your plan next regarding this food/drink?_____

For client to use when completing tasters (individual session, groups, meals)

Thomas & Eddy, 2019

HOW TO CHOOSE TASTERS

What are they curious about? What impacts their life the most?

Food List & Hierarchy

- Start with lower SUDs scores
- Decisional Balance
- Culturally curious when developing hierarchies

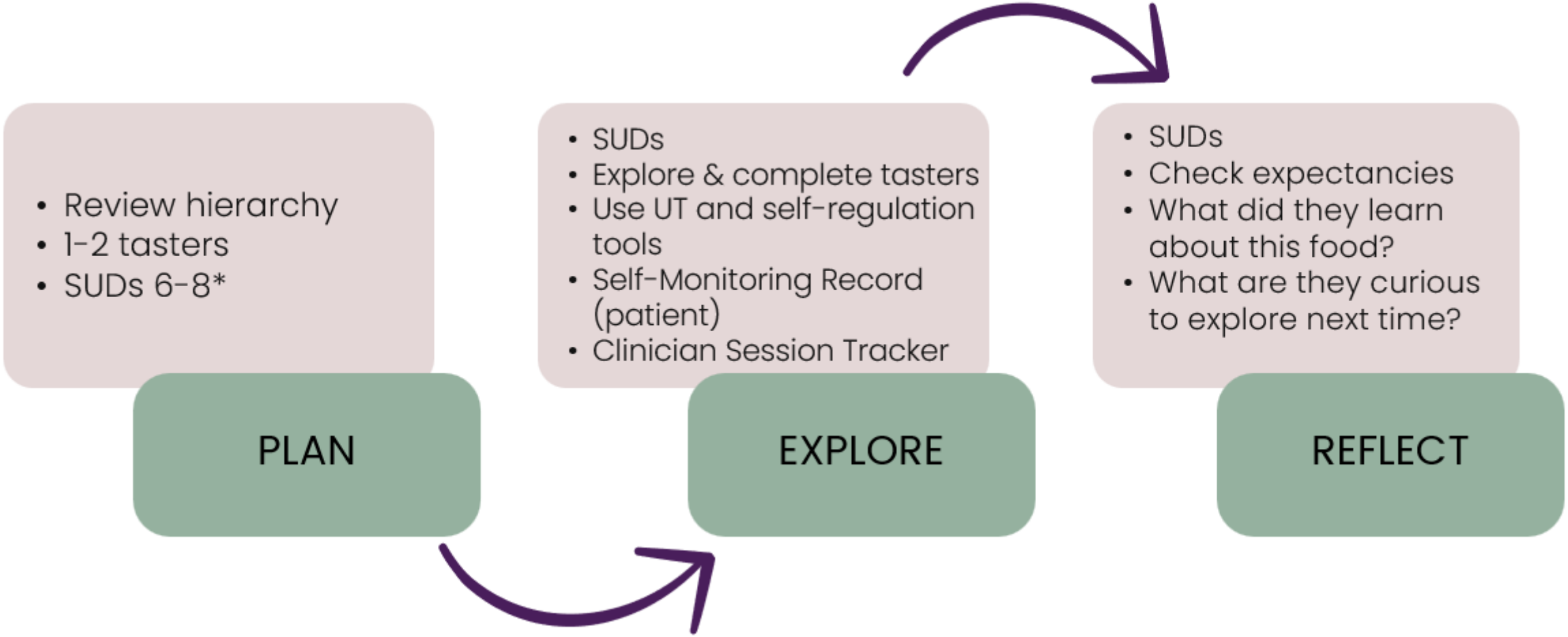
Collaborative Planning

- Patient & value led
- RD/Therapist can offer suggestions as needed

Explore Ways to Try Foods

- Get creative
- What are they most curious about?
- Variety of environments

GROUPS, MEALS & INDIVIDUAL SESSIONS



FOOD HIERARCHY: SENSORY SENSITIVITY

3 Key Points

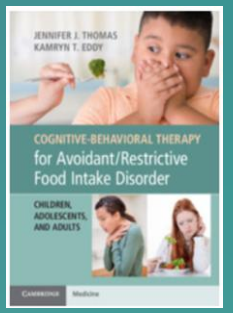
- The **purpose of exposure is to learn about a new food**, not necessarily to like it
- Patient should always take the lead on which foods to learn about.
- **Primary goal = help patient taste the food**

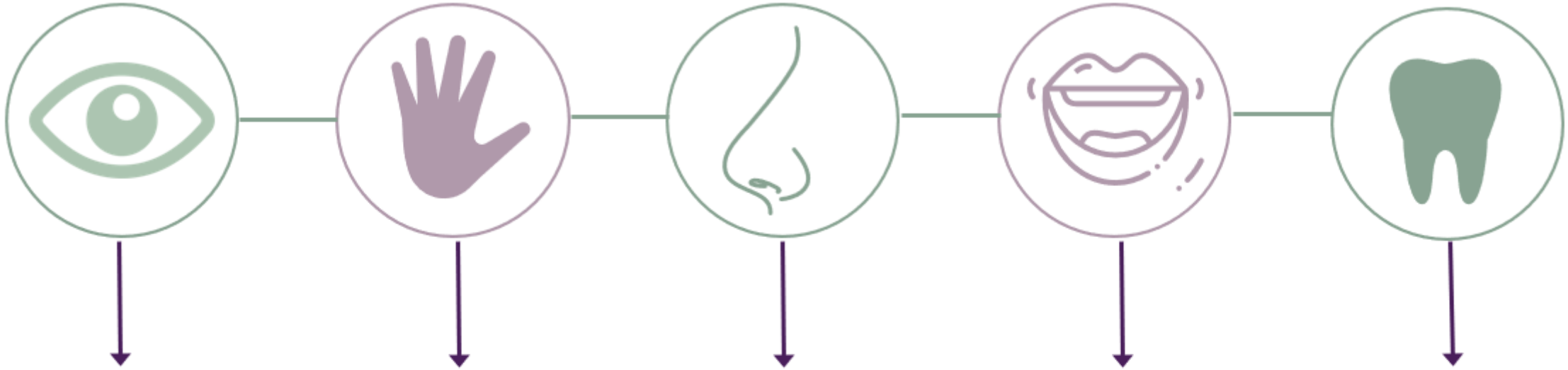
Systemic desensitization to novel foods by exploring sight, feel, smell, taste, texture

May need to focus in on a particular sense at first to build tolerance

Thomas & Eddy, 2019

5 QUESTIONS





What does it look like (e.g. green, round, bumpy)

What does it feel like (e.g. rough, smooth)

What does it smell like (e.g. rough, smooth)

What does it taste like (e.g. sweet, salty, bitter)

What is the texture like (e.g. chewy, crunchy)

Thomas & Eddy, 2019

Strategies for Incorporating New Foods at Home

*In CBT-AR, you first learn about new foods by TASTING small amounts of simple foods and practicing this at home

*As you continue to learn about more foods, you will work on mixing foods together and trying complex foods

*As you become more comfortable with these foods, it is time to INCORPORATE them into your meals and snacks

Here are some strategies for incorporating new foods into your meals and snacks at home

1 Fade it in

Start with a high proportion of a preferred food (e.g., applesauce) and add a small portion of a novel food (e.g., pieces of raw apple). Then gradually increase the proportion of the novel food while fading out the preferred food

2 Add some spice

Preferred condiments and spices can act as training wheels for trying new foods. For example, add cheese to your broccoli, ketchup to your meat, ranch dressing to your carrots, or garlic salt to vegetables

3 Chain to a goal

Use a preferred food to chain to a novel food. For example, if you currently prefer potato chips, try veggie chips. Before you know it, you might feel comfortable trying raw veggies!

4 Switch it up

If at first you don't succeed, try, try again -but change it up! Try different presentations of novel foods. Think cooked versus raw, salted versus unsalted, etc

5 Deconstruct

If you have never tried a new food like pizza, try starting with one component of the food and then layering on individual components one-by-one. For example, try crust alone, then crust with cheese, then crust with cheese and sauce, and, finally, a slice of pizza!

Thomas, J.J. and Eddy, K.T. (2018). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults*. Cambridge: Cambridge University Press.

Thomas & Eddy, 2019

QUICK TIPS

Tasting New Foods

Eating foods not normally eaten alone:

Example: cottage cheese
Pair with familiar or preferred foods

Identify a variety of things to add (options to build on the taster with spice, veggies, fruit)

Eating unfamiliar foods:

Example: hummus
Add veggies, pita chips, crackers, etc.

Example: plain oatmeal
Add sweetener, toppings, nut/seed butter

Example: jelly/jam
Spread on toast or crackers

LACK OF INTEREST IN FOOD/EATING PRIMARY INTERVENTIONS

- Interoceptive exposure to bloating, fullness, and/or nausea
- In-session exposure to highly preferred foods
- Working with and through hunger fullness scale
- Identify alternative signs of hunger: headaches, dizziness, increased difficulty concentrating

Thomas & Eddy, 2019

LACK OF INTEREST

Interoceptive Exposures

Internal sensations that individuals with ARFID may find difficult to tolerate:	Exposure exercises that will illicit these physical sensations:
Bloating	Push belly out as far as possible (30 seconds)
Fullness	Gulping several glasses of water
Nausea	Spinning in a chair (30 seconds)

ENHANCING THE EATING EXPERIENCE

Pairing a new food with a preferred food	Ex: Patient pairs veggie (new) with a preferred dipping sauce
Managing food exposures	Ex: Focusing on 1-2 tasters at a time to reduce overwhelm
Trying new foods when most hungry	Ex: Patient is most hungry at dinner and focuses on tasters at that time
Including preferred textures in meals/snacks	Ex: Client enjoys crunchy textures, included in all meals/snacks for familiarity

FOOD HIERARCHY:
FEAR OF AVERSIVE CONSEQUENCES

- Negative experiences with food such as choking, vomiting, an allergic reaction, or pain after eating can be **traumatic**.
- These experiences might cause a **limited diet to prevent further trauma**.
- "**Safety behaviors**" may be used to try and prevent another traumatic experience from happening. Safety behaviors prevent us from testing negative predictions about eating.

UT + CBT-AR CONCEPTUALIZATION(LEE)

ANTECEDENT	Mother's illness, uncomfortable physical sensations, social exclusion, food trauma (gluten allergy)
EMOTION	Anxiety, fear, helplessness, sadness
AVOIDANCE	Food restriction, social withdrawal, distraction, interoceptive avoidance
SHORT-TERM RELIEF	Reduced exposure to feared physical sensations, relief
LONG-TERM COST	Nutritional compromise, low body weight, limited social interaction, increased anxiety

MAINTENANCE FACTORS (LEE)

INTEROCEPTIVE TOLERANCE	Distressing physical sensations → Fear of food → Restriction
FOOD ALLERGY	Only eats one brand of gluten free items from one specific store (intolerance of uncertainty, fear of allergic reaction, only this food is "safe")
COGNITIVE APPRIASALS	I can't trust things that feel unsafe. Things that are unpredictable are unsafe. Food feels "disgusting" (interoceptively)
SAFETY BEHAVIORS	Reliance on few "safe" foods, restriction/avoidance
SOCIAL AVOIDANCE	Isolation and shut down when feeling overwhelmed and/or unsafe

LEE'S DECISIONAL BALANCE

Cons/Costs: Why don't you want to change? Why do you want to stay the same?	Pros/Benefits: Why do you want to change? Why don't you want to stay the same?
• I don't want the panic and anxiety to get worse. • I know the foods I eat are safe and won't make me sick. • I can avoid the sensations in my body that feel disgusting. • I don't have to worry about trusting food or those around me. • Feel more in control.	• My mom might worry about me less and be able to focus on her health. • I won't feel as weird and like everyone is staring at me during lunch at school. • I might feel more confident. • Better able to tolerate emotions • Feel happier and more connected to others. • Feel better/healthier in my body

WHAT DO ARFID TASTERS LOOK LIKE IN PRACTICE?

SITUATION

Jess (patient) meets with Mehak (therapist) after ARFID lunch

Jess did not complete planned taster due to feeling overwhelmed, gagged on clementine

Left ARFID lunch early

ANTECEDENTS/ CONTEX

Jess struggles with the sensory experience of sticky textures, tart/sour flavors & acidic foods

Has avoided clementines since childhood due to choking on the strings

TREATMENT PLAN

Sensory sensitivity with secondary **fear of aversive consequences** (food trauma)

Lots of practice with RD & therapist to build readiness/willingness to try clementine

UT + CBT-AR CONCEPTUALIZATION (JESS)

ANTECEDENT	Sensory overwhelm with tart/sour flavors & acidic foods; food trauma (choking on clementine)
EMOTION	Anxiety, fear, overwhelm, panic
AVOIDANCE	Food restriction, distraction, interoceptive avoidance, avoids sticky textures/foods
SHORT-TERM RELIEF	Reduced exposure to feared physical sensations (gross), relief/calm
LONG-TERM COST	Nutritional compromise, increased anxiety & panic around "unsafe foods;" impacts social eating

MAINTENANCE FACTORS (JESS)

INTEROCEPTIVE TOLERANCE	Distressing physical sensations → Fear of food → Restriction
FOOD TRAUMA	Choking on clementine strings, panic/fear, avoids stringy foods
COGNITIVE APPRIASALS	"I can't do this," "This isn't safe," "This is unbearable," "This is making my skin crawl"
SAFETY BEHAVIORS	Reliance on few "safe" foods, avoiding stringy foods, avoiding acidic foods, overuse of napkins/washing hands (stickiness)
ANXIETY	Increased anxiety around new foods; panic/overwhelm with tasters & new foods

Physical Sensations

Dizzy
Vibration
Warm
Sweaty

Bloated
Nauseous
Queasy

Headache
Tense shoulders/back, body/jaw
Clenched jaw

Pit in stomach
Heart fluttering
Knot in stomach

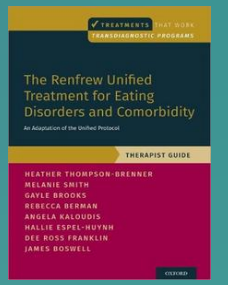
Increased heart rate
Breathless
Jittery, restless

Tight throat
Itchy
Lump in throat
Dry throat

JESS'S DECISIONAL BALANCE

Cons/Costs: Why don't you want to change? Why do you want to stay the same?	Pros/Benefits: Why do you want to change? Why don't you want to stay the same?
• I don't want the panic and anxiety to get worse. • I can avoid the sensations in my body that feel uncomfortable. • I don't have to pay attention to what is happening in my body. • Feel more in control. • What if I always have a hard time with sticky textures?	• I can eat with my friends and feel less overwhelmed. • I might feel more confident. • Better able to tolerate emotions. • I don't want to feel this way forever. • Feel better/healthier in my body. • Not be so panicked when I eat foods that have strings.

SAFETY SIGNALS (JESS)



COGNITIVE	SUBTLE BEHAVIORAL	SAFETY SIGNALS
Dissociation	Humor	Water bottle
Intellectualizing	Shaking legs	Medications
Reading	Fidgeting	Best friend
Distraction		Phone

QUICK TIPS

Navigating Sensation of Swallowing

Jess struggles with stringy foods that feel similar to clementine

Induces choking/gag reflex
Difficulties swallowing
Involuntary vomiting

Is there an oral-motor issue and we need to include an OT?

Has this always been an issue? Is this related to food trauma?

Strategies for building tolerance to interoceptive experience of swallowing (swallowing without food/liquids, swallowing clear liquids, swallowing thicker liquids, etc.)

HIERARCHY: SENSORY SENSITIVITY

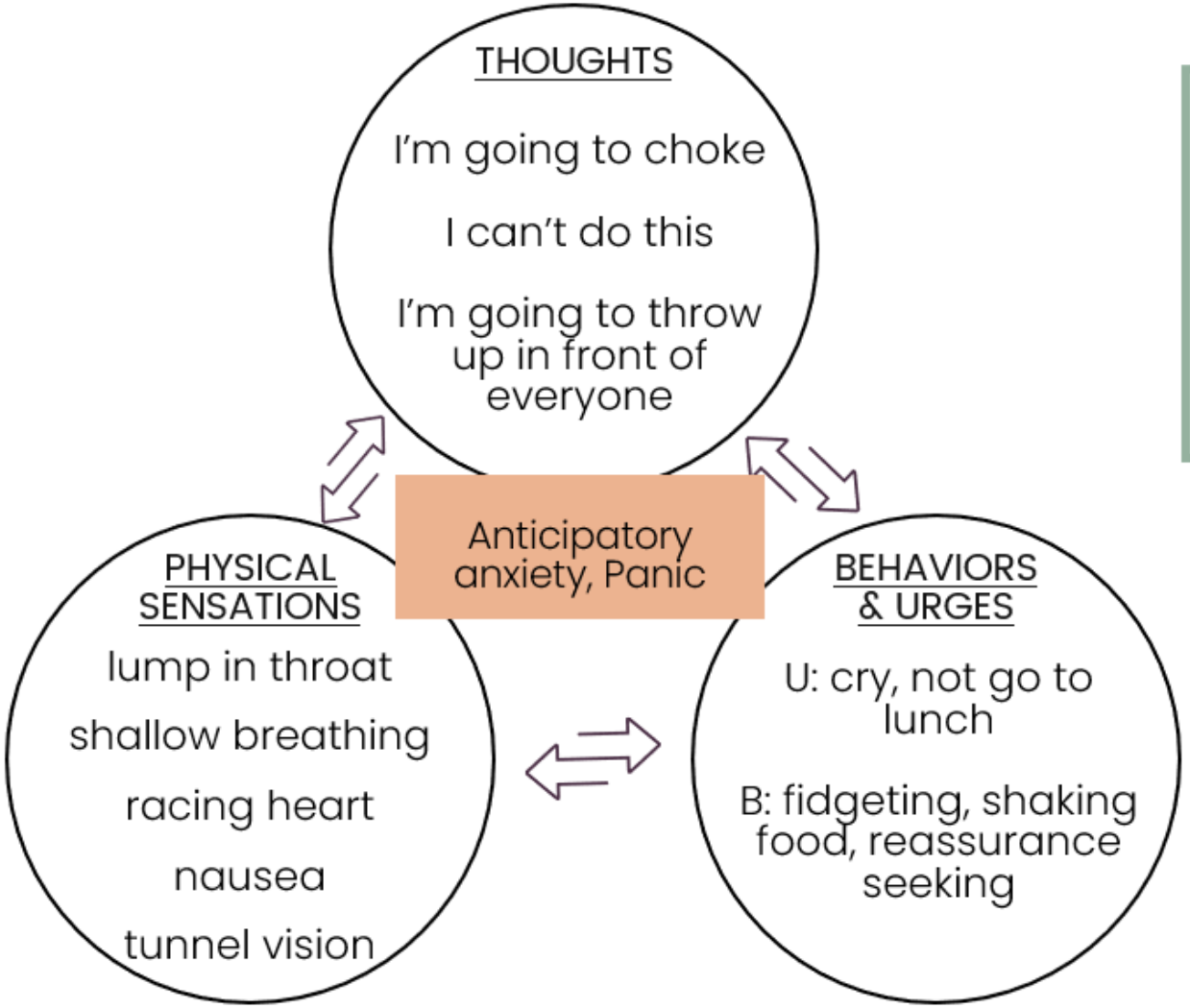
HIGH SENSORY FOODS

Clementines
Peaches
Sour candy
Syrup
Grapes
Tomatoes
Ice cream cones
Sloppy Joe's
Spaghetti

Do Not Avoid		Hesitate To Enter But Rarely Avoid		Sometimes Avoid		Usually Avoid		Always Avoid
0	1	2	3	4	5	6	7	8
No Distress		Slight Distress		Definite Distress		Strong Distress		Extreme Distress

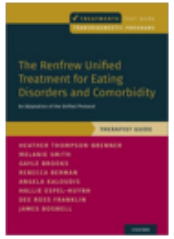
	Description	Avoid	Distress
1 WORST	Peel clementine and take two bites without wiping hands	8+	8+
2	Peel clementine and take two bites; delay wiping hands for 2 mintues	8+	8+
3	Peel clementine and wipe hands	8	8+
4	Complete peeled clementine while wiping hands	7	8
5	Take three bites of peeled clementine while wiping hands	7	7
6	Take one bite of peeled clementine while wiping hands	7	7
7	Take one bite of peeled clementine	5	6
8	Drinking regular orange juice	4	5
9	Drinking 75 % diluted orange juice	3	4
10	Drinking 50 % diluted orange juice	2	2

EMOTION AWARENESS (JESS)



Immediate Antecedent:
Heightened distress thinking about planned taster in lunch this week

UT Application:
Develop emotion awareness using 3-point check



INDIVIDUAL SESSION RECAP

Relational Skills

Validation & Empathy
Reflecting back
Emphasis on victories & effort
Emotional attunement
Encouraging self-reflection
Curiosity
Asking vs Telling
Check in about new plan
Assessing for willingness

UT + CBT-AR Skills

3-Point Check
Identifying Physical Sensations
Antecedents
Automatic/Core Appraisals
Hierarchy
Distress tolerance
Chaining to preferred food
Decisional Balance
Values
Motivational Interviewing
Emotion Tracking
Psychoeducation (exposure)

WHAT'S NEXT FOR JESS?

What did Jess accomplish?

Weight restored

Completed exposures with therapist and dietitian and incorporated new tasters weekly

Improved flexibility around sensory sensitivity (sticky textures) and fear of aversive consequences (choking)

Able to stay grounded/present during tasters, meals, and ARFID groups

Built confidence and readiness to complete tasters outside treatment

What are Jess's treatment goals moving forward?

Established ARFID meal plan and grocery list guide

Identified tasters/exposures to continue with OP treatment team

Recommendations for continuation of structured meals at consistent times.

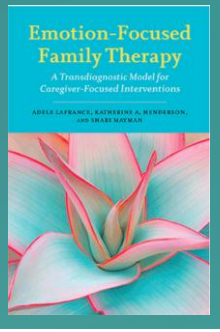
Identified family and friend supports to increase accountability with meals

Daily practice of UT and self-regulation skills

FAMILY SUPPORT & INVOLVEMENT

BENEFITS	WHAT IS LEARNED
• Increased awareness of own emotions & how that sustains ARFID behaviors • Emphasis on relational connection • Gain perspective • Support reduces caregiver burnout	• Caregivers/supports learn advanced caregiving skills • Emotion coaching • Validation • Understanding of meal plan & nutrition goals • Practical tools to support tasters & exposures

BECOMING A RECOVERY COACH



Empower caregivers to embrace new role

Brainstorm behavioral strategies specific to loved one's needs

Emotion Coach and practice new skills

Prepare caregivers for possibility of strong emotional reaction

FAMILY DYNAMICS

AVOIDANCE STRATEGIES

Refusing to complete tasters at home

Only completing tasters tried in treatment

Rushing through tasters at home (lack of mindfulness)

PARENT RESPONSE

Parents often react to avoidance behaviors with frustration

Demands placed on Ray to complete meals with rigid time frames

Struggle to pivot when Ray is overwhelmed and unable to complete tasters/meals

EMOTION DYSREGULATION

Ray lashes out in anger and frustration when overwhelmed (EDB)

Default to “You can’t make me” or “No thank you” when dysregulated

Restrict, refuse tasters, crying

WHAT IS HAPPENING FOR PARENTS?

ANTECEDENT

Immediate: Ray refuses tasters at home

Earlier: Overwhelmed by the demands of recovery

Difficulties connecting with Ray

RESPONSE

Anger/frustration, helplessness

"I can't do this with them again."

Hot face, pit in stomach, eyes fill with tears

Leave the table

CONSEQUENCE

Short term: immediate relief, guilt, hopelessness, frustration, rigidity with planned tasters

Long term: avoids tasters at home; increasing frustration with recovery; attempts to reconnect with Ray

EXPOSURE THERAPY SUPPORT

Preparation	Supportive Action
• Environmental changes (decrease distractions) • Emotion coaching (distress tolerance) • Review meal plan & hierarchy • Identify tasters with Ray • Review exposure forms to be completed • Practice in family session • Helpful skills/tools for tolerating distressing emotions	• Reminders of planned tasters • Emotion coaching, 3-point check • Completing tasters with Ray • Step away if activated/frustrated • Modify tasters if needed • Identifying emotions & physical sensations • What did you learn from this experience?

IN SUMMARY

Evidence-based treatment for ARFID is **exposure therapy**

Multidisciplinary treatment team is best

Targeting the feared outcome to eating (ex: emotion, physical sensation)

Sensory tools (tool vs. toy) help the patient engage in treatment

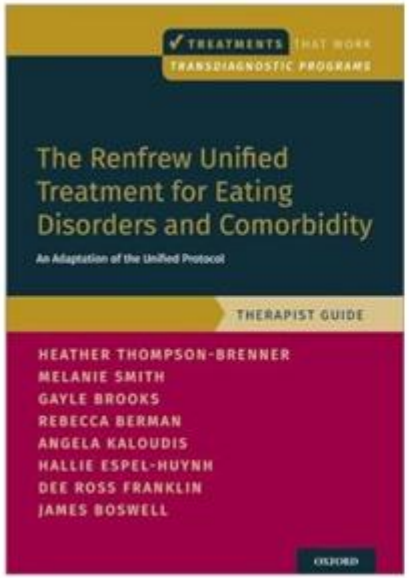
Family/supports are allies and active participants

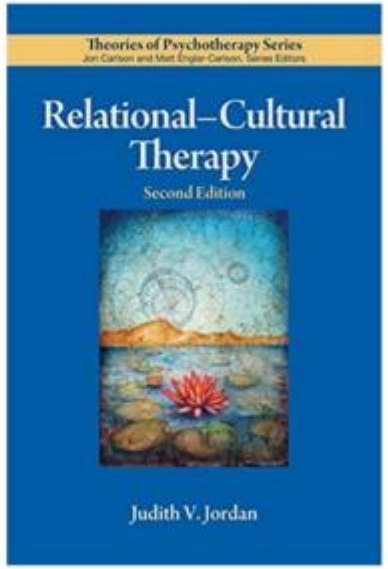
The goal of ARFID treatment is not necessarily to “enjoy eating”

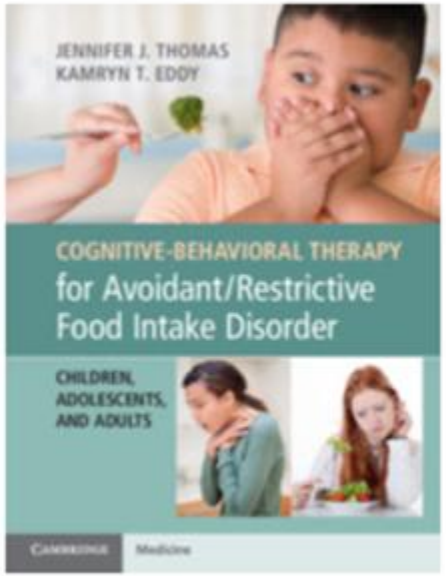
Building **distress tolerance** to increase volume/variety

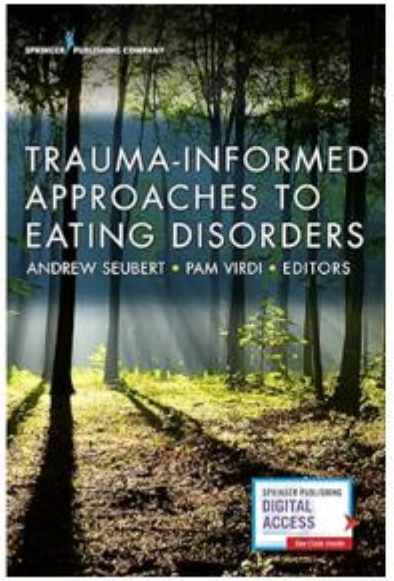
Practice, practice, practice & modify often!

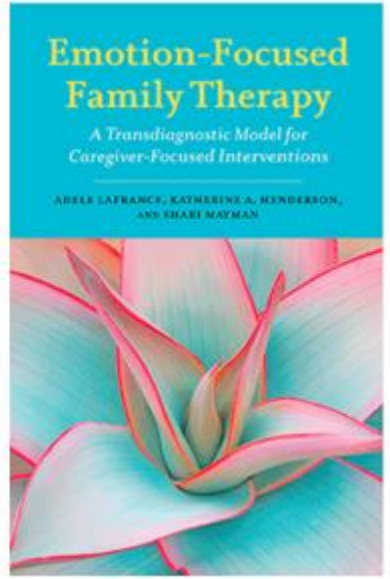
BOOK RECOMMENDATIONS











CONTACT INFORMATION

The Renfrew Center
FIRST IN EATING DISORDERS
CELEBRATING 40 YEARS

Laura McLain (she/her), PsyD, BC-TMH
Director of Training

lmclain@renfrewcenter.com

For more information about The Renfrew Center's programs and services, please call **1-800-RENFREW (736-3739)** or visit www.renfrewcenter.com.

CITATIONS

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Boswell, J. F., Anderson, L. M., & Barlow, D. H. (2015). Interoceptive exposure in the treatment of anxiety disorders: A meta-analysis. Journal of Anxiety Disorders, 29, 1–10. https://doi.org/10.1016/j.janxdis.2014.11.003

Craske, M. G., Treanor, M., Conway, C. C., Zbozinek, T. D., & Vervliet, B. (2014). Maximizing exposure therapy: An inhibitory learning approach. Behaviour Research and Therapy, 58, 10–23. https://doi.org/10.1016/j.brat.2014.04.006

Gailani-Simal, A., Muñoz-Martinez, V., & Beto-Fernandez, L. (2017). Connecting eating disorders and sensory processing disorder: A sensory eating disorder hypothesis. Global Journal of Intellectual and Developmental Disabilities, 3(4), 555671.

Kambanis, P. E., Kuhnle, M. C., Wons, O. B., et al. (2020). Prevalence and correlates of psychiatric comorbidities in children and adolescents with full and subthreshold avoidant/restrictive food intake disorder. International Journal of Eating Disorders, 53, 256–265. American College Health Association. (2002). National college health assessment summary. Reports_ACHA-NCHAIII

Gailani-Simal, A., Muñoz-Martinez, V., & Beto-Fernandez, L. (2017). Connecting eating disorders and sensory processing disorder: A sensory eating disorder hypothesis. Global Journal of Intellectual and Developmental Disabilities, 3(4), 555671.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. Behaviour Research and Therapy, 44(1), 1–25. https://doi.org/10.1016/j.brat.2005.06.006

Iversen, R. & Lewis, C. (2021). Executive function skills are linked to restricted and repetitive behaviors: Three correlational meta analyses. Autism Research, 14, 1163-1185.

Kashdan, T. B., Rose, P., & Fincham, F. D. (2006). Curiosity and exploration: Facilitating positive subjective experiences and personal growth opportunities. Journal of Personality Assessment, 87(3), 292–302. https://doi.org/10.1207/s15327752jpa8703_05

Lafrance, A., Files, N., & Paluzzi, S. (2016). Emotion-focused family therapy: Strengthening attachment bonds. Routledge.

CITATIONS

Nitsch, A., Watters, A., Manwaring, J., Bauschka, M., Hebert, M., & Mehler, P. S. (2023). Clinical features of adult patients with avoidant/restrictive food intake disorder presenting for medical stabilization: A descriptive study. International Journal of Eating Disorders, 56(5), 978–990.

Nitsch, A., Watters, A., Manwaring, J., Bauschka, M., Hebert, M., & Mehler, P. S. (2023). Clinical features of adult patients with avoidant/restrictive food intake disorder presenting for medical stabilization: A descriptive study. International Journal of Eating Disorders, 56(5), 978–990.

Price, C. J. & Hooven, C. (2018). Interoceptive Awareness Skills for Emotion Regulation: Theory and Approach of Mindful Awareness in Body-Oriented Therapy (MABT). Frontiers in Psychology, 9, p. 798. doi: 10.3389/fpsyg.2018.00798

Qi et al. (2025). Suicidal ideation and avoidant/restrictive food intake disorder: Findings from the ARFID-GEN study. *Psychiatry Research, 348*, 116741.

Thomas, J. J. & Eddy, K. T. (2019). Cognitive-behavioral therapy for avoidant/restrictive food intake disorder: Children, adolescents, and adults. Cambridge University Press, iv-iv.

Thomas, K. S., Keating, J., Ross, A. A., Cooper, K., & Jones, C. R. G. (2025). Avoidant/restrictive food intake disorder (ARFID) symptoms in gender diverse adults and their relation to autistic traits, ADHD traits, and sensory sensitivities. Journal of Eating Disorders, 13, Article 33. https://doi.org/10.1186/s40337-025-01215-z

Thompson-Brenner, H., Smith, M., Brooks, G. E., Berman, R., Kaloudis, A., Espel-Huynh, H., Ross Franklin, D., & Boswell, J. (2021). The Renfrew Unified Treatment for Eating Disorders and Comorbidity: An Adaptation of the Unified Protocol, Therapist Guide (Treatments That Work). Oxford, England: Oxford University Press.

Yeung et al. (2025). Is alexithymia a transdiagnostic factor across depressive, anxiety, and eating disorders in adults? A meta-analytic review. Clinical Psychology: Science and Practice, https://doi.org.10.1037/cps0000288.

Zickgraf, H. F. & Ellis, J. M. (2018). "Initial validation of the Nine Item Avoidant/Restrictive Food Intake disorder screen (NIAS): A measure of three restrictive eating patterns." Appetite, 123, 32-42.

Zucker, N. L., Merwin, R. M., Bulik, C. M., Moskovich, A., Wildes, J. E., & Groh, J. (2013). Subjective experience of sensation in anorexia nervosa. Behaviour Research and Therapy, 51(4–5), 256–265. https://doi.org/10.1016/j.brat.2013.01.002