

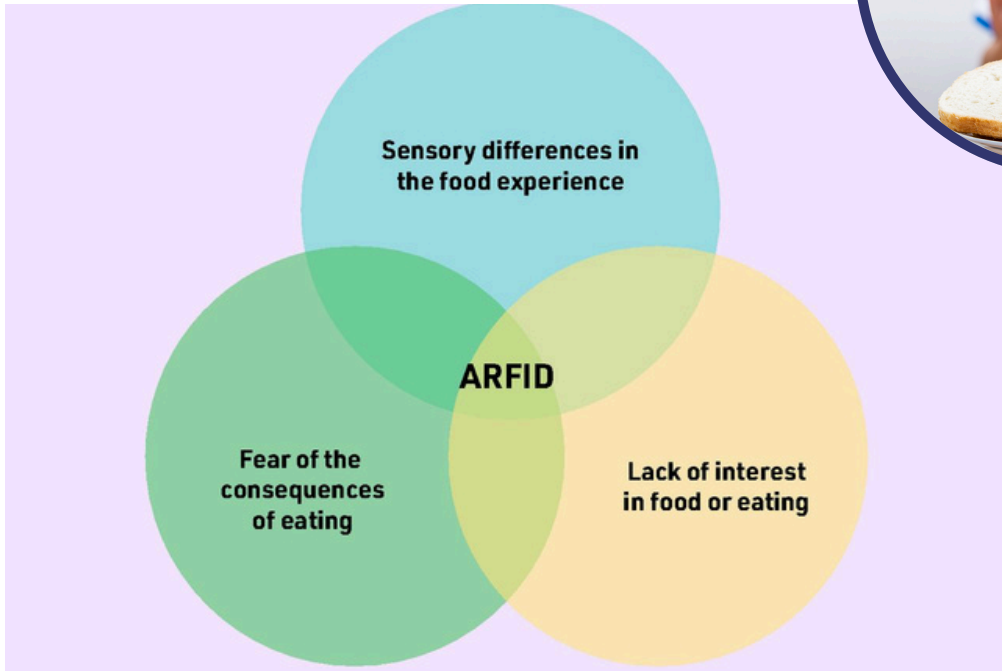
ARFID

AVOIDANT RESTRICTIVE FOOD INTAKE DISORDER

What is ARFID?

AARFID is a feeding and eating disorder defined by a persistent restriction or avoidance of food intake (Royal College of Psychiatrists, 2025; Banner *et al.*, 2022). Unlike other eating disorders such as Anorexia Nervosa, ARFID is not associated with weight control or body image concerns (National ARFID Foundation, 2025; Ellison *et al.*, 2024). Although it presents differently across individuals, it is typically characterised by one or more of the following:

- aversion to food for sensory reasons, such as sensitivity to taste, texture, or appearance
- fear of consequences of eating, for example concerns about choking, vomiting, or allergic reactions
- lack of interest in food or eating, including difficulty recognising hunger or prioritising eating



Signs and Symptoms

Image Reference- British Journal of General Practice, 2024

Signs and symptoms can emerge at any age but most commonly appear in early infancy and childhood (American Psychiatric Association, 2015). Without effective support, ARFID can lead to significant medical complications including nutritional deficiency, impaired growth, and psychosocial distress (Menzel and Perry, 2024). It is considered one of the earliest eating disorders identified in young children (Duke Health, 2024) and may lead to serious, even life-threatening consequences due to malnutrition (Feldman *et al.*, 2019). Although ARFID was only formally recognised in the Diagnostic and Statistical Manual of Mental Disorders in 2013 (Davis, 2023; Di Cara *et al.*, 2023), research indicates it often co-occurs with autism and other neurodevelopmental differences (Nygren *et al.*, 2021; Dinkler *et al.*, 2022; Dinkler *et al.*, 2025). Consequently, while it is classified as an eating disorder, ARFID can also be understood within a neurodiversity framework as a difference in development (Sader *et al.*, 2025; Driscoll, 2025).

Diagnosis and Challenges

The diagnostic process for ARFID typically requires input from multidisciplinary teams, including medical, dietetic, and psychiatric professionals, making coordination complex (Golding *et al.*, 2026; Cucinotta *et al.*, 2023). This can delay diagnosis and increase stress for children and families (Bourne *et al.*, 2026). Identification is further complicated because children with ARFID are not always underweight, meaning clinicians may overlook risks if they focus on weight rather than dietary quality (James *et al.*, 2024; Schimansky *et al.*, 2024). ARFID may also be missed when co-occurring conditions are present, even though these do not fully explain feeding difficulties (Williams *et al.*, 2015; Hall *et al.*, 2024). Additionally, there is limited research on children under five despite evidence that ARFID often begins in early childhood (Hall *et al.*, 2024; Dinkler *et al.*, 2025). These challenges suggest that younger children, autistic children, and those with complex needs are particularly at risk of being undiagnosed.

Barriers in Education

In Wales, the Additional Learning Need (ALN) framework defines an additional learning need as a difficulty or disability requiring extra support to enable access to education and full potential (Children’s Commissioner for Wales, 2024). ARFID can affect children physically, emotionally, and socially, creating barriers to learning.



Physical

Physically, restricted intake can result in nutritional deficiencies and low energy levels, even in children who are not underweight (James *et al.*, 2024). This may lead to fatigue, poor concentration, and reduced engagement in learning (James *et al.*, 2024; Beat Eating Disorders, 2024). Maslow’s hierarchy of needs suggests basic physiological needs, such as nutrition, must be met before higher-level cognitive processes can occur (Maslow, 1943). Inadequate nutrition has been linked to impaired brain development, cognitive functioning, and behaviour (Brkić *et al.*, 2026). Research also indicates that children with ARFID may show differences in brain areas related to attention and behaviour, further affecting concentration and educational engagement (Sader *et al.*, 2024). As a result, undernourished children may struggle to focus, complete tasks, and participate fully, leading to poorer academic outcomes (Azzura *et al.*, 2025).



Image Reference- Downs, E (2026)

Emotional

Emotionally, ARFID is frequently associated with anxiety, particularly around eating, including fears of choking or vomiting (Watts *et al.*, 2023; Gianneschi *et al.*, 2024). In educational settings, this can result in distress during meals or food-related activities, leading to avoidance behaviours (Dunn *et al.*, 2026). Children may feel overwhelmed, embarrassed, or fearful, affecting confidence, attendance, and participation. This emotional impact can also hinder relationship building with peers and practitioners, reducing engagement and contributing to broader social and emotional difficulties (Golding *et al.*, 2026; Attia, 2026).

Social

Welsh Government policy highlights the importance of social and emotional development, positioning educators as key in fostering resilience through shared experiences (Welsh Government, 2024). However, this assumes that all children can access such experiences. Mealtimes are important contexts for developing communication and social interaction (Willemsen *et al.*, 2023; Bateman, 2024), yet for children with ARFID they can present significant barriers. ARFID has been shown to have a 'marked impact on psychosocial functioning', potentially causing anxiety severe enough to prevent school attendance (Barker and Oldman, 2021). Avoidance of eating situations can limit peer interaction and social learning opportunities, contributing to social withdrawal and feelings of difference (Dunn *et al.*, 2026; Golding *et al.*, 2026). Consequently, children with ARFID may be disproportionately disadvantaged in achieving Curriculum for Wales outcomes related to communication and social competence, highlighting a gap between policy intentions and lived experiences.



Supporting Inclusion in Education

Models of Disability

Supporting children with ARFID requires consideration of different models of disability, as these shape responses and interventions (Selisko *et al.*, 2024). The medical model views ARFID as a condition within the child requiring treatment, such as therapy or dietary intervention, placing responsibility on the individual (Olkin, 2022; Johnson, 2016). In contrast, the social model emphasises that environmental barriers restrict participation, rather than the condition itself (Selisko *et al.*, 2024; Agyemang and Zuberu, 2025). While ARFID is linked to anxiety and participation difficulties, these may be intensified in structured mealtimes where pressure to eat increases distress and exclusion. Legally, the Equality Act 2010 requires education settings to make reasonable adjustments to ensure pupils with additional needs are not disadvantaged (UK Public General Acts, 2010). In Wales, this is reinforced by the Additional Learning Needs and Education Tribunal (Wales) Act 2018 and ALN Code (Welsh Government, 2021), which require identification of barriers and provision of appropriate support. These duties are underpinned by international frameworks such as the UN Convention on the Rights of Persons with Disabilities, which promotes inclusive and equitable education (United Nations, 2006).



Flexible Mealtime Arrangements and Reasonable Adjustments

A practical example of a reasonable adjustment for a child with ARFID is flexible mealtime arrangements. Children often experience sensory sensitivities and anxiety around food (Dovey *et al.*, 2019), meaning typical dining environments can be overwhelming and inhibit eating (Sadeh-Sharvit, 2026; NHS Wales, Aneurin Bevan University Health Board, 2022). Providing quieter, low-stimulus environments can support emotional regulation (Feeding Matters, 2025). Additionally, children may require extended time and reduced pressure due to slower eating and distress, with flexibility linked to improved outcomes (Harris and Mason, 2024). Calm and predictable eating environments are therefore essential, as reducing anxiety is key to supporting eating behaviours (NHS Cumbria, Northumberland, Tyne and Wear, 2024). However, implementing flexible approaches can be challenging. Determining what constitutes a “reasonable adjustment” depends on factors such as available resources, practicality, and impact on the child (Equality and Human Rights Commission, 2015). This is particularly complex when a child does not have a formal diagnosis, making it difficult to balance accommodating diversity with addressing needs that may create substantial disadvantage over time. Nevertheless, initiatives such as the “Fantastic Food in Schools programme” demonstrate how whole-school approaches promoting inclusive eating behaviours can support all children in developing healthier relationships with food and each other (Concha *et al.*, 2026).