

Module: ECEY6006

Supporting Children with Additional Learning Needs

Webinar – Presentation of academic poster (Script)

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AI Declaration -

I acknowledge the use of Google Scholar [<https://scholar.google.com/>] and Canva AI generated images (included in academic poster) between period:

(20/04/2026) - (14/05/2026) to help search for relevant academic journals and literature which are not always available via the university online library.

The following prompt themes were used:

- *Symptoms of ARFID, diagnosis and support/treatment*
- *Symptoms of ARFID, diagnosis and support/ treatment for children*
- *Physical, emotional, and social impacts of ARFID for children*
- *Impact of ARFID on educational attainment for children*
- *Support strategies for children with ARFID in educational settings*

I confirm that I have not presented any other AI generated text as my own work. I confirm that I have copies of my drafts, notes, and other resources I used before, and after the use of AI tools which I may be asked to provide as evidence.

Webinar Presentation Script:

Introduction

Hello everyone and thank you for joining the Webinar this evening.

During this session, myself, Emily Downs, Barbara Sliwinska and Maka Osis will present academic posters that each explore different examples of a medical and/or social disability, and how these conditions impact the lives of children in Early Years Education and Care.

Our aim today is to explore how these conditions affect young children, how they present, how they impact their lives, what barriers they may face because of their condition, and examples of effective support strategies in education and care settings when their disability is determined to be an 'additional learning need' which allows for professional intervention and support.

I will be discussing ARFID- 'Avoidant, Restrictive, Food Intake Disorder'. Maka will discuss PDA- 'Pathological Demand Avoidance', and Barbara's presentation will discuss 'Noonan Syndrome'.

The supporting academic posters will be viewable on screen during each presentation with opportunities for group questions at the end of each discussion.

My Presentation

Section 1 - ARFID

I will begin today's webinar with my presentation on 'Avoidant, Restrictive, Food Intake Disorder', which will be referred to using the acronym 'ARFID', please bear with me whilst I share the screen so that the poster is viewable during my presentation **[SHARE POSTER]**. Thankyou!

So, what is ARFID?

ARFID is a feeding and eating disorder which is defined by a persistent restriction or avoidance of food intake (Royal College of Psychiatrists, 2025; Banner *et al.*, 2022), and 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). It can present differently between person to person; however, it is usually defined to include one or more of the following three characteristics (*as seen in the visual diagram taken from the British Journal of General Practice 2024, in the poster on screen*):

- aversion to food for sensory reasons for example, a child being sensitive to tastes, textures, or how a food looks
- fear of the consequences of eating, for example a child may worry that food might give them an allergic reaction, or to vomit or choke
- lack of interest in food or eating, for example, a child is unable to recognise that they are hungry, will not ask for food or prioritise other tasks instead of eating

Signs and symptoms of ARFID can develop at any age, but they most commonly appear in early infancy and childhood (American Psychiatric Association, 2015), and without effective support and treatment, can lead to significant medical complications including nutritional deficiency, impaired growth and psychosocial distress (Menzel and Perry, 2024). ARFID is thought to be the earliest eating disorder identified in young children (Duke Health, 2024), which can lead to serious, even life-threatening impacts because of malnutrition (Feldman *et al.*, 2019).

Although ARFID is a relatively newly recognised diagnosable condition, added to the Diagnostic and Statistical Manual of Mental Disorders in 2013 (Davis, 2023; Di Cara *et al.*, 2023), current research suggests it often occurs alongside autism and other neurodevelopmental differences in children (Nygren *et al.*, 2021; Dinkler *et al.*, 2022; Dinkler *et al.*, 2025). Therefore, while ARFID is classified as an eating disorder, it can also be understood within the broader framework of neurodiversity as an individual difference in development (Sader *et al.*, 2025; Driscoll, 2025).

The diagnostic assessment for ARFID usually requires input from a range of professionals, including medical, dietetic, and psychiatric teams. This can make the process more difficult, as it relies on coordination between different services (Golding *et al.*, 2026; Cucinotta *et al.*, 2023). As a result, diagnosis may be delayed and can increase stress for both children and their families, affecting everyday life and routines (Bourne *et al.*, 2026). Further challenges arise because children with ARFID are not always underweight. This means that clinicians may overlook potential risks if they focus too much on weight instead of the overall quality of the child's diet (James *et al.*, 2024; Schimansky *et al.*, 2024). In addition, ARFID may be missed when a child has another medical or developmental condition, even though these often occur alongside ARFID and do not fully explain the eating difficulties (Williams *et al.*, 2015; Hall *et al.*, 2024). Finally, research highlights a lack of studies focusing on children under five years old, despite evidence that ARFID often begins in early childhood (Hall *et al.*, 2024; Dinkler *et al.*, 2025). Together, these challenges

suggest that the children who are most vulnerable, such as younger children, autistic children, or those with complex medical needs, are also the most likely to go undiagnosed.

Section 2 - Barriers

So how can ARFID affect children and create barriers to learning in an educational setting, to the extent that it may be considered an additional learning need?

In Wales, the Additional Learning Need (ALN) framework defines an additional learning need as a difficulty or disability that requires extra support to help a child access education and reach their full potential (Children's Commissioner for Wales, 2024). ARFID can affect young children in several ways, including physical, emotional, and social difficulties, all of which can create barriers to learning.

Physically -

For example, physically, the limited food intake associated with ARFID can lead to nutritional deficiencies and reduced energy levels, even in children who are not underweight (James *et al.*, 2024). This can result in fatigue, poor concentration, and reduced energy levels, making it difficult for children to engage in learning activities (James *et al.*, 2024; Beat Eating Disorders, 2024). From a theoretical perspective, this can be understood through Maslow's hierarchy of needs, which highlights those basic physiological needs, such as adequate nutrition, must be met before higher level processes like learning and cognitive engagement can occur (Maslow, 1943). A lack of adequate nutrition has been shown to impact brain development, cognitive functioning, and behaviour, all of which are essential for learning (Brkić *et al.*, 2026). Research also suggests that children with ARFID may have differences in brain areas linked to attention and behaviour, alongside reduced energy intake, which can negatively affect concentration and learning in educational settings (Sader *et al.*, 2024). Consequently, a child who is undernourished may struggle to focus during lessons, complete tasks, or participate fully in the school day, leading to poorer academic outcomes (Azzura *et al.*, 2025).

Emotionally -

Emotionally, ARFID is often linked with anxiety, particularly around eating or mealtimes, with fear of negative consequences such as choking or vomiting frequently reported in children (Watts *et al.*,

2023; Gianneschi *et al.*, 2024). In an educational setting, this can cause distress during snack times, lunch periods, or activities involving food, as children may experience heightened anxiety and avoidance behaviours during eating situations (Dunn *et al.*, 2026). Children may feel overwhelmed, embarrassed, or fearful, which can reduce their confidence and willingness to attend or participate in school. This emotional impact can also make it harder for children to build relationships with their peers and supporting practitioners, which may reduce how much they take part in learning, as ARFID is linked to wider social and emotional difficulties (Golding *et al.*, 2026; Attia and Walsh, 2026).

Socially -

The importance of social and emotional development is emphasised within Welsh Government policy, which positions educators as central to fostering resilience through shared play, learning, and care experiences (Welsh Government, 2024). However, this expectation assumes children can fully access these shared experiences. Mealtimes in early education settings are a key context for developing communication skills, social interaction, and relationships (Willemsen *et al.*, 2023; Bateman, 2024), yet for children with ARFID, these same environments may present significant barriers. Barker and Oldman state that ARFID is likely to have a '*marked impact on psychosocial functioning*' which causes anxiety and can even stop the child from attending school completely (Barker and Oldman, 2021). Avoidance of eating situations or heightened anxiety can lead to exclusion from peer interactions and limit opportunities for informal social learning. This reflects wider evidence that ARFID is associated with social withdrawal, feelings of difference, and broader psychosocial difficulties (Dunn *et al.*, 2026; Golding *et al.*, 2026). Consequently, while the Curriculum for Wales emphasises the development of communication and social competence, children with ARFID may be disproportionately disadvantaged in achieving these outcomes, highlighting a potential gap between policy intentions and the lived experiences of learners.

Section 3 – Support

How then, can children with ARFID be supported in an educational environment?

In supporting young children with ARFID in an educational environment, it is important to consider how different models of disability shape our responses, as these frameworks influence how disability is understood and determine the types of support and interventions that are implemented in educational settings (Selisko *et al.*, 2024). From a medical model perspective, ARFID is viewed as a condition located within the child that requires treatment, such as therapy or dietary

intervention. While this approach is important for addressing nutritional and psychological needs, it places primary responsibility on the individual, as the medical model conceptualises disability as a pathology that must be treated or corrected through professional intervention (Olkin, 2022; Johnson, 2016). In contrast, the social model of disability suggests that it is the environment and the barriers within it that prevent person, in this case, the child from taking part, rather than the child's condition itself (Selisko *et al.*, 2024; Agyemang and Zuberu, 2025). As discussed, research shows that ARFID is often linked to anxiety, social withdrawal, and difficulty taking part in everyday activities, however these challenges may be intensified during structured mealtimes, where pressure to eat can worsen symptoms and increase the likelihood of the child feeling excluded.

Under the Equality Act 2010, education settings within the United Kingdom have a legal obligation to make *reasonable adjustments* for pupils with additional needs so that they are not placed at a disadvantage and can participate on the same basis as their peers (UK Public General Acts, 2010). In Wales, this is further supported by the Additional Learning Needs and Education Tribunal (Wales) Act 2018 highlighted in the Additional Learning Needs (ALN) Code for Wales framework (Welsh Government, 2021), which requires schools to identify barriers to learning and provide appropriate additional learning provision to enable children to participate fully and achieve their potential. These statutory requirements are all underpinned by UNESCO frameworks such as the *Convention on the Rights of Persons with Disabilities* (UNCRPD) that emphasise high quality, inclusive and equitable education for all (United Nations, 2006).

An example of a *reasonable adjustment* in the case for a child with ARFID could be that the setting allows for flexible mealtime arrangements. Children with ARFID often experience heightened sensory issues and anxiety around food (Dovey *et al.*, 2019), meaning that typical school dining environments such as noisy, large busy dining halls, can bring about stress and significantly inhibit their ability to eat (Sadeh-Sharvit, 2026, National Health Service Wales, Aneurin Bevan University Health Board, 2022). Providing access to quieter, low-stimulus environments and reducing sensory demands has been recommended in supporting children's emotional regulation during mealtimes, (Feeding Matters, 2025). Furthermore, children with ARFID may require extended time and flexible eating opportunities due to slow eating pace and distress associated with food, and reducing pressure around mealtimes is linked to improved outcomes (Harris and Mason, 2024). Creating calm, predictable eating conditions is therefore essential, as anxiety reduction is a key

component in supporting eating behaviours in this population (National Health Service, Cumbria, Northumberland, Tyne and Wear, 2024).

Taking a flexible approach to supporting eating and nutrition may however be challenging in practice. For example, it can be difficult for education providers to determine what constitutes a “*reasonable adjustment*” in this context. The Equality Act doesn’t say what reasonable adjustments are, but the Equality and Human Rights Commission outlines several factors to be considered, including the resources available to the setting, how practical the adjustment is, the impact it will have on the young person amongst others (Equality and Human Rights Commission, 2015).

Working out what is “*reasonable*” may therefore be challenging, especially where a child doesn’t have a formal diagnosis. It can be difficult to draw the line between accommodating diversity and responding to genuine needs that may create “*substantial disadvantage*” to being included in education over time (Equality and Human Rights Commission, 2015). However, there are examples such as the “*Fantastic Food in Schools programme*” that show how whole-school approaches that promote more flexible and inclusive eating behaviours can support all primary school children to have a healthier relationship with food and with each other (Concha *et al.*, 2026).

Finally, it is important to distinguish between supporting children with ARFID and treatment. Treatment for ARFID is still underdeveloped, but the most evidence-based approach is adapted Cognitive Behavioural Therapy (CBT-AR) (Thomas and Eddy, 2018; Thomas *et al.*, 2020) which focusses on changing thoughts and feelings around food and eating and exposing children to a wider variety of foods in a graded way over time. This can include psychoeducation and guidelines recommend that treatment is individualised to the needs of the young person and their caregivers (Howard *et al.*, 2023). In an educational setting, the role of practitioners is not to provide treatment or expect to solve the young person’s difficulties, but to support their inclusion in education and learning as much as possible. This may include supporting any treatment in liaison with healthcare professionals (Be Body Positive, 2024).

Thanks, and Questions

I hope this presentation has been informative in giving an overview of ARFID, and what this can look like for young children in educational settings. I welcome any questions

Question 1:

What would an early year's practitioner do if they suspected a child had ARFID but didn't have a diagnosis?

Main points for answer:

- Practitioner to respond in a supportive and professional way, being mindful not to label the child (e.g. 'fussy eater'), or to highlight difficult behaviours as the child's fault (non-blaming approach)
- Importance of ongoing observation by multiple practitioners so that accurate information is communicated sensitively and promptly parents/caregivers and relevant professionals
- Research highlights that early identification, and intervention is shown to be the most effective way to limit bad outcomes for children with ARFID (Jaydeokar *et al.*, 2025)
- Important to remember that it is not the role of the practitioner to diagnose/treat/solve concerns but to work alongside support network (*family, caregivers and professionals*) to allow for access to inclusive education

Question 2:

Why did you choose this example for your presentation?

Main points for answer:**Professionally: -**

- Noticed how much food/nutrition impacts children's ability to access education, supporting basic physiological needs, link to learning about this at university – Maslow's theory.
- How mealtimes/ snack times, are especially important to help children develop social skills that support emotional wellbeing and development
- Have seen real examples in practice of children with eating disorders. Reading around topic has shown me that eating disorders are increasing in young children
- Exciting research projects such as eight- year project funded by the Wellcome Trust at Cardiff University, specifically researching ARFID (Chawner, 2024)

Personally: -

- Subject important to me as close family member directly impacted by and eating disorder and I have seen how difficult it is for people to access prompt/ appropriate support to allow them to access education/life generally

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