PACED

Clinical Companion Notes

A framework for working with fear-based ARFID.

Core idea: fear-based ARFID is driven by anticipatory anxiety about a physical outcome, not sensory aversion or low appetite, where the food is not the problem but the predicted outcome is.

P - Person-Directed

The most important clinical question is not which intervention to use - it is what the person actually wants from the work.

Questions to ask:

- What is most getting in the way for you right now?
- Is the restriction itself the problem, or the anxiety around eating?
- Why are you here, and do you experience your eating as a problem?

In practice:

- Do not assume dietary expansion is the goal
- Use ‘tolerated foods’ rather than ‘safe foods’ - the safe/unsafe framing reinforces the threat architecture that maintains avoidance
- Tolerated foods/supplements are a clinical asset, not a problem to solve - do not dismantle them before the person is ready
- Goals set by the person may look different from what the referrer had in mind. A skilled clinician will hold both in mind

A - Anticipatory Anxiety is the Primary Target

The anxiety before eating is often more clinically significant than the eating behaviour itself.

In practice:

- Identify and validate the specific feared consequence before any active work
- Map the anxiety - when does it start, what does it look like, what makes it worse
- Ask specifically about anxiety around eating - the anticipatory window before eating is often where most distress sits, and it won't always be visible in the room
- Stabilise anxiety before moving to any expansion work - a highly anxious person cannot engage meaningfully with exposure

Watch for: people who appear calm or minimise distress in session but are highly anxious in the lead-up to eating. Some individuals mask well - presentation in the room is not always a reliable indicator of what eating actually costs them.

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Identify which fear profiles apply:

- Choking or gagging - often after a prior incident; texture selectivity, hyper-chewing, restriction to soft foods
- Vomiting - may co-occur with emetophobia; avoidance in public, before events, foods perceived as risky
- GI distress - avoidance of categories perceived as likely to cause pain, bloating, or reflux
- Allergic reaction - restriction of unfamiliar foods; may be triggered by prior reaction or generalised fear
- Illness, contamination, or death - vigilance around food safety, refusal of food prepared by others, escalating restriction; closer in character to health anxiety or contamination OCD

Mixed presentations are common. Always strive to understand the picture before intervening.

C - Consent and Readiness Before Exposure

Exposure is one option, not the default.

Exposure may be appropriate when:

- The feared consequence is specific and identifiable
- The person has given genuine informed consent - not reluctant compliance
- Anxiety is sufficiently stabilised
- The therapeutic relationship is strong enough to sustain discomfort
- The person's goals include expansion or anxiety reduction around food

Defer or reconsider exposure when:

- Consent is absent or coerced by family or systemic pressure
- Anxiety is too severe - overwhelm does not produce learning
- The feared consequence cannot be disconfirmed (e.g. a genuine allergy)
- The therapeutic relationship is not yet strong enough
- The primary goal is distress reduction, not expansion

Premature exposure can entrench avoidance, damage the therapeutic relationship, and reinforce the person's belief that eating is dangerous. Readiness is a prerequisite.

E - Exposure Follows Inhibitory Learning Principles

If exposure is indicated, how it is done matters as much as whether it is done.

Consider which approach fits the person and their presentation before structuring any exposure work:

- CBT - prediction testing, evidence evaluation, expectancy violation
- ACT - defusion from catastrophic predictions, values-based action in the presence of anxiety rather than waiting for it to reduce
- DBT - distress tolerance skills to manage the anticipatory window, effectiveness-focused goals
- Sensorimotor/somatic approaches - particularly where the fear is body-based or linked to a traumatic triggering event; working with physical sensation and nervous system regulation before or alongside exposure

Regardless of approach:

- Where possible, vary the context and conditions of exposure rather than always the food itself - generalisation across situations strengthens learning and reduces the chance that gains are context-specific
- Some anxiety during exposure is necessary - it means the threat prediction is active and can be updated
- Exposure in a state of overwhelming anxiety does not produce learning - monitor the window of tolerance and step back if needed
- Stepping back from an exposure that is too distressing is a clinical decision, not a failure

The core shift across all approaches: the goal is not anxiety reduction within a session. It is helping the person register that the feared outcome did not occur - or building their capacity to act in the presence of fear without needing it to resolve first.

D - De-escalate the Environment

The eating environment is also a target - not just the eating.

In practice:

- Reduce social pressure at mealtimes - explicitly permission the person to eat only what they can manage without comment from others
- Modify time constraints where possible - time pressure narrows what is manageable
- Identify high-risk contexts (school canteen, family celebrations, work lunches) and reduce exposure to these while longer-term work is underway
- Work with families to reduce well-meaning commentary - encouragement often functions as pressure

Working with the system:

- Families, schools, and GPs often respond to fear-based ARFID with pressure or repeated food introductions - explain why this is counterproductive
- Write letters to schools where needed; communicate with GPs to ensure a consistent approach
- Environmental accommodation is a legitimate clinical strategy - not a failure to progress
- For some presentations, environmental de-escalation is a long-term support, not a temporary measure