A GUIDE FOR FAMILY & LOVED ONES

# Understanding ARFID

Understanding avoidant/restrictive food intake disorder, protecting nutrition, reducing fear and pressure, supporting gradual change, and safeguarding the wellbeing of the whole family.

**ARFID is not 'fussy eating'**

Avoidant/restrictive food intake disorder can seriously affect nutrition, growth, physical health, social life and everyday functioning. Unlike anorexia nervosa or bulimia nervosa, restriction in ARFID is not primarily driven by weight or shape concerns. The person's difficulty may be rooted in sensory properties of food, fear of adverse consequences, low appetite or interest in eating, or a mixture of these.

## Three common ARFID pathways

**Sensory sensitivity:** taste, smell, texture, temperature, appearance, brand, packaging or inconsistency can make foods genuinely difficult to tolerate. **Fear of consequences:** eating may become associated with choking, vomiting, allergic reaction, pain or another frightening experience. **Low interest or appetite:** the person may rarely feel hungry, forget to eat, become full quickly or experience eating as effort rather than pleasure.

People do not always fit neatly into one pathway. Sensory sensitivity can coexist with fear, low appetite or neurodivergent differences. The presentation can also change over time.

## Safe foods are doing an important job

A 'safe food' is often predictable. The person knows its texture, smell, appearance and what will happen in their mouth. A change of brand, recipe, packaging or cooking method can make a previously safe food feel completely different. Losing a safe food can therefore be frightening, particularly when the person's range is already small.

Families may understandably want to remove safe foods to force variety. When intake is already limited, however, abruptly removing reliable nutrition can increase risk and fear. Expansion should usually be gradual and guided by the person's clinical and nutritional needs.

## Sensory processing

Texture may be as important as flavour. Mixed textures, unexpected lumps, wet foods, fibrous foods, strong smells, foods touching, temperature changes or inconsistent bites can be overwhelming. What looks like a tiny difference to somebody else may be highly noticeable to a sensory-sensitive eater.

Sensory distress is not a behaviour that can simply be argued away. Support begins by believing the experience, identifying predictable features and finding tolerable steps rather than using shame.

## Fear of choking, vomiting or illness

ARFID can begin or intensify after choking, vomiting, reflux, an allergic reaction, gastrointestinal illness or seeing somebody else become unwell. The person may chew excessively, take tiny bites, avoid particular textures, need liquids with meals or restrict to foods they believe cannot cause the feared event.

Reassurance can help briefly but may become repetitive. Treatment aims to build safety and confidence without requiring family members to promise that choking, vomiting or illness can never happen.

## Low appetite and interoception

Some people do not notice hunger clearly or recognise it only when they feel shaky, nauseous or exhausted. Others become full very quickly. ADHD, autism, anxiety, medication effects and physical conditions may affect eating patterns in different ways. Timed eating or reminders can sometimes be more useful than waiting for hunger, but individual advice should come from the relevant clinician or dietitian.

**Important distinction**

ARFID can coexist with food allergy, gastrointestinal disease, swallowing difficulty, reflux, chronic illness or other medical conditions. Psychological or sensory explanations must never be used to dismiss genuine physical symptoms. Appropriate medical assessment is part of good ARFID care.

## Why pressure often backfires

'Just try it', 'one bite for me', 'you'll eat when you're hungry', withholding safe foods, punishment or prolonged battles at the table can increase threat. If eating already feels unsafe, coercion teaches the nervous system that mealtimes are even less safe.

This does not mean families can never encourage change. It means change works better when it is structured, predictable, appropriately paced and linked to treatment rather than conflict.

## Do not hide or disguise foods

Secretly blending, swapping or concealing a feared food may seem like a shortcut. For somebody who relies on predictability, discovering the deception can damage trust in the whole meal, the cook and previously safe foods. Be transparent unless a qualified treatment plan specifically says otherwise.

## A supportive mealtime environment

Predictability can reduce load: knowing when food is coming, where the person will sit, what food will be available and whether foods will touch. Reduce unnecessary commentary about how much they have eaten. Avoid turning every bite into applause or scrutiny unless that approach is part of an agreed intervention.

Where appropriate, include at least one reliable food alongside learning foods. The exact nutritional plan should be individualised, particularly where intake, growth or physical health is compromised.

## Food chaining and small changes

Some people expand variety by moving between foods with similar properties: one shape of pasta to another, one brand to a close alternative, or a tiny change in texture. A new food may first be tolerated in the room, then on the table, touched, smelled or tasted. Progress is not measured only by swallowing a full portion.

Repeated exposure should not become repeated coercion. A step is useful when it creates learning rather than overwhelming the person.

## When a safe food suddenly disappears

A manufacturer may change a recipe, packaging or texture, or the person may become unable to tolerate a food after illness or one unpleasant experience. Families can panic because the nutritional consequences may be immediate. Protect current intake, identify the sensory change if possible and seek dietetic or clinical support if the range is becoming unsafe.

## Eating outside the home

Restaurants, school canteens, parties, hospitals, travel and other people's homes contain uncertainty: brands are unknown, smells mix, food may touch and there may be social pressure. Planning can include checking menus, bringing a safe food, eating beforehand, choosing a quieter location or explaining needs without requiring the person to perform normality for others.

## School, college and work

ARFID can affect concentration, energy, attendance and social inclusion. Reasonable support might include permission to bring suitable food, a quieter eating space, additional time, access to drinks, predictable breaks or flexibility around food-centred events. Needs should be based on the individual rather than assumptions.

## Comments that can hurt

Avoid 'You're so picky', 'That's baby food', 'Everyone else can eat it', 'You used to eat this', 'You're embarrassing me', or jokes about the person's plate. Shame rarely creates flexibility. Try: 'I know this food is difficult for you', 'What part feels hardest?', or 'Let's work out the next manageable step with your plan.'

## Family meals and siblings

Siblings may resent different meals or perceive special treatment. Explain in age-appropriate language that fair support does not always mean identical food. At the same time, avoid allowing ARFID to dictate every family member's diet. Preserve shared connection even when plates are different.

**Different food can still mean belonging**

A successful family meal does not require everybody to eat the same thing. Connection may come from sitting together, talking, sharing a routine or celebrating the person's participation without making their plate the centre of attention.

## Assessment and treatment

Assessment should consider nutritional adequacy, growth where relevant, physical health, eating history, sensory features, fear, appetite, gastrointestinal symptoms, swallowing concerns, allergies, neurodevelopmental differences, medication and the impact on daily life. A multidisciplinary approach may be helpful.

## Dietetic support

A dietitian can help assess whether the current range meets nutritional needs and advise on fortification, meal structure or supplementation where indicated. Supplements can be important for some people but should not be treated as a universal substitute for assessment or broader nutritional planning.

## Psychological approaches

Treatment is tailored. Cognitive behavioural approaches designed for ARFID, including CBT-AR in appropriate settings, work with maintaining mechanisms such as sensory sensitivity, fear and low interest. Exposure-based work may be used gradually. Children and families may need developmentally adapted approaches and active caregiver involvement.

## Occupational and sensory considerations

Where sensory processing significantly affects eating, occupational-therapy-informed assessment may contribute to understanding the environment and sensory demands. Sensory work should still sit within a broader plan that considers nutrition, medical safety and the person's functional goals.

## Neurodivergence

ARFID is seen alongside autism and ADHD, but neurodivergence does not mean every restricted eater has ARFID or that all autistic food preferences require treatment. The question is whether restriction is creating nutritional, physical, developmental or psychosocial difficulty and what support respects the person's neurotype.

## Recovery does not have to mean eating everything

A realistic recovery goal may be adequate nutrition, greater flexibility, fewer frightening situations, a broader reliable range and more freedom to travel, work, learn or socialise. Somebody may retain sensory preferences. The aim is not to erase difference but to reduce danger and restriction.

## Medical warning signs

Seek appropriate medical advice for significant weight or growth concerns, dehydration, fainting, marked weakness, persistent vomiting, swallowing problems, chest symptoms, severe constipation, nutritional-deficiency concerns or rapid deterioration. If a person cannot maintain adequate food or fluids, prompt assessment is important.

## Allergy and choking safety

Known allergies and swallowing disorders require proper medical plans. Exposure work should never involve deliberately giving an allergen or ignoring genuine swallowing risk. If choking difficulty or dysphagia is suspected, seek appropriate medical or speech-and-language assessment rather than treating it as anxiety alone.

## Urgent mental-health support

ARFID can coexist with severe anxiety, depression, self-harm or suicidal thoughts. Seek urgent mental-health support if the person cannot stay safe. Call 999 or attend A&E; for immediate danger to life; use NHS 111 or relevant local services for urgent advice.

### A useful recovery question

Instead of asking only, **'Did they eat the new food?'** ask: Did they stay at the table? Tolerate the smell? Touch it? Describe it? Recover from distress more quickly? Keep adequate nutrition? Attend the event? Small changes can be meaningful clinical information.

## Safeguarding yourself as the supporter

ARFID can require enormous practical labour. Families may cook several meals, visit multiple shops for one brand, carry food everywhere, check menus in advance and worry constantly about nutrition. This work is often invisible to other people.

## When the whole household revolves around food

You may stop travelling, visiting friends or eating foods you enjoy because the person's needs dominate every decision. Some accommodation is necessary and humane; unlimited accommodation can leave the entire family increasingly restricted. Treatment should help identify what protects nutrition and what can gradually become more flexible.

## The cost of safe foods

Specific brands, single-serve products, supplements and wasted trial foods can be expensive. Families are allowed to talk honestly about money. Clinicians and dietitians may be able to help identify nutritionally equivalent or lower-cost options, but substitutions should be introduced carefully when predictability is central.

## You are allowed to dislike mealtimes

Supporters can feel guilt for becoming frustrated or bored with preparing the same food. You can love somebody and still feel exhausted by ARFID. Shame about your own feelings makes burnout more likely; honest support for carers matters.

## Boundaries without punishment

A boundary might be: 'I will make sure there is something you can reliably eat, but I cannot cook four completely separate meals tonight.' Or: 'I will help plan food for the trip, but I need you and your clinician to help create the list.' Boundaries should protect the supporter without using hunger or humiliation as leverage.

## Do not become the sole therapist

Parents and partners can support exposure or meal plans when clinicians have taught them how, but they should not have to invent treatment. Ask professionals for clear roles, written plans, warning signs and what to do when progress stalls.

## Protect siblings and relationships

Siblings should not be required to give up all preferred foods or become cheerleaders for every bite. Partners need time together that is not spent planning meals. Keep family identity broader than ARFID.

## Eight practical coaching tools

**1. Safe-food map.** List reliable foods by texture, temperature, flavour, brand and preparation. Look for patterns rather than judging the size of the list.

**2. Sensory detective sheet.** For a difficult food, identify smell, appearance, sound, texture, temperature, aftertaste and unpredictability. This can reveal a smaller, more workable problem.

**3. Fear ladder.** Break a feared food situation into manageable steps, from being near the food to interacting with it and, when appropriate, tasting it. Use professional guidance where medical or choking fears are involved.

**4. Safe-food loss plan.** Record close alternatives, what made the original predictable, who to contact if intake falls and how the family will protect nutrition while seeking help.

**5. Eating-away-from-home plan.** Venue, safe option, backup food, sensory concerns, exit plan, helpful language and what success will mean beyond eating a conventional meal.

**6. Supporter accommodation check.** What accommodation is currently essential for nutrition or access? What is driven mainly by fear? Which one small family restriction could be reviewed with the treatment team?

**7. Progress-beyond-bites tracker.** Record sitting near food, touching, smelling, tolerating a changed package, trying another brand, eating in a new place or recovering from distress.

**8. Supporter wellbeing plan.** Who shares shopping and cooking? What time is protected for you? What situations are becoming unsustainable? What professional or family support can be added?

## Common myths

**'They will eat when they are hungry.'** Hunger cues may be weak and fear or sensory distress can override them. **'They are just fussy.'** ARFID can cause significant medical and psychosocial impairment. **'It is about body image.'** ARFID is not primarily driven by weight or shape concerns. **'Hide vegetables and they will learn.'** Deception can damage food trust. **'Recovery means eating everything.'** Adequacy, flexibility and freedom are more useful goals.

## Recommended reading

**The Picky Eater's Recovery Book** - Jennifer J. Thomas, Kendra R. Becker and Kamryn T. Eddy, an ARFID-focused self-help resource for adults.
**Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder** - Jennifer J. Thomas and Kamryn T. Eddy, a clinician-oriented treatment resource. Families may also benefit from reputable ARFID materials produced by specialist eating-disorder services and charities.

## UK resources and clinical sources

Useful starting points include NHS eating-disorder information, Beat's ARFID information and support, GP and specialist eating-disorder services, and local paediatric or adult services where available. Some NHS trusts publish practical ARFID mealtime resources. NICE eating-disorder guideline NG69 does not currently

provide ARFID-specific treatment recommendations, so care should be individualised using appropriate specialist expertise.

### Clinical note

This guide is educational and does not diagnose ARFID, prescribe a meal plan or replace medical, dietetic or specialist eating-disorder assessment. ARFID can coexist with allergy, gastrointestinal disease, dysphagia, chronic illness, autism, ADHD and other conditions. Restriction should not automatically be assumed to be psychological, and exposure should never override genuine allergy or swallowing safety.

## A message from Maggie

*ARFID is a subject that matters deeply to me because it is so easy for the outside world to misunderstand what eating can feel like when food does not feel safe. People see a small range of foods and may see stubbornness. They see one brand being accepted and another refused and think it makes no sense. But predictability can be the very thing that allows somebody to eat at all.*

*For families, that can mean living with a level of food planning other people never see. You may know which shop has the right version, which packet has changed, which texture will work today and what has to travel with you everywhere. You may also be frightened about nutrition while being told by others to simply stop giving in.*

*Supporting ARFID is not about choosing between acceptance and change. We can respect sensory needs, protect safe foods and believe somebody's fear while still helping them build more flexibility when they are ready and appropriately supported. Safety first does not mean staying stuck forever.*

*Please also remember yourself. You are allowed to feel tired of cooking, shopping and planning. You are allowed to want family life to include things other than food. You do not have to prove your care by carrying every part of ARFID alone.*

*Different eaters can still belong at the same table. Recovery does not have to look like everybody eating an identical plate. Sometimes it begins with enough nutrition, less fear, one more option, one less cancelled event and a family that can breathe a little more easily around food.*

**Maggie Learoyd**
**Space to Breathe Therapy**

### Final reflection

What would progress look like if you measured not only **new foods**, but also safety, adequate nutrition, flexibility, participation, trust and the amount of life the whole family can reclaim?