Thoughts & Mind

Feeling Full

When fullness creates fear, discomfort or panic

Fullness is an ordinary body sensation, but in an eating disorder it can become loaded with fear and meaning. A person may interpret fullness as evidence that they have eaten 'too much', fear body change, worry they will be sick, feel trapped by the sensation or become overwhelmed by pressure, bloating or internal sensory signals. The discomfort can then trigger restriction, checking, reassurance seeking or an urge to compensate.

Key idea: Fullness can be uncomfortable without being dangerous. The sensation and the story the eating disorder tells about it are not the same thing. Appropriate medical symptoms should be assessed, while recovery can also help the nervous system become less alarmed by normal post-eating sensations.

Why fullness can feel unusually intense

After periods of restriction, irregular eating or changes in intake, digestive sensations may feel unfamiliar or particularly noticeable. Anxiety increases attention to the body, and attention can amplify sensations further. The person may then scan repeatedly for pressure, bloating, nausea or changes in how clothes feel, making the sensation even harder to ignore.

Fullness is not a moral judgement

Feeling full does not mean you were greedy, lacked control or did something wrong. Bodies require nourishment and fullness naturally varies between meals, foods, times of day and individuals. Eating-disorder rules can turn a temporary physical sensation into a judgement about character or body size.

Fear of vomiting, choking or illness

For some people - including some with ARFID - fullness may be frightening because it is linked with nausea, vomiting, reflux, pain or a previous adverse experience. These concerns should be understood in context. Persistent or significant gastrointestinal, swallowing or allergic symptoms deserve appropriate medical assessment rather than being automatically attributed to anxiety.

Interoception and sensory processing

Interoception is the processing of internal body signals such as hunger, fullness, heartbeat and nausea. People vary greatly in how clearly or intensely they notice these signals. Neurodivergent people may experience interoceptive differences, and a sensation that seems minor to someone else can be extremely intrusive or difficult to interpret.

I notice fullness becoming difficult when:

Separate sensation, thought and fear

This exercise helps untangle what your body is experiencing from what the eating disorder predicts will happen next.

1. What sensation am I noticing?

Pressure, stretching, warmth, bloating, nausea, reflux, heaviness, tight clothing, reduced appetite or another internal signal?

The sensation:

2. What thought appears?

Examples: 'I ate too much', 'This will not go away', 'My body is changing', 'I will be sick' or 'I cannot cope with this feeling'.

The thought:

3. What am I afraid the sensation means?

Notice the prediction beneath the thought: danger, body change, loss of control, judgement, illness or being trapped in discomfort.

The fear underneath:

4. What does the eating disorder urge me to do?

Skip later food, compensate, check the body, loosen or change clothing repeatedly, seek reassurance, lie down, avoid future foods or create a new rule?

The urge:

5. What do I know that is more reliable?

Use your treatment plan, medical advice and previous experience. A sensation can rise and fall. Anxiety can amplify it. Nourishment still matters even when fullness feels difficult.

What I know:

Getting through uncomfortable fullness

The aim is not to make the sensation disappear immediately. Trying urgently to remove it can teach the brain that fullness is an emergency. Instead, use comfort and regulation while allowing the body time to digest.

Helpful response	What it supports
Wear comfortable clothing.	Reduces unnecessary pressure without using clothing fit to repeatedly check the body.
Use a neutral post-meal activity.	Moves attention away from continuous internal scanning.
Sit in a comfortable position.	Supports physical comfort; follow medical advice if reflux or another condition affects positioning.
Use paced, gentle breathing.	Can reduce the additional layer of panic and muscle tension around the sensation.
Avoid body checking.	Prevents fullness from becoming a repeated visual or tactile inspection of the body.
Continue the eating plan.	Stops temporary discomfort from rewriting later nourishment or creating compensation.
Use factual language.	“I notice fullness” is different from “I have done something wrong.”

When hunger and fullness cues feel unreliable

During eating-disorder recovery, internal cues may be difficult to interpret or may not yet reliably support adequate intake. Some people therefore need structured eating or a clinician-guided meal plan rather than waiting for hunger or stopping solely because fullness appears. Individual guidance is especially important where nutritional rehabilitation or medical risk is involved.

Supporting someone after eating

Avoid saying 'you didn't eat that much', commenting on stomach size or offering appearance reassurance. Acknowledge that the sensation is difficult, help the person use their agreed post-meal plan and avoid supporting restriction or compensation. If there are genuine physical symptoms, help them access appropriate medical advice.

ARFID and fullness

Low appetite, early satiety, fear of vomiting and sensitivity to internal sensations can all contribute to ARFID presentations. Treatment may involve nutritional strategies, medical assessment and carefully paced behavioural work. The goal is not to dismiss fullness but to prevent it from becoming an automatic stop signal when nutritional needs are not being met.

My comfort plan for fullness:

When to seek medical or specialist support

Persistent early fullness, pain, vomiting, swallowing difficulty, significant reflux, gastrointestinal symptoms or unexplained physical change should be medically assessed. Eating-disorder support is important when fullness fear drives significant restriction, compensatory behaviour or distress. Acute severe symptoms require urgent medical attention.

My interactive Feeling Full Plan

Complete this at a settled time. The plan is designed to help you respond to fullness without turning the sensation into a judgement or allowing it to dictate the rest of the day's eating.

NOTICE - What fullness sensations are hardest for me?

ORIENT - What facts help me separate discomfort from danger?

COMFORT - What helps without checking, avoiding or compensating?

CONTINUE - What is my next treatment-aligned nourishment step?

SUPPORT - Who can stay with me without minimising or reinforcing the fear?

A message from Maggie

> *Feeling full can be much more than a physical sensation. It can bring fear, memories, sensory overwhelm and eating-disorder thoughts all at once. You do not have to pretend that the discomfort is easy. But discomfort does not automatically mean you have eaten wrongly or that something needs to be undone. With the right medical care where needed, and gentle repeated support around the sensation, fullness can become something your body experiences rather than something your whole day has to revolve around.*

Books, resources & clinical sources

NICE NG69: Eating disorders: recognition and treatment. NHS eating-disorders information. Beat eating-disorders information and support. Fairburn, *Cognitive Behavior Therapy and Eating Disorders*. Thomas, Lawson & Eddy, *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder*. Gastrointestinal, swallowing, allergy or other persistent physical symptoms require appropriate medical assessment alongside eating-disorder care.

This educational resource does not replace medical, nutritional or specialist eating-disorder assessment and treatment.