

Supporting Someone Without Policing Food

Compassionate support for eating disorders, disordered eating, ARFID and difficult relationships with food

When someone you care about is struggling with food, it is understandable to feel frightened and to want to make things better. Yet support can quietly turn into watching, questioning, bargaining, checking and commenting. Even when it comes from love, the person may begin to feel that every plate is being assessed and every mouthful is evidence of whether they are 'trying'. This guide is about staying alongside somebody without turning yourself into the food police.

There are many reasons somebody may struggle to eat

Food difficulties are not always about weight or body image. A person may be living with an eating disorder, ARFID, sensory differences, autism or ADHD, depression, anxiety, trauma, grief, chronic stress, physical illness, nausea, fear of choking or vomiting, executive-function difficulties, loss of appetite, intense food thoughts or a need for predictability and control. Some people want to eat but their body or nervous system makes it extraordinarily difficult. Others may not fully understand what is happening themselves. Start with curiosity rather than assumptions.

The goal is not to stop caring about what happens with food. The goal is to make care feel safer, more respectful and more useful.

What food policing can look like

Food policing can include watching every mouthful, repeatedly asking whether someone has eaten, commenting on portion size, calories, ingredients, weight or appearance, labelling foods 'good' or 'bad', praising eating as if it is a performance, comparing plates, hiding foods, insisting that a particular food must be eaten, or making plans and privileges depend on finishing a meal. Structured meal support prescribed by an eating-disorder team is different: when a clinician has given a specific plan, follow it while protecting dignity and communication.

Why pressure can make eating harder

Eating can already feel threatening. Anxiety can tighten the stomach and create nausea. Sensory overload can make smell, texture, temperature or mixed foods unbearable. Trauma can make control and bodily sensations difficult. Depression and grief can remove appetite and the energy needed to shop, prepare or choose food. When pressure, arguments or scrutiny are added, the nervous system may experience even more threat. The person may hide difficulties, avoid shared meals, become more rigid or stop speaking honestly.

Replacing monitoring with connection

Instead of...	Try...
"Have you eaten?" again and again	"How is food feeling today? Is there anything that would make it a little easier?"
"You need to finish that."	"Would company, distraction, a quieter space or a different option help?"
"That portion is too small."	"I can see this is difficult. What support feels manageable?"
"But you ate it yesterday."	"Food can feel different from day to day. We can work with what is possible today."

Different food journeys need different support

ARFID and sensory differences

With ARFID and sensory-based eating difficulties, the problem may have little or nothing to do with body image. Smell, texture, temperature, chewing, swallowing, mixed foods, packaging changes, unpredictable brands, nausea and previous frightening experiences can all matter. A safe food is not a moral failure. Sometimes it is the food keeping a person nourished enough to continue. Removing safe foods to force variety can increase fear. Expansion is generally more sustainable when safety is preserved and new experiences are approached gradually with appropriate professional support.

Depression, grief and loss of appetite

Depression and grief can flatten appetite and motivation. Choosing a meal may require more executive energy than the person has. Practical care can therefore matter: keeping familiar foods available, preparing something accepted, offering two manageable choices rather than an open question, helping with shopping, or simply sitting nearby. A person who cannot organise food may need help with the steps around eating, not a lecture about why eating matters.

Anxiety, trauma and fear

Fear can become attached to food, swallowing, sickness, body sensations or loss of control. Avoid forcing somebody to explain more than they can. Ask what increases distress and what lowers it. Predictability, grounding, reduced conflict and a calm environment can help. If trauma is part of the picture, eating support should not recreate experiences of powerlessness.

Food noise and preoccupation

Some people experience relentless thoughts about food, rules, guilt, calories, eating or what they are 'allowed' to have. A household full of diet talk, weight comments and moral judgements about food can make that noise louder. Consider creating a home culture where plates and bodies are not routinely evaluated.

ADHD, autism and executive function

Neurodivergence can affect hunger awareness, interoception, transitions, planning, remembering to eat, shopping, decision-making and sensory processing. Somebody can care about recovery and still forget a meal, become stuck choosing, or find the available food impossible on a particular day. Repeatable meals, visible routines, stocked safe foods, reminders agreed with the person and shared preparation can reduce the executive load without becoming surveillance.

What supportive meals can look like

Talk about support away from the meal itself. Agree what helps when everyone is calm: sitting together, talking about ordinary life rather than food, watching something familiar, using a preferred plate, serving components separately, having a backup safe food, reducing smells or noise, or checking in once rather than repeatedly. Ask rather than assume. If the person has a specialist treatment plan, work with the team so that home support reinforces treatment without becoming punitive.

Support the person, not only the plate

Eating difficulties can take over family life. Deliberately make room for conversations and activities that have nothing to do with food. Notice effort that is not visible on a plate: attending an appointment, describing a fear, tolerating uncertainty, asking for help, preparing a food, sitting at the table or trying again after a difficult day. Recovery is rarely a straight line.

Concern, safety and getting help

Compassion does not mean ignoring medical risk

Eating disorders and severe restriction can become medically dangerous. Seek urgent medical assessment for collapse or fainting, severe weakness or confusion, chest pain, breathing difficulty, vomiting blood, signs of severe dehydration, inability to keep fluids down, or another rapidly worsening physical change. In an immediate emergency use emergency services. For concerning deterioration that is not immediately life-threatening, contact the person's GP, NHS 111 or their eating-disorder service and describe the specific changes you have noticed.

If they say they do not want help

Stay calm and concrete. Explain what you have observed rather than arguing about labels: 'I have noticed you are struggling to manage fluids and you nearly fainted today. I am worried about your physical safety.' Offer practical help with making an appointment, travelling, writing symptoms down or sitting in the waiting room. Avoid debates about whether somebody is 'ill enough'. If they are an adult, there are limits to what relatives can control, but you can still give relevant information to healthcare professionals even when confidentiality means the professional cannot give information back.

A reflection for the supporter

- 1. What am I frightened will happen?** Notice whether fear is pushing you towards monitoring, arguing or demanding reassurance.
- 2. What does the person say makes food harder?** Write down their explanation rather than replacing it with your own theory.
- 3. What makes eating 5% safer?** Think about sensory load, timing, predictability, company, language, preparation and environment.
- 4. What practical burden can I remove?** Shopping, cooking, washing up, transport, appointments, childcare or decision-making may all be places to help.
- 5. What needs professional input?** Medical instability, escalating restriction, purging, rapid deterioration, significant distress or uncertainty about safe support should not be carried by a family alone.

A message from Space to Breathe Therapy

You do not have to choose between caring and respecting somebody's autonomy. Good support can hold both. You can take risk seriously without making every meal a battle. You can encourage treatment without reducing somebody to what is on their plate. The person in front of you is still a whole person—with relationships, humour, fears, sensory needs, memories, interests and hopes that exist beyond food.

Further reading and UK support

Beat offers UK eating-disorder information and support for people affected and for families and friends. **NHS** information on eating disorders explains symptoms and routes into care. Useful family reading includes *Skills-based Caring for a Loved One with an Eating Disorder* by Janet Treasure, Anna Crane and colleagues, and *When Your Teen Has an Eating Disorder* by Lauren Muhlheim. For ARFID, choose resources that recognise sensory, fear-based and low-interest presentations rather than assuming all restrictive eating is driven by body image.

This guide is educational and supportive. It does not replace individual medical, dietetic or eating-disorder