# THEY JUST WON'T EAT

## What the Parent Sees vs What the Child May Be Experiencing

**ARFID Parents Series - Resource 1**

**Eating is the behaviour we can see. ARFID is often about everything happening underneath it.**

This resource is deliberately detailed. It is written for the parent who has been told their child is fussy, for the parent who has tried every ordinary feeding tip, for the parent whose kitchen has become a place of negotiation, and for the parent who is frightened by how little their child can manage. It is also for the parent whose child eats enough to look 'fine' but whose world has become smaller because food is difficult everywhere else.

Avoidant/restrictive food intake disorder (ARFID) is not defined by a desire to lose weight or change body shape. Restriction may be driven by sensory sensitivity, low interest in food or eating, fear of aversive consequences such as choking, vomiting or pain, or a mixture of these. The same child can show more than one pattern, and the pattern can change over time.

The most useful shift a parent can make is from asking, 'How do I get this food into my child?' to asking, 'What is my child's nervous system, body and experience telling us about why eating is difficult?' That does not mean ignoring nutrition. It means protecting health while becoming more accurate about the problem we are trying to solve.

### 1. When 'fussy eating' is not the whole story

Ordinary food preferences are common in childhood. ARFID is different because restriction or avoidance has meaningful consequences: inadequate energy or nutrition, weight or growth concerns, reliance on supplements or enteral feeding, and/or significant interference with everyday psychosocial functioning. A child does not have to be visibly underweight for their eating to be serious. A child may grow along a curve while eating an extremely narrow range, or may meet energy needs through a small number of foods while family life, school, travel and social participation become increasingly restricted.

Parents often notice the difference before other people do. You may be carrying specific brands everywhere, cooking separate meals, checking menus before leaving home, avoiding holidays, worrying when packaging changes, or watching a once-safe list shrink. Recent UK qualitative research with parents describes ARFID as having a huge practical and emotional impact on the whole family, with parents reporting sensory sensitivities, interoceptive difficulties, stressful trigger events, pressure, judgement from others and the constant work of keeping accepted foods available.

### 2. What the parent sees versus what the child may feel

| What you may see | What may be happening underneath |
|---|---|
| They ate it yesterday. | The batch, smell, temperature, texture, colour or appearance may be different today. The child may also remember feeling ill after it. |
| They are hungry, so they will eat eventually. | Hunger does not automatically override disgust, |

| | |
|---|---|
| | fear, nausea, pain or sensory distress. Hunger itself may become unpleasant if recognised late. |
| They are controlling us. | Rigid rules about brands, plates, foods touching or preparation can be attempts to make an unpredictable experience predictable. |
| They have not even tasted it. | The eating experience begins with anticipation, sight, smell, preparation sounds and memory. A threat response can begin before the first bite. |
| They are making themselves gag. | Gagging, nausea and retching can be involuntary. Treating them as deliberate can add shame and increase anticipatory fear. |
| They eat it at school, so they can eat it at home. | Context matters. Masking, peer influence, different sensory conditions, exhaustion, safety, expectations and delayed distress can all change what is possible. |

## 3. The three common ARFID drivers - and why they overlap

Sensory sensitivity can involve taste, smell, texture, temperature, appearance, sound, consistency, foods touching, packaging and even the way a food is cut or prepared. Food disgust can be intense and bodily. The child may not be able to 'push through' it simply because an adult says the food is safe.

Fear of aversive consequences can develop after choking, vomiting, an allergic reaction, severe reflux, abdominal pain or another frightening event. Sometimes the original event has passed but the brain has learned that eating predicts danger. Anticipation then becomes part of the problem: throat sensations, nausea, racing heart, gagging or panic may appear before eating.

Low interest or low appetite may look like forgetting to eat, stopping after a few bites, finding eating boring or effortful, or failing to notice hunger until the body feels awful. Some children describe fullness very quickly. Others struggle to distinguish hunger, nausea, anxiety and abdominal discomfort. These are not excuses; they are clues about the system that needs support.

These drivers are not neat boxes. A child can begin with sensory selectivity, develop pain or vomiting, become afraid of eating, lose more foods, eat less overall, become constipated because intake has fallen, then experience more abdominal discomfort. That cycle is why looking only at behaviour can miss the maintenance loop.

## 4. Sensory processing: when 'the same food' is not the same

Adults often categorise foods by name: yoghurt is yoghurt, toast is toast, chips are chips. A sensory-sensitive child may categorise them by exact properties. One yoghurt may be smooth and predictable; another may have a tiny grain, a stronger smell or a different temperature. One packet of crisps may be acceptable until the manufacturer changes seasoning. Bread from a new loaf may feel wetter. A banana can move from tolerable to impossible as it ripens. The parent sees sameness; the child's sensory system detects difference.

This is why 'but you like this' can be such a frustrating sentence for both sides. The parent is describing the category. The child is responding to the current sensory object. Try replacing certainty with curiosity: 'Something is different today. Can you tell whether it is the smell, look, feel, temperature or something else?' If the child cannot answer, that does not mean nothing is wrong. It may mean they do not yet have language precise enough to describe it.

## 5. Interoception: hunger, fullness and the confusing body

Interoception is the perception of internal bodily signals. Hunger, thirst, fullness, nausea, reflux, pain, needing the toilet, a racing heart and internal temperature are examples. Some children notice these signals late, faintly, intensely or ambiguously. A child may not notice hunger until they are ravenous, shaky or nauseated. At that point the body feels so unpleasant that eating becomes harder, not easier.

Parents can help by building predictable eating opportunities rather than relying only on the child to announce hunger. The aim is not rigid clock-feeding regardless of distress, but providing regular, low-pressure access to foods the child can manage and learning the child's early cues. Those cues may be behavioural - irritability, fatigue, loss of concentration or becoming more dysregulated - rather than a clear statement of hunger.

## 6. Gut responses and the gut-brain loop

The gastrointestinal system must be taken seriously in ARFID. Reflux, constipation, abdominal pain, bloating, nausea, early fullness, diarrhoea, swallowing difficulty and other symptoms can precede restriction, result from restriction, or interact with it. Recent clinical reviews describe a bidirectional relationship between ARFID and disorders of gut-brain interaction: gastrointestinal symptoms can precipitate restriction, while restricted intake can worsen gastrointestinal symptoms.

This creates a difficult loop. A child eats, experiences pain or nausea, becomes more cautious, eats less or removes foods, then may develop constipation or altered gastrointestinal function because intake and variety have fallen. The resulting symptoms confirm the child's belief that eating feels bad. The answer is not to decide that symptoms are 'all anxiety' or, at the other extreme, to assume every avoided food represents a true intolerance. The answer is careful assessment.

**ARFID must never become a label that stops appropriate investigation of persistent physical symptoms.**

## 7. Allergy, intolerance, gastrointestinal disease and sensory aversion

Parents deserve clearer language here. A food allergy involves an immune response and can include symptoms such as hives, swelling, wheeze, vomiting or, in severe cases, anaphylaxis. Food intolerance is a broader term for reproducible adverse reactions that are not necessarily immune-mediated. Gastrointestinal conditions can cause pain, reflux, altered bowel habits or swallowing problems. Sensory aversion is a response to sensory properties. Fear-based avoidance can develop after any frightening consequence. These experiences can coexist.

If a child repeatedly reports pain, burning, food sticking, vomiting, itching, swelling, bowel symptoms or other reproducible physical responses, record what happens and discuss it with an appropriate clinician. Do not repeatedly challenge a suspected allergen at home. Equally, when a child's diet is already very narrow, removing whole food groups without appropriate assessment can create additional nutritional risk.

## 8. The brain learns from what happens after food

Learning is central to understanding some ARFID. If eating is followed by vomiting, choking or severe pain, the brain may begin predicting that consequence. Prediction can become powerful enough to trigger real physical sensations before the feared event occurs. This is not pretending. Fear changes attention, muscle tension, breathing, gastrointestinal sensation and the way bodily signals are interpreted.

Emerging neurobiological research suggests that anticipation of eating may be particularly relevant for some people with ARFID. The science is still developing, so we should not turn this into a single explanation for everyone. What it does support is the parent's observation that a child can become distressed before food reaches their mouth.

## 9. Sugar, glucose and the child's brain: separating observation from myth

Parents often notice that their child seems different after particular sweet foods and understandably wonder about sugar and the brain. Glucose is an important fuel for the brain and body, but the simple claim that sugar causes hyperactivity is not a good explanation for every change in behaviour. Energy, mood and regulation are influenced by total intake, how long the child has gone without eating, sleep, stress, caffeine, illness, sensory load, excitement and individual physiology.

In ARFID, this needs particular care because a sweet or refined-carbohydrate food may be one of the child's few reliable sources of energy. Removing it abruptly because it is labelled 'unhealthy' can reduce intake and increase fear. Nutritional improvement is not achieved by making a child less fed. When parents observe a repeated pattern, document the whole context: what was eaten, how much, what came before it, time since the previous food, physical symptoms, emotional state and what happened later. If there is a genuine concern about blood glucose or metabolic health, seek individual clinical assessment.

## 10. Safe foods are doing a job

A safe food is not simply a food the child has 'got their own way' about. It is a food whose sensory and bodily consequences feel sufficiently predictable to permit eating. Safe foods may provide calories, protein, fat, micronutrients, hydration, routine and emotional security. When the range is tiny, every safe food can carry disproportionate importance.

That does not mean families must never work toward variety. It means expansion should not begin by destabilising the foundation. Withholding safe foods to create hunger can backfire when hunger does not override fear or sensory aversion. It can also teach the child that the adult who controls food may remove the only things they can reliably eat.

## 11. When a safe food disappears

Losing a safe food can be frightening for the whole family. Sometimes there is an obvious trigger: illness, vomiting, a changed recipe, packaging, a different batch, a bad texture or a painful gastrointestinal episode. Sometimes the reason is unclear. Avoid immediately turning the loss into a test. Keep other reliable foods available, note what changed, and if appropriate reintroduce contact later without pressure. If the safe list is rapidly shrinking, seek specialist help sooner rather than waiting for the child to become medically compromised.

## 12. Pressure: obvious and invisible

Pressure is not only 'eat it or you cannot leave the table.' It can be watching every bite, asking repeatedly whether the child has finished, bargaining, offering escalating rewards, hiding ingredients, excessive praise for swallowing, comparing siblings, talking about the child's eating in front of them, showing visible panic when they refuse, or making the next family activity conditional on eating.

Parents usually do these things because they are scared, not because they want to distress their child. That distinction matters. We can validate the parent's fear and still examine whether the strategy is helping. Recent parent research describes pressure as something families often fear has worsened the problem, while creating a safer, lower-pressure environment and allowing motivation to develop from within were described as helpful.

Reducing pressure is not the same as becoming passive. Parents still provide structure, access to food, medical follow-up, nutrition support and appropriate boundaries. The difference is that the child is not required to prove safety by overriding their body on demand.

## 13. What not to do - and what to do instead

| Instead of | Try |
|---|---|
| “You will eat when you're hungry.” | Offer predictable eating opportunities and protect reliable foods while learning the child's hunger cues. |
| “Just one bite.” repeated throughout the meal | Agree any exploration separately and keep ordinary eating opportunities as safe as possible. |
| Removing safe foods to force variety | Preserve reliable intake while expanding alongside it. |
| Hiding ingredients in a trusted food | Protect trust. Discuss nutritional fortification openly where developmentally appropriate and seek dietetic advice. |
| “There is nothing wrong with it.” | “I believe something feels wrong to you. Let's work out what.” |
| Discussing weight, calories or the child's eating in front of others | Protect privacy and use neutral, functional language about nourishment and safety. |
| Assuming every symptom is anxiety | Record persistent symptoms and seek appropriate medical assessment. |
| Assuming every symptom proves intolerance | Investigate systematically and avoid unnecessary restriction. |

## 14. Nutrition: protecting the body without frightening the child

A restricted diet can affect energy intake, protein, essential fats, fibre, iron, calcium, vitamin D, vitamin B12, folate, zinc and other nutrients depending on the foods excluded. The risk is individual. A child eating ten foods can have a different nutritional profile from another child eating the same number because the actual foods, quantities, fortification and supplements differ.

This is why nutritional assessment matters more than counting the number of foods. An ARFID-informed dietitian can examine what the child actually eats, growth and weight history, symptoms, supplements, relevant blood tests and the feasibility of fortification or supplementation. The goal is to protect nutrition now while longer-term work on flexibility and variety proceeds at a tolerable pace.

Avoid moralising foods as 'good', 'bad', 'clean' or 'junk' in front of a child whose intake is already precarious. A food that is reliably eaten has nutritional value because it is eaten. Nutrient density matters, but so does adequacy. Sometimes the first clinical priority is simply enough energy and fluid.

## 15. School, nursery and eating away from home

School can either reduce pressure or multiply it. A child may face noisy dining halls, strong smells, short lunch periods, unfamiliar staff, foods touching, rules about finishing, comments from peers, or adults who interpret accommodations as indulgence. Other children may eat more at school because peers provide motivation or because they mask distress until later. Neither pattern proves that the difficulty is voluntary.

Useful school planning can include access to accepted food, a quieter eating location if needed, enough time, permission not to be pressured into tasting, a named adult, a plan for missed intake, discretion around peers, and communication with home about meaningful changes. The exact plan should reflect the child's needs and medical advice rather than a generic ARFID rule.

## 16. Restaurants, parties, holidays and grandparents

Families often describe the invisible planning burden: checking menus, carrying food, booking self-catering accommodation, locating supermarkets, packing duplicates and worrying about what happens if a product is unavailable. This is not overprotective by definition. It may be what makes participation possible.

Where possible, create a 'food safety net' for outings: at least one reliable food, water, a backup option, information about the environment, and permission for the child not to perform eating for other people. Grandparents and relatives need a simple message: the goal is not to prove that the child will eat when sufficiently hungry; the goal is to keep them nourished and safe while treatment and development continue.

## 17. Siblings and the rest of the family

ARFID can alter family meals, budgets, routines and attention. Siblings may perceive that one child receives special food, different rules or more parental attention. Their feelings deserve acknowledgement without turning the child with ARFID into the cause of family problems. Explain accommodations in terms of need: fairness is not always everybody receiving the same thing; sometimes it is everybody receiving what allows them to participate safely.

Parents also need support. Constant vigilance around food can produce guilt, anger, grief, isolation and conflict between adults who have different ideas about how firm to be. A parent who is exhausted is not a bad parent. But exhaustion can make pressure more likely, which is why supporting the caregiver is part of supporting the child.

## 18. From my side of the table - lived perspective

This section is personal perspective, not a claim that every person with ARFID experiences food in the same way.

My experience of ARFID began in childhood. At different times my safe range became extremely small, and physical reactions and food intolerances added another layer to eating. From the outside, a person can look as though they are refusing an ordinary food. From the inside, there can be a very strong sense that the food is not safe for your body, even when you cannot explain exactly why.

One of the hardest things is when another person decides that because they cannot see or feel the response, it is not real. A child may not have words such as nausea, reflux, sensory overload, interoception or intolerance. They may only have 'I don't like it', 'it is wrong', 'my tummy hurts' or 'I can't'. Those words should begin an investigation, not automatically end in an argument.

I would want a parent to know that believing the child's experience does not mean agreeing with every conclusion about what caused it. You can say, 'I believe that felt awful. Let's work out what happened.' That keeps the relationship intact while leaving room for medical assessment, nutrition support and gradual change.

**Your child may notice something about their body or a food long before they have the vocabulary to explain it.**

## 19. The Look Beyond the Plate method

For two weeks, observe patterns without turning the record into surveillance. The purpose is to learn. Record the food and exact brand; preparation; appearance; smell; texture; temperature; whether foods touched; where the meal happened; who was present; noise and cooking smells; time since last intake; tiredness; emotional state; sensory load; hunger signals; gastrointestinal symptoms before eating; what the child could approach, touch, smell or eat; and symptoms afterwards.

Then look for clusters rather than single incidents. Does eating become harder after school? Are mornings easier? Does constipation precede a drop in intake? Are particular textures associated with gagging? Does a changed packet cause refusal before the food is opened? Does the child manage socially and then stop eating later? Patterns help parents and clinicians ask better questions.

## 20. Parent pressure audit

☐ Do I watch the plate more than I watch my child's state?

☐ Do I repeatedly ask for 'one more' after the child has said no?

☐ Do I remove reliable foods because I fear I am 'giving in'?

☐ Do I hide ingredients in foods my child trusts?

☐ Do I talk about the child's eating to other adults while the child can hear?

☐ Do I show panic, anger or disappointment when a food is refused?

☐ Do I assume refusal means defiance before checking sensory or physical factors?

☐ Have meals become the main place where my child and I struggle for control?

☐ Can my child tell me 'not today' without fearing punishment or humiliation?

☐ Do I have professional support for the nutritional worries that are driving my pressure?

## 21. Questions to take to the GP, paediatrician or dietitian

• Could pain, reflux, constipation, swallowing difficulty, allergy or another medical problem be contributing?

• How are growth, hydration and nutritional adequacy being assessed over time?

• Are blood tests or other investigations clinically indicated for this child's presentation?

• Could medication, illness or gastrointestinal symptoms be affecting appetite or nausea?

• Can we have input from a clinician or dietitian familiar with ARFID rather than generic picky-eating advice?

• What should we do if intake falls further, and what are our urgent red flags?

• How can we protect nutrition without unnecessarily removing safe foods?

• What support can be coordinated with school or nursery?

## 22. Red flags: when not to wait

Seek urgent medical advice when there are signs of dehydration, fainting, marked weakness, altered consciousness, inability to keep fluids down, acute allergic symptoms, significant swallowing difficulty, or another rapidly worsening physical concern. Seek timely clinical review for weight loss or faltering growth, a rapidly shrinking food range, persistent vomiting or pain, severe constipation, suspected nutritional deficiency, increasing dependence on supplements, or psychosocial impairment that is escalating.

Parents should be given an individual escalation plan by the child's clinical team when medical risk is present. Internet information cannot determine medical stability for a particular child.

## 23. Building permanent change at home

Permanent change is not a perfect meal plan. It is a family system that no longer relies on crisis and coercion. Keep reliable foods available. Build predictable opportunities to eat. Reduce unnecessary sensory load. Talk about bodily experiences without ridicule. Investigate symptoms. Let professionals carry some of the nutritional risk assessment so the parent does not have to turn every meal into an emergency. Introduce flexibility gradually rather than destabilising everything at once.

Create language the child can use: safe, unsure, too strong, wrong texture, hurts, makes me feel sick, too full, not hungry yet, scared of choking, need a break, can smell it, not today. Communication itself is progress. A child who can identify what is happening is better equipped to participate in treatment and self-advocate as they grow.

## 24. What progress can look like before the diet gets bigger

Progress may be sitting at the table with less fear, tolerating another person's food nearby, recovering more quickly from a changed brand, telling you that a texture is the problem rather than melting down, accepting that a new food can be present without being eaten, noticing hunger earlier, drinking more reliably, allowing a clinician to discuss symptoms, or trusting that a parent will not secretly change a safe food. These changes can be clinically meaningful even before the number of foods increases.

Do not make variety the only measure of recovery. Nutrition, medical stability, reduced fear, improved flexibility, better communication, increased participation in life and a less adversarial relationship with food all matter.

## 25. A permanent family ARFID plan

| Area | Our plan |
|---|---|
| Nutrition safety | Which foods currently keep energy, fluid and key nutrients going? Who is overseeing nutritional adequacy? |
| Medical understanding | Which symptoms need investigation or monitoring? What is the escalation plan? |
| Safe-food security | Which brands/preparations are reliable? What backups can we keep without creating panic? |
| Sensory environment | What smells, sounds, textures, temperatures or settings make eating harder? |
| Communication | What words or visual scales help the child communicate internal experiences? |
| School | Who understands the plan? Where can the child eat? What happens if lunch is missed? |
| Expansion | Who is guiding food exploration? How will we keep it collaborative and tolerable? |
| Parent support | Who can the parent talk to when fear or exhaustion is driving pressure? |
| Review | What has changed in the last month - not just foods eaten, but fear, participation, symptoms and trust? |

## 26. The message I want parents to leave with

You are not required to choose between protecting your child's nutrition and respecting their experience. Good ARFID support attempts to do both. It takes the eating difficulty seriously enough to assess health, nutrition and physical symptoms, while also taking the child's sensory and emotional reality seriously enough not to turn every mouthful into a contest.

Your child may need treatment, dietetic support, medical investigation and carefully supported food expansion. They may also need you to remain the person who believes them when they say something feels wrong. Curiosity is not indulgence. Safety is not giving in. A reliable food is not a parenting failure. And progress is not always visible on a dinner plate first.

**Look beyond the plate. Protect the body. Listen to the child. Build trust. Change what can be changed around them while helping them develop what can change within them.**

## References and evidence base

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• Burton-Murray H, et al. (2025). Avoidant/restrictive food intake disorder in disorders of gut-brain interaction. Best Practice & Research Clinical Gastroenterology.

• Burton-Murray H, et al. (2024). Cognitive-behavioral therapy for avoidant/restrictive food intake disorder: mechanisms of change and target engagement. International Journal of Eating Disorders.

• Schmidt R, et al. (2025). Sensory sensitivity and food disgust in ARFID presentations across ages. Appetite.

• Prospective longitudinal research in youth (2025) examining persistence and outcomes across sensory sensitivity, fear of aversive consequences and lack-of-interest ARFID profiles.

• Recent 2026 reviews of ARFID neurobiology describe possible roles for sensory processing, hunger/satiety signalling, conditioned aversion and gut-brain mechanisms, while emphasising that direct ARFID-specific biological evidence remains limited.

This resource is educational and does not replace individual medical, dietetic, psychological or emergency assessment. Treatment should be tailored to the child's presentation, nutritional status, physical health, developmental needs and family context.