

BUT THEY ATE IT BEFORE

Why a Safe Food Can Suddenly Stop Being Safe

ARFID Parents Series - Resource 2

A previously safe food disappearing is information. It is not proof that your child is being difficult.

1. The sentence parents hear themselves saying

“But you ate this yesterday.” “You have eaten this for years.” “Nothing has changed.” For a parent, the sudden loss of a safe food can feel irrational and frightening, particularly when the accepted range is already tiny. Yet the history of eating a food does not guarantee that the child's nervous system, gut, sensory experience or learned associations will continue to classify it as safe. A food can change. The child's body can change. The context can change. The meaning attached to the food can change. Sometimes several of those things happen together.

2. Safe does not simply mean 'liked'

In ARFID, a safe food is often a food with sufficiently predictable sensory and bodily consequences to permit eating. It may have a known smell, texture, temperature, appearance, brand, packet, shape and preparation. The child knows what is going to happen in their mouth and has a reasonable expectation about what will happen afterwards. That predictability reduces uncertainty. When one element changes, the parent may still see the same category of food while the child experiences a different object.

3. The batch-change problem

Manufactured foods are not perfectly identical. Seasoning can vary, potatoes come from different crops, bread moisture changes, cereal pieces differ, fruit ripens, cheese matures, cooking alters crispness, and manufacturers reformulate recipes. Packaging can change before a child even tastes the product. A sensory-sensitive person may detect differences that another family member genuinely cannot. The useful response is not to argue about whether the difference exists. Ask what changed from the child's perspective and, where possible, compare packet, batch, recipe, preparation, temperature and appearance.

4. Brand loyalty may be predictability, not stubbornness

Parents can understandably become frustrated when a child accepts one brand but rejects an apparently identical alternative. Brand-specific eating can look controlling, but the brand may act as a prediction system: the packet tells the child what texture, smell, size and flavour to expect. Generic substitution may remove that certainty. Where flexibility is a longer-term goal, it is usually safer to build it alongside reliable intake rather than testing flexibility at the moment the child is hungry and dependent on the food.

5. Food jags and repetition

Some children eat the same food repeatedly for weeks or months and then abruptly stop. Repetition can increase predictability, but it can also lead to sensory fatigue or a sudden shift in tolerance. Parents sometimes respond by rationing a preferred food to prevent the child 'getting bored of it'. That strategy can create scarcity and anxiety, particularly when alternatives are limited. There is no universal way to prevent a safe food being lost. A better plan is to maintain several reliable options where possible and gradually develop backups without threatening the food currently keeping the child nourished.

6. Illness can rewrite a food

A stomach bug, vomiting episode, choking event, reflux flare, allergic reaction or severe abdominal pain can transform the meaning of a previously safe food. Humans are particularly capable of learning food aversions after nausea and vomiting. The association may be with the food eaten before the illness even when the food did not cause the illness. For a child with an already sensitive eating system, one event can remove an important food quickly.

7. When the body remembers

After a frightening eating-related event, the next encounter with that food can trigger anticipation. Anticipation can produce nausea, throat tightness, increased heart rate, gagging, muscle tension and an urge to escape. Those sensations then appear to confirm that the food is dangerous. Avoidance reduces the distress immediately, reinforcing the avoidance. This learning loop helps explain why saying 'you know it is safe' may have little effect: cognitive reassurance is competing with a body that has learned a threat prediction.

8. Gut symptoms can change food safety

Reflux, constipation, abdominal pain, bloating, diarrhoea, nausea, early fullness and swallowing problems can all alter a child's willingness to eat. A child may connect a particular food with symptoms, correctly or incorrectly. Sometimes restriction itself contributes to gastrointestinal symptoms, creating a circular pattern. Persistent symptoms deserve medical attention; they should not automatically be labelled anxiety or ARFID. Equally, a suspected intolerance should not lead to increasingly broad exclusions without appropriate assessment when the diet is already narrow.

9. Allergy, intolerance and learned avoidance

A true food allergy, a non-allergic intolerance, gastrointestinal disease, sensory aversion and conditioned fear are different mechanisms, but they can overlap in one child. Parents need permission to hold uncertainty: 'I believe you felt unwell, and we need to work out why.' That stance validates the experience without prematurely deciding the cause. Acute allergic symptoms require appropriate emergency action; recurring symptoms need clinical investigation.

10. Medication, illness and appetite changes

Illness can temporarily reduce appetite, change smell and taste, increase nausea or make swallowing uncomfortable. Some medications can affect appetite or gastrointestinal function. If a food disappears during or after illness, look at the timeline. Did the child vomit? Was their nose blocked? Did the food taste different? Was there pain? Did a medicine coincide with nausea? A timeline is often more informative than repeatedly presenting the food and asking why it is being refused.

11. Temperature and preparation matter more than adults realise

The same food can become a different sensory experience when reheated, cooled, toasted for thirty seconds longer, microwaved instead of oven-cooked, cut differently or served on a different plate. Crisp foods can become soft. Sauces thicken as they cool. Fat changes mouthfeel. Smells intensify with heat. Parents who record preparation details sometimes discover that a 'random' refusal is highly consistent from the child's sensory perspective.

12. Visual safety comes before tasting

Children often decide whether a food is approachable before it reaches the mouth. A broken biscuit, darker chip, bruised fruit, sauce touching another item, unfamiliar plate, altered packet or unexpectedly large

portion can signal uncertainty. This does not mean the child must control every presentation forever. It means visual predictability may be part of the starting point from which flexibility is gradually built.

13. Stress can shrink the safe range

A child may tolerate more foods when rested and regulated and fewer when exhausted, anxious, ill or overloaded. School days, transitions, noisy environments, social demands and masking can consume regulatory capacity. Parents sometimes see this as inconsistency: 'You ate it on Saturday, so why not tonight?' Capacity is not fixed. The question is not only whether the child has eaten the food before, but what else their nervous system is carrying today.

14. A safe food disappearing is not the moment to prove a point

When a key food is suddenly refused, parental fear can lead to confrontation: 'You have to eat something', 'I'm not making anything else', or 'you loved this yesterday'. If the child's range is already restricted, a standoff can reduce intake further and increase the threat attached to eating. First protect immediate nutritional and fluid safety using other accepted options. Investigation and re-exploration can happen separately.

15. Do not secretly change the trusted food

Hiding ingredients, swapping brands without telling the child or disguising a new product in familiar packaging can appear efficient, but discovery can damage trust beyond that single food. The child may begin inspecting every safe food for evidence that it has been altered. Where nutritional fortification is clinically needed, work transparently and with appropriate professional guidance whenever developmentally possible.

16. The parent fear underneath 'you have to eat it'

When only five, ten or fifteen foods are accepted, losing one can feel enormous. The parent's mind may immediately calculate calories, protein, school lunches, holidays and what happens if another food disappears tomorrow. That fear deserves support. But fear can turn into pressure, and pressure can turn the lost food into an even stronger threat cue. Parents need a plan for what to do when a food disappears so they are not inventing a strategy while frightened.

17. Protect the nutritional floor

The immediate priority after losing a safe food is to understand what nutritional role it played. Was it a major source of energy, protein, fat, calcium, iron, fibre or fluid? What accepted foods provide similar functions? If the lost food represented a substantial part of intake, or if the range is rapidly narrowing, contact the child's dietitian, GP, paediatric team or ARFID service rather than waiting. Nutritional risk is determined by what and how much the child actually consumes, not simply by the number of foods on a list.

18. Build backups before crisis where possible

A backup is not necessarily a completely new food. It might be a second acceptable flavour, a similar preparation, another packet size, frozen stock of a trusted batch, or a closely related food that has already been explored without pressure. The goal is resilience: if one product disappears from shops or changes recipe, the family is not left with no route to adequate intake. Backup building should be gradual and should not threaten the primary safe food.

19. Reintroducing contact without turning it into a test

A lost food does not always need to be permanently abandoned, but reintroduction should be thoughtful. After illness or a frightening event, allow recovery. Later, the food might simply return to the room, then the table, then the child's plate if tolerated. Smelling, touching or discussing it may be steps. A specialist may use

structured exposure or CBT-based approaches for fear. The key is that exposure is planned to support learning, not used as forced endurance.

20. When fear is about choking or vomiting

Fear of choking and fear of vomiting can become highly restrictive because the feared consequence feels catastrophic. Children may chew excessively, avoid textures requiring more chewing, prefer liquids or soft foods, inspect every bite, eat extremely slowly or stop after bodily sensations that others would ignore. Swallowing difficulty must be medically assessed where indicated. Once physical causes are considered, targeted psychological treatment may be needed rather than generic encouragement to eat more.

21. The child who cannot explain why

Some children simply say 'wrong', 'yucky', 'different', 'my tummy', or 'I don't know'. Language limitations, alexithymia, developmental stage, distress and interoceptive differences can make precise explanations difficult. Avoid treating lack of explanation as evidence that there is no reason. Offer choices: 'Is it the smell, look, texture, temperature, tummy feeling, fear, or something else?' Allow 'I don't know' to remain a valid answer.

22. From my side of the table

Lived experience can help parents understand why previous eating does not prove present safety. A food can be something you relied on and then suddenly become something your body refuses. When physical reactions and intolerances are part of your history, you learn that 'you ate it before' is not the reassurance other people think it is. What matters is what is happening now. I would want a parent to remain curious enough to ask what changed rather than using the past to overrule the present experience.

23. Believe the experience without assuming the explanation

There is an important middle ground. A parent can believe that the child's nausea, pain, disgust or fear is real without concluding immediately that a specific ingredient is definitely responsible. This protects the relationship and improves assessment. 'I believe you felt sick after that. We are going to record it and work out what might be happening' is both validating and clinically sensible.

24. School needs to know when a safe food is lost

If a food forms part of a school lunch plan and suddenly disappears, tell the relevant staff. A child should not be pressured at school to eat the rejected food because 'mum says you normally eat it'. Arrange an accepted backup and update any support plan. If the child is coming home having eaten very little, that information is clinically relevant and should not be hidden by focusing only on what was packed.

25. What progress looks like after losing a food

Progress is not necessarily eating the lost food again quickly. It may be being able to talk about what happened, tolerating the packet nearby, identifying the sensory difference, trying the old preparation again, accepting a replacement food, or allowing a clinician to explore the fear. A food may return, be replaced, or remain unavailable. The broader goal is nutritional security, flexibility, reduced fear and trust.

Safe Food Loss Investigation

Check	What to record
The food	Exact product, brand, flavour, packet, batch/date if relevant.
What changed	Recipe, packaging, appearance, smell, texture,

	temperature, preparation, portion.
What happened before	Illness, vomiting, choking, pain, allergy symptoms, stressful event, medication change.
Body response	Nausea, reflux, pain, bloating, bowel change, itching, swallowing sensation, gagging.
Context	School/home, people present, noise, pressure, tiredness, sensory overload.
Current intake	What reliable foods and fluids remain? What nutritional role did the lost food play?
Child's words	Record their description without correcting it.
Next step	Protect intake, investigate symptoms, create backup, seek clinical advice if needed.

Parent response plan: the first 48 hours

- ☐ Stay neutral: do not turn the refusal into a confrontation.
- ☐ Offer another reliable food if available and protect fluid intake.
- ☐ Check whether there are acute symptoms that require medical attention.
- ☐ Ask once, calmly, what seems different; do not interrogate.
- ☐ Record brand, batch, preparation and recent illness or symptoms.
- ☐ Work out what nutritional role the food played.
- ☐ Tell school or other caregivers if the loss affects their plan.
- ☐ Seek professional advice promptly if intake is substantially reduced or the safe range is rapidly shrinking.

Questions for professionals

- Could gastrointestinal symptoms, reflux, constipation, allergy, swallowing problems or another medical issue be contributing?
- Has the lost food created a meaningful nutritional gap?
- Do growth, hydration, symptoms or intake indicate that we need more urgent review?
- Could a dietitian help us replace nutrients without destabilising the remaining safe foods?
- If this followed choking, vomiting or another frightening event, would ARFID-specific psychological treatment be appropriate?
- How should school respond while this food is unavailable?
- What are our individual red flags and escalation plan?

A Safe Food Security Plan

Reliable now: List the foods and drinks currently eaten reliably, including exact brands and preparation.

Backups: Identify already tolerated alternatives rather than inventing them during a crisis.

Stock: Where appropriate, keep a reasonable supply without creating panic or excessive hoarding.

Change warning: Tell the child when you know a packet, recipe or preparation is different.

Symptom record: Track reproducible physical responses and bring the record to clinicians.

Exploration: Keep new-food work separate from emergency hunger whenever possible.

School: Make sure there is at least one realistic accepted option and a backup.

Review: Watch the direction of travel: stable, expanding or rapidly narrowing?

When to seek urgent or timely help

Seek urgent medical advice for dehydration, fainting, marked weakness, inability to keep fluids down, acute allergic symptoms, significant swallowing difficulty or another rapidly worsening physical concern. Arrange timely clinical review for weight loss or faltering growth, persistent pain or vomiting, severe constipation, suspected nutritional deficiency, increasing reliance on supplements, rapidly narrowing intake, or escalating interference with school, family or social life.

The goal is not to win the lost food back. The goal is to understand what changed, keep the child nourished, protect trust and build enough safety and flexibility that one food does not have to carry the whole system.

Evidence and further reading

- American Psychiatric Association. DSM-5-TR: Avoidant/Restrictive Food Intake Disorder diagnostic framework.
- Bryant-Waugh R and colleagues: clinical research and guidance on ARFID assessment and treatment.
- Thomas JJ, Eddy KT and colleagues: ARFID presentations, mechanisms and treatment research.
- Recent qualitative UK research with parents of children and young people with ARFID: sensory differences, interoception, trigger events, family impact and pressure.
- Recent gastroenterology reviews examining ARFID and disorders of gut-brain interaction.
- ARFID treatment literature on CBT-based approaches, fear of aversive consequences and graded exposure.

This resource is educational and does not replace individual medical, dietetic or psychological assessment. Persistent or concerning symptoms, suspected allergy, nutritional compromise, swallowing difficulty or rapidly worsening restriction require appropriate professional assessment.