

THEY'LL EAT WHEN THEY'RE HUNGRY

Why Hunger Doesn't Always Override ARFID

ARFID Parents Series - Resource 3

Hunger can tell us the body needs food. ARFID can still make the act of eating extraordinarily difficult.

“They’ll eat when they’re hungry” is one of the most persistent pieces of advice given to parents of children who struggle with food. It assumes that hunger will eventually become stronger than every other signal. ARFID shows us why that is not always true. A child may need energy and still be stopped by sensory disgust, fear, nausea, pain, early fullness, weak interoception, executive-function difficulty or overload. This handbook looks beneath the refusal and gives parents a way to protect nourishment while understanding what the child’s brain and body may be doing.

This is not an argument for leaving ARFID unchallenged. It is an argument for using the right challenge. Hunger is not a treatment plan. Good support asks what is preventing adequate intake, what medical or nutritional risks need attention, what the child can currently manage, and how flexibility can be built without turning every meal into a battle.

Understanding hunger in ARFID

Why “they’ll eat when they’re hungry” can be misleading

Hunger is a biological signal, but it is not a command that automatically makes eating possible. A child with ARFID may need energy and still be stopped by sensory disgust, fear of choking or vomiting, nausea, pain, early fullness, weak awareness of internal signals, executive-function difficulties or overload. Some children do not notice hunger until it is intense; some experience it as irritability, tiredness, headache, shakiness or “feeling sick”; some notice an empty stomach but still cannot approach the available food. This is why waiting for hunger to become stronger can fail. The parent sees a body that must need food. The child may be experiencing several louder signals saying that eating is unsafe, unpleasant or simply too difficult.

What the parent sees and what may be happening underneath

A parent may see a child playing happily after refusing breakfast, leaving lunch untouched, eating only a few bites at dinner or saying they are not hungry after hours without food. It is understandable to conclude that the child cannot really need nourishment. ARFID asks us to separate nutritional need from subjective appetite and from capacity to eat. A child can have an energy need without a strong conscious hunger cue. They can feel hungry without finding the offered food manageable. They can start hungry and become full unusually quickly. They can also become so dysregulated by a long gap that choosing, sitting, smelling food and beginning the first bite become harder rather than easier.

The three common ARFID pathways can all interfere with hunger

Sensory sensitivity can make smell, texture, temperature, appearance or mouthfeel more powerful than hunger. Fear of aversive consequences can make the brain prioritise avoiding choking, vomiting, allergy, pain or another feared event. Low interest in eating can involve poor appetite, weak hunger cues and early satiety. Many children have a mixed presentation. A useful parent question is therefore not “Why isn’t hunger winning?” but “What is hunger competing with in my child today?”

Hunger cues, interoception and early fullness

Interoception: knowing what the body is saying

Interoception is the perception and interpretation of internal signals such as hunger, fullness, nausea, thirst, pain, temperature and heartbeat. Children vary greatly in how clearly they notice and label these signals. A child may use one word—“sick”, “full”, “weird” or “tummy”—for several different sensations. Others may notice very little until the signal becomes extreme. Neurodivergent children can have particular differences in sensory and interoceptive processing. The aim is not to tell the child what their body “really” feels. It is to help them build a vocabulary and recognise patterns over time.

Early fullness can be genuine

Some children begin a meal hungry and feel completely full after only a small amount. From the adult side this can look impossible: “You have only had three bites.” From the child’s side the fullness may be very real. Repeatedly overriding that report can create mistrust, yet simply accepting tiny intake without assessing nutritional consequences is not enough either. This is where paediatric and dietetic assessment matters. Parents can respect the sensation while professionals help determine whether meal structure, energy density, gastrointestinal symptoms or another factor needs attention.

External structure can support an unreliable internal system

If hunger is inconsistent, regular eating opportunities can act as an external scaffold. A predictable breakfast, snack, lunch, snack and evening meal pattern may be more useful than repeatedly asking whether the child feels hungry. Timers, visual schedules, prepared food and calm prompts are not evidence that the child has failed to listen to their body; they can be accessibility tools while body awareness develops. The exact schedule should be individualised where nutritional or medical risk is present.

When hunger makes eating harder, not easier

The missed eating window

Families often discover that there is a point at which a child is more able to eat, followed by a point where the long gap has made everything harder. Falling energy can bring irritability, nausea, headache, shakiness, tearfulness, sensory sensitivity and cognitive inflexibility. Executive functioning may deteriorate. The child who could have managed toast forty minutes earlier may now be unable to decide, tolerate the smell, sit down or begin. Waiting for maximum hunger can therefore mean missing the most workable eating window.

Stress physiology and the table

When a child is anxious or overloaded, the body may prioritise threat responses over digestion and exploration. The parent may see refusal at the very moment they expect hunger to create motivation. The child may experience a tight throat, nausea, racing heart or an urgent need to escape. Pressure—watching, bargaining, counting bites, threatening consequences or repeatedly explaining nutrition—can add another layer of arousal. Reducing unnecessary demand does not mean abandoning nutritional goals; it can create the conditions in which those goals become more achievable.

What to look for instead of waiting

Notice the child’s earliest pre-hunger signs: a drop in concentration, sudden irritability, asking for a familiar activity, becoming pale or tired, rubbing the stomach, losing flexibility, or beginning to search for a particular safe food. Record when eating is easiest and when it repeatedly becomes difficult. A week of patterns can tell a family far more than a single argument about whether the child “should” be hungry.

Sensory processing: an empty stomach does not switch off disgust

Sensory barriers remain sensory barriers

Hunger does not make an intolerable texture neutral. A child can have an empty stomach and still gag at a smell, recoil from a mixed texture, reject a food that is the wrong temperature or be unable to manage a product whose appearance has changed. Disgust is a powerful protective response and can produce nausea and avoidance. For a child with high sensory sensitivity, stronger hunger may increase urgency without increasing the number of foods that are actually accessible.

Safe foods are doing a job

A safe food may be predictable in brand, shape, colour, temperature, texture and after-feeling. When the range is restricted, these foods can carry a large proportion of the child’s energy and nutrient intake. Removing them to make the child hungry enough for something else turns a nutritional need into a behavioural experiment. If the child still cannot eat the alternative, intake simply falls. Expansion work can happen, but nourishment and exposure do not have to be made into the same event every time.

Build from the sensory profile

Parents can map what accepted foods have in common: dry or wet, crunchy or smooth, bland or strongly flavoured, hot or cold, separate or mixed, uniform or variable. This is not about keeping the diet narrow forever. It gives the family and clinicians a starting point for building bridges. A child who reliably manages dry, uniform, crunchy foods may need a different progression from a child who prefers smooth, cold foods.

Fear can overpower hunger

When eating predicts danger

A child who has choked, vomited, experienced severe reflux, pain, an allergic reaction or another frightening event may learn that eating predicts danger. The threat system can then become more powerful than hunger. The child may want to eat and still be unable to swallow. They may chew excessively, inspect every bite, take tiny mouthfuls, avoid particular textures, prefer liquids or stop after an unfamiliar sensation. This can be profoundly confusing for parents because the child may be visibly hungry.

The body can make fear feel true

Fear can cause throat tightness, nausea, altered breathing, abdominal discomfort and gagging. Those sensations can then seem to confirm the feared prediction. Avoiding the food reduces distress immediately, which teaches the brain that avoidance worked. This is one reason reassurance alone—“you won’t choke”, “you aren’t going to be sick”—may not undo the pattern.

Physical assessment and psychological learning can both matter

Swallowing difficulty, recurrent coughing during meals, significant pain, allergic symptoms or persistent gastrointestinal problems require appropriate clinical assessment. Once physical causes have been considered or treated, learned fear may remain. ARFID-focused psychological treatment can then help build new experiences of safety. The important point for parents is that “physical” and “psychological” are not opposing teams; a child can have a genuine physical trigger and a nervous system that continues protecting them afterwards.

Gut, nausea, constipation and the hunger puzzle

Eating can become associated with discomfort

Reflux, abdominal pain, bloating, constipation, diarrhoea, nausea and early satiety can all reduce willingness to eat. ARFID and gastrointestinal problems can coexist, and the direction of cause is not always simple. A child may restrict because eating hurts; restriction and irregular intake may then contribute to constipation or fullness, which makes eating harder again. This loop deserves careful assessment rather than the assumption that the child is merely anxious or difficult.

Hunger itself may feel like sickness

Long gaps without food can create sensations that some children interpret as nausea or illness. If the child has limited interoceptive vocabulary, “I feel sick” may be the most accurate description they can give. A parent expecting hunger to encourage eating may instead see the child retreat further from food. Recording the timing of symptoms, bowel pattern, reflux, pain, fluid intake and what happens after eating can help clinicians see patterns.

Allergy, intolerance and ARFID should not be blurred together

A food allergy, non-allergic intolerance, gastrointestinal condition, sensory aversion and conditioned fear are different mechanisms, although they can overlap. A useful parental position is: “I believe that something felt wrong, and we need to work out why.” This validates the child without prematurely diagnosing the cause. Acute allergic symptoms require appropriate emergency action; persistent physical symptoms should not be dismissed simply because the child also has ARFID.

Neurodivergence, attention and executive functioning

Noticing hunger is only the first step

A child may notice a body signal and still need to stop an activity, shift attention, decide what food is possible, tolerate preparation smells, organise utensils, sit down, start the first bite and continue eating. ADHD, autism and other neurodevelopmental differences can affect several of these steps. A parent may see “they would rather play than eat”; the more useful question may be “which part of moving from activity to eating is breaking down?”

Hyperfocus and transitions

A child deeply absorbed in a game, book, construction activity or special interest may not respond to subtle hunger cues. By the time they stop, the body may be depleted and the transition itself difficult. Abruptly removing the activity and demanding immediate eating can add conflict. Advance warnings, predictable routines, a prepared safe option and low-language prompts may reduce the executive load.

Demand and autonomy

Repeated commands can make food feel like another demand rather than a body need. Supporting autonomy does not mean asking an overwhelmed child an unlimited “what do you want?” question. It can mean offering two realistic accepted choices, giving notice before the transition and allowing the child some control over where or how the food is eaten.

Medication, illness, sleep and changing appetite

Appetite lives in a wider body

Acute illness, pain, poor sleep and some medications can affect appetite, taste, nausea or gastrointestinal function. If intake changes suddenly, look at the timeline. Did medication change? Has the child been unwell? Are they constipated? Are they sleeping badly? Did vomiting create a new fear? A change in appetite should not automatically be attributed to the eating disorder.

Medication deserves a joined-up conversation

If appetite reduction appears linked to prescribed medication, discuss timing, dose effects, growth and nutritional concerns with the prescriber and dietitian where relevant. Do not abruptly stop prescribed treatment without advice. Sometimes the practical answer involves adjusting eating opportunities around periods when appetite is more available; this needs to be individualised.

Recovery can lag behind the infection

A child may be medically recovered from a virus while taste, smell, nausea, fatigue or fear remains altered. Parents can become alarmed when eating does not immediately return to baseline. Watch the direction of travel, protect reliable intake and seek review if restriction continues to worsen or physical concerns emerge.

Why withholding safe foods can backfire

Hunger is not a behavioural trump card

The strategy “serve the family meal and offer nothing else” assumes that enough hunger will eventually make the child eat. In ARFID, the child may remain unable to eat the offered food. The result can be reduced total intake, escalating distress and a stronger association between meals and threat. This is especially concerning when the diet is already nutritionally fragile.

Trust matters If a child learns that access to manageable food is conditional on first eating something frightening or intolerable, they may approach meals with greater vigilance. Similarly, secretly swapping brands, hiding ingredients or changing trusted food without telling them can make the entire safe-food system feel unreliable. Where fortification or therapeutic exposure is needed, transparency and appropriate professional guidance are preferable whenever developmentally possible.

Exposure is not starvation Evidence-informed ARFID treatment may include exposure to feared or sensory-challenging foods, increasing volume and building flexibility. That is not the same as removing all accepted options and waiting for desperation. Therapeutic challenge should have a rationale, a manageable step size and attention to nutritional safety.

The parent's fear: am I giving in?

Parents are placed in an impossible argument

Families are often told either to accommodate every difficulty or to stop accommodating altogether. ARFID support is more nuanced. Some accommodations are essential because they protect nutrition, school attendance, sleep and participation. Other patterns may eventually maintain avoidable fear and can be changed with support. The question is not “am I being too soft?” but “what function is this accommodation serving right now?”

A safe-food breakfast may be treatment-supportive

If a predictable breakfast is the difference between a child arriving at school nourished or arriving after eating nothing, protecting that breakfast may be sensible while broader work happens elsewhere. Flexibility can be built gradually rather than demanded at the most nutritionally important moment of the day.

Parents need regulation too

Watching a child refuse food can activate panic. Parents may calculate calories, growth, tomorrow’s lunch and the possibility of another safe food disappearing, all while trying to appear calm. A written response plan reduces the need to invent a strategy at the table. Parent support is part of ARFID support, not an optional extra.

What the child may be trying to communicate

“I am not hungry” may contain several meanings

It may mean: I cannot feel hunger. I feel full. My stomach feels strange. The food smells unbearable. I am frightened I will be sick. I cannot stop what I am doing. I am exhausted. I do not know what I am feeling. I know that if I say the texture is wrong we will argue, so “not hungry” is easier. Parents do not have to guess which one is true; they can become curious without interrogating.

Useful language

Try: “You don’t have to explain it perfectly. Is it more that your body doesn’t feel hungry, that you feel full or sick, or that the food itself feels difficult?” If the child says “I don’t know”, accept that answer. Over time, observations and patterns may give more information than a pressured conversation.

Avoid turning appetite into a credibility test

Statements such as “you must be hungry”, “you ate nothing at lunch”, or “if you were really hungry you would eat this” can make the child feel disbelieved. A more useful response is: “Your body needs regular fuel even when hunger is hard to notice. Let’s use the food we know is manageable and keep learning what your signals feel like.”

From My Side of the Table

Hunger and the ability to eat are not the same thing

From my own lived experience of ARFID, the idea that hunger will simply take over does not reflect how restrictive eating can feel from inside it. A body can need food while the eating system remains blocked. Safe foods, sensory experience, bodily reactions, predictability and fear can all be more powerful than an empty stomach. That is why a person can go far longer with very little intake than someone watching them believes should be possible.

What I would want a parent to know

If your child does not suddenly eat normally when they become hungry, do not read that as proof of stubbornness. Read it as information. Something else is louder than the hunger signal. The task is to find out what that is while keeping the child nourished. Sometimes that means medical investigation. Sometimes sensory support. Sometimes psychological treatment. Often it is a mixture.

My experience is not every child's experience

Lived experience can help widen understanding, but it should never be used to assume that every child feels what I felt. Each child deserves their own assessment. I include my perspective because parents are frequently given advice that sounds logical from outside ARFID and can feel completely impossible from inside it.

Home: build a rhythm before the crisis point

Predictable opportunities

Where clinically appropriate, regular meals and snacks can reduce reliance on hunger as the sole cue to eat. The child does not need to prove they are hungry before food is available. A routine also lets parents observe whether certain times consistently work better than others.

Reduce decision load

An overwhelmed child may not be able to answer “what do you want?” Offering two or three realistic accepted choices can make initiation easier. Keep portions visually manageable; more can be offered if wanted. A huge portion can create pressure before the first bite.

After school

For some children the first priority after school is regulation. A reliable snack in a quiet environment may work better than waiting for dinner. If the child masks or copes through the school day, their food flexibility may be lowest when they arrive home. That does not mean they have manipulated school successfully and are now choosing not to cope; capacity changes with load.

Bedtime and mornings

If breakfast is consistently difficult, look at sleep, morning nausea, medication timing, constipation, rushed transitions and the sensory properties of breakfast foods. If evening intake is poor, consider whether the child is exhausted by then. Moving some nutritional opportunity earlier may be useful with dietetic guidance.

School: the hidden part of the eating day

Find out what is actually eaten

A packed lunch is not evidence of intake. Food may be returned, discarded, hidden, swapped or simply untouched. Ask school for factual information without making the child feel monitored. If lunch is routinely minimal, that matters when interpreting after-school behaviour and total intake.

Environment can defeat hunger

Noise, smells, short lunch periods, queues, social observation and unfamiliar staff can make eating harder. A child may be hungry but unable to use that hunger in the dining hall. Reasonable adjustments might include a quieter place, more time, access to familiar food, discreet prompts or a trusted adult.

Do not let staff use hunger as discipline

A child should not be told that if they refuse the available meal they can wait until home, unless this is part of an individually agreed clinical plan. School needs a realistic backup strategy for a child whose nutritional intake is already restricted.

Communicate changes

If a safe food disappears or appetite changes, update school quickly. The plan on paper must match what the child can currently eat, not what they ate last term.

Restaurants, parties, holidays and grandparents

Hunger does not create predictability

A restaurant may offer plenty of food while offering nothing the child can reliably manage. Different brands, cooking oils, shapes, smells and presentation can make a familiar food unfamiliar. Arriving very hungry can increase distress rather than solve it.

Plan nourishment, then participation

Eating an accepted food before an event, taking food with you where appropriate or checking menus in advance can protect participation. These strategies are sometimes criticised as “giving in”, but a child who is nourished and regulated may be more able to engage socially and eventually explore than a child pushed into a crisis.

Set family boundaries

Relatives may say “they’ll eat if they’re hungry enough” because that principle worked with ordinary selective eating in their own experience. Parents can say: “ARFID is different. We are protecting nutrition while working on the reasons eating is difficult. Please don’t comment on what or how much they eat.”

Siblings matter too

Siblings should not become food police or examples used to shame the child. They may also need acknowledgement that ARFID changes family routines. Fairness does not always mean identical food rules; it can mean each child receiving what they need without being blamed for those needs.

Sugar, glucose and energy: keep the explanation balanced

Glucose is fuel, not a moral category

Carbohydrate is broken down into glucose, an important energy source for the body and brain. Energy, attention and behaviour are influenced by total intake, meal timing, sleep, stress, illness, caffeine and many other variables. It is not accurate to claim that ordinary sugar intake universally causes hyperactivity or that removing sugar will correct ARFID.

Do not abruptly remove a safe food because it contains sugar

When a child has a very narrow diet, a food that looks nutritionally imperfect may still be providing crucial energy. Removing it without a workable replacement can worsen overall intake. Nutritional improvement should consider what the child currently consumes and what change is realistically sustainable.

Long gaps can affect functioning

Inadequate intake can contribute to fatigue, irritability, poor concentration, headache or shakiness. These experiences can make the child less able to cope with sensory and executive demands. The answer is not automatically “more sugar” or “less sugar”; it is a better understanding of total nutrition and timing.

Use a dietitian when the diet is narrow

A paediatric dietitian familiar with ARFID can identify nutritional priorities, consider fortification or supplementation where appropriate, and help families avoid destabilising the small number of foods currently carrying intake.

When inadequate intake needs more than home strategies

Do not judge risk by appearance alone

ARFID can be clinically significant without a child appearing extremely thin. Concern may include faltering growth, weight loss, nutritional deficiency, dehydration, dependence on oral supplements, fatigue, weakness, dizziness, constipation or substantial psychosocial impairment. Growth and nutritional assessment belong with appropriately qualified professionals.

Urgent concerns

Seek urgent medical advice for acute allergic symptoms, significant breathing or swallowing difficulty, severe dehydration, fainting, inability to keep fluids down, marked weakness or another rapidly worsening physical concern. Parents should follow local emergency guidance and any individual medical plan.

Timely review

Arrange clinical review when intake is progressively narrowing, meals dominate family life, school participation is affected, pain or vomiting persists, constipation is severe, swallowing is concerning, growth is faltering or the child repeatedly cannot meet needs despite structured support.

Joined-up care

Depending on the presentation, the team may involve a GP, paediatrician, dietitian, ARFID/eating-disorder clinician, psychologist or therapist, gastroenterology, allergy, speech and language therapy for swallowing, occupational therapy or other specialists. The child benefits when these professionals share information rather than each treating one isolated piece.

A practical parent plan for 'I'm not hungry'

1. Do not argue with the sensation

Start with: “Okay, I believe that you don’t feel hungry.” This reduces the need for the child to defend their body experience.

2. Keep the eating opportunity

Follow with: “Your body still needs regular fuel, so let’s see what feels most manageable.” Offer an accepted option or follow the child’s individual clinical plan. Hunger does not have to be the entry ticket to nourishment.

3. Make the task smaller

Reduce choice, sensory load and portion size. Check whether the child needs a quieter place, a familiar plate, a different temperature or a short transition from the previous activity.

4. Observe without surveillance

Notice what happens after the first few bites. Does appetite appear? Does fullness arrive immediately? Is there nausea, pain, fear or sensory disgust? Record patterns rather than commenting on every bite.

5. Escalate rather than repeatedly battling

If this happens across most eating opportunities and intake is inadequate, the answer is not more force. Take the pattern to the appropriate clinicians and ask what mechanism is preventing adequate intake.

Parent toolkit: turn observation into useful information

The seven-day hunger and eating map

Record wake time, each eating opportunity, what was actually eaten, body clues before eating, mood/energy, gastrointestinal symptoms, school demands, medication timing and significant sensory or emotional events. Keep the record neutral. The purpose is to discover patterns, not to prove the child wrong.

Find the easiest windows

Highlight times when eating occurs with the least resistance. These may become nutritional anchors. If breakfast is poor but a mid-morning snack is consistently easier, that information is useful. If dinner collapses after demanding school days, consider whether more intake earlier could reduce risk.

Find the danger zones

Mark long gaps, rushed transitions, noisy environments, medication peaks, constipation days, after-school overload or late-night exhaustion. Then choose one change at a time: an earlier snack, quieter space, prepared safe option, transition warning or school prompt.

The pressure audit

For one week notice how often adults ask about hunger, count bites, praise eating, bargain, threaten, hover, discuss nutrition at the table or compare with siblings. Choose one pressure behaviour to reduce. This is not about blaming parents; it is about seeing whether anxiety has accidentally become part of the eating environment.

Questions to take to professionals

Medical

Could reflux, constipation, gastrointestinal disease, allergy, swallowing difficulty, pain, medication effects or another physical condition be suppressing appetite or making eating uncomfortable? Which symptoms would change the urgency?

Dietetic

Is total energy and nutrient intake adequate? Which current safe foods are nutritionally important? Would fortification or supplementation be appropriate? Should we use a structured eating schedule rather than waiting for hunger?

Psychological/ARFID

Does the presentation appear mainly low-interest, sensory, fear-based or mixed? What is maintaining the restriction? Which intervention fits that mechanism? How do we challenge ARFID without compromising nutritional safety?

School

What is actually eaten during the day? Does the child need a prompt, more time, a quieter place or a backup food? Are staff inadvertently increasing pressure?

Whole team

What are this child's individual red flags, goals and escalation plan? How will we distinguish a temporary difficult day from a pattern requiring more intensive support?

What progress can look like before appetite becomes reliable

Regularity before hunger

A child may begin eating at predictable times even when they cannot yet identify strong hunger. That is progress. They are learning a supportive rhythm rather than waiting for a signal that may remain inconsistent for some time.

Better body vocabulary

The child may begin distinguishing empty, full, nauseated, anxious, painful, shaky or "not sure". They may tell an adult earlier that something feels wrong instead of reaching crisis point.

More resilience

The family may develop backup foods, school may have a workable plan, and one failed meal may no longer mean the entire day collapses. Nutritional resilience is an important form of progress even before variety expands dramatically.

Less conflict

Parents may stop debating whether the child "must" be hungry and instead use a shared plan. The child may feel less watched. Meals may become less emotionally charged. A safer relationship with eating creates better conditions for therapeutic work.

Functioning matters

Improved energy, concentration, sleep, school attendance, family participation and confidence can be meaningful outcomes alongside food variety and volume.

Final understanding: hunger is information, not a test of willpower

What we can say with confidence

ARFID is commonly understood through overlapping sensory sensitivity, low interest in eating and fear of aversive consequences. Low-interest presentations can include poor appetite and early satiety. Sensory and fear mechanisms can prevent eating even when nutritional need is present. Medical and gastrointestinal contributors also require consideration.

What remains individual

No single explanation fits every child. The precise role of neurobiology, gut-brain mechanisms, sensory processing, learning, anxiety and developmental differences varies. Parents should be cautious of anyone offering one test, supplement, diet rule or parenting technique as a universal cure.

The sentence to leave behind

“If they were really hungry, they would eat” confuses the body’s need for food with the child’s capacity to act on that need. It can lead adults to interpret a complex eating disorder as a contest of will.

The sentence to carry forward

“My child needs nourishment, and I also need to understand what is making nourishment difficult.” That sentence makes room for nutrition, medicine, sensory understanding, psychological treatment, neurodivergent needs and the parent-child relationship at the same time.

Message to parents

You do not have to prove your child is hungry enough. You do not have to solve ARFID at tonight’s dinner. Protect what keeps them nourished, notice the patterns, take physical symptoms seriously, reduce avoidable pressure and ask for specialist help when intake or functioning is compromised. Eating is the behaviour we can see. ARFID is often about everything happening underneath it.