IT'S NOT ABOUT THE FOOD

Looking Beyond the Dinner Table to Understand What's Really Going On

ARFID Parents Series - Resource 4

Eating is the behaviour we can see. The work is understanding what may be happening underneath it.

This resource is for the parent who has tried changing the food, changing the plate, changing the rules and changing the rewards, yet still senses that the real difficulty is bigger than dinner. ARFID can be shaped by sensory processing, interoception, gut symptoms, fear learning, neurodivergence, exhaustion, school demands, physical reactions and the emotional environment around eating. Looking beyond the table does not mean ignoring nutrition. It means understanding the system well enough to support nutrition more effectively.

1. The plate is often the last part of the story

When a child with ARFID cannot eat, the visible moment happens at the table, so it is understandable that adults focus on the food. Yet the difficulty may have started hours earlier. Poor sleep, constipation, a rushed morning, sensory overload at school, a change in routine, a frightening memory, an unfamiliar smell, medication effects, illness, social anxiety or exhaustion can all change what becomes possible at the next meal. The plate is where the problem becomes visible; it is not always where the problem began. Looking beyond the dinner table means asking what happened before the food arrived, what the child's body is experiencing now and what the eating demand represents to them.

2. Behaviour is communication - even when the child cannot explain it

Turning away, covering the mouth, leaving the table, crying, pushing a plate away, asking the same question repeatedly, inspecting food, becoming angry or saying "I'm not hungry" can look oppositional from outside. In ARFID these behaviours may be attempts to communicate sensory disgust, uncertainty, nausea, fullness, fear, pain or overload. A child does not need to possess the vocabulary to make the bodily response real. The useful shift is from "How do I stop this behaviour?" to "What might this behaviour be protecting the child from, and what information does it give us?" This does not mean every behaviour is left without boundaries; it means the response is based on understanding rather than assuming intent.

3. Start with the nervous system, not the argument

A frightened or overloaded nervous system is less available for reasoning, experimentation and flexible problem-solving. Repeating nutritional facts, negotiating one more bite or explaining why the child "has to" eat may increase the amount of language and demand at the exact moment their capacity is lowest. Before trying to persuade, look at regulation: noise, smell, lighting, seating, time pressure, conflict, fatigue and whether the child feels watched. Sometimes the most useful first intervention is not a different food but a different state of nervous-system arousal.

4. Sensory load does not begin with taste

Eating starts before food enters the mouth. The child sees the packet, colour and shape; hears preparation sounds; smells cooking; notices steam, grease or crumbs; feels the chair, clothing and room temperature; anticipates the texture; and may already know that somebody is watching their reaction. A meal that appears simple to an adult can therefore contain dozens of sensory events. Parents can map which stages are difficult: shopping, unpacking, preparation, seeing food, smelling it, touching it, having it on the same plate, bringing it near the mouth, chewing or swallowing. That map gives far more useful information than simply recording "refused dinner".

5. Interoception: what is happening inside the body?

Interoception is the ability to notice and interpret internal sensations such as hunger, fullness, nausea, pain, thirst and anxiety. Some children experience these signals faintly; others experience them intensely but cannot identify what they mean. A child may say "full" when the sensation is nausea, "sick" when it is hunger, or "not hungry" when their stomach feels tight with anxiety. Rather than correcting the child, build curiosity: where is the feeling, when did it start, what makes it stronger or weaker, and what happens after an accepted food? Interoceptive differences are one reason the words used at the table may not tell the whole story.

6. The gut can change the whole eating experience

Constipation, reflux, abdominal pain, bloating, nausea, diarrhoea, early fullness and swallowing discomfort can all alter willingness to eat. ARFID and gastrointestinal problems can coexist, and the relationship may run in both directions: discomfort can increase restriction, while restricted or irregular intake can contribute to further gut symptoms. Persistent physical symptoms should not be dismissed as “just anxiety” or “just ARFID”. Parents can keep a neutral record of pain, bowel pattern, nausea, reflux, timing, food intake and medication to help clinicians identify patterns. A child may notice that eating leads to discomfort long before they can explain the mechanism.

7. Allergy, intolerance, sensory aversion and fear are not the same

A food allergy, non-allergic intolerance, gastrointestinal condition, sensory aversion and learned fear are different processes, although one child can experience more than one. Parents are often forced into an unhelpful choice between believing every symptom is a medical intolerance and being told that everything is behavioural. A better stance is: “I believe something felt wrong, and we need to understand why.” Acute allergic symptoms require appropriate medical action; recurrent physical reactions deserve assessment; sensory and fear-based responses also deserve support. Broad food exclusions should not be added casually when the child’s range is already narrow.

8. What happened the last time they ate it?

Food carries memory. Vomiting after a meal, choking, gagging, pain, a frightening allergic reaction or even an intense episode of nausea can change the meaning of a previously accepted food. The next encounter may trigger anticipation before a bite is taken. Anticipation itself can create nausea, throat tightness, gagging, muscle tension and an urge to escape, which then seems to prove that the food is unsafe. Parents may see a child who “suddenly decided” not to eat; the child’s nervous system may be responding to a learned prediction of danger.

9. School may be using up the capacity needed for dinner

Some children cope through the school day by masking distress, tolerating smells, navigating noisy lunch halls, managing social demands and ignoring body signals. When they arrive home, the eating difficulty can become more obvious because the effort of coping has depleted their capacity. This can create a misleading comparison: “They manage at school, so why not at home?” School and home are different contexts. Ask what was actually eaten, how much effort it took, whether the child felt safe and what the sensory environment was like. A child falling apart at home can be showing that home is the place where they finally cannot hold everything together.

10. The transition from school to food matters

Moving straight from a demanding day into questions about dinner can create another demand before the child has regulated. For some families a predictable decompression period, familiar drink or accepted snack, quieter room, change of clothes or reduced conversation makes later eating more possible. This is not a universal formula and should not replace nutritional assessment; it is an example of changing the environment around eating rather than repeatedly changing the child. Track whether certain transitions consistently precede difficult meals.

11. Sleep, fatigue and eating capacity

A tired child often has less tolerance for sensory discomfort, uncertainty and decision-making. Late meals may therefore be the hardest meals even when the child has eaten little earlier. Poor sleep can also affect appetite, mood and regulation. If dinner repeatedly collapses, consider the whole day: what time the child woke, what they managed at school, whether they are constipated or unwell, how much sensory demand they have carried and whether the meal is arriving after their coping resources are exhausted. Sometimes moving nutritional opportunities earlier is more effective than intensifying pressure at dinner.

12. Neurodivergence changes the context

Autistic and ADHD children may experience differences in sensory processing, interoception, attention shifting, routine, executive functioning and demand. Eating requires many hidden tasks: stopping an activity, recognising hunger, deciding what is possible, tolerating preparation, moving to the table, beginning, chewing and sustaining attention long enough to finish. What looks like “won’t” may include several points of “can’t yet without support”. Predictability, advance warning, visual routines, manageable choices and reduced sensory load can support access while longer-term flexibility is developed.

13. Food preparation can be part of the problem

A child may tolerate eating a food but not tolerate watching or smelling it being prepared. Frying smells, blender noise, steam, mixed ingredients, touching wet food or seeing a trusted product transferred into a different container can change the experience before the meal begins. Parents can ask whether the child needs distance from preparation, whether a door can be closed, whether an extractor fan helps or whether accepted food can be prepared before the child enters the kitchen. These environmental adjustments are information-gathering tools as well as practical supports.

14. Predictability can look like control from the outside

Brand loyalty, a particular plate, food not touching, exact cooking time or insistence on a familiar packet can be interpreted as the child controlling the household. In ARFID, predictability may be functioning as a safety system. The packet predicts taste; the plate predicts presentation; separation predicts that one disliked texture will not contaminate another. Flexibility can still be a long-term goal, but it is usually more useful to build it gradually alongside reliable nourishment than to remove predictability at the moment the child is most dependent on it.

15. Parent anxiety also enters the room

Parents are not neutral observers. When a child eats very little, the adult may arrive at dinner already frightened: calculating what has been eaten, remembering yesterday's refusal, worrying about growth, imagining another safe food disappearing and anticipating criticism from relatives or professionals. That fear can understandably produce hovering, questioning, bargaining, praise, counting or visible disappointment. None of this makes the parent the cause of ARFID. It does mean that supporting the parent's regulation can change the emotional environment in which eating happens.

16. The pressure audit

For one week, notice pressure without judging yourself. How often does somebody ask whether the child is hungry, comment on quantity, count bites, praise eating, bargain with dessert, compare with siblings, threaten consequences, discuss nutrition at the table or stare at the plate? Then choose one behaviour to reduce. Pressure can be subtle and loving; it often grows from fear. The purpose of the audit is not blame but information: if pressure falls, does the child become more communicative, stay at the table longer or show less anticipatory distress?

17. What to say instead

Try language that creates curiosity and safety: "You don't have to explain it perfectly." "Something about this feels difficult today." "Is it the food, your body, the room, or are you not sure?" "We can keep your safe option while we work this out." "I believe you noticed something." Avoid arguing that a food is identical, insisting the child cannot be full, or telling them that hunger will eventually force them to eat. The aim is not endless reassurance; it is communication that gives adults better information and the child less reason to defend their experience.

18. What not to make the child responsible for

Children should not carry the parent's fear about weight, growth or nutritional deficiency. They should not be asked to reassure adults that they will eat later, to explain every refusal perfectly or to prove that a symptom is real. The clinical team and adults hold responsibility for nutritional safety. The child can be involved in describing experience, identifying manageable foods and building goals appropriate to their age, but they should not have to solve the family's anxiety at the table.

19. Siblings and the wider family

ARFID affects siblings too. They may experience different meals, altered outings, cancelled restaurants or repeated conversations about food. They can become resentful or begin policing the child's intake. Explain that fairness does not always mean identical food rules. Set a family boundary that nobody comments on another person's plate. Grandparents and relatives may need a simple script: "We are following an ARFID plan. Please do not persuade, tease, reward or test them with food." Protecting the child from commentary can also protect family relationships.

20. Restaurants, parties and holidays reveal environmental barriers

A child may be more restricted away from home not because they are being difficult but because predictability disappears. Brands change, smells multiply, food touches, preparation is unseen and other people are watching. Taking an accepted food, checking menus, eating beforehand or choosing self-catering accommodation can be accessibility strategies. Participation matters. A child who can attend the birthday party without eating the party food may be making meaningful social progress while nutritional needs are met elsewhere.

21. Look at the pattern across a week, not one dinner

Single meals are emotionally powerful but clinically incomplete. Map seven days: sleep, school demands, bowel symptoms, medication, illness, eating opportunities, what was actually eaten, sensory load, emotional events and where eating was easiest. Patterns may show that mornings are consistently nauseating, after-school snacks are reliable, dinner fails after certain school days or constipation predicts restriction. This turns “every meal is a disaster” into specific questions that can be worked on.

22. Protect nutrition while you investigate

Looking beyond food does not mean ignoring food. If intake is inadequate, nutritional protection remains essential. Accepted foods may need to stay available while medical, sensory and psychological factors are explored. A paediatric dietitian familiar with ARFID can help assess energy, nutrient adequacy, fortification, supplementation and realistic priorities. Do not remove a nutritionally important safe food simply because it is processed, repetitive or contains sugar unless there is a clinically justified plan for replacement.

23. When professional assessment matters

Seek clinical review when the child’s range is progressively narrowing, weight or growth is concerning, nutritional deficiencies are suspected, fluids are inadequate, pain or vomiting persists, swallowing is difficult, constipation is significant, the child depends heavily on supplements, school or social life is impaired, or family life is increasingly organised around avoiding food crises. Urgent symptoms such as severe dehydration, fainting, acute allergic reaction, marked weakness or significant breathing/swallowing difficulty require urgent medical attention according to local guidance.

24. Questions to take to the GP, paediatrician or dietitian

Ask: Could pain, reflux, constipation, allergy, gastrointestinal disease, swallowing difficulty, medication or another medical factor be affecting intake? Is growth following the expected pattern? Are nutritional deficiencies possible despite the child’s appearance? Which current foods are carrying important nutrients? What symptoms should trigger urgent review? Would structured eating opportunities, fortification or supplementation be appropriate? If physical investigations are reassuring but the child remains frightened or restricted, what ARFID-specific support is available?

25. Questions for school

What does the child actually eat rather than what is sent? How noisy and smelly is the lunch environment? Is there enough time? Are adults commenting on intake? Can the child access a quieter place, familiar food or a discreet prompt? What happens if the planned lunch becomes unsafe? Is the child using all their coping capacity during the day and arriving home depleted? A useful school plan describes practical support rather than simply instructing staff to encourage the child to eat more.

26. From My Side of the Table

From my own experience of ARFID, the food on the plate has often been only the visible end of something much bigger. What another person sees as a simple bite can carry sensory information, body memories, fear, physical reactions and the knowledge that everybody is waiting to see what you do. When adults focus only on getting the food eaten, the person inside the experience can disappear. What helped me understand ARFID more deeply was recognising that the behaviour has a history and a reason, even when that reason is not immediately obvious to anybody else.

27. A child may know before the parent knows

One of the most important things I want parents to hold onto is that a child may notice something about their body or a food long before they have the vocabulary to explain it. They may know that a texture has changed, that a food makes them feel wrong, that their stomach behaves differently afterwards or that a situation feels unsafe. That does not mean every interpretation will turn out to be medically correct. It means the observation deserves curiosity. “I believe you felt something; let’s work out what it was” is very different from “there is nothing wrong with it.”

28. The Look Beyond the Plate method

When a meal becomes difficult, work through five areas. BODY: hunger, fullness, nausea, pain, constipation, reflux, illness, medication and fatigue. SENSES: smell, texture, temperature, appearance, sound and food touching. NERVOUS SYSTEM: fear, previous vomiting or choking, overload and anticipation. ENVIRONMENT: noise, people, time pressure, preparation smells, school or restaurant context. COMMUNICATION: what the child is doing or saying and what adults are doing in response. You do not need an answer in every box. The method stops the plate becoming the only evidence considered.

29. Change one variable at a time

When parents are desperate, it is tempting to change the menu, schedule, seating, rules and rewards all at once. That makes it impossible to know what helped. Choose one hypothesis and one small adjustment. If smell appears to be the problem, reduce cooking odour while keeping the food and timing stable. If transition is difficult, add a warning and decompression period without changing everything else. If constipation is suspected, take that pattern to the clinician. Small controlled changes produce better information than repeated crisis-driven reinvention.

30. What progress can look like before the diet expands

Progress may first appear as the child staying in the room, naming a body sensation, recovering more quickly after a difficult meal, accepting that a safe food is present beside an unfamiliar one, eating more reliably at one time of day, using a backup food without panic, tolerating school lunch with an adjustment or trusting a parent enough to say “I don’t know why, but it feels wrong.” Variety and volume matter, but they are not the only early signs that the system is becoming safer and more flexible.

31. The family plan moving forward

Write down the child’s current reliable foods, backup foods, common sensory triggers, physical symptoms, easiest eating times, difficult environments, useful language, school adjustments, professional contacts and individual red flags. Decide which adults need the plan and what they should do when eating deteriorates. Review it as the child changes. A plan turns ARFID from a daily emergency into a shared framework. It also reduces the likelihood that a frightened adult will have to invent a response in the middle of a difficult meal.

32. Message to parents

Looking beyond the dinner table is not about finding somebody to blame. It is about refusing to reduce a complex eating disorder to a plate of food and a battle of wills. Your child’s eating may be shaped by their sensory world, body, gut, nervous system, development, memories, environment and ability to communicate what they feel. You can protect nutrition and still be curious. You can seek medical answers without dismissing psychological learning. You can set boundaries without turning food into punishment. The behaviour is what you can see. The deeper work is understanding what it is trying to tell you.

Evidence and further reading

Current ARFID literature describes restriction as commonly associated with sensory sensitivity, low interest in eating and/or fear of aversive consequences, with these drivers frequently overlapping. Recent UK qualitative research with parents highlights contextual stressors, sensory sensitivities, the burden on families and the importance of developing practical toolkits. Research also documents overlap between ARFID and gastrointestinal symptoms and supports multidisciplinary, caregiver-involved approaches. Useful starting points for professional reading include work by Rachel Bryant-Waugh and colleagues on ARFID assessment and treatment, the PARDI diagnostic framework, CBT-AR literature by Thomas and colleagues, family-based treatment research, and current Journal of Eating Disorders publications on caregiver experience. For parents, specialist eating-disorder services and paediatric dietitians can help translate evidence into an individual plan. Evidence in ARFID is developing; no single mechanism or intervention fits every child.