

The Food I Could Not Simply Eat

From My Side of the Table to Yours

Inside this guide

An 18-page resource combining Maggie's personal reflection with practical guidance for parents and carers supporting a child with ARFID.

- Maggie's lived experience: childhood food difficulties, safe foods, long periods of restricted eating, and the understanding that came with a later autism and ADHD diagnosis.
- What may sit beneath eating distress, including sensory experiences, fear, low interest in food, body signals and possible health needs.
- Ways to make mealtimes safer, more predictable and less pressured while keeping familiar foods available.
- How to protect trust, communicate with care, repair difficult moments and approach food exploration only with the child's agreement and appropriate support.
- Guidance on health concerns, working with clinicians and school, supporting family life and caring for parent wellbeing.
- A practical appointment and home-support plan, plus current UK information and further reading.

The Food I Could Not Simply Eat

From My Side of the Table to Yours • My ARFID reflection and a guide for parents

MY SIDE OF THE TABLE

Before I had the words

This is my lived experience. It is not a template for every person with ARFID, and I cannot speak for every child or adult who struggles to eat. I offer it because a story can sometimes make room for understanding before someone has the words to explain what is happening.

For much of my life, I did not know how to describe my relationship with food. I only knew that eating did not feel simple, natural or safe in the way other people seemed to expect. What I now understand as Avoidant/Restrictive Food Intake Disorder, or ARFID, began for me when I was around nine.

People often talk about eating as if it is one straightforward action: sit down, choose, take a bite, swallow. My experience could involve fear, sensory overwhelm, physical discomfort, uncertainty and a body that seemed to refuse what my thinking mind knew I needed. I was not trying to become thinner. This was not a diet, a performance or a way to control my shape. It was a genuine difficulty managing food.

A child may not have the language for texture, smell, temperature, fear, fullness, nausea, pain or the way a food changes in the mouth. They may only know that the plate feels impossible. Adults see the plate. The child lives through the whole experience of trying to approach it.

When I look back, I feel tenderness for the child I was. She was not being difficult. She was coping with reactions she could not explain. The question I wish someone had asked is not, 'Why won't you just eat?' It is, 'What is making this hard for you, and what would help you feel safer?'

I have had to learn that a difficulty can be real even when another person cannot see it. A child may look quiet at the table while working very hard to manage smell, uncertainty, fear or the physical sensation of swallowing. They may also be too young, tired, frightened or overwhelmed to explain. Not having an explanation ready does not mean the child is making it up.

This reflection is not asking parents to accept every limit without question. It is asking us to begin with respect. When a child believes that an adult will listen and will not trick them, there is more chance they will tell us when something changes or when their body feels unwell. That honesty can help families and professionals make a safer plan.

A child may read an adult's face before they hear the words. If you feel panic rising, try to soften your expression, lower your voice and pause the conversation. You can return to the practical concern later with another adult or a clinician. A calm moment does not solve ARFID, but it can help the child experience you as someone who is still safe to approach.

A note to the reader: this first section is Maggie's personal reflection. The parent guidance that follows offers ideas to consider alongside the child and with appropriate health professionals.

MY SIDE OF THE TABLE

When eating became survival

There were periods when my range of safe foods became very small. At different times, familiar foods such as white toast and jam, smooth soups, or a particular combination of foods were among the few things I could manage. A safe food was not a bad habit to be stamped out. It was a bridge through a meal, a day, or a difficult period.

Between the ages of twenty and thirty-seven, I went through long stretches when I ate very little. From the outside, someone might see a meal missed, a plate left, or a choice they could not understand. From the inside, it could feel like being caught between needing nourishment and a nervous system sounding an alarm.

Familiarity mattered. Texture, smell, temperature, appearance and predictability could change whether I could approach something. A small difference that another person might barely notice could make a food feel entirely different. Pressure did not make my world of food larger. Usually, it made it smaller.

There can be grief in this experience: grief for the ease other people seem to have, for shared meals that become complicated, or for the years spent thinking the problem was a personal failure. There can also be shame because eating happens in public. Questions may be kindly meant, but when every mouthful is watched, the table can stop feeling like a place of connection and start feeling like a test.

I want parents to know that a familiar food may be helping their child get through today. That does not mean the family should ignore nutrition or health. It means that removing the one food a child can manage can increase fear and reduce access to nourishment. Safety and clinical support can sit alongside one another.

Some of the food combinations I managed changed over time. At one point, familiar foods could include cottage cheese with brown sauce, fried bread and egg yolk; later, I became intolerant to some foods. I mention this because a food history can be complicated and can change. A parent may remember a food that once worked, while the child now finds it difficult or their body no longer tolerates it. What mattered was not whether the food looked ordinary. What mattered was what I could manage then.

A family may be tempted to celebrate each safe food as proof that the problem is over. Please leave room for change in both directions. An illness, a different brand, a new place or a difficult day may alter what feels possible. The useful question is not 'Why could you eat it yesterday?' but 'What is different for you today, and do we need health advice?'

For a parent, it can be hard to see a safe food repeated day after day and worry that the child's diet will never widen. Keep that fear in the adult space while you arrange assessment. Make a note of what is accepted and what is not tolerated, and bring it to the health professional. Let the child know that the familiar food is not being taken away as a test.

A safe food can be a lifeline. Keep health needs in view, and do not make a child earn access to foods they can currently manage.

MY SIDE OF THE TABLE

The whole person at the table

I was diagnosed as autistic and with ADHD at fifty. That understanding helped many parts of my life fall into place. My sensory experiences, need for predictability, difficulty noticing or responding to body signals, and exhaustion when overwhelmed were not separate from eating. They belonged to the same whole person.

For some people, food difficulty is strongly connected to sensory qualities. For others, fear follows a frightening experience such as choking, vomiting or becoming unwell. Some people have little interest in eating or find it hard to notice hunger. Many experience a mixture. Physical health, pain, reflux, allergies or intolerances, medication, anxiety, fatigue and earlier experiences can also matter. No single explanation fits everyone.

Being neurodivergent does not automatically mean someone has ARFID, and ARFID does not look the same in every autistic or ADHD person. A useful starting point is to be curious about this person: what happens before, during and after eating? Which parts are predictable? What does their body notice? What makes things easier or harder?

I may not always have been able to name hunger, fullness or discomfort quickly. A person might realise they need food only when they are already exhausted or shaky; another may experience fullness after a small amount. A busy, noisy, rushed or unpredictable day can also use up the energy needed to eat.

Seeing a whole person changes the conversation. Instead of judging a plate, we can notice sensory load, body signals, timing, stress, access, health and the person's own explanation. That is not a shortcut to a diagnosis. It is a more respectful way to begin understanding.

Body signals are not always clear or timely. Hunger, fullness, nausea, thirst and stress can be hard to distinguish, especially when a person is tired, busy or overwhelmed. A child who does not ask for food may not be choosing to go without it. A child who says they are full may be describing a real sensation, even if an adult thinks the portion was small.

You can gently make body awareness easier without turning it into a quiz. Offer regular, predictable opportunities for food and drink; use simple choices such as 'Would something to drink help?'; and accept that the child may need time to notice. If the pattern is affecting health, discuss it with a clinician rather than relying on reminders alone.

A practical family question can be: 'What part of eating costs you the most energy?' The answer may be planning, remembering, deciding, tolerating the room, managing the smell or getting through the first bite. An adjustment to one part of the task can matter. If body signals or intake are concerning, include those details in the clinical assessment too.

Curiosity is not a substitute for assessment. It is a better beginning for conversation.

MY SIDE OF THE TABLE

What helped, and what did not

Being told to 'just try it', having food withheld as a consequence, being surprised by hidden ingredients, being compared with someone else, or being praised for eating what another person could not would have made trust harder. Even encouragement can feel like pressure if everyone is waiting for the next bite.

What helped was safety: being believed, having some choice, knowing a familiar food would be available, and being allowed to move at a pace my nervous system could tolerate. It helped when progress was not measured only by swallowing something new. Looking at a food, learning about it, having it nearby, tolerating its smell, or preparing it can all be meaningful steps if the person experiences them as manageable.

I needed people to understand that intention and impact can differ. Someone may be trying to help when they comment on a portion or ask for one more bite. The person eating may experience that attention as scrutiny. A calm, private conversation away from the table is usually kinder than a public negotiation over food.

Support must also respect nutritional and medical needs. Compassion does not mean ignoring risk. It means addressing risk without humiliation and involving the person in decisions as much as possible. A GP, paediatrician, registered dietitian or appropriately experienced eating-disorder service can help assess what is happening and what support is needed.

I cannot promise that every change will feel easy, or that one approach will work for everyone. I can say that being taken seriously matters. Trust gives a person a reason to stay in the conversation.

Encouragement is complicated because people use the word to mean many things. A quiet offer can communicate care. Repeated requests, countdowns, bargaining or an audience can communicate that the child's 'no' will not be respected. If the child has asked you not to comment, the kindest encouragement may be to stop drawing attention to the food and be present in another way.

Adults can agree privately on a shared response before meals, so one caregiver is not pressuring while another is trying to reassure. Consistency does not mean forcing the child through a plan. It means the adults use honest language, keep agreed safe foods available, and know whom to contact if intake or health changes.

There is no need to persuade a child that the food is safe by telling them how it tastes to you. Your experience of it is not their experience. You can describe it truthfully if they ask, then leave space for them to decide whether they want any contact with it. Trust depends on children being able to rely on what adults say about food.

Safety is not the opposite of progress. For many people, it is what makes any next step possible.

MY SIDE OF THE TABLE

The reflection I carry forward

Living with ARFID has shaped the way I work as a psychotherapist and coach. It has taught me that behaviour has a context. What looks confusing from the outside may be a person's best attempt to stay safe with the understanding and resources available to them at that time.

I no longer look at my younger self through the language of failure. I see resourcefulness: a child, and later an adult, managing without the explanation I have now. I also recognise the sadness of wondering how different those years might have felt if somebody had understood sooner. Both truths can sit together. A person can be proud of surviving and still wish they had been better supported.

Recovery and progress do not have to mean eating exactly like everybody else. They may mean improved safety, adequate nourishment, less fear, more flexibility, better self-understanding, or a life that is not organised entirely around avoiding distress. What progress looks like must be individual, humane and realistic, and it must not replace medical care where that is needed.

If you recognise yourself or someone you love in my words, you are not failing at something simple. Your experience deserves to be taken seriously. Start with safety. Start with curiosity. Start with one manageable step, agreed with the person, and let that be enough for today.

This is the point where I turn from my side of the table towards yours. I cannot tell you exactly what your child feels. I can ask you to make space for the possibility that their experience is very different from what you see.

My work with people is also shaped by remembering how easily distress can be mistaken for defiance. That does not mean every response has one hidden cause, and it does not mean a parent must be a detective at every meal. It means that a behaviour is a clue to context. A child may be communicating through avoidance because words are not available or because previous words were not heard.

There may be anger, frustration or grief in the parent's story as well. You might be mourning the ease you hoped mealtimes would have, or the family routines you have had to change. Let that be true without making the child responsible for it. You can seek support for your own feelings and still stay alongside your child.

I hope parents can hold both compassion and realism. I do not want a child to be shamed into eating, and I do not want anyone to ignore health concerns. The way through is to ask for help early, share accurate information, and build a plan that keeps the child's dignity beside their physical needs.

From my side of the table to yours: let understanding arrive before instruction.

WALKING BESIDE YOUR CHILD

What ARFID can mean for a family

Avoidant/Restrictive Food Intake Disorder describes a pattern of avoiding or restricting food that can affect a person's nutrition, energy needs, physical health, growth or everyday life. Difficulties may relate to sensory qualities, low interest in food, fear of consequences such as choking or vomiting, or a combination. A qualified professional must assess the child; a checklist or one difficult meal cannot diagnose ARFID.

ARFID is not simply 'being fussy', and it is not defined by weight or shape concerns in the way some other eating disorders are. A child can look outwardly well and still be struggling with limited intake, nutritional risk, anxiety or social participation. Equally, not every selective eater has ARFID. The degree of impact, the child's history and possible medical explanations all matter.

Parents often carry two realities at once: they want to protect their child from fear and distress, and they worry about nourishment, growth and health. You may feel exhausted by the planning, anxious at mealtimes, guilty when your child eats very little, or isolated when family members misunderstand. Those feelings do not make you a bad parent. They are signs that the situation is asking a lot of you.

Try to keep the child's difficulty separate from their character. 'She is refusing' describes what you see; 'she may be frightened, overwhelmed, in pain, not hungry, or unable to manage this food today' leaves room to understand why. You do not need to know the answer immediately. You do need to take ongoing restriction seriously and seek advice when health, growth or daily life is affected.

There is room for both compassion and action: listen to the child, keep familiar foods available, and involve health professionals when needed. These are not competing choices.

A professional assessment may explore how long the difficulties have been present, the reasons for avoidance, nutritional intake, physical health, growth and the effect on daily life. It may also consider other explanations, including pain, swallowing problems, gastrointestinal symptoms, medication effects, anxiety, sensory differences, food allergy or access to adequate food. The assessment belongs with a qualified practitioner who can consider the whole picture.

Parents sometimes worry that asking for help will mean their child is immediately labelled or forced into a treatment they cannot manage. You can say this to the clinician. Ask what will happen, what choices your child will have, how distress will be handled, and what information will be shared. A good conversation makes room for questions and explains why any proposed checks or treatment matter.

If you are unsure whether to seek help, describe the effect rather than waiting to be certain of a label: 'My child is missing meals, is frightened by food, and cannot manage lunch at school.' A GP can consider the wider picture and advise on assessment or referral. Ask for the next step in writing if the pathway is confusing.

ARFID is a clinical possibility to discuss with a professional—not a label to apply from a distance.

WALKING BESIDE YOUR CHILD

Look for the difficulty underneath

Instead of asking only how many foods your child eats, look at the whole pattern. Do they avoid foods because of texture, smell, temperature, colour, brand, presentation or mixed ingredients? Are they worried about choking, vomiting, pain, contamination or being unwell? Do they often forget to eat, struggle to notice hunger, feel full quickly, or say that food feels like too much effort?

Notice the effect on daily life. Does eating take a long time? Does your child skip food at school or when away from home? Have family outings, parties, trips or friendships become difficult because food is involved? Has there been a change in growth, energy, concentration, mood, bowel habits or general health? These details can help a clinician understand the picture.

Keep observations factual and private. If it helps, jot down what was offered, what the child could manage, the setting, any symptoms or worries they mentioned, and what made the situation easier. Avoid turning the record into a scorecard or discussing it in front of your child as proof that they have failed. The purpose is to communicate useful information to the care team, not to monitor every mouthful.

Ask your child what words they want you to use. 'Safe', 'familiar', 'hard today' or 'not manageable' may feel better than 'good', 'bad' or 'naughty' foods. Some children will explain a lot; others may need time, pictures, choices or simple questions. Do not press for an explanation while they are distressed.

A child may not know why eating is hard. Their uncertainty is still real information. You can say, 'You don't have to explain it perfectly. I believe that something is difficult, and we can work it out together.'

Try noticing patterns without assuming they are deliberate. Is eating harder after school, during illness, in a particular room, with unfamiliar people, or when the meal changes unexpectedly? Does your child cope better when foods are separate, when they can see packaging, or when they know there is no requirement to taste? Patterns can guide support, but they do not prove a cause by themselves.

If your child cannot answer a broad question, make it easier to respond. Offer two or three possibilities, a simple scale, pictures, or a chance to point: 'Is it the smell, the texture, the worry, or something else?' Include 'I don't know' and 'none of these' as valid answers. Do not keep asking once the child signals that the conversation has become too much.

A useful distinction is between exposure to a food and pressure to eat it. A food can be present without being a demand, if the child agrees and can leave it untouched. The child should know exactly what is happening. If even its presence feels unsafe, listen to that and ask the clinical team how to proceed.

A simple observation record can help a health appointment. It should never become a mealtime scoreboard.

WALKING BESIDE YOUR CHILD

Your worry has a place too

Parents may be frightened by how little a child eats, worried that a safe-food range will shrink, or tired of arranging every outing around food. You may hear advice from relatives, school staff or strangers that makes you feel judged. It is possible to love your child deeply and still feel angry, depleted, helpless or resentful of how much space the problem takes up.

Try to find a separate place for adult worry. Speak with a trusted person, GP, counsellor, parent group or professional who understands eating difficulties. At the table, the child should not have to carry the full weight of your fear. This does not mean pretending you are calm all the time. It means seeking support so that fear is not expressed as pressure directed at the child.

Avoid telling the child they are frightening you, ruining a family meal, making everyone late, or causing financial strain. Those may be real pressures for a parent, but they can land as blame. You can share an age-appropriate, contained truth—‘I am working out how to help, and the adults are getting advice’—without asking the child to soothe you.

If you have used pressure because you were scared, you can repair. Try: ‘I’m sorry I pushed you at dinner. I was worried, but it was my job to handle that worry. I want to understand what happened for you. Your familiar food will still be available while we get help.’ A repair does not erase the past, but it can make the next conversation safer.

You are allowed to need help too. Supporting your own wellbeing is part of making support sustainable for your child.

Worry can also be practical: the cost of foods that are accepted, preparing different meals, missing work for appointments, or the uncertainty of waiting for help. These pressures deserve recognition. Ask services whether they know of carer support, benefits advice, school support or local peer groups. Let another trusted adult take a specific task when possible, such as contacting school or keeping appointment notes.

Set a boundary with unsolicited advice. A simple response can be enough: ‘Thank you for caring. We are following advice that fits our child’s needs. Please do not comment on what they eat.’ You do not owe extended explanations to people who are not part of the child’s care. Protecting your child’s privacy is part of supporting them.

Your capacity matters. If meal planning is taking over every hour, choose what can be simplified safely and ask for help with the rest. Another adult can prepare a known meal, contact a service, or accompany you to an appointment. You should not have to prove that you are coping before you are allowed support.

Parent reminder: your fear matters. Find adult support for it so the child does not have to carry it alone.

WALKING BESIDE YOUR CHILD

Make the table safer before changing the food

The eating environment can make a difficult task more or less manageable. Ask your child what helps: a quieter room, less conversation, a predictable place to sit, dimmer light, familiar cutlery, a smaller serving, foods kept separate, or permission to eat at a different time. A small practical adjustment may reduce the work of getting to the food.

Whenever possible, let your child know what will be served and how it will look. Keep ingredients visible and do not disguise, blend or substitute foods without telling them. Separate components if mixed textures are difficult. Consider temperature, smell, packaging, plate colour and whether food touches. A child may need a familiar brand or preparation to feel able to eat.

Offer manageable choices that do not turn into a test: 'Would you like this here or on the side?' 'Would you prefer to eat now or after you have settled?' 'Would you like me to stay or give you space?' If every option feels impossible, reduce demands and return to a reliable source of nourishment while you seek guidance.

Try to make family connection larger than eating. If your child cannot manage the family meal, they can still sit with you, arrive afterwards, share conversation, or join another part of the routine. Do not make togetherness conditional on finishing food. At the same time, avoid isolating the child as the default; ask what arrangement feels least difficult and revisit it together.

The aim is not a perfectly calm table. It is a setting where the child is not being watched, tricked, shamed or hurried, and where health needs are being addressed by the right people.

A predictable routine can help without becoming rigid. Tell your child roughly when food will be available, what the options are, and what will happen if plans change. If the family is eating somewhere unfamiliar, show a menu or explain the setting in advance when that helps. Keep the plan flexible enough to respond if the child becomes unwell or the expected food is not available.

Some children manage better with a smaller amount visible and more available nearby. Others need to see the full portion or prefer food served in a particular way. Ask rather than assuming. Avoid making a child sit at the table for a fixed period after they have become distressed. A break can preserve connection and make it possible to return to the routine later.

Some adjustments may help one day and not another. Keep the conversation open: 'Would you like the same set-up today, or should we change something?' A practical support is not a contract the child must follow forever. It is an option that can be reviewed as their needs, health and confidence change.

Predictability, choice and a familiar option can reduce pressure without asking you to ignore health concerns.

WALKING BESIDE YOUR CHILD

Words that protect trust

Food talk can become intense very quickly. Keep your voice neutral and your questions brief. Instead of 'You have to eat this', try 'I've put your familiar food here. You can tell me if something about the meal is making it harder.' Instead of 'One more bite for me', try 'Would you like help, a break, or for me to stop asking?'

Avoid commenting on body size, portions, speed, bite counts or what another child eats. Do not call foods clean, junk, naughty or disgusting. Praise can feel like a spotlight if it is tied to eating. If your child takes a step they chose, you might say, 'Thank you for telling me what you were comfortable with,' or simply follow their lead and let the moment pass.

Do not hide ingredients, pretend a food is something else, threaten consequences, remove the only food the child can manage, or make dessert and activities conditional on eating. These approaches can damage trust, increase anxiety and make it harder for your child to tell you what is happening. If a health professional suggests a structured feeding plan, ask how it will be explained to your child and how safety foods and distress will be handled.

A calm boundary can still exist. You can say that food will be served at a predictable time, while keeping an agreed safe option available and avoiding a battle. If a meal is not going to work, end the negotiation kindly and consult the child's care team about a plan that protects nutrition and reduces distress.

If you slip into pressure, return to connection. 'I got anxious and started asking too many questions. I'm sorry. I'm listening now.' Repair is a skill, not proof that you have failed.

If you need to talk about health or nutrition, choose a private time away from eating and use factual, non-shaming language. 'The nurse would like to check how your body is doing because eating has been difficult' is clearer than 'You are not eating properly.' Tell the child what will and will not happen at an appointment. Do not promise that something will not happen if the clinician may recommend it; instead, find out together and explain honestly.

Parents can ask relatives and other caregivers to follow the same approach. Share a short written agreement: no food comments, no hidden ingredients, safe food remains accessible, and concerns go to the parent rather than becoming a discussion over the child's plate. This lowers the chance that the child faces a different rule at every table.

Families can agree a neutral phrase that ends pressure, such as 'We have a plan for this.' Use it when relatives start commenting or when the meal begins to feel like a negotiation. Then redirect the conversation. The child should not need to defend their eating in order to be treated with respect.

Trust grows when the child can tell the truth about food without expecting punishment or surprise.

WALKING BESIDE YOUR CHILD

Exploration should be shared, gradual and supported

Some children want to become more comfortable around new foods; others are not ready, or have medical and nutritional priorities that need attention first. Do not set a target for your child without them. Ask what they would like to be easier: eating at school, tolerating a smell, joining a family meal, or feeling less frightened around a particular situation.

If the child is willing and the care team agrees, exploration can happen in steps. A person might choose to hear about a food, see it, have it nearby, touch it, smell it, prepare it, or taste it. These are examples, not a required ladder. A step only counts as useful if it is chosen, manageable and relevant to that child. They can pause or stop.

Keep the familiar food available during exploration. Avoid making a new food the price of access to the safe one. Tell the truth about what is on the plate and ask permission before changing a preparation. If the child becomes distressed, stop and return to safety; do not treat distress as a reason to push harder.

Do not conduct exposure work as a home treatment plan when the child has significant restriction, fear, trauma, pain, swallowing difficulty, allergy risk or nutritional compromise. A qualified professional should assess what is appropriate and guide treatment. A dietitian can help with nutritional adequacy; other practitioners may support anxiety, sensory needs or feeding skills, depending on the child's needs.

Progress might be a child asking for help, explaining a sensory boundary, eating enough of a familiar food, or joining a social activity. Those steps can matter even when the list of accepted foods has not changed.

Consent matters at every step. A child may agree to look at a food but not to smell it; they may want to stop after the first step. Respecting that choice helps the child learn that adults will not turn a small yes into an unwanted bigger demand. If an activity repeatedly ends in panic or shutdown, pause and speak with the clinician about whether the approach, timing or goal is right.

Keep exploration distinct from nutrition. A tasting activity does not prove that the child has eaten enough, and not tasting does not mean the child has failed. Nutritional adequacy should be reviewed by an appropriate health professional. Do not use a home 'food ladder' as a substitute for assessment when there are concerns about growth, nutrition, pain, swallowing or significant distress.

When choosing any next step, ask whose goal it serves and what the child thinks about it. If the only reason for a tasting task is to reassure adults, pause. If the child has a goal of being able to eat during a school trip, discuss a supported plan with the care team. A meaningful goal should connect to the child's life and wellbeing.

Ask: 'Would you like to explore this, and what would make it feel safer?' A genuine 'no' needs to be heard.

WALKING BESIDE YOUR CHILD

Health comes before a food challenge

Restrictive eating can affect energy, growth, nutrition and physical health. You do not have to work out the cause alone. Contact your child's GP or paediatrician if eating has become increasingly limited, meals are frequently missed, your child has pain or difficulty swallowing, energy or mood has changed, growth is a concern, or social and school life are being significantly affected.

Tell the clinician what you observe and what the child says. Bring a brief history: when the difficulty began, foods or situations they can manage, symptoms, changes in intake, any weight or growth concerns already known to the clinician, medication, allergies or intolerances, and the effect on everyday life. You can ask what medical causes need to be considered, what checks are appropriate, and which service has experience with ARFID.

Seek urgent medical advice if your child is unable to keep fluids down, is becoming dehydrated, faints, seems unusually weak or confused, has severe pain, or you are worried about a rapid deterioration. If it feels like an emergency, use emergency services or attend an emergency department. In England, NHS 111 can advise; Cornwall's child ARFID service page also directs families to the GP for immediate concerns and to 999 or emergency care in an emergency.

Do not wait for a child to look visibly unwell before asking for help. Some difficulties are longstanding and can be missed because the child is managing quietly. Likewise, avoid deciding that every symptom is caused by ARFID. Pain, swallowing problems and other health concerns need appropriate assessment.

Medical care and emotional safety belong together. A clinician should explain why checks or treatment are needed in words the child can understand and involve them as much as possible.

Write down what is different from your child's usual pattern, not only what is different from another child. A sudden change, repeated vomiting, new pain, swallowing difficulty, marked tiredness, dizziness, fainting, reduced urination or a child becoming difficult to rouse deserves medical attention. The right urgency depends on the child and the symptoms; when unsure, call the GP or NHS 111 for advice. If the child seems acutely unwell, use emergency care.

A clinician may need to assess growth and physical health over time, not from one number alone. Ask what measures are being used, what they mean, and when you should follow up. Do not start supplements, restrictive diets or major food changes without suitable advice, particularly if the child has medical conditions, allergies or a very limited intake.

A health appointment should not become a test of whether the child can prove they are ill enough. Explain the reason for each question or check. If your child becomes distressed, ask for a pause and help them understand what is happening. If a professional is not experienced with ARFID, ask them to consult or refer to someone who is.

If you are worried about immediate physical safety, seek urgent medical help. This guide cannot assess your child's risk.

WALKING BESIDE YOUR CHILD

Working with your child's support team

A child may need more than one kind of support. Depending on the assessment, the team might include a GP or paediatrician, a registered dietitian, a mental health professional, a specialist eating-disorder service, an occupational therapist, or a speech and language therapist. The right mix depends on the child's health, sensory experience, anxiety, feeding or swallowing skills and local service availability.

Ask professionals to explain their roles and how they will work together. Useful questions include: 'Who is monitoring physical health and growth?' 'Who can help us understand the nutritional picture?' 'What is the plan if intake worsens?' 'How will my child's sensory needs and views be included?' 'What should school do?' 'Who do we contact between appointments?' Keep names and agreed next steps in one place.

If your child is anxious about appointments, tell them what will happen in advance. Ask whether they can meet the clinician before discussing food, bring a familiar object, take breaks, use written or visual questions, or have time alone with a trusted adult. Explain honestly what will be asked; do not surprise them with weigh-ins or examinations. If a measure is needed, ask how dignity and consent will be protected.

A short written summary can help when you repeat the story. Include the child's own words, strengths and interests—not only problems. If the child does not want to speak, offer another way to communicate. Their voice can be heard through choices, written notes, drawings or a trusted adult, while keeping them involved at a level that feels manageable.

If the first service cannot help, ask where the referral should go next and what support is available while you wait. Availability differs across the UK; a lack of a local specialist service does not mean the problem is unimportant.

You can ask for a named contact and a written plan. It should say who is monitoring the child's physical health, what to do if symptoms worsen, how to contact the team, what school needs to know, and which professional will coordinate the next steps. If no one can answer a question, ask who can. A clear handover prevents parents from having to retell the story without knowing what happens next.

If you disagree with a proposed plan, say what worries you and ask for the reasoning. You can request that the child's own view is heard, that sensory or communication needs are accommodated, and that the team explains possible benefits and risks. Partnership does not require you to pretend everything is fine. It means concerns are discussed openly and decisions are made with the child's needs in view.

When professionals use different language or recommend different steps, ask them to communicate with each other and identify who is coordinating care. You can ask for a meeting that includes the family and, where appropriate, school. Keep the child's voice central while avoiding asking them to resolve disagreements between adults.

A referral is a start, not a promise of instant answers. Ask what to do while waiting and who owns the next step.

WALKING BESIDE YOUR CHILD

School, family, outings and ordinary life

Food difficulties follow a child beyond the kitchen. A school day may involve noise, short lunch breaks, unfamiliar smells, fear of being watched or no access to a reliable option. With your child's agreement, share only the information school needs to keep them safe and included. Ask for a named adult, a private way to request help, suitable time and space to eat, access to agreed foods, and a plan for trips or changes in routine.

Relatives may need a simple explanation: 'Eating is difficult for them for real reasons. Please don't comment on their plate or ask for a taste. We'll let you know what helps.' You do not need to convince everyone or disclose every detail. Set a boundary if discussion turns into blame or comparison.

For outings, plan with your child rather than around them without their input. Check what food will be available, bring an agreed familiar option where possible, identify a quieter place, and make an exit plan that does not shame them. Let the child choose whether to attend and what support they want. A successful outing does not have to include eating the host's food.

Siblings may need reassurance that the family's attention is not a measure of who matters most. Explain in age-appropriate terms that one child is having a hard time with food and adults are getting help. Make time for siblings and protect them from being turned into food supervisors or judges.

Try to keep ordinary pleasures in the week that are not about treatment: stories, games, walks, music, shared interests or quiet time. A child is more than their eating. Your relationship deserves places where food is not the main subject.

Ask school to avoid weighing, praising or questioning the child publicly, and to tell you privately about patterns that may affect health or participation. Agree how staff will handle lunch when the familiar food is unavailable, what happens on trips, and how the child can leave a noisy space. If the child has an education or healthcare plan, align food-related adjustments with the wider support already agreed.

Family gatherings can be planned with a host who is willing to help: bring a familiar food, keep ingredients clear, and agree that no one will comment. If this is not possible, it is reasonable to shorten the visit or skip the meal portion. Inclusion should not require the child to endure a distressing food situation to prove they are trying.

Some days the plan will be disrupted by illness, a substitute teacher, a late journey or a family emergency. Decide in advance which familiar option can travel with the child and whom they can tell if it is unavailable. A backup plan can reduce the feeling that one unexpected change will make the whole day impossible.

A useful school plan focuses on access, dignity, safety and participation—not on persuading the child to eat.

WALKING BESIDE YOUR CHILD

When a meal goes wrong

Hard meals will happen. A child may refuse a food they accepted yesterday, become overwhelmed by a change, or be unable to explain what is wrong. Try to lower the demand before trying to solve the whole problem. Use fewer words, reduce noise or attention, offer the familiar option, and ask whether they want space or company.

Afterwards, do not conduct a long post-mortem while everyone is upset. When calm returns, ask one gentle question: 'Was anything especially hard today?' If the child does not want to talk, let them know the door is open. Share urgent health information with the care team, but avoid turning the next meal into a test of whether the last one was resolved.

A repair can be specific: 'I changed the meal without telling you. I can see that made it harder. I'm sorry. Next time I'll tell you first.' Or: 'I kept asking after you said stop. I'll try to listen sooner.' Do not add 'but you need to understand' to the apology. The child can hear your explanation later, when trust is steadier.

Notice what helped, without making the child responsible for managing the adults. Perhaps a quieter room, a smaller portion, or a familiar food beside the meal made it more possible. Share these observations with the child and care team. Ask the child whether they want to try the same support again.

If the difficulty is recurring or getting worse, seek professional advice rather than waiting for a perfect family strategy. The purpose of home adjustments is to make daily life safer while the right assessment and support are arranged.

If a meal ends early, try to avoid turning the next one into compensation or punishment. Return to the agreed routine and follow the health plan. Do not force extra food later to 'make up' for what happened unless that is part of advice from the child's clinical team. If you are uncertain how to respond after a missed meal, ask the clinician for a plan in advance, so you are not deciding in the middle of a stressful moment.

You can notice your own early signs of escalation: speaking faster, asking the same question repeatedly, bargaining, or feeling that you must solve the whole problem now. When safe, pause, take a breath, and ask another adult to step in. A brief pause is not giving up; it can prevent a frightened moment from becoming a family confrontation.

It is all right if you need a pause too. If another adult is available, agree a handover before the situation reaches crisis point: 'I need ten minutes; please keep the routine calm and leave the safe option available.' After the meal, discuss any health concern privately and contact the care team if needed.

Try this repair: 'I'm sorry I made that harder. I believe you. Let's work out what would help next time.'

WALKING BESIDE YOUR CHILD

A parent's practical plan

You do not need a perfect system. Choose a few steps that make the next week more predictable. First, agree with your child on the familiar foods and drinks that should remain available, and where they will be accessible. Second, decide how you will tell them about meals, changes, appointments and outings. Third, identify one calm time to ask what makes eating easier or harder.

For a health appointment, take a short note with: when the difficulty began; the foods and situations currently manageable; any fear, sensory concerns, pain, nausea, swallowing difficulty, appetite or body-signal concerns your child describes; how school and social life are affected; any change in energy, growth or health; and what you have already tried. Include allergies, intolerances, medication and relevant medical history. Do not delay seeking help while you try to make the notes complete.

Ask the clinician: 'Could there be a medical or swallowing issue?' 'How will nutrition and physical health be assessed?' 'Which local team supports ARFID?' 'What should we do if intake drops further?' 'Can we have a written safety plan?' 'How can school be involved?' Write down the answers and who is responsible for each follow-up.

At home, choose one pressure-reducing change, not six at once. It could be no plate comments, serving foods separately, or keeping a familiar option available. Review with your child whether the change helped. If it did not, you can change course without calling it failure.

Keep a note of progress that is broader than trying new foods: asking for support, attending an appointment, taking a drink, explaining a boundary, or joining a social moment. This is not a reward chart. It is a reminder that recovery includes safety, trust and participation.

A written plan can also help when caregivers share responsibility. Include the child's communication preferences, known allergy or medical information, safe foods and drinks, what to do if a usual option is unavailable, how to recognise the child's distress, and who to contact. Keep it factual and private. Update it with the child and clinicians when their needs change.

Set a review date instead of asking every day whether the plan is working. At that review, ask the child what felt safer, what still felt difficult, and whether any change is wanted. Ask yourself whether the plan is protecting health without making home life revolve entirely around eating. Adjust one thing at a time and seek professional input when risk or uncertainty remains.

This plan should be realistic for the people who will use it. If it requires more time, money or energy than the family has, tell the clinician. Ask which parts are essential for safety, which can be simplified, and what support is available. A plan that cannot be followed needs adjustment, not blame.

Small plan: one safety step, one support contact, one question for your child.

A MESSAGE FROM MAGGIE

From my side of the table to yours

To the parent reading this: I know how frightening it can be to watch a child struggle with something people often assume should be easy. You may be trying to keep them safe and wondering whether you are doing enough. You may be carrying advice from people who have never sat inside your child's experience.

You do not have to choose between believing your child and seeking help. You can respect what food feels like for them and still ask for assessment, nutritional support and a plan. You can keep familiar foods available while working with professionals. You can offer hope without promising a quick fix.

To the child who may one day read this: you are not a problem to be solved at the table. Your body and your words matter. You deserve support that takes your health seriously and treats you with dignity. If speaking is hard, you can show, write, point, choose or ask someone safe to help explain.

My experience is one story, not everybody's story. I share it because understanding arrived late for me, and I want families to have more room for curiosity and less room for blame. You may not know the next step yet. Start with the person in front of you. Ask what feels hard. Keep safety and connection in the room. Then seek the right help together.

If something in this guide feels familiar, please speak with your GP or an appropriate health professional. If eating restriction is affecting physical health, nutrition or daily life, it deserves proper attention. In an emergency, use local emergency services.

Please remember that caring well does not mean having no difficult feelings. You may need a break, a listening ear or help with practical tasks. If you share care with another adult, agree how you will hand over without criticising one another in front of the child. When families can talk privately and repair disagreements, children are less likely to feel caught between competing adults.

I hope this guide helps you look beyond the dinner table. Your child is a whole person, and you are a whole person too. There can be progress in asking for help, making space for honest communication and protecting a relationship, even before the eating feels easier. Keep going gently, and bring in support when you need it.

If your child is an adult reading this with a parent, you remain the expert on your own experience. You can choose what information to share, what support you want, and whether a relative joins an appointment. If you want help, a GP can discuss assessment and referral options. You deserve care that respects your autonomy.

Until next time, give yourself—and each other—space to breathe.

CURRENT UK INFORMATION

Support and further reading

Cornwall High Risk Avoidant Restrictive Food Intake Disorder Service (NHS Cornwall): current eligibility, referral route, local service information and family guidance. At the time this guide was prepared, the service page described high-risk referrals for children aged 8–18 registered with a Cornwall GP, referred by a GP or paediatrician. Service pathways can change; check the live page or ask your child's clinician. Phone: 01726 873 408. Website: cornwallft.nhs.uk/arfid-service.

Beat: ARFID information for individuals and families, signs to look out for, seeking help and support options. Website: beateatingdisorders.org.uk/get-information-and-support/about-eating-disorders/types/arfid/.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust: Support for Avoidant Restrictive Food Intake Disorder. Includes practical resources for parents, carers, schools and adults. Website: cntw.nhs.uk/resources/support-avoidant-restrictive-food-intake-disorder-arfid/.

NICE guideline NG69, Eating disorders: recognition and treatment, gives broader UK guidance on eating-disorder recognition and care. It is not an ARFID-specific treatment manual. NICE website: nice.org.uk/guidance/ng69.

For immediate concerns about a child's health, contact their GP or current clinical team. NHS 111 can advise in England; if there is an emergency, call 999 or attend an emergency department. Service availability, referral criteria and contact details can change, so check the official source before relying on them.

This booklet offers lived perspective and general educational guidance. It does not diagnose ARFID or replace medical, dietetic, psychological or emergency care. A child's needs, risks and appropriate treatment must be assessed individually.

These sources provide general information and may not reflect every local pathway. Beat explains that support can vary across the UK; the Cornwall NHS page sets out a local pathway with specific age and referral criteria. If the first contact is not the right service, ask the GP or paediatrician to explain the next referral route and what interim support is available.

For families seeking peer support, check current options through Beat's ARFID and carer services or ARFID Awareness UK. Support groups can reduce isolation, but they do not replace medical assessment. Bring clinical questions to the child's health team, especially where nutrition, growth, swallowing, pain, hydration or rapid changes are involved.

This guide was prepared in September 2026. Service information and contact details can change. The websites listed here are the authoritative place to check current eligibility and availability.

Before relying on any service detail, check the linked official page. If a webpage is unavailable, ask the GP or paediatrician for an up-to-date referral route. If you are in Cornwall, the cited service page explains its current pathway, but eligibility and capacity may change. Keep emergency decisions based on the child's current health, not on waiting-list criteria.