

A practical, compassionate guide for parents and carers

Understand what your child may be experiencing, recognise overload earlier, and make food experiences safer and more predictable. This guide supports children with ARFID and sensory-related eating difficulties; it does not replace individual clinical assessment.

SPACE TO BREATHE THERAPY | ARFID PARENTS

01 When food feels like too much

Eating is not simply a decision to put food in the mouth. A child may have to process its appearance, temperature, smell, sound, texture, flavour and the sensations of chewing and swallowing—all while managing the room, people, expectations and their own body signals.

In avoidant/restrictive food intake disorder (ARFID), sensory sensitivity can be one reason a child eats a very limited range of foods. Other drivers include fear of aversive consequences (such as choking or vomiting) and low interest in food. These can overlap. ARFID is not defined by a desire to change weight or shape.

Sensory differences are real experiences, not a child being awkward, rude or deliberately difficult. A food that looks almost identical to a safe food may still feel completely different.

> **The central shift**
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> Instead of asking, “How do I make them eat this?”, try, “What is their sensory system telling us, and what would help them feel safer?”

What overload can look like

• Turning away, gagging, coughing, retching or spitting out food.

• Covering the nose or ears; squinting or looking away from a plate.

• Becoming unusually quiet, frozen, tearful, irritable or restless.

• Leaving the table, hiding, refusing utensils or needing to eat alone.

• Eating less as the meal continues, even if the child started comfortably.

Some signs may also indicate swallowing or medical difficulties. Repeated choking, coughing with drinks, pain, or food sticking needs clinical assessment rather than sensory strategies alone.

A useful distinction

A child can be hungry and still unable to tolerate the food offered. Appetite does not automatically override sensory distress.

02 The sensory layers of a meal

LOOK	Colour, shape, mixed foods, sauce touching another food, visible seeds or unexpected marks.
SMELL	Cooking odours, strong spices, someone else’s meal, packaging smells.
TOUCH	Sticky hands, wet fingertips, crumbs, utensils, food on lips or teeth.
TEXTURE	Crunchy, slimy, fibrous, lumpy, mushy, grainy or mixed textures.
TASTE	Intensity, bitterness, sourness, seasoning and unfamiliar aftertastes.
SOUND	Crunching, cutlery scraping, chewing noises, extractor fans and conversation.
TEMPERATURE	Food cooling, hot/cold contrasts, changes from one bite to the next.
BODY SIGNALS	Nausea, reflux, fullness, pain, thirst, fatigue and uncertain hunger cues.

Sensory load adds up

A child may manage a familiar food in a quiet room but struggle with the same food in a bright, noisy dining hall. This does not mean they are pretending. Their capacity can change with sleep, illness, anxiety, transitions and accumulated demands.

Parent reflection

Think about a meal that went well. What was different about the environment, food presentation, timing, company or expectations? The answers may be more useful than a list of “refused foods”.

03 Food safety is often about predictability

Many children rely on “safe foods”: items they can usually eat without substantial distress. Safety may depend on an exact brand, packet, size, shape, cooking method, temperature or plate. A reformulated product, a broken biscuit or a different pasta shape can genuinely change the experience.

Why tiny changes can feel enormous

• A familiar crisp may become too thick or too strongly flavoured.

• Toast cut into triangles may feel different from toast cut into strips.

• A preferred yoghurt may be rejected after a packaging or recipe change.

• Foods touching each other can change the smell, moisture and texture of both.

Support without reinforcing fear

Preserve reliable foods while building safety and trust. Do not secretly swap ingredients, disguise new foods as familiar ones, or make eating a test of obedience. Predictability is a starting point for support, not a permanent limit on what may be possible.

When nutritional adequacy is a concern, a registered dietitian and appropriately trained ARFID clinician can help develop a graded plan without removing the child’s existing food security.

Try a food profile

Record the exact food, brand, packaging, preferred preparation, temperature, utensil, presentation and setting. Note what is tolerated rather than only what is avoided.

The language of safety

“I can see that this looks different today.” “You do not have to explain every sensation.” “We can work out what changed.” “Your safe food is still available.”

04 Reduce overload before changing food

When a child is overwhelmed, the first intervention is often to reduce demands—not to increase exposure. Environmental changes may improve access to eating without requiring a child to tolerate a difficult food.

A calmer eating environment

- Offer a quieter location or reduce overlapping conversation, television and kitchen noise.
- Adjust lighting, seating, strong odours and visual clutter where possible.
- Allow appropriate sensory supports such as ear defenders or a preferred chair.
- Consider a separate plate, compartments, familiar cutlery and consistent portion presentation.
- Allow breaks and a predictable beginning and end to meals.
- Provide access to water and agreed coping tools; avoid making these contingent on bites eaten.

Before the meal

Give a neutral preview of what will be served. Offer a manageable choice where possible. Allow time to transition from play, school or other high-demand activities. Some children need movement, quiet or rest before they can engage with food.

During the meal

Keep language calm and specific. Notice signs of distress early. Avoid bargaining (“one more bite”), public praise that creates pressure, comparisons with siblings, or comments about how much is left on the plate.

After the meal

Focus on recovery and connection, not a performance review. If useful, ask later: “Was anything too loud, smelly, mixed or unexpected?” A child may prefer pointing, drawing or selecting from visual options.

What success might look like

A child stayed regulated, asked for a change, sat nearby, ate a reliable food, or recovered from overload sooner. These are meaningful observations even if no new food was eaten.

05 The overload ladder: recognise the early signs

GREEN | Available

The child is relatively settled. Offer familiar foods and a predictable routine. No need to introduce a challenge.

AMBER | Building discomfort

Fidgeting, sniffing, moving food, slower eating, avoiding eye contact or asking repeated questions. Reduce sensory load, check choices and lower demands.

RED | Overloaded

Gagging, panic, crying, freezing, bolting or intense refusal. Stop food demands. Support regulation, safety and recovery.

RECOVERY | After the event

Avoid interrogation or consequences. Reassure the child and return to predictable routines. Reflect later, if they want to.

When a child says “I can’t”

Treat this as useful information about capacity. Try “What feels hardest right now?” or offer options: smell, texture, noise, temperature, being watched, or “not sure”. For children who cannot explain verbally, use gestures, picture choices or a simple yes/no system.

Do not confuse regulation with compliance

A child becoming quiet after pressure is not always a sign they are comfortable. Some children shut down or mask distress. Look for ease, engagement and bodily signs of comfort, not only whether they remained seated.

06 Exploration without pressure

For some children, food exploration may be useful when it is collaborative, optional and guided by a trained professional where appropriate. Exploration is not the same as requiring a bite. The child should know what will happen and be able to stop.

Possible steps—not a compulsory sequence

• Notice a food from a distance, perhaps in its packet.

• Look at a photograph, learn about the food or choose how it is presented.

• Have the food nearby, without it touching their own food.

• Use a utensil to move or explore it, if the child wishes.

• Smell, touch, lick or taste only with genuine consent and readiness.

Some children will not want to progress through these steps; that is information, not failure. Sensory play should never contaminate a safe meal or become a hidden test.

Helpful scripts

“You can look without touching.” “You can say stop.” “We are learning what your senses notice.” “You do not have to eat it today.”

When to involve a specialist

If the child has significant nutritional restriction, weight or growth concerns, fear of choking/vomiting, marked distress or medical complications, use a clinician-led plan rather than attempting systematic exposure alone.

Avoid the common trap

Repeatedly offering an unwanted food without adapting the environment, acknowledging distress or providing a sense of control can make meals feel less safe—not more.

07 Real-life situations and supportive responses

“They ate it yesterday!”

Capacity changes. Ask whether the food, room, temperature, fatigue or anxiety changed. Respond: “Yesterday felt different. Let’s find what would help today.”

“They only eat one brand.”

Brands can provide dependable texture and flavour. Keep the reliable option available. If changes are needed, make them transparent and collaborative, ideally with dietetic support.

“They gag when they smell dinner.”

Move the child away from cooking odours, use ventilation and consider a separate preparation time or eating space. Do not insist that repeated exposure to strong smells will automatically help.

“They cannot eat in the school dining hall.”

Explore quiet seating, a different time or location, familiar packed foods, predictable routines, and staff who understand ARFID. Agree how the child can request a break discreetly.

“They will eat snacks but not family meals.”

Snack foods may be more consistent in taste, texture and packaging. Avoid moral labels such as “good” and “bad” foods. Work with a dietitian if the child’s range is too limited to meet nutritional needs.

“Relatives keep telling them to try one bite.”

Explain the family rule: no pressure, no comparisons and no surprise ingredients. Adults can model curiosity without making the child’s eating the focus of attention.

> **A phrase for family members**
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> “We are supporting their eating by reducing stress and keeping food predictable. Please do not comment on portions, reward bites or ask them to try something.”

08 The family sensory detective

Use these prompts to notice patterns. This is not a diagnostic questionnaire. Invite the child’s perspective where possible, including non-verbal ways of communicating.

Which foods and preparations currently feel reliable?

Which sensory qualities are most difficult: sight, smell, touch, taste, sound or temperature?

What happens before overload? What does the child do first?

Which environments and supports make eating easier?

What do adults do that helps? What unintentionally increases pressure?

09 My child’s sensory-friendly meal plan

Complete this together where appropriate. Share with school, family or professionals only with suitable consent and privacy.

My child’s preferred foods, brands and presentation:

Sensory triggers or early warning signs:

Helpful seating, sound, lighting, utensils or breaks:

Words, gestures or cards my child uses to say “stop” or “too much”:

What we will do when overload begins:

Who can help us review nutrition, health and eating concerns:

10 Nutrition, medical care and getting help

Sensory adjustments can make meals safer, but they do not replace assessment of nutritional intake, growth, hydration or medical symptoms. A child can have nutritional deficiencies even when their weight appears typical. If food variety or volume is very restricted, seek advice from a GP or paediatric clinician and a dietitian experienced in ARFID.

Ask for specialist support when

- Eating is affecting growth, energy, hydration, development or day-to-day functioning.
- The child relies on a very small number of foods, or the range is shrinking.
- Meals cause repeated panic, gagging, vomiting, pain or significant family distress.
- Fear of choking, vomiting or other consequences is restricting intake.
- There are signs of nutritional deficiency or dependence on supplements to meet needs.

Urgent concerns

Seek urgent medical advice for signs of dehydration, fainting, severe weakness, inability to keep fluids down, or rapidly deteriorating intake. In the UK, NHS 111 can advise when you are unsure; use emergency services for immediate danger.

Who may be involved?

A GP or paediatrician can assess physical health and growth; a registered dietitian can review nutritional adequacy; appropriately trained eating-disorder or ARFID clinicians can address avoidance and anxiety; occupational therapy or speech and language therapy may be relevant for sensory, oral-motor or swallowing difficulties, depending on assessment.

Further reading and support

NHS: information on ARFID and children’s eating concerns. Beat Eating Disorders: ARFID information and support. NICE guideline NG69: Eating disorders: recognition and treatment (clinical guidance). Royal College of Occupational Therapists and local NHS services may provide relevant sensory support information.

Resources are for orientation; service pathways vary across the UK. This guide does not recommend forcing exposure or changing a prescribed medical or nutritional plan.

11 A note to parents and carers

When a child struggles with food, it can affect the whole family. You may be worried about nutrition, exhausted by planning, or unsure whether to encourage, adapt or step away. These feelings deserve support too.

Your child does not need to prove that a sensation is unbearable before it is taken seriously. And you do not have to solve everything in one meal. Consistency, curiosity, predictable options and the right clinical help can create the conditions in which progress becomes possible.

Three things to remember

Safety first. Protect access to reliable nourishment.
Connection over pressure. Help your child communicate what feels difficult.
Support is collaborative. Adapt the environment and seek professional guidance when nutrition or health is affected.

A reflection to take away

One adjustment we can make this week is:

_____

One way I can reduce pressure is:

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Space to Breathe Therapy

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