

IT'S MORE THAN PICKY EATING

Understanding the many reasons behind ARFID — a detailed guide for parents, carers and anyone supporting a child, young person or adult whose eating feels difficult.

By Maggie Learoyd | Space to Breathe Therapy

The struggle you can see is not always the struggle they are having

A child may refuse a meal, eat only a handful of foods, insist on particular packaging or brands, leave the table, gag at a smell, or say they are not hungry. From the outside these behaviours can look like fussiness, defiance, habit or a bid for control. On the inside, however, eating may feel unpredictable, physically unpleasant, frightening or impossible. The question is not simply *"How can I make them eat?"* It is *"What is making eating hard, and what would help them feel safer?"*

Avoidant/Restrictive Food Intake Disorder (ARFID) is a recognised eating disorder in which restricted intake or variety can lead to nutritional deficiencies, poor growth or weight consequences, reliance on supplements or tube feeding, and/or substantial disruption to daily or social life. It is not defined by a drive to lose weight or change body shape. Children and adults can experience ARFID at any body size; a person does not have to look underweight to need support.

Not one cause, not one experience

ARFID is often described through three overlapping patterns: sensitivity to sensory properties of food; fear of aversive consequences such as choking or vomiting; and low interest in food or eating. These are descriptions, not separate boxes or a diagnostic quiz. A person may experience several at once, and those experiences may change across time. Physical illness, neurodevelopmental differences, stress and previous eating experiences can intensify them.

1 | Sensory differences: when food feels overwhelming

Texture, smell, temperature, appearance, taste and even the sound of chewing may matter far more than another person realises. Lumps in a smooth food, an unexpected seed, a brand changing its recipe or two foods touching can turn a previously manageable meal into something that feels unsafe. Gagging may be an involuntary response, not a performance. A food may be "safe" because its sensory qualities are consistent and predictable.

What helps: Ask which particular feature is difficult. Respect predictable presentation, keep safe foods available, and offer separate opportunities to explore foods without requiring a bite. Being near, looking at or smelling a new food can be a meaningful step, but no step should be forced.

2 | Fear: choking, vomiting, pain or something going wrong

Some people develop intense food-related fear after a choking episode, vomiting illness, reflux, allergic reaction or another distressing event; others fear these possibilities without a single clear trigger. Anxiety can make swallowing feel difficult, tighten the throat and increase nausea, which then reinforces avoidance. Repeated reassurance alone may not resolve the cycle.

What helps: Take the fear seriously and investigate potential medical causes. Use calm, simple language and arrange appropriately supported treatment. Do not disguise feared foods or push a person to “prove” they can swallow.

3 | Low interest, early fullness and the effort of eating

Hunger signals may be faint or inconsistent; someone might forget to eat, feel full very quickly, find chewing exhausting or experience eating as a chore rather than a pleasure. Pain, nausea, constipation, medications, sleep problems and stress may contribute. Statements such as “They will eat when they are hungry” may be unsafe when intake is already inadequate.

What helps: A clinician or dietitian can assess nutrition and help establish manageable, predictable eating opportunities. Smaller, familiar portions and practical reminders may assist, depending on the person’s needs and health.

4 | When physical health and ARFID overlap

Reflux, constipation, swallowing difficulties, food allergies, oral-motor difficulties, gastrointestinal conditions and painful experiences can all change someone’s relationship with food. These concerns need assessment rather than being dismissed as behavioural. A genuine allergy or medically required exclusion must remain respected; equally, unnecessarily eliminating foods can restrict intake further. A personalised review helps distinguish what is medically unsafe, physically uncomfortable, feared or sensory-aversive.

5 | Neurodivergence and a need for predictability

Autistic people may experience heightened sensory responses, differences in interoception (noticing bodily signals), strong preferences for routine or distress when familiar foods change. ADHD can affect meal organisation, attention, remembering to eat and recognition of hunger. None of this means that every autistic or ADHD person has ARFID, nor that ARFID is caused by poor parenting. Support should be adapted to communication, processing, sensory and executive-function needs.

What the parent sees — and what may be happening underneath

- **“They ate it last week.”** The food may look, smell or feel different today; illness, tiredness and stress can change tolerance.
- **“They will eat biscuits but not dinner.”** A familiar biscuit may have a predictable texture while a mixed meal contains multiple uncertain sensations.
- **“They say they are hungry, then refuse.”** Wanting to eat and being able to tolerate that food are not the same thing.
- **“They only eat one brand.”** Packaging and consistency may be important safety cues, not stubborn preferences.
- **“They were fine at school.”** They may have masked distress, eaten very little or used considerable energy coping.
- **“They just need to try one bite.”** For someone overwhelmed by fear or sensory distress, one bite may feel like an enormous demand.

Why well-intended pressure can deepen the difficulty

Parents are often frightened: Is my child growing? Are they getting enough nutrients? What if their list of foods shrinks? In that fear, coaxing, bargaining, bribing, counting bites, threatening to remove safe foods or negotiating “just one more mouthful” can seem like necessary solutions. These approaches may occasionally result in a bite, but they can also increase vigilance, shame, mistrust and avoidance, especially when the underlying difficulty has not been understood.

Reducing pressure does not mean ignoring malnutrition or simply waiting indefinitely. It means building a coordinated plan that meets medical and nutritional needs while reducing unnecessary confrontation. A young person who is medically compromised may require urgent assessment and more structured specialist support.

From my side of the table — a personal reflection

I have lived with ARFID since childhood. My own relationship with food began to change when I was around nine, long before I had language for what I was experiencing. What looks small or ordinary to someone else can carry an enormous amount of difficulty for the person expected to eat it. A plate can represent uncertainty rather than nourishment; a familiar food can represent safety rather than a narrow-minded choice.

There were times in my life when my range of manageable foods was extremely limited. From the outside, people might focus on what I was not eating. From the inside, the experience was far more complicated than a decision to refuse. I know how easily eating difficulties can be misunderstood when the conversation centres on the plate rather than the person.

Today, through my work with people and families, I also see the other side: adults who are frightened, exhausted and desperate to help. Their concern is real. So is the distress of the person being asked to eat. Both deserve compassion. The way forward begins when we stop trying to decide who is being difficult and start asking what each person needs.

Personal note: This section is drafted in Maggie's voice from her shared experience and should be reviewed by her before publication.

Practical support: ten things that can change the atmosphere

- **Protect reliable foods.** If possible, maintain access to established safe foods while nutritional needs are assessed; removing them as leverage may leave someone with nothing they can manage.
- **Separate connection from consumption.** A family meal can still include conversation, companionship and belonging even when the person eats something different.
- **Make expectations explicit.** Say what food is available and whether tasting is optional; avoid surprise ingredients and hidden changes.
- **Use neutral curiosity.** "Is it the smell, texture, taste, fear or something else?" is often more useful than "Why are you being difficult?"
- **Offer agency.** Choice over utensils, seat, food arrangement, portion and timing may reduce uncertainty.
- **Learn the pattern.** Keep a simple record of accepted foods, distress, pain, nausea, setting and changes; share it with professionals without turning it into surveillance.
- **Notice the body.** Consider constipation, reflux, swallowing, pain, medication effects, allergies and fatigue; ask the GP about concerns.
- **Protect dignity.** Avoid public commentary, comparisons with siblings or celebrating intake in a way that makes someone feel watched.
- **Coordinate across settings.** School, relatives and other carers should understand the agreed approach, including what to do when a safe food is unavailable.
- **Accept professional help.** Medical assessment, dietetic input and ARFID-informed psychological or occupational/feeding support may be appropriate according to individual needs.

Helpful words when the meal is not working

Instead of: "It is only one bite." **Try:** "I can see this feels difficult. Tell me what part is hardest."

Instead of: "You liked this yesterday." **Try:** "Something about it feels different today. Shall we work out what changed?"

Instead of: "You cannot leave until you finish." **Try:** "We need to make sure you get enough food and support. Let's find a plan that feels manageable."

Instead of: "You are being fussy." **Try:** "I believe there is a reason this feels hard, even if we do not understand it yet."

When to seek assessment — and when not to wait

Seek advice from a GP or appropriate paediatric/medical professional if a person eats very few foods, their diet is becoming more restricted, eating causes significant fear or distress, growth or weight has changed, they seem tired or unwell, there are suspected nutrient deficiencies, or school and social life are affected. Ask specifically about ARFID and any relevant medical or swallowing issues. A person can need help without appearing underweight.

Seek urgent medical advice for signs of dehydration, fainting, marked weakness, rapid deterioration, significant weight loss, inability to swallow safely, or little/no oral intake. If there is immediate danger, severe difficulty breathing or choking, call 999. For urgent UK advice when it is not an emergency, use NHS 111. Do not rely on a self-help article to manage significant nutritional compromise.

What meaningful progress can look like

Progress is not simply the number of foods on a plate. It may be a child describing a fear, returning to sit near the table, tolerating the smell of a food, accepting a consistent meal, eating enough of familiar foods, asking for a change without panic, or recovering more quickly after distress. Treatment goals should still include safe nutrition and physical health, but emotional safety and trust are part of sustainable change.

A conversation to begin at home

Ask together: When is eating easiest? Which foods are dependable, and why? What happens in the body when a food feels wrong? What would make meals feel less watched? Is there a setting, person or routine that helps? Which worries should we bring to a professional? You do not need to answer everything at once.

From my table to yours

If there is one message I want families to take away, it is this: food difficulties are not measured only by what is left on the plate. Listen to the experience behind the behaviour. Parents need support, too. You can care deeply about nutrition while being gentle about the journey. Understanding does not remove every challenge, but it changes how we meet it.

Space to Breathe Therapy offers support and resources for people experiencing ARFID and those who care for them. Learn more and find booking information at spacetobreathetherapy.co.uk.

Further reading and support

Beat (UK eating disorder charity): guidance, carer support and ARFID-specific programmes — beateatingdisorders.org.uk. NHS: contact your GP for assessment, referral and advice; NHS 111 for urgent but non-emergency concerns. Information here is educational and does not replace individual clinical assessment.