

Beyond the Mealtime Struggles

Supporting Your Child Through the Whole Day, Not Just at the Table

ARFID can follow a child well beyond the kitchen. The effects may appear in classrooms, friendships, sleep, outings, family relationships and a child's confidence in their own body. This parent-focused guide looks at the whole day, not simply what ends up on a plate. It is written with compassion for the child *and* for the people trying to help.

> **The central idea**
> A child may need support with uncertainty, sensory overload, exhaustion, shame and belonging, as well as with food itself. Being able to eat one particular food does not mean they can eat it everywhere, at every temperature or under every set of circumstances.

1 | ARFID is more than selective eating

Avoidant/Restrictive Food Intake Disorder (ARFID) involves a persistent difficulty eating enough food or enough variety, with significant consequences for physical health, nutrition or day-to-day functioning. It can involve sensory characteristics of food, fear of unpleasant consequences such as choking or vomiting, or low interest in eating. These patterns can overlap. ARFID is not defined by a wish to change body weight or shape, although another eating disorder can sometimes co-occur and requires careful assessment.

Not every limited diet is ARFID. Diagnosis belongs with an appropriately qualified clinician who can consider medical causes, growth, nutrition, distress and functional impact. A child's presentation can also change over time.

2 | The invisible work of an ordinary day

For a child with ARFID, the morning may already begin with negotiation: whether a safe breakfast food is available, whether its texture has changed, whether they have enough time to eat without being watched, and whether they will be hungry later. At school, unfamiliar smells, busy rooms and the worry of being noticed may use up energy that could otherwise go towards learning. By home time, a child can be utterly depleted.

It is useful to ask, “What has eating *cost* my child today?” rather than only, “How much did they eat?” Those are different questions and both matter.

3 | At home: the hours outside mealtimes

Before meals: A child may become anxious as soon as food preparation begins; even hearing pans or smelling cooking may trigger distress. **After meals:** They may need time to recover from gagging, nausea, a difficult conversation or feeling observed. **In between:** Low energy, irritability, headaches, difficulty concentrating and emotional volatility may reflect insufficient intake, stress, poor sleep or another medical issue, rather than deliberate misbehaviour.

Predictability can help: tell your child what food is available, where they can eat and whether there will be changes. When a particular brand or preparation is important, treat that information as useful rather than trivial. Keep reliable, accepted foods accessible while you seek individualised nutritional guidance.

4 | School: lunch is only one part of the problem

The canteen can be loud, crowded and full of mixed food smells. Queues, time limits and comments from classmates can make eating feel impossible. A child may avoid school trips, stay away from clubs or worry about being asked why their lunch looks different. Hunger, dehydration or anxiety may reduce attention and participation in the afternoon.

Ask school for a practical plan: an agreed quiet eating place if needed; permission to bring reliable food; discreet access to snacks and drinks; extra time or a flexible lunch arrangement; an identified trusted adult; and no public food challenges, rewards or punishments tied to bites eaten. If the child has additional needs, consider the school’s SEN support arrangements or relevant statutory plans. Agree how staff will respond if eating becomes difficult, without singling the child out.

5 | Friends, celebrations and belonging

Birthday parties, sleepovers, restaurant visits and family gatherings can seem centred on food. Children may refuse invitations not because they dislike friends, but because they cannot control what will be served or fear being questioned. They may dread being different. Let hosts know privately what helps, arrange a familiar food to bring and make participation about the activity and connection. A child should not have to prove they can eat the same food as everyone else in order to belong.

6 | Sensory load, neurodivergence and uncertainty

Autistic and ADHD children may experience differences in sensory processing, attention, interoception (noticing internal cues), flexibility and executive functioning. These do not automatically cause ARFID, nor does every person with ARFID have a neurodevelopmental condition. However, they can shape how eating difficulties are experienced and supported. Changes in packaging, lighting, smell, temperature, food touching or unexpected schedule changes may affect whether an otherwise familiar food feels manageable.

A child who looks calm on the outside may still be using considerable effort to cope. Ask what aspect is hardest: smell, appearance, sound, taste, temperature, texture, body sensations, uncertainty, being watched, or something else. More than one answer can be true.

7 | The body, health and energy

Restricted intake may lead to nutritional deficiencies, inadequate energy, poor growth, constipation, dizziness, fatigue or difficulty with everyday activities. Some children maintain an expected weight and still have nutritional deficiencies or significant impairment. Seek timely assessment from a GP or paediatric service if intake is persistently restricted, growth or weight changes, there are repeated physical symptoms, or family life and school participation are affected.

Seek urgent medical advice if your child is fainting, unusually drowsy or confused, showing signs of dehydration, unable to keep fluids down, rapidly deteriorating or taking very little food or fluid. In the UK, use NHS 111 for urgent advice, and 999/A&E for a medical emergency. Do not wait for an ARFID diagnosis before seeking help for physical concerns.

8 | Why pressure often makes the day harder

Parents understandably worry about nutrients and health. When a child seems to be surviving on very little, counting bites, persuading, bargaining, hiding ingredients or withholding accepted foods can feel like the only available options. Yet these approaches may teach a child that eating is a test they can fail. Pressure can heighten vigilance, reduce trust and make the next meal feel even less safe. That does not mean parents should ignore risks; it means medical safety and compassionate mealtime support need to work together.

Try replacing “Just take one bite” with “I can see this feels difficult. What would make the situation feel safer?” Replace “You ate it yesterday” with “Something about it feels different today. Can you tell me what changed?” These phrases are invitations to share information, not guarantees that a child will eat.

9 | From my side of the table

> *“From my table to yours: there may be a great deal happening inside a person that nobody can see from the other side of the plate.”*

A personal perspective drafted for Maggie Learoyd to review before publication: My experience of ARFID began in childhood. When I think about eating difficulties, I do not see only a meal refused or a plate left untouched. I think about how powerful the body’s reactions to food can feel and how difficult it is to explain those reactions to someone who has never experienced them. The outside world may see a narrow food range; the person living it may be managing fear, discomfort, sensory overwhelm and the exhaustion of anticipating the next food situation.

Today, through my work supporting individuals and families, I see how easily both sides of the table can become frightened. The parent is worried about health; the child is struggling with an experience they cannot simply switch off. It matters to me that neither is made into the problem. Understanding grows when we stop asking only what a child *will* eat and start listening to what makes eating feel possible or impossible.

10 | A whole-day support plan

Morning: Offer a known breakfast option without surprise changes; allow sufficient time; notice if rushing worsens eating. **School:** Confirm accepted food and a low-pressure arrangement; agree who the child can go to for help. **After school:** Build in recovery time before demanding conversations about lunch. **Evening:** Give advance notice of plans and prepare reliable food alongside the family meal if appropriate. **Outings:** Check menus, carry accepted food where possible and plan an exit or quiet break. **Bedtime:** Listen for worries about tomorrow and keep the discussion separate from judgement about today’s intake.

Keep a short pattern record if it helps: **setting / what was difficult / what made it easier / energy or symptoms / what the child wants adults to know**. Avoid making the child feel continually monitored. This record can support a GP, dietitian or therapeutic assessment without turning every meal into a scorecard.

11 | Working together without turning home into treatment

Ask the child what they would like adults to do when they struggle. Agree one or two small environmental changes at a time. Teach siblings that food comments are not helpful. Give carers and teachers consistent, non-shaming information. Where possible, protect activities that have nothing to do with eating: friendships, movement they enjoy, play, creativity and rest. Recovery support may include medical monitoring, nutritional support, psychological therapy and family involvement tailored to age and need.

Food exploration, when clinically appropriate, should be collaborative, paced and sensitive to the child's particular ARFID presentation. It should not mean forcing exposure, removing all safe foods or expecting every child to follow the same progression. If weight, hydration or nutrition is a concern, consult a qualified medical or dietetic professional before making major dietary changes.

12 | Questions worth asking your child

"When during the day does food feel hardest?" "Is it worse when people watch, ask questions or comment?" "What feels different about food at school?" "How can I help without making you feel pushed?" "What would make an outing easier?" A child might answer through writing, drawing, pictures, choices or a trusted adult. They may need time and may not know the answer straight away.

13 | When families need more help

Contact your GP if your child has a very restricted diet, nutritional or growth concerns, significant distress, fear of choking or vomiting, or is missing school and social opportunities because of eating. Ask about appropriate paediatric, dietetic, eating-disorder and neurodevelopmental pathways depending on the presentation. In England, local referral arrangements vary. Support for parents is valuable too: fear and exhaustion can build up when every day seems organised around food.

A message from Maggie | From my table to yours

A difficult mealtime is not the whole story of your child. Their world is much bigger than the food on the plate, and their support needs may be too. I hope this guide helps you notice what has been hidden, listen with curiosity and find small, compassionate changes that make everyday life less difficult. You do not need to navigate it alone.

Space to Breathe Therapy — further ARFID resources and information about booking support: spacetobreathetherapy.co.uk.

Further reading and clinical grounding

Royal College of Psychiatrists — information on ARFID and eating disorders; NHS — eating-disorder advice and when to seek urgent help; National Institute for Health and Care Excellence (NICE), NG69 — recognition and treatment of eating disorders; American Psychiatric Association — DSM-5-TR diagnostic framework for ARFID. This educational article is not a substitute for assessment or individual treatment.