ARFID: What the Parent Sees vs What the Child May Be Experiencing

A compassionate companion article for parents, carers and the people supporting children with Avoidant/Restrictive Food Intake Disorder.

SPACE TO BREATHE THERAPY

Two people can sit at the same table and experience entirely different things. A parent may see a meal going uneaten. A child may be managing a frightening sensation, overwhelming smell, unpredictable texture, nausea or a fear they do not yet know how to describe.

This article is an invitation to look beneath visible behaviours without dismissing parental worries about nutrition, growth or health. The two perspectives both matter.

What ARFID actually is

Avoidant/Restrictive Food Intake Disorder (ARFID) is a recognised eating disorder. The restriction or avoidance is associated with consequences such as insufficient nutrition or energy, growth or weight difficulties, reliance on nutritional supplements or feeds, or significant interference with everyday life. ARFID is not primarily driven by body-image or weight-shape concerns.

Common, sometimes overlapping drivers include: heightened sensitivity to sensory qualities of food; fear of unpleasant outcomes such as choking, vomiting or pain; and limited interest in food or eating. A child may experience more than one driver, and these can change across settings or over time.

ARFID can affect children across a wide range of body sizes. A child does not need to look underweight for their difficulties to deserve attention.

One table, two perspectives

The parent may see: food untouched, one brand accepted, tears at the table, a full lunchbox, rejection of yesterday's favourite, or a child claiming not to be hungry.

The child may experience: a texture that feels unbearable, a smell that triggers gagging, a fear of choking, a body that does not register hunger clearly, or the exhausting need to eat while being watched.

These are possibilities, not explanations to impose. Children know aspects of their own experience that adults cannot see. Their words, gestures and preferences should guide the conversation.

> "It may look like refusal from the outside, while feeling impossible on the inside."

When the same food is suddenly refused

A change in recipe, brand, shape, temperature or even packaging can change how predictable a food feels. A child may also be ill, tired, anxious or overwhelmed. "But you ate it yesterday" can unintentionally invalidate a very real difference in today's experience.

A helpful response: "Something feels different about this today. Can you show me what?" Avoid disguising ingredients or changing safe foods without agreement.

Why hunger may not solve the difficulty

Hunger is only one part of eating. Fear, nausea, sensory distress, gastrointestinal symptoms and differences in recognising bodily signals can interfere even when nourishment is urgently needed. Some children also experience early fullness or very little interest in eating.

A child saying “I’m not hungry” may be expressing their best understanding of their body. The answer is not to assume they will eventually eat whatever is offered; it is to assess intake and work towards a clinically appropriate, compassionate plan.

What pressure can do

Parents are often asked to set boundaries or encourage “one more bite”. They may be worried about deficiencies, missed growth or the next meal. However, bargaining, shaming, surprise substitutions and making children remain at the table can increase fear and erode trust. This does not mean stepping away from nutritional care; it means finding ways to protect safety while reducing unnecessary conflict.

Swap “You have to try it” for: “What feels difficult about this food?” **Swap “You ate it before” for:** “Has anything changed?” **Swap “Stop being fussy” for:** “I believe eating feels hard right now.”

Life beyond the dinner table

ARFID can make school lunches, parties, holidays, sleepovers and restaurants difficult. Background noise, time limits, unfamiliar smells, comments from peers and a lack of suitable foods can make eating harder outside the home. Ask schools or carers about flexible eating arrangements, permitted familiar foods, reduced social pressure and privacy where needed.

A child’s willingness to attend a social occasion should not automatically depend on eating what everyone else eats. Meaningful inclusion may begin with simply being present, feeling safe and having a plan.

Working with your child, not against them

Find a calm time away from meals. Ask what foods feel reliable, what sensory experiences are hardest, what happens in their body before a difficult meal and what they wish adults understood. Offer alternative communication: pointing, drawing, writing, pictures or speaking through another trusted person.

A child who is minimally speaking, overwhelmed or unable to identify internal sensations may need particularly flexible ways to communicate. Do not mistake difficulty explaining for an absence of distress.

Take a collaborative approach: protect adequate nourishment, preserve predictability, support autonomy where clinically appropriate and involve experienced professionals for nutritional rehabilitation or food exploration.

Signs that call for professional assessment

Contact a GP or suitably qualified healthcare professional if there is a restricted food range, concerns about growth or weight, possible nutrient deficiencies, increasing distress, gastrointestinal symptoms, or substantial disruption to family, school or social life. A team may include a paediatrician or GP, dietitian, psychologist or other clinicians experienced with ARFID.

Seek urgent medical advice for dehydration, fainting, marked weakness, rapid reduction in intake, or other worrying physical changes. In the UK, NHS 111 can provide urgent advice; call 999 in an emergency. Do not rely on this article to decide whether a child is medically stable.

Parent reflection: looking beneath the surface

1. What happens immediately before the food difficulty? Consider setting, sensory input, demands, tiredness, pain and changes in routine.

2. What has my child communicated about eating, verbally or otherwise? What am I still unsure about?

3. When does eating seem easier? What makes the environment or food feel more predictable?

4. Is there one pressure I could reduce while still safeguarding nutrition and following clinical advice?

5. What support do I need as the parent or carer, and who could help us build a shared plan?

You are allowed to feel concerned, exhausted or uncertain. Supporting a child with ARFID can be demanding. Parents benefit from empathy and support too.

From My Table to Yours

Behind a plate of untouched food there may be a child doing their best with a difficult experience, and a parent doing their best to protect them. Progress begins when both are listened to. Compassion and nutritional care can, and should, sit at the same table.

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This educational article complements the interactive ARFID parent-and-child perspectives resource. It is not a diagnosis or a substitute for individual medical assessment.