A Parent’s Pocket Guide to Supporting a Child with ARFID

Understand your child. Protect nourishment. Build safety around food.

PRESSURE-FREE SUPPORT • PRACTICAL GUIDANCE • PARENT REFLECTION

Different appetites. Same love. Same support.

Space to Breathe Therapy

Understanding ARFID: look beyond the plate

Recognise the pattern

Avoidant/restrictive food intake disorder (ARFID) involves avoiding or restricting food in a way that affects nourishment, growth, health, or everyday life. It is not driven by a wish to change body shape or weight. A child may eat very few foods, very small amounts, or both. The difficulty is real even when a child looks well or can manage one meal in one setting.

Different routes into difficulty

Sensory differences can make a food 's smell, texture, temperature, colour, brand or appearance feel unbearable. A frightening experience such as choking, vomiting, pain or an allergic reaction can lead to fear of eating or of particular foods. Low interest may mean hunger is faint, eating is easily forgotten, or a child becomes full after only a small amount. More than one pattern can be present, and it can change over time.

Listen for the child 's experience

Questions such as “What feels hardest about this food?” or “What would make lunch feel safer?” invite useful information. A child may describe a texture as painful, a smell as overpowering, or a body sensation they cannot name. Interoception□the noticing and interpreting of internal signals such as hunger, fullness or nausea□can be difficult. Autism, ADHD, anxiety, sensory processing differences, pain and other health conditions may affect eating, but no single diagnosis explains every child's experience.

Not wilfulness or a parenting failure

Restriction is not solved by assuming a child will eat when hungry, by bargaining, or by removing reliable foods. Pressure can increase fear and reduce trust. ARFID is assessed through the pattern 's impact and the child's health and functioning, not by a parent deciding whether the child is “fussy

enough.” A GP or specialist team can help explore the whole picture.

Assessment makes the pattern clearer

A useful assessment listens to the child and family, considers physical and emotional health, and looks at what eating is like across home, school and social settings. It can help distinguish sensory barriers, fear, low appetite, pain, swallowing concerns and other contributors. It should lead to a plan that protects health and participation while respecting the child 's pace. If you have concerns, you do not need to wait until the situation feels severe before asking for help.

How this differs from ordinary pickiness

Many children go through brief periods of preferring familiar foods. ARFID is considered when restriction is persistent or severe enough to affect nourishment, growth, health, or daily life. There is no single number of accepted foods that proves or rules it out. A child may manage more in one place than another, and a narrow range can still have a significant impact even if weight appears stable. Describe duration, effort, distress and consequences rather than debating whether the child is “fussy.”

Needs can shift with context

A child may manage food at home but not at school, or eat more when rested and less when worried, ill or in pain. This does not mean the difficulty is chosen or inconsistent. It may show how much energy the child is using to cope, or how the environment changes what feels possible. Share easier and harder moments with the team so support is built around conditions that help.

IN PRACTICE Notice what happens before, during and after eating: the setting, body sensations, food features, time, stress and recovery. Describe what you observe without labelling the child as difficult. REFLECT What does my child seem to be communicating through their eating?

Protect nourishment and reliable foods

Reliable foods are a bridge

A food a child currently manages can provide predictability and nourishment. Keep reliable foods available while support is being arranged. A safe food is an informal description, not a guarantee that a food is nutritionally complete or medically safe for every child. If a familiar product changes, becomes unavailable, or is no longer tolerated, tell the clinical team and plan a substitute together where possible.

Check health without blame

Ask the GP or child 's clinical team to consider growth over time, energy, hydration, pain, constipation, reflux, swallowing, dental concerns, allergies, medication effects and the child's emotional wellbeing. A child's weight alone cannot show the full impact of restricted eating. Share changes in stamina, concentration, mood, sleep, social participation and time spent eating. Seek advice early if intake is falling, the range of foods is shrinking, meals are becoming more distressing, or you are worried about growth or hydration.

Avoid sudden food rules

Do not remove a major food group, dilute or alter a reliable food, hide ingredients, or create hunger to prompt eating without individual advice from an appropriately qualified clinician or dietitian. Possible allergy or intolerance needs proper assessment; avoid experimenting with elimination diets on your own. If a child has a prescribed nutrition plan, follow that plan and contact the team when it no longer works.

Build safety first

Regular, predictable opportunities to eat can help a child know what to expect. Offer familiar foods in a calm place and allow enough time without turning the meal into a test. If the child accepts it, a new food can be nearby without any expectation to touch or taste it. Looking, smelling or being near a

food may be a meaningful step for one child; another may need the food kept farther away. Progress is individual and does not have to be linear.

Notice changes worth sharing

Tell the clinician if a reliable food disappears, a child is eating or drinking less, meals take much longer, or new symptoms appear. Share what still works as well as what is hard. This helps the team plan around the child 's current intake instead of starting with assumptions. If you are concerned about an immediate change in hydration or physical health, seek timely medical advice.

Think about the whole day

Nourishment is affected by more than the food placed on the table. Consider what happens at breakfast, school, travel, clubs, after a difficult lesson and before bed. A child may arrive home depleted after managing a noisy day or may skip food because there is no safe option at school. Recording the full pattern can reveal practical barriers and reduce the temptation to judge one meal in isolation. Include drinks and the time and effort needed to eat.

Stable weight does not settle every concern

A child can experience low energy, nutritional gaps, anxiety, pain or restricted participation even if weight has not changed noticeably. Growth information is best interpreted by a clinician over time and alongside the wider picture. Do not use appearance to decide whether support is deserved. If eating affects health, development, concentration, friendships or family life, explain the impact and ask what assessment or support is appropriate.

IN PRACTICE Keep a short, neutral record for the GP or dietitian: foods and drinks managed, changes from usual, symptoms, mealtime duration, settings that help, and the child 's own words. REFLECT Which reliable foods and routines help my child feel safer today?

Make home meals lower pressure

Adjust the environment

Think about noise, strong smells, bright light, crowded tables, timing, seating, utensils and the way foods touch. Small adjustments can reduce the amount of sensory work a child is doing. Some children need foods separated; some need a familiar plate, cup or brand; others need quiet or movement before sitting. Ask the child what helps, and change one thing at a time so you can tell whether it made a difference.

Use language that protects trust

Try “You can decide whether to try it,” “Your familiar food is here,” or “I can see this feels hard.” Avoid threats, surprise ingredients, praise that spotlights every bite, comparisons with siblings, or comments about weight and portion size. A calm offer is still an offer; accepting no can keep the relationship safe enough for future support.

Separate eating from food practice

Not every meal needs to be a learning exercise. If your child is willing, create a separate, brief, low-pressure opportunity to explore food in a way agreed with them. Exploration might mean choosing the plate, noticing a food from a distance, or preparing it without tasting. Stop if distress rises. The child should know what will happen and be able to pause.

Food chaining needs a starting point

Food chaining means exploring a very small, planned change from a food the child already accepts for example, a familiar shape, brand or presentation. It is not a trick, and the original food should remain available. Changes can be too big even when they look small to an adult. Consider guidance from a dietitian or feeding-trained clinician, particularly where nutrition, swallowing, choking fears, allergy, pain or growth are concerns.

Keep connection bigger than the meal

Share enjoyable time that has nothing to do with eating. Let the child take part in family life without requiring them to eat the same food or amount as everyone else. When a meal becomes difficult, a simple reset can help: reduce questions, return to the agreed familiar option, and reconnect afterward. A setback is information about support needs, not proof that the child or parent has failed.

Repair after a difficult meal

If pressure has crept in, repair matters more than finding perfect words. You might say, “I got worried and pushed. I'm sorry. I want to understand what felt hard, and we can make a calmer plan together.” Then listen without immediately correcting or persuading. Adults can take their fear to another adult or professional so the child is not asked to carry the family's worry at the table.

An example of a smaller step

If a child accepts one familiar cracker, the next step may be choosing whether another packet sits on the table, noticing a different shape from a distance, or helping put the familiar crackers on a plate. It may not be tasting. Ask first, say exactly what will happen, keep the usual food available, and stop when the child asks. If the change raises distress, return to the previous step or pause. An adult 's idea of a tiny change may feel large to the child.

IN PRACTICE Agree on one change that could make the next meal easier. Keep a familiar option available and make the change reversible. REFLECT How can I show my child that connection does not depend on eating?

Work with school, family and clinicians

Make a practical school plan

With your child 's agreement and the right staff, explain what the child can reliably eat, what support is needed, and what to do if lunch is missed or a food changes. Include where the child can eat, time to eat, sensory needs, storage or heating arrangements, an acceptable backup, and a named adult to contact. Ask that staff do not pressure, shame, bargain, reward bites, or remove the reliable food. Review the plan when needs change.

Prepare for appointments

Bring a short timeline: when restriction began, what changed, foods and drinks currently managed, symptoms, growth or energy concerns, situations that help, and the child 's own words. Ask what assessments are appropriate, who coordinates care, what signs need urgent attention, and whom to contact between appointments. Request written advice and a review date. ARFID support may involve primary care, paediatrics, dietetics and mental health or feeding specialists; the right team depends on the child and local services.

Help other adults respond consistently

Share only the information needed with relatives and caregivers. Ask them to offer the agreed familiar food, avoid comments and pressure, and tell you about changes or concerns. You can say: “We are following a support plan. Please leave food offers calm and let us know if anything changes.” Siblings may need a simple explanation that different people need different support; do not make them responsible for monitoring or persuading the child.

Know when to seek urgent help

If you are worried about dehydration or a child 's physical condition, contact the child's clinical team, GP or NHS 111 for urgent advice. Follow local emergency guidance and call 999 if there is an immediate emergency. Do

not wait for a routine appointment when the child is rapidly worsening, unable to keep fluids down, fainting, unusually drowsy, or showing signs that cause you serious concern. If there is a choking incident or severe allergic reaction, use emergency services.

Keep the child involved

Explain the plan in words the child understands and ask what they want adults to know. Offer choices where possible: who joins an appointment, what gets shared with school, or which backup food feels most manageable. A young person may want some conversations privately with a clinician. Respecting privacy and choice can strengthen trust while adults remain responsible for health and safety.

Plan for outings and changes

Parties, trips and appointments can add uncertainty about food, smells, timing and social attention. Beforehand, find out what food will be available, pack an accepted option if appropriate, and agree a quiet place or exit plan. Tell the child what is known and be honest about what is not. A child does not have to eat a host 's food to show gratitude. A brief, neutral explanation such as “We bring food that works for them” can protect privacy without inviting a debate.

Review the plan instead of blaming the child

A support plan should say who will do what, where it will happen and when you will review it. If lunch is missed, a food is unavailable or a strategy causes distress, record what happened and adjust the plan. Do not treat the child 's response as defiance or use the plan as a reward chart. School staff and family can share observations, but health and treatment decisions belong with the child, family and appropriate professionals.

IN PRACTICE Write down the school contact, GP or clinical-team number, agreed backup food, and what to do if intake or health worsens. REFLECT Who needs to know the plan so my child is supported consistently?

From My Side of the Table: a parent s next steps

Maggie 's lived experience

I have lived with ARFID since I was nine. At different times, my reliable foods included white toast with jam and smooth soups. From my twenties into my late thirties, I ate very little for long periods. These details belong to my life; they are not a checklist for another child and do not predict what recovery or support will look like for them. My experience has taught me how important safety, predictability, being believed and having food available without pressure can feel. A child 's own account may be completely different, so keep asking what their experience is.

A small next-step plan

Choose one priority for this week: arrange a GP conversation; write down changes in eating or health; ask school for a named contact; protect one reliable mealtime routine; or reduce pressure around a meal. You do not need to solve every part at once. If the child is willing, invite them to choose the first step. Review it together and adjust if it increases distress.

Support and further reading

For accessible information, see NHS ARFID guidance at nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/eating-disorders/overview/; Royal College of Psychiatrists ARFID information at rcpsych.ac.uk; Beat 's ARFID and family-support pages at beateatingdisorders.org.uk; and NHS dehydration advice at nhs.uk/conditions/dehydration/. NHS England publishes guidance for children's eating-disorder services at england.nhs.uk. Service routes and eligibility differ across the UK and may change, so check current websites or ask a clinician about local options. This pocket guide is educational and does not replace an individual assessment, medical advice, dietetic support or an agreed care plan.

A note to the parent or carer

You may be holding worry about health, school, family judgement and whether you are doing enough. You deserve support too. Choose one person who can listen without blaming you or your child, and ask for a practical task to be shared. A steady adult response does not mean you feel calm all the time; it means you return to curiosity, seek help when needed and keep your child 's dignity in view.

A message from Maggie

You do not have to persuade everyone that your child 's experience is real before you seek help. Start with what you notice and what your child tells you. Keep the food they can manage within reach while you ask for support. If a professional does not understand the full picture, bring your notes, ask your questions again, and request help finding the right service. Small, respectful changes can matter, and needing more help is not a failure.

A note to take into the next conversation

Keep it simple: “My child says□”, “I have noticed□”, “This affects□”, “What helps is□”, and “I am worried about□”. Add one question you want answered, such as what to monitor, who will coordinate support, or what to do if intake drops further. You can ask the professional to explain unfamiliar terms, write down the plan, and name the next review point. Clear, concrete examples can make a short appointment more useful.

IN PRACTICE If you are unsure what to do next, start with the child 's GP or existing clinical team and describe the change that worries you most. REFLECT What is one manageable action I can take, while keeping our relationship at the centre?