

BEYOND THE WAITING LIST

FOOD REFUSAL,
GAGGING,
MELTDOWNS

MEDICAL HEALTH
MOTOR SKILLS
DEVELOPMENT
ENVIRONMENT
NUTRITIONAL DEFICIENCIES
SENSORY PROCESSING
DIFFICULTIES
LEARNING HISTORY
E.G. TRAUMATIC EXPERIENCES

*Eating draws on several systems at once –
struggles at the table are rarely just one thing.* ✨

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Registered Paediatric Dietitian

A deeper guide for parents and carers, while you wait for support

UK Paediatric Dietitian · 13+ Years · SOS-Trained · HCPC Registered

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TSD
The Sensory Dietitian

Hello, I'm Iwona



I'm a UK paediatric dietitian with over 13 years of experience, specialising in sensory and selective eating, ARFID, and paediatric feeding disorder (PFD). I'm SOS-trained, HCPC registered, and I've spent my career working in joint feeding clinics alongside speech and language therapists and occupational therapists. I've also completed the British Dietetic Association's Advancing Dietetics in Avoidant Restrictive Food Intake Disorder (ARFID) training, so my practice reflects current, evidence-based care.

If you've ever kept a stash of "safe" snacks in every bag just in case, dreaded a party because of the food table, or flinched slightly when someone leaned in and said "go on, just one bite," I want to say this clearly before anything else:

THIS IS NOT YOUR FAULT

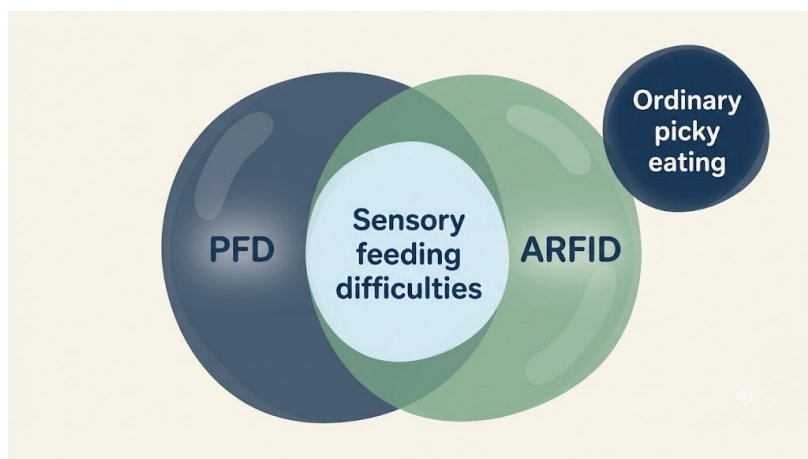
It isn't your child's fault either. Feeding difficulties are not caused by poor parenting, and they're not deliberate misbehaviour: they're a real, physiological response, and there is a great deal you can do about them, starting today.

This guide is general information, not individual medical or dietetic advice, and it can't replace an assessment of your own child. If you're worried about your child's health right now, please see your GP, health visitor, or NHS 111 (see Red Flags, page 14).

You're doing better than you think.

Picky Eating, Sensory Eating, ARFID or PFD?

These terms get used interchangeably, even by professionals. Here's the plain-English version.



Ordinary picky eating is common between ages 2 and 6, and usually settles with time. A picky eater still eats a fairly wide range of foods and keeps growing well.

Sensory feeding difficulties sit further along the spectrum: a child's nervous system registers taste, texture, smell, or appearance far more intensely, so accepted foods narrow more, and mealtimes involve real, visible distress.

ARFID (Avoidant/Restrictive Food Intake Disorder) is a recognised feeding and eating disorder, defined in the DSM-5-TR diagnostic manual used across the NHS.² It's a persistent difficulty eating enough, or varied enough, to affect growth, nutrition, or daily life, and isn't driven by a wish to control weight or shape.

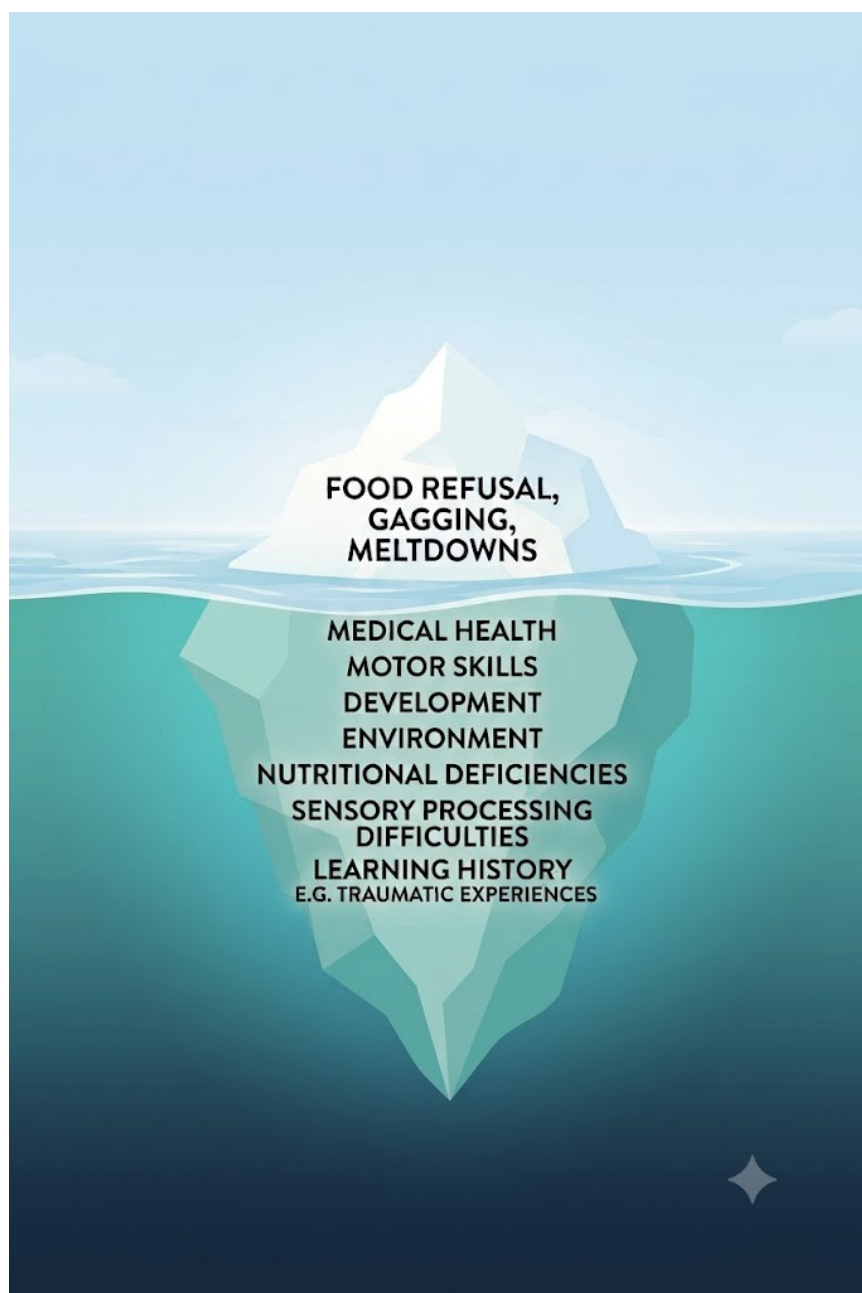
PFD (Paediatric Feeding Disorder) is a broader clinical term, defined in a 2019 consensus framework,³ covering difficulties from medical, motor-skill, nutritional, psychosocial, or sensory factors. ARFID can sit inside this wider picture as its emotional component.

One nuance: growth isn't the whole picture. Some children with ARFID or PFD grow steadily, sometimes by relying on energy-dense foods. Weight gain alone doesn't rule out a feeding difficulty; a diet built mainly around low-nutrient foods can leave real gaps in vitamins and minerals.

How to tell which applies: you don't need the exact label before getting help. Narrow foods but growth broadly unaffected is often ordinary pickiness. If eating affects growth, nutrition, or daily life, ask your GP or health visitor for an assessment.

What Might Be Going On

Feeding specialists often picture an iceberg, the same image on this guide's cover. What you see at the table (food refusal, gagging, meltdowns) is only the tip. Underneath sit several systems that all have to work together for a child to eat comfortably: medical health, motor skills, sensory processing, learning history, development, nutrition, and environment.



When mealtimes go wrong, it's rarely because a child is "being difficult." It's usually because something below the surface needs attention, most often sensory processing: some children's nervous systems register taste, texture, smell, and sound far more intensely than others.

Why Pressure Backfires

If you've ever found yourself bargaining, bribing, or insisting on "just one bite," you're in very good company. Here's why it usually makes things harder, not easier.

Imagine being served something that looks, to you, exactly like a spider on a plate. No amount of "it's actually delicious, just try it" would make that easier; your alarm response would simply take over. For a child with a strong sensory or fear-based reaction to a food, an unfamiliar plate can feel genuinely similar, even when the food itself is perfectly ordinary and safe.

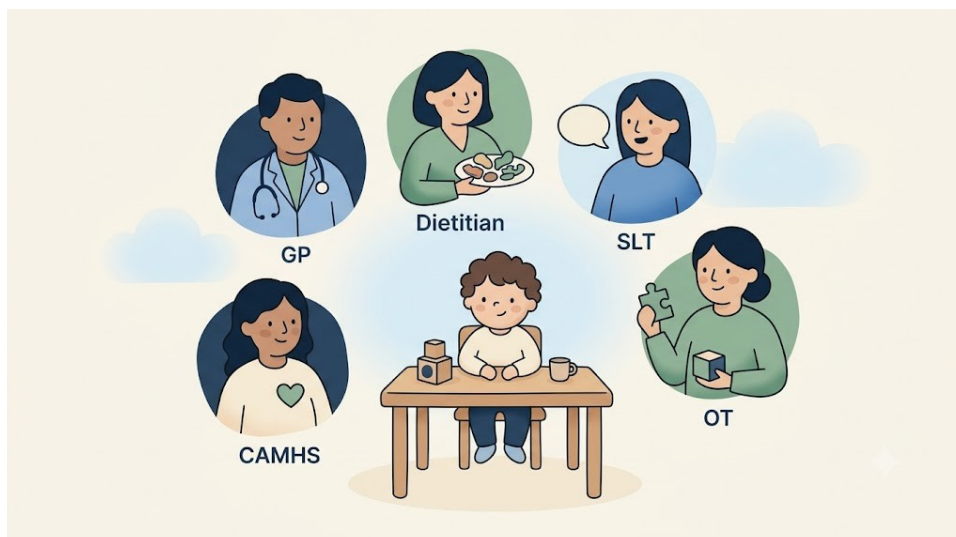


The brain is very good at linking things that happen together, especially when one is unpleasant. If a child chokes, gags, or feels reflux pain while eating a food, their brain can quietly file that food away as "dangerous." The next time it appears, their body can react with genuine alarm, even though the food hasn't changed; it's an automatic protective reflex, not a choice. Children also can't simply "reason their way out" of this the way adults can: the amygdala, the brain's alarm centre, is active from early childhood, but the prefrontal cortex, which calms that alarm, is still developing.

What this means in practice: your child's brain needs new, repeated, low-pressure experiences to build a different association over time. That's slower than pressure, but it's what actually lasts.

Building Your Team: Who Can Help

You don't need a diagnosis before you're allowed to ask for help. Here's who's usually involved, and roughly how a referral tends to work.



- Your GP or health visitor: usually the first step, and the required route in most areas, though a small and growing number now allow self-referral.
- The dietitian: nutrition, growth over time, and a realistic plan to build variety without adding pressure at the table.
- The SLT: assesses the physical, mechanical side of eating, matching food textures to your child's stage of development.
- The OT: sensory processing, motor skills, coping strategies for textures and mess, and equipment such as supportive seating.
- CAMHS or a clinical psychologist: the emotional and anxiety side. Worth knowing honestly: ARFID often falls into a genuine gap between services, since many CAMHS teams only accept referrals meeting separate mental health criteria; not something you're failing to navigate.

A typical pathway: GP or health visitor, then a paediatrician and/or dietitian assessment, then SLT and/or OT as needed, and CAMHS or psychology if anxiety is significant. Every NHS Trust or Health Board sets its own local pathway, so the order, waiting times, and self-referral options can differ; it's worth asking your GP surgery what their process is.

A good sign, not a shortcut: some areas run joint feeding clinics, a dietitian and SLT seeing your child together, a sign the service is well set up to help. Some also run parent groups, or combine a psychologist and dietitian jointly; it varies by area, so it's worth asking what's on offer locally.

What You Can Do While You Wait

You don't need to wait for every step of the referral pathway, or your first appointment, before making things calmer at home. Here's where I'd start:



- Take the pressure off: drop “just one bite,” praise for eating, and visible disappointment when food isn't touched. Aim for a neutral, low-key table.
- Keep at least one safe food on the plate at every meal, always. This removes the fear of “nothing to eat,” which often drives distress more than the new food itself.
- Build predictable structure: similar meal and snack times each day, and a short, consistent “getting ready for a meal” routine.
- Keep a simple food and symptom diary (there's a template on page 18): useful for you, and invaluable for whichever professional you eventually see.
- Protect your child's nutritional basics with what's already accepted, rather than waiting for variety to arrive first.
- Look after yourself too. This is genuinely hard, and your wellbeing is not a lower priority than your child's.

A NOTE ON LANGUAGE

Small changes in the exact words you use at the table can lower pressure without changing anything else. See the phrase-swap table overleaf.

Swap These Phrases: What to Say Instead

The exact words you use at the table matter more than most parents realise. Small changes in phrasing can lower pressure without you having to change anything else about the meal itself. Here are the swaps I suggest most often in clinic.

Instead of...	Try...
"Just try one bite"	"You don't have to eat it."
"Why won't you eat it?"	"I wonder what it smells like."
"Eat your dinner"	"Your food is there when you're ready."
"Eat that, it's good for you"	"That's an interesting shape." Neutral language about shape, colour or smell tends to land better than health talk.
"Stay at the table till it's finished"	"We'll clear away in 20 minutes, finished or not." A calm, predictable ending, rather than a rule that can make mealtimes something to dread.
"No pudding till dinner's done"	Serve pudding as simply another course, no conditions. Conditions turn it into the prize children want most.
"You need to swallow that"	"You can spit it in the bowl." A spit bowl removes the fear of being trapped into swallowing an unpleasant taste.

TWO THINGS THAT HELP

Talk about food neutrally (shape, colour, temperature, smell) rather than health benefits. Avoid "stay till it's finished" rules; a calm, time-bound ending works better long-term.

A gentle note: if this list makes you wish you had support putting it into practice, that's what my 1:1 programme is for. More on the final page, no pressure to look now.

A Low-Pressure Routine, and Protecting Safe Foods

Predictability lowers anxiety at the table. Offer 3 meals and 2 to 3 snacks at roughly similar times each day, keep meals time-bound (around 20 to 30 minutes) and then calmly clear away regardless of what's been eaten, and build a short, consistent "getting ready for a meal" routine your child can rely on.

Children also learn a great deal simply by watching people around them eat, without any pressure on themselves in that moment, sometimes called social learning.⁵ I once worked with a young autistic boy who would eat alone on the kitchen floor rather than at the table; it turned out the only regular "eating" he'd ever watched was the family dog, since his family never ate together in front of him. Once his school built in consistent mealtime modelling, he was eating with his classmates within about a year. (Details changed to protect the family's privacy.)

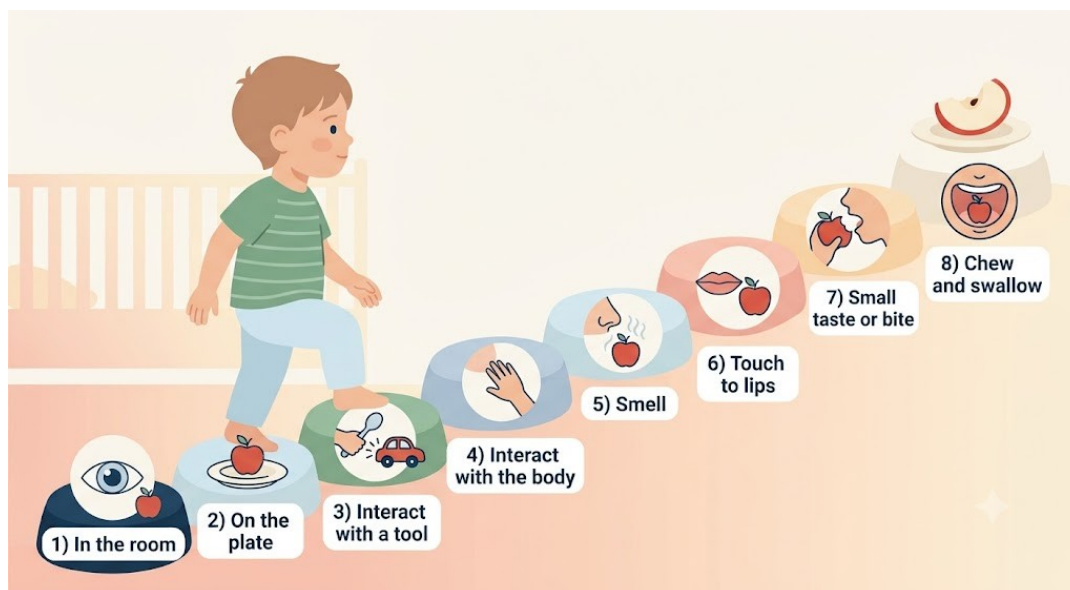
If your child eats the same handful of foods over and over, those foods are doing real nutritional and emotional work right now. Protecting them, not rushing away from them, is a genuine, active part of treatment.

How safe foods are lost: an unannounced change of brand, serving it slightly differently than usual, pressure to eat "just a bit more," or overusing the same food until your child tires of it (sometimes called a "food jag"). None of these are mistakes to feel guilty about; they're just useful to know. The antidote is small, planned variety you control: rotating between two or three safe foods across the week, and occasionally varying just one property, such as temperature or shape.

TAKING ACTION

Gently Expanding the Menu: Food Chaining

Food chaining means moving in small steps from a food your child already accepts to something similar, changing one thing at a time (texture, shape, temperature, or brand), used alongside gradual, paced exposure.¹ A typical ladder moves through steps long before “eating” itself: being in the room with a food, touching it, smelling it, a small taste, then a bite. Moving backward after a bad day is normal, not a failure.



WHAT THIS ISN'T

Not insisting your child move on before they're ready, and not using “just taste it” as a condition for a reward. What works is a slow ladder paired with calm encouragement, never pressure.

Research suggests it commonly takes many repeated, pressure-free exposures before a new food feels familiar, often more than the 3 to 5 tries most parents give before stopping, and generally more for older children than toddlers.⁴ It's a slow process by design.

TAKING ACTION

Trying New Foods Elsewhere

Acceptance also depends on setting: a food refused at home often gets eaten on holiday, at school, or in a restaurant. Research describes food acceptance as genuinely context-dependent, likely because a new setting carries less pressure and none of the weight of previous refusals.⁶



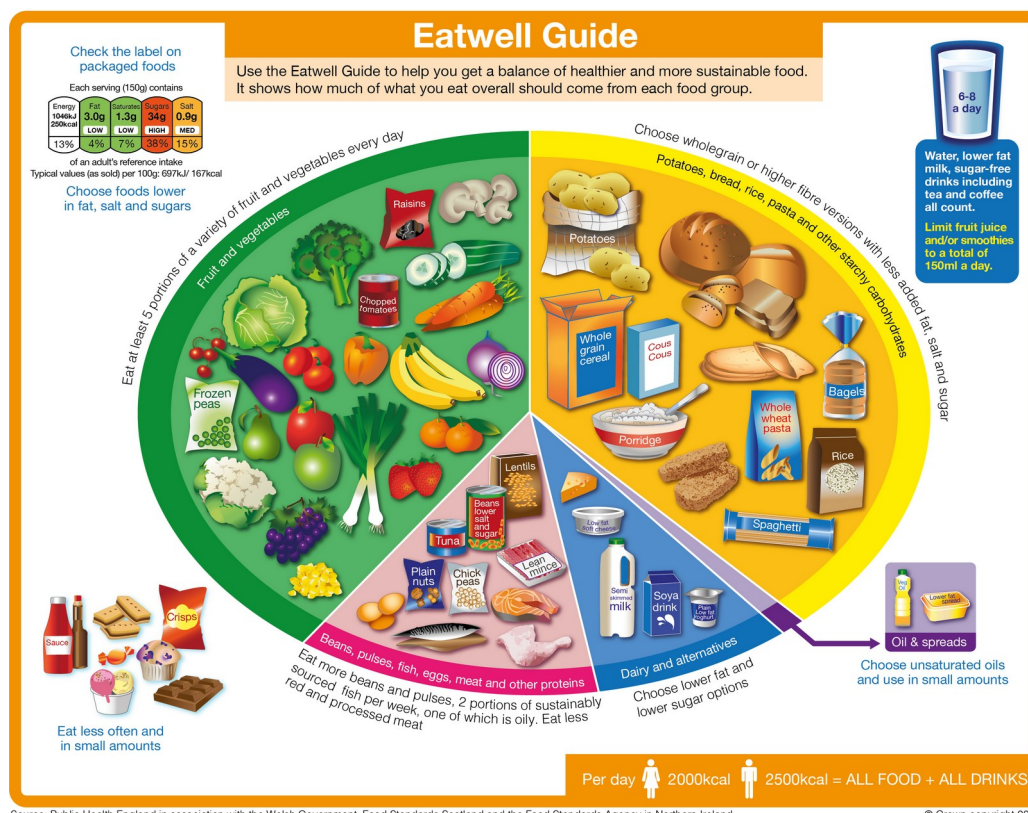
WORTH TRYING

Use a new environment deliberately: often a better moment to offer a genuinely new food than repeat a request that's failed at home. One parent added cucumber to her son's lunchbox for weeks with no comment; he never touched it, until she forgot it once and asked, with real concern, "where's my cucumber?" He later ate it. (Details changed to protect privacy.)

NUTRITION BASICS

What Does “Balanced Diet” Actually Mean?

A balanced diet means eating a variety of foods from all five food groups, in roughly the right proportions: not just the vitamins in fruit and veg, but the energy from starchy carbohydrates, the protein for growth and repair, the calcium from dairy, and the fats needed to absorb certain vitamins. Each group does a different job; none can fully replace another.



Source: Public Health England in association with the Welsh Government, Food Standards Scotland and the Food Standards Agency in Northern Ireland

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PLEASE READ THIS PART

This chart isn't a target to hit right away, and it isn't here to invite comparison. If your child's diet is currently narrow, it's simply useful background, so you know what's meant when this guide talks about “food groups” or “balance.” The rest of this guide is about getting there gently.

British Food Swap Ideas by Sensory Profile

Starting points for gentle food bridges, grouped by sensory profile rather than food group, since that's usually a better guide to what your child might accept next. The goal is variety itself: a same-profile swap that's simply a different brand still counts as genuine progress.

Sensory profile	Common safe foods	Gentle swap ideas
Dry & crunchy	Rich Tea / digestive biscuits, breadsticks, rice cakes, plain crisps	Water biscuits, oatcakes, plain popcorn, a different brand of breadstick or rice cake
Smooth & uniform	Smooth yoghurt, mashed potato, plain hummus	Smooth soup, custard, plain porridge, cream cheese
Soft & doughy	White bread, plain bagel, pancakes	Brioche, crumpets, naan, pitta bread
Cold & crisp	Cucumber, apple slices, carrot sticks	Other raw vegetable sticks, cold cooked pasta shapes
Warm & starchy	Chips, potato waffles, jacket potato	Roast potatoes, hash browns, sweet potato fries
Dry protein	Chicken nuggets, fish fingers	Breaded chicken goujons, fish cakes, plain sausages

When to Seek Help Sooner

Most of this guide is about gentle, gradual change, but a few signs mean it's worth contacting your GP, health visitor, or NHS 111 promptly, rather than waiting for your referral:

- Rapid or ongoing weight loss, or a noticeable slow-down or drop across growth-chart centiles
- Signs of dehydration: noticeably fewer wet nappies, a dry mouth, or unusual lethargy
- Frequent choking, coughing, or vomiting specifically during meals
- Persistent low mood, high anxiety, or physical symptoms (unusual tiredness, pale skin, frequent infections) alongside a very limited diet

You know your child. If something feels wrong, even if it doesn't neatly match a list like this one, that's reason enough to seek medical advice.

TAKING ACTION

Family Meals, School, and Eating Out

Keep one thing on the table your child already eats, and let everyone else's plate look however it needs to. If a relative leans in with “go on, just one bite,” an agreed line helps: “we're not doing that at the moment” is a complete sentence.



School support below covers England and Wales, since education is devolved. In England, schools have a legal duty under the Children and Families Act 2014 to support pupils with medical conditions, including adjustments such as a packed lunch arrangement.⁷ In Wales, schools work under separate statutory guidance, and catering dietitians can often adapt the meal itself directly.⁷ In Scotland or Northern Ireland, arrangements differ; it's best to check directly with your child's school, health board, or education authority.

EATING OUT, IN SHORT

Check menus in advance, bring a familiar safe food as backup, and remember: “this is what's working for us at the moment” is a complete sentence. You don't owe anyone a full explanation.

Talking to Others About Your Child's Eating

Explaining your child's eating to other people is its own kind of tiring. It's worth deciding in advance how much detail you want to give, and to whom.

- Grandparents and family who push back: give a short “why” rather than a list of rules (“his brain reacts to some textures the way ours would react to something genuinely disgusting, it's not naughtiness”), and give them a positive role, such as not commenting on what's on his plate.
- School and nursery staff: a short written summary saves you repeating yourself: your child's name, a one-line explanation, and what to do if there's a genuine concern.
- Other parents: a short, boring answer (“he's just working through some feeding stuff, it's really common”) closes down unwanted questions better than a longer, defensive one.

ABOVE ALL

You are not failing, and you are not alone. Those two sentences show up more than any others in my clinic room, because they're the ones parents need to hear most and are told least.

Looking After You: Your Half of the 50/50

Supporting a child through feeding difficulties is hard, often for years. It's completely normal to feel exhausted, anxious about mealtimes yourself, or isolated.

Someone once told me that a parent's needs matter just as much as their child's: a real 50/50, not less. When every meal feels like a worry, your own needs quietly slip to the bottom of the list. But you're not only a parent. You're a person too, with your own friendships, interests, and the things that make you feel like you. And a parent who has had a chance to rest and recharge often brings a calmer energy to the table, which helps your child as well.



It doesn't need to be big or perfectly planned. It might look like:

- A coffee or a walk with a friend who makes you laugh
- Talking to someone you trust: a partner, a friend, another parent who understands, or your GP if you're struggling
- A trip to the cinema, or an evening watching something you actually chose
- A long bath, a chapter of a book, or twenty quiet minutes with a cup of tea
- Picking up a hobby or activity you used to love

If guilt creeps in, that's normal too. Looking after yourself isn't taking anything away from your child.

I hold onto that 50/50 in every family I work with: I will never tell you to force your child to eat, I will never judge what's in your cupboards or your child's lunchbox, and if something is outside what I can help with, I'll tell you honestly and point you towards who can.

A Simple Food & Symptom Tracker

Photocopy this page or recreate it in a notebook. Keep it for a week or two: it's useful for spotting patterns yourself, and genuinely helpful for whichever professional you eventually see.

Date	Foods/drinks offered	What was eaten/drunk	Any symptoms?	Notes

Note down foods and drinks offered (not just eaten), roughly how much was eaten or drunk, and anything that stood out physically, such as tummy ache, reflux, or unusual tiredness.

Helpful UK Resources

- ARFID Awareness UK (arfidawarenessuk.org): the UK's dedicated ARFID charity, with free resources for parents, carers, and professionals.
- Beat (beateatingdisorders.org.uk): the UK's eating disorder charity, helpline 0808 801 0677, runs an online ARFID peer-support group.
- National Autistic Society (autism.org.uk): helpline 0808 800 4104, for autism-specific advice and support.
- Contact (contact.org.uk): the charity for families with disabled or additional-needs children, helpline 0808 808 3555; no diagnosis needed.
- British Dietetic Association, Find a Dietitian (bda.uk.com/find-a-dietitian.html): to find a HCPC-registered dietitian near you.

NEXT STEPS

Ready for Personalised Support?

Everything in this guide is general information, useful while you wait, but no substitute for a proper look at your own child's eating, growth, and sensory profile.

I run a focused six-week programme, Beyond the Waiting List, for families across the UK: understanding your child's full picture, lowering pressure and protecting nutrition, one realistic food bridge at a time, and a review with a clear plan and onward referral if needed. A short suitability check comes before any booking or payment.

If you'd like to talk through your child's specific situation, I'd love to hear from you.

Find Out More on My Website

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