



Nutritional Solutions
REGISTERED DIETITIANS

Nutritional Care of the Neurodivergent Child

Addressing nutrition and feeding challenges and through family-centred approaches

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This information is intended for use by healthcare professionals only.

Introduction: Neurodiversity



- Neurodiversity, including **ADHD** and **autism spectrum disorder (ASD)**, affects **learning, behaviour and long-term health**.
- Complex, heterogeneous and multifactorial.
- Emerging evidence links **diet quality, dietary patterns and micronutrient status** to symptom severity and functional outcomes.
 - **Key nutrients:** omega-3s, vitamin D, iron, zinc, magnesium, probiotics
 - **Dietary patterns:** “healthy” vs. Western / junk-food patterns

Optimising diet and key nutrients may support brain function, behaviour and outcomes in neurodiverse children and adults.

Defining and Diagnosing Neurodiversity



Neurodiversity

- Natural variation in brain development.
- Includes ADHD, autism, dyslexia and more.



Neurodivergent

- Individuals whose brain functions differ from the 'typical'.



Diagnostic Criteria

- Clinically diagnosable neurodevelopmental conditions.
- DSM-5 and clinical rating scales.



Proposed Treatment

- Pharmacological
- Lifestyle
- Psychological

Neurodiversity: By the Numbers



6–7%

Global prevalence of ADHD



5%

Prevalence of ADHD in South Africa



78%

Of children with ADHD have co-occurring conditions



4 in 10

Children with ADHD have anxiety



55%

Of children with Tourette's also have ADHD



17%

Of children with ADHD have learning disabilities



42%

Children diagnosed with ASD also have ADHD

Pathophysiology of Autism Spectrum Disorder (ASD)



Collection of neurodevelopmental disorders marked by challenges in **social interaction, communication and repetitive behaviours.**

Highly heritable condition – >100 genes implicated in autism.

Pathophysiology not yet well understood: oxidative stress, mitochondrial dysfunction, immune dysregulation, gut-brain axis.

Origins are complex, with multiple contributors: **genetics, environment and nutrition.**



Pathophysiology of ASD: Nutritional Vulnerability



Micronutrients are pivotal for many physiological processes: structural elements of the CNS; nerve-cell development, migration and differentiation.

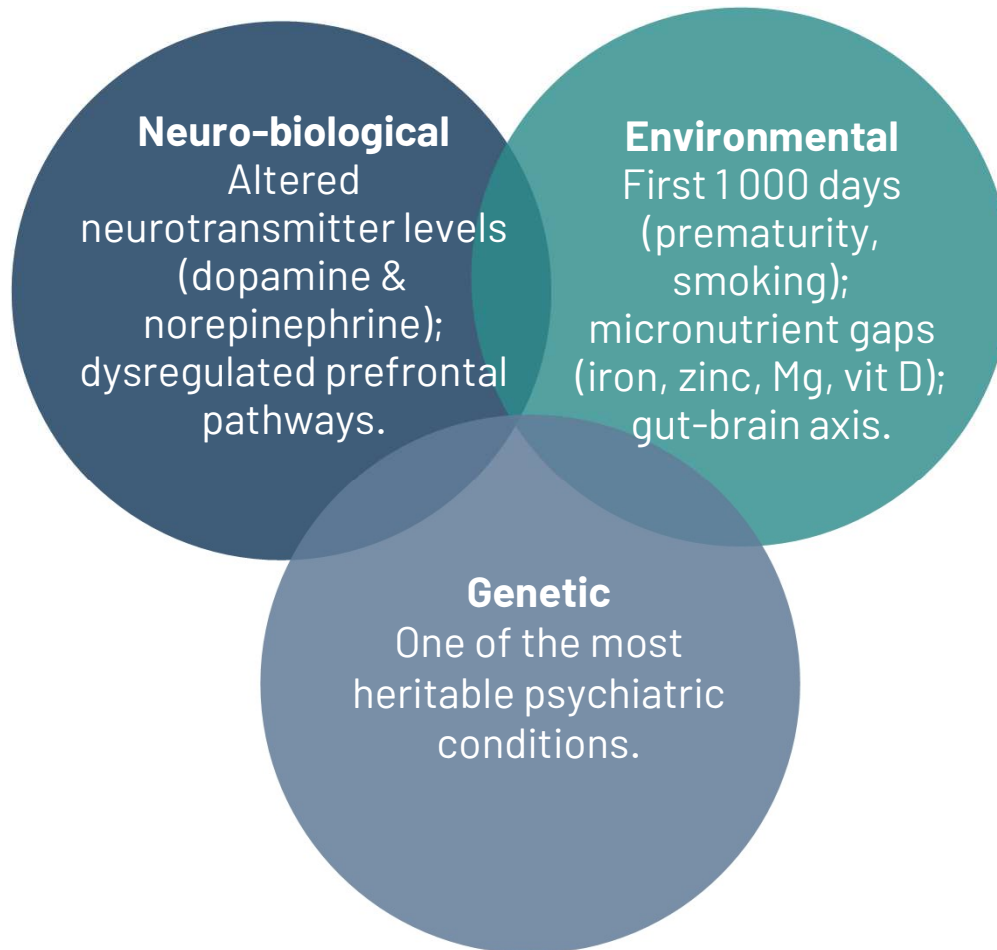
Pre-natal nutrition influences autism risk – folate, iodine, vitamin D, vitamin B12, iron.

Children with ASD show **unique dietary patterns, preferences and aversions** that may predispose to nutritional imbalances.

Sensory sensitivities: restrictive eating limits nutrient-rich foods. **GIT concerns:** affect nutrient absorption and metabolism.

Together these elevate the risk of micronutrient deficiencies, which may further intensify ASD-related symptoms and challenges.

Attention-Deficit / Hyperactivity Disorder



Classification types

1. **Predominantly inattentive** – meets inattention but not hyperactivity-impulsivity criteria for ≥ 6 months.
2. **Predominantly hyperactive-impulsive** – meets hyperactivity-impulsivity but not inattention criteria for ≥ 6 months.
3. **Combined presentation** – meets both inattentive and hyperactive-impulsive criteria for ≥ 6 months.

Presentation severity: mild . moderate . severe

Major Diagnostic Frameworks & Tools



Group	Tool / Framework	What it does	Key point
Core classification systems	DSM-5	Diagnoses neurodevelopmental conditions (ASD, ADHD, learning disorders)	Symptom-based; categorical yes/no; widely used
	ICD-11	International medical diagnostic standard	Broader descriptions; aligns better globally & dimensionally
Gold standards for autism	ADOS-2	Autism assessment via observation	Directly observes social interaction, play, communication
	ADI-R	Parent / caregiver interview for autism	Focus on early development, language, social skills; used with ADOS-2
Most used for ADHD	Conners Rating Scales	Questionnaires for parents, teachers, self-report	Practical, multi-informant screening
	Vanderbilt ADHD Scales	Performance & behaviour items	Practical for schools
	SNAP-IV	Short DSM-based rating scale	Reliable & widely used
SDQ	General behavioural / emotional screening	Covers emotional, conduct, hyperactivity, peer & prosocial behaviour	

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)



DSM-5 is the **gold standard** for diagnosing neurodevelopmental conditions such as ASD, ADHD and learning disorders.

- **Symptom-based criteria**, age of onset, and impairment in daily life.
- Symptoms / behaviours that have **persisted ≥ 6 months and present in ≥ 2 settings** (e.g. school, home, church).
- Symptoms have **negatively impacted academic, social and/or occupational functioning**.
- **Validity**: widely validated, but criticised for a categorical (yes/no) approach that may not reflect the neurodiversity spectrum.

DSM-5: Symptom Criteria



Inattention (IA)

≥5 for adults. ≥9 for children

- Fails to give close attention to detail; makes careless mistakes.
- Has trouble holding attention on tasks or play.
- Often does not seem to listen when spoken to directly.
- Does not follow through on instructions; fails to finish tasks.
- Has trouble organising tasks and activities.
- Avoids / dislikes tasks requiring sustained mental effort.
- Often loses things necessary for tasks.
- Is easily distracted by extraneous stimuli.
- Is often forgetful in daily activities.

Hyperactivity–Impulsivity (HY/IM)

≥5 for adults. ≥9 for children

- Fidgets with or taps hands/feet, or squirms in seat.
- Often leaves seat when remaining seated is expected.
- Runs about or climbs where inappropriate (restlessness in adults).
- Is often unable to play or work quietly.
- Is often “on the go,” as if “driven by a motor.”
- Often talks excessively.
- Blurts out an answer before a question is completed.
- Has trouble waiting his or her turn.
- Often interrupts or intrudes on others.

Pharmacological Management: Stimulants vs Non-Stimulants



	STIMULANTS	NON-STIMULANTS
Indicated	First-line (70–80%); moderate–severe ADHD; gold standard.	Alternative when stimulants are ineffective or contraindicated .
Action	Methylphenidate blocks DA/NE reuptake; amphetamine boosts release.	Work gradually on other pathways. Atomoxetine : selective NE reuptake inhibitor. Bupropion : NE-DA reuptake inhibitor.
Onset	Within 30–60 minutes.	Takes 5–7 days to see benefit.
Dosing	IR 2–3×/day (3–5 h); ER 1×/day (10–14 h).	1–2×/day depending on need.
Benefits	Most effective; quick relief.	No abuse risk; gentler for sensitive cases.
Side-effects	Decreased appetite, weight loss, insomnia, headache, irritability, jitteriness, tics.	Upset stomach, decreased appetite, dizziness, fatigue, mood swings, dry mouth, insomnia.
Examples	Methylphenidate : Ritalin, Concerta, Contramyl, Medikinet. Adderall.	Atomoxetine : Strattera, Inir. Bupropion : Wellbutrin.

Changes in Meal Timing and Intake Patterns



Appetite Suppression

- Especially stimulant medication.
- Most evident during daytime peak.
- Missed meals; reduced energy intake.
- Poor dietary quality from skipped meals and overeating.
- Reduced intake of key nutrients.



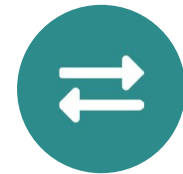
Irregular Mealtimes

- Compensatory eating in the evening once medication wears off.
- Overeating at night → sleep and GIT disturbances.



Medication Breaks

- Holidays and weekends.
- Irregular eating behaviours.
- Difficulty regulating appetite.



Drug–Nutrient Interactions

- Caffeine can intensify medication effects.
- Vitamin C / acidic foods can lower amphetamine efficacy.
- High-fat meals may delay absorption (Adderall, not Concerta).

Picky Eating and Feeding Challenges



Behavioural

- Impulsivity: binge eating.
- Attention-deficit: grazing, forgetting to eat, distraction at meals.
- Hyperactivity: disrupted mealtimes, inability to sit still.



Food-related

- Food-selective: limited variety, picky eating.
- Sensory: texture and smell aversions.
- External cues.

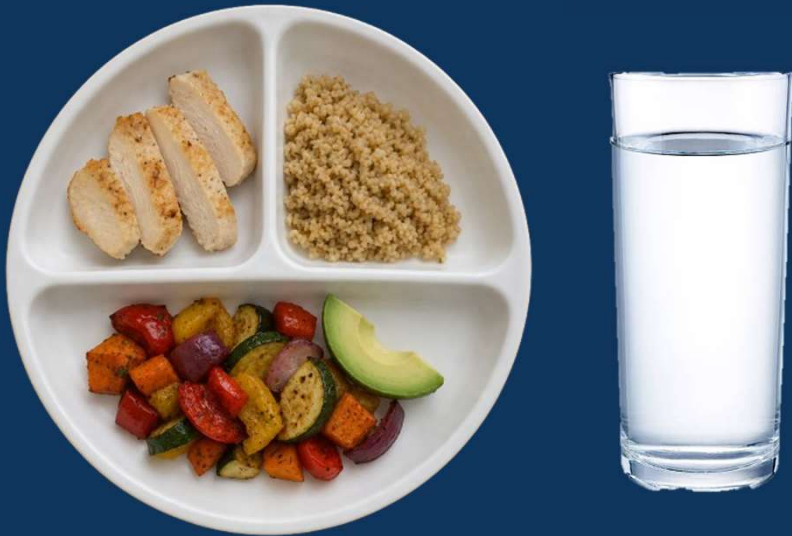


Medication & family

- Mealtime stress and family conflict.
- Executive dysfunction: skipped meals and snack reliance.



A Balanced Plate



- ✓ **Iron + B-vitamins:** energy, mood, concentration, neurotransmitter synthesis
- ✓ **Protein:** growth, immunity, brain chemical production
- ✓ **Fibre + complex carbs:** gut motility, stable energy, no blood sugar spikes
- ✓ **Water:** improves gut motility
- ✓ **Omega-3 + healthy fats:** attention, mood regulation, memory support
- ✓ **Vitamin D + zinc:** immune function, bone health, sleep quality



The Neurodivergent Plate



- X **No iron sources:** fatigue, irritability, poor concentration
- X **Minimal protein:** one brand of nuggets, inconsistently eaten
- X **No fibre:** chronic constipation, blood sugar spikes and crashes
- X **High carbs (glucose):** blood sugar spikes and crashes, affects energy and mood
- X **No healthy fats:** omega-3 index low, impacting focus and mood
- X **No vitamin D or zinc:** weakened immunity, poor growth, poor sleep

Anthropometric Concerns in Neurodiversity



Undernutrition (underweight)

- Appetite suppression from medications.
- Hyperfocus or inattention can cause meal skipping.
- Missed hunger cues from chaotic routines or poor interoception.

Anthropometric Concerns in Neurodiversity



Overnutrition (overweight / obese)

- More prevalent when off medication.
- Impulsive or emotional eating.
- Ultra-processed preference.
- Poor self-regulation of hunger and fullness.
- Screen-time distractions.
- Compensatory overeating.

Salvat H, et al. Nutrient intake, dietary patterns and anthropometric variables of children with ADHD: a case-control study. BMC Pediatr. 2022.

Sensory Support Strategies



Driven by occupational therapists (OTs)

- Sensory-based feeding.
- “Just-right” mealtime environment.
- Seating & posture aids.
- Oral-motor tools.
- Visual systems.
- Combine into a structured sensory diet.



The dietitian's role

- Identify red flags.
- Collaborate with OTs on integrated feeding plans.
- Reinforce sensory strategies.
- Ensure food-exposure goals align with sensory tolerance.

Nutrient Concerns in Neurodiversity



Iron

- **Systemic iron findings mixed** (10/18 studies ↓ ferritin; only 2/10 ↓ serum iron).
- **Brain iron more relevant** – MRI shows lower thalamic iron in ADHD.
- Iron deficiency at 12–18 months predicted ADHD & sluggish cognitive tempo at 5, 10, 16 years.
- Benefits more evident in low baseline iron/zinc subgroups.

Current research: treat if there is a deficiency.



Omega-3s

- Poor maternal diet (low ω -3, high ω -6) linked to ADHD.
- **Lower blood ω -3 and higher ω -6: ω -3 ratio** in ADHD; linked to greater severity.
- **Dosage:** no conclusive evidence (studies <16 weeks, <500 mg EPA).
- Positive correlation when **EPA >500 mg** – individualise.

Current research: supplement ω -3 with >500 mg EPA and a higher EPA:DHA ratio.



Zinc

- **Early/present zinc deficiency may increase ADHD risk.**
- Symptoms improved with supplementation in low-zinc children.
- Linked to hyperactivity & impulsivity, not inattention.
- Small but significant improvement in ADHD scores; best over 6–12 weeks.

Current research: treat if there is a deficiency.

Nutrient Concerns in Neurodiversity



Magnesium

- People with ADHD may have **lower magnesium** (low intake or higher need).
- Symptoms may improve with supplementation.
- **Magnesium L-threonate** improved symptoms (small open-label, no placebo).
- **RCT: Mg + vitamin D over 8 weeks** improved emotional, behavioural & social symptoms in children.

Current research: treat if deficient (Mg glycinate, citrate or L-threonate).



Vitamin D

- Early deficiency (esp. newborn period) is a **risk factor for later ADHD**.
- Supports brain development, neuroprotection & dopamine regulation.
- Low maternal/neonatal levels may disrupt early brain development.
- Observational: lower vitamin D linked to **greater symptom severity**; supplementation to reduced symptoms.

Current research: not a standalone treatment; treat if deficient.



Probiotics

- **Gut-brain axis** may influence brain function, behaviour & mental health.
- **Microbiome differences seen in ADHD** (findings inconsistent); some benefit for hyperactivity & focus.
- L. rhamnosus . L. acidophilus . B. bifidum.
- **Larger, high-quality trials needed.**

Current research: treat if there are gut problems.

Guidelines for Correcting Nutrient Deficiencies in Children



Omega-3	No standardised guidelines. Up to 1 500 mg/day (1–8 yrs); aim for EPA >500 mg; ratio 9:3:1 EPA:DHA:GLA.
Iron	6–23 mo: 10–12.5 mg/day. 24–59 mo: 30 mg/day. 5–12 yrs: 30–60 mg/day elemental iron, for 3 months.
Zinc	Birth–6 mo: 2 mg. 7–12 mo: 3 mg. 9–13 yrs: 8 mg. 14–18 yrs: 9–11 mg.
Vitamin D	AAP: 400 IU for breastfed infants / <1 L fortified milk daily. Deficiency (<30 ng/mL): 2 000 IU/day or 50 000 IU weekly ×6 wks. Maintenance 1 000 IU once >30 ng/mL.
Magnesium	No standardised guideline. Supplement upper limits: 1–3 yrs: 65 mg. 4–8 yrs: 110 mg. 9–18 yrs: 350 mg.

Micronutrients & Neurodiversity: Evidence Summary



Nutrient	Dosage studied	Population / context	Reported outcomes	Evidence
Iron	Ferritin <30 ng/mL; individualised	Children with ADHD; deficient infants	↑ ADHD symptoms with low ferritin; benefit in deficient subgroups	Mixed but promising
Zinc	10–40 mg/day (6–12 wks)	ADHD, often adjunct to methylphenidate	Improved ADHD scores, esp. in zinc-deficient children	Moderate
Magnesium	6 mg/kg/day ×8 wks (often + vit D)	Children with ADHD	Better behaviour & mental health when combined with vit D	Emerging
Vitamin D	50 000 IU/wk ×6–8 wks (adjunct)	Children with ADHD	Improved hyperactivity, inattention, behaviour (esp. if deficient)	Good (adjunct)
Folate (B9)	0.4–0.8 mg/day; 5 mg/day high-risk mothers	Prenatal	Prevents neural-tube defects; ↓ autism risk pre/early pregnancy	Strong (prenatal)
Vitamin B12	Individualised deficiency correction	Pregnant women & children	Deficiency → delays; very high maternal levels linked to ↑ autism risk	Conflicting
Iodine	250 µg/day in pregnancy	Pregnant women	Essential for thyroid-driven neurodevelopment; prevents impairments	Strong (prenatal)
Choline	450 mg/day (RCTs to 930 mg)	Pregnant women	Supports hippocampal growth & neural-tube closure	Promising, limited
Omega-3 (EPA/DHA)	300–600 mg/day in RCTs	Children/adolescents with ADHD	Mixed: some ↓ impulsivity, others no effect	Inconsistent

How the Type of Diet Influences ADHD Risk



Meta-analysis: 6 dietary-pattern studies (n = 8 816 children) examined adherence to **“healthy”**, **“Western”** and **“junk-food”** patterns and ADHD risk.



“Junk-food” pattern
Sweetened beverages,
desserts
50% higher risk $p = 0.02$



“Healthy” pattern
Vegetables, fruit, legumes,
fish
37% lower odds of ADHD



“Western” pattern
Red/processed meat, refined
grains, hydrogenated fats
Near-doubled risk $p = 0.016$

Healthy diets associate with **reduced** and **unhealthy diets** with **increased** ADHD risk.
Data are observational – **causality cannot be confirmed.**

Dietary Patterns vs Single Nutrients



Whole diets and dietary patterns – rather than single, isolated nutrients – appear most helpful in managing ADHD.

Dietary patterns linked to ADHD risk

- Higher intake of **sweets, ready-made meals and low micronutrient intake** is associated with ADHD.
- **Western-style diets** positively associated; **healthy patterns** (fruit, vegetables, lean protein) protective.
- Diets rich in **vegetable protein, zinc, calcium and phytochemicals** correlate with fewer symptoms.
- **Sugar intake:** inconsistent; prospective data show **no causal link** – may be a consequence, not a cause.

Maternal diet quality

Better maternal diet in pregnancy associates with lower ADHD risk in offspring, but child diet quality at age 3 showed no link with ADHD at 8 years.

Dietary Patterns: The Mediterranean Diet & Inflammation



Greater adherence to a Mediterranean diet (↑ fruit, vegetables, whole grains, legumes, fish) is associated with lower ADHD odds.

- **Chronic inflammation** is associated with some individuals with ADHD.
- Early-childhood stress exposure plays a role.
- ADHD is also associated with **auto-immune and inflammatory disorders** – asthma, diabetes, allergic rhinitis, maternal autoimmune disease and maternal stress.
- **Possible mechanisms:**
 - HPA-axis dysregulation and altered cortisol.
 - Gut dysregulation → inflammation, anxiety or hyperactivity.
 - → favours **anti-inflammatory, polyphenol-rich diets** (i.e. the Mediterranean diet).



The Few-Foods Diet



Emerging evidence suggests a role for food hypersensitivities in ADHD.

Few-foods diet: short-term elimination of most foods → stepwise reintroduction to identify triggers.

- ~60% of children show symptom improvement within 4 weeks.
- Common triggers: milk/dairy, cocoa, peanuts, grains, corn.
- Benefits extend to physical complaints (headaches, GI, sleep).
- May reduce need or dose of ADHD medication.
- Long-term improvement possible (up to 3.5 years).

Mechanism: whole-brain analyses show a correlation between reduced ADHD symptoms and increased precuneus activation. Findings support food intolerance as a possible contributor – but careful application and more RCTs are needed.



Dietary Patterns: DASH & Lifestyle



DASH-style diet

A DASH-style diet **improved hyperactivity and conduct problems** in an RCT.

Direction of association

ADHD symptoms may **predict poorer diet quality** rather than diet driving ADHD risk.

Lifestyle factors

Children with ADHD are **nearly twice as likely to have fewer healthy lifestyle behaviours** (diet, activity, sleep, screen time) — highlighting the need for multifaceted lifestyle interventions.

Food Additives & Artificial Colours

A subgroup of children appears sensitive to **artificial food colours (AFCs) and certain preservatives** – small average effects, but meaningful for responders.



The evidence

- Southampton study (McCann, 2007): AFC + sodium benzoate mixes ↑ hyperactivity in the general child population.
- Meta-analyses show a small but real effect of colour elimination.
- Greatest benefit in children with confirmed sensitivity – not all respond.



Additives implicated

- Azo dyes: tartrazine (E102), sunset yellow (E110), carmoisine (E122), ponceau 4R (E124), allura red (E129); quinoline yellow (E104).
- Sodium benzoate (E211) preservative.
- EU requires a warning label on these colours.



Practical approach

- Feingold-type elimination: remove artificial colours, flavours, preservatives (± salicylates).
- Trial a supervised elimination only where sensitivity is suspected.
- Read labels; choose minimally processed foods; ensure the diet stays balanced.

Alternative Nutrients & Supplements for Neurodiversity



L-Tyrosine

May support the dopamine pathway. Only mild benefit unless there is a deficiency.

Studies from the 1980s.



Citicoline / CDP-Choline

Increases acetylcholine and dopamine – mild improvements.

Hübner, et al. 2024.



NAC (N-acetylcysteine)

↑ glutathione → ↓ inflammation. Small studies show improved emotional regulation.

Smaga, et al. 2021.



Saffron extract

Works similarly to methylphenidate in small studies, with fewer side-effects – but evidence is insufficient.

Blasco-Fontecilla, et al. 2022.

The Role of HCPs in Managing Neurodiversity



Nutritional deficiencies

- Assess for deficiencies.
- Assess attention, mood or sleep.
- Evidence-based supplementation.



Nutritional intake

- Manage appetite during stimulant hours.
- Encourage nutrient-dense meals & snacks.
- Support growth; prevent nutrient gaps.
- Time meals to minimise drug-nutrient interactions.



Allergies & sensitivities

- Few-foods diet; screen for triggers.
- Guide safe elimination & reintroduction.
- Keep the diet balanced.



Gut health

- Address constipation / GI issues.
- Recommend fibre, fluids ± probiotics.
- Consider the gut-brain connection.
- Encourage exercise.



Family support

- Help with mealtime structure & routines.
- Strategies for picky / impulsive eating.
- Collaborate across the care team.

Practical Applications for Neurodivergent Children



Hands-on energy- and protein-boosting strategies for poor appetite and stimulant-related appetite suppression



Lead with full-cream dairy

- Use full-cream (full-fat) milk, yoghurt, cheese and cream – more energy in less volume.
- Full-cream milk on cereal/porridge, in cooking, and as a drink between meals.



Add healthy fats to every meal & snack

- Olive/canola oil, avocado, nut butters, seeds, cheese, full-fat yoghurt, oily fish.
- Drizzle oil over veg, spread nut butter on toast/fruit, add avocado to meals.

Practical Applications for Neurodivergent Children



Hands-on energy- and protein-boosting strategies for poor appetite and stimulant-related appetite suppression



Front-load the morning

- Appetite is best before the stimulant peaks — make breakfast the biggest, highest-energy meal.
- Combine protein + healthy fat + slow carbs (e.g. eggs, full-cream yoghurt, oats, nut butter).



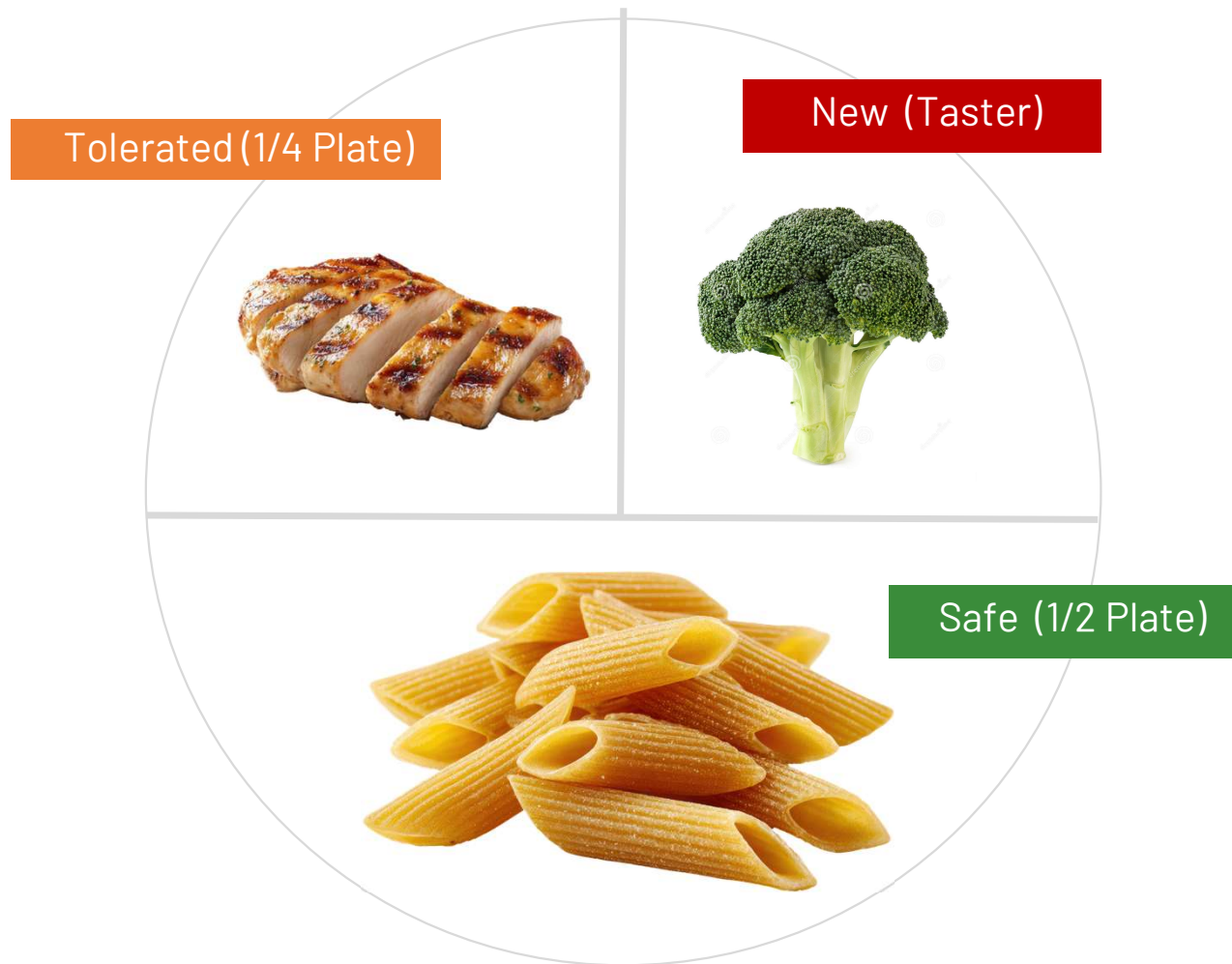
Catch the appetite rebound

- Appetite returns late afternoon/evening as medication wears off — offer a substantial after-school meal.
- Put the (often-untouched) lunchbox in the car for the drive home to capture that rebound.



Fortify with neutral whey protein. A neutral-tasting whey stirs invisibly into **porridge/oats, yoghurt, milk & milkshakes, smoothies, mashed potato, soups and sauces, or scrambled egg** — boosting protein and energy without changing taste; ideal for fussy eaters.

Practical Applications: The Robot Approach



 Safe food = largest portion (feel secure)

 Tolerated food = medium portion (exposure)

 New food = smallest portion (just present it)

Practical Applications: Food Chaining



Liked food



Change the temperature



Change the texture



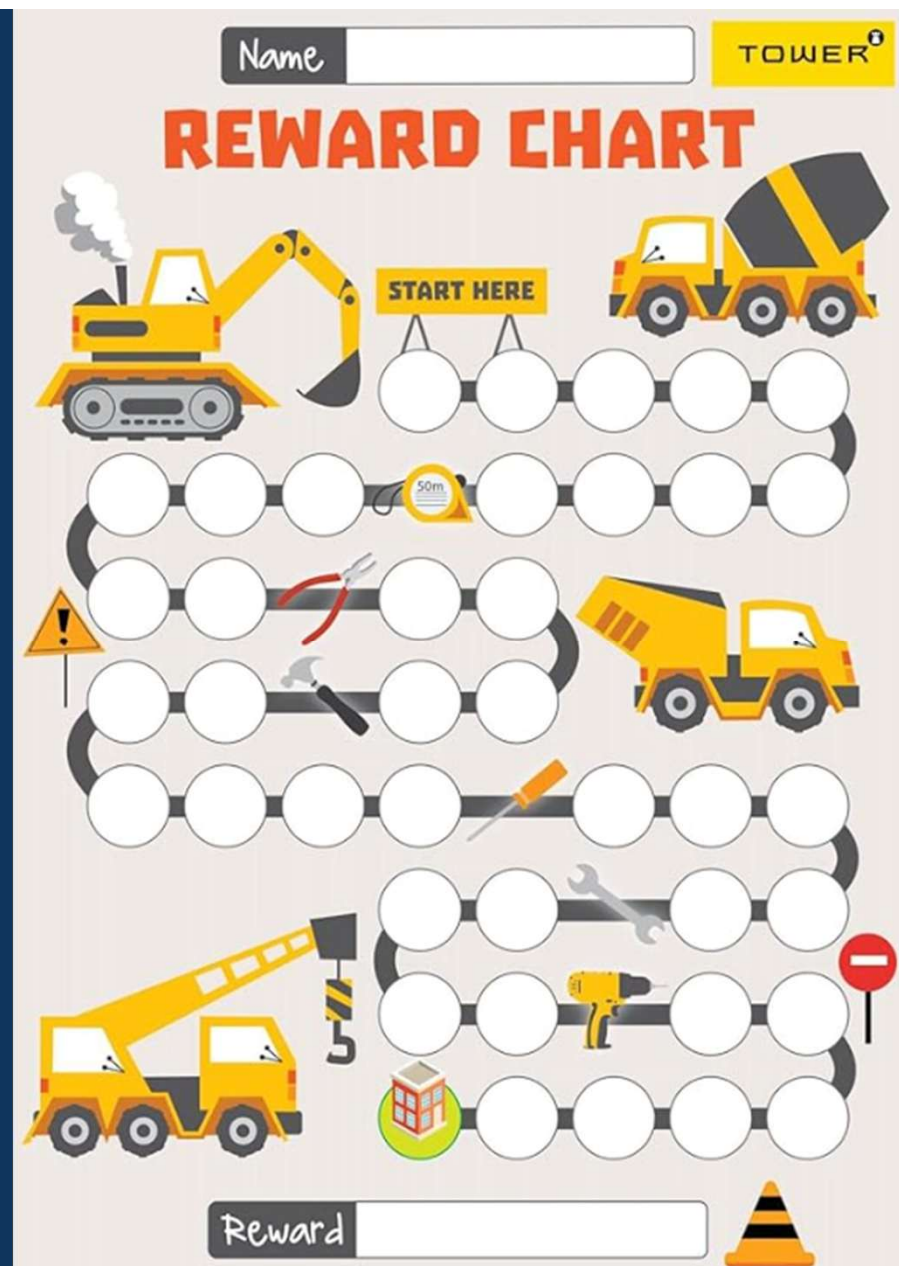
Offer the whole food











Multidisciplinary Collaboration in Neurodiversity



Registered dietitians

Optimise nutrition for growth, brain function and behaviour; manage feeding difficulties.

Paediatricians

Medical diagnosis; monitor growth & development; manage medications.

Psychiatrists

Oversee mental health; prescribe and adjust ADHD/ASD medications.

Occupational therapists

Support fine-motor skills, sensory regulation and daily living.

Physiotherapists

Assist with gross-motor skills, coordination and body awareness.

Educational psychologists

Assess learning difficulties; advise on school accommodations.

Speech therapists

Improve communication, language and social-interaction skills.

Conclusion



- Neurodiversity is a **dynamic, complex** group of neurodevelopmental conditions with **multifactorial** influences, including nutrition.
- Dietitians play a vital role in supporting growth, behaviour and overall health.
- Key areas of focus:
 - **Nutrient adequacy** (especially iron, zinc, omega-3s, vitamin D).
 - Managing **medication-related appetite changes**.
 - Addressing **feeding challenges and picky eating**.
 - Considering **dietary patterns, additives and sensitivities**.
 - Supporting **gut health and regularity**.
- Care should be **individualised, practical and family-centred**.
- **Ongoing collaboration with families and multidisciplinary teams** is essential for meaningful impact.
- Research is still limited – but this is a growing field.

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REGISTERED DIETITIANS

Nourishing Neurodivergent Minds

Thank you

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