AMPLE

Clinical Companion Notes

A framework for working with low food interest and low appetite in ARFID

Core idea: low food interest and low appetite ARFID is characterised by an absence of drive toward eating - not anxiety or sensory aversion. The aim is to support nutritional adequacy and the person's own goals, not to produce a ‘normal’ or neurotypical relationship with food.

A - Adequacy, Not Normalcy

Focus on nutritional safety - not dietary normalisation.

- The threshold for intervention is nutritional safety or the individual's own goals - not how their eating looks compared to others
- Supplements are a legitimate long-term clinical solution, not a stepping stone to ‘real’ eating - communicate this clearly to individuals and families
- Format and texture modifications (smoothies, fortified drinks, soft foods) are appropriate ongoing strategies
- Do not set goals around variety or volume beyond the individual’s goals or what is needed for nutritional safety

Reframe for families: The supplements are the treatment - not evidence that treatment isn't working.

M - Modified Clinician Expectations

This population requires clinicians to examine their own assumptions about food and appetite.

Watch your reactions:

- Visible concern, surprise, or discomfort when someone describes low food interest can reinforce shame - monitor your own response
- Maintain a genuinely neutral, curious stance - not performed neutrality, but real acceptance that this is how this person is built
- Avoid language that frames low appetite as something to overcome eg. "we just need to get you eating more"

Challenge your assumptions:

- Food does not have to be pleasurable or social to be adequate
- A limited but nutritionally sufficient diet is not a clinical failure
- Eating as a functional act, not as a source of pleasure or connection, is a valid experience for this population

Ask yourself: Am I setting goals that reflect this person's needs, or goals that reflect my assumptions about what a healthy or normal relationship with food should look like?

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P - Person-Directed Goals

Goals for this population may look quite different from conventional eating disorder recovery targets.

Questions to ask:

- What would a good outcome look like for you?
- What is actually getting in the way in your daily life?
- Why are you here - and do you experience your eating as a problem?

In practice

- Goals might be nutritional (address a deficiency, maintain weight), functional (less cognitive effort around eating, less family conflict), or simply maintaining the status quo with less external pressure
- If the person does not experience their eating as a problem and is medically stable, the clinical task may be primarily systemic - working with the people around them rather than with the person directly
- Name explicitly that treatment goals may not look like conventional recovery - with the person, their family, and the referrer

A person who is medically stable ends treatment eating the same foods they always have, with adequate nutrition and less external pressure, has had a successful outcome.

L - Look to the System, Not Just the Individual

Low food interest ARFID often becomes a clinical problem because of how the people around the person respond to it - not because the person is in distress.

How systemic pressure becomes clinical:

- Parents, partners, schools, and GPs respond to low intake with concern, monitoring, and pressure
- Mealtimes become a site of conflict and anxiety - often more distressing than the eating itself
- By the time a family arrives at a clinician, the systemic response to the presentation may be driving as much distress as the presentation itself

In practice:

- Provide psychoeducation to families i.e. this is not a phase, not a choice
- Help families identify and reduce pressure behaviours - commenting on food, monitoring intake, offering incentives, expressing worry at mealtimes
- Write letters to schools recommending specific accommodations where needed
- Communicate with other treating clinicians to ensure a consistent, non-pressuring approach across the system
- For children and young people, working with parents is often the primary clinical task - parents who understand the presentation and reduce pressure are the most powerful intervention available
- Advocate for the individual in systemic contexts - NDIS planning, school meetings, medical consultations - where normative expectations are being applied

E - Evidence-Based Monitoring Where Clinically Indicated

Monitoring has an important role - but the approach to it matters as much as whether it happens.

In practice

- Monitor where there is clinical indication - not as a default response to a restricted diet
- Involve the person in decisions about what is monitored and how, where possible - ideally, monitoring is collaborative, not imposed
- Share findings factually and without moral weight - a clinical finding warrants a clinical response, not a judgement about how the person eats
- When a concern is identified, address it in the least invasive way consistent with the person's goals and the other AMPLE principles
- Ensure consistency across the treating team - other clinicians may default to expansion-focused language when raising monitoring concerns

Medical necessity: Only divert from the AMPLE principles where there is clear medical necessity - and even then, apply them as much as the situation allows.