EATING DISORDERS AND AUTISM: UNDERSTANDING THE OVERLAP AND SUPPORTING RECOVERY

Heather Gallivan, PsyD, LP (she/her)

Clinical Director, Melrose Center

Andrea Zuellig, PhD, LP (she/her)

Clinical Psychologist, Melrose Center

Zephyr James (any pronouns)

Director of Marketing & Communications

AUSM

Learning Objectives

By the end of the session, participants will be able to:

- Describe the rates of co-occurrence and unique presentation of eating disorders in autistic individuals, with a focus on anorexia and ARFID.
- Explain why autistic traits—such as sensory sensitivities, cognitive rigidity, and interoception challenges—can contribute to or complicate eating disorders.
- Identify systemic barriers and common shortcomings in current eating disorder treatments for autistic people.
- Understand key elements of more effective, neurodiversity-affirming approaches to treatment.

Content Advisory!

- This presentation contains sensitive topics that may be upsetting to some individuals who face their own body image and/or eating disorder challenges
- Research on autism spectrum disorders and eating disorders has limitations with regards to diversity in samples with regards to age, gender, and ethnicity

My Story

Developed an eating disorder at 18

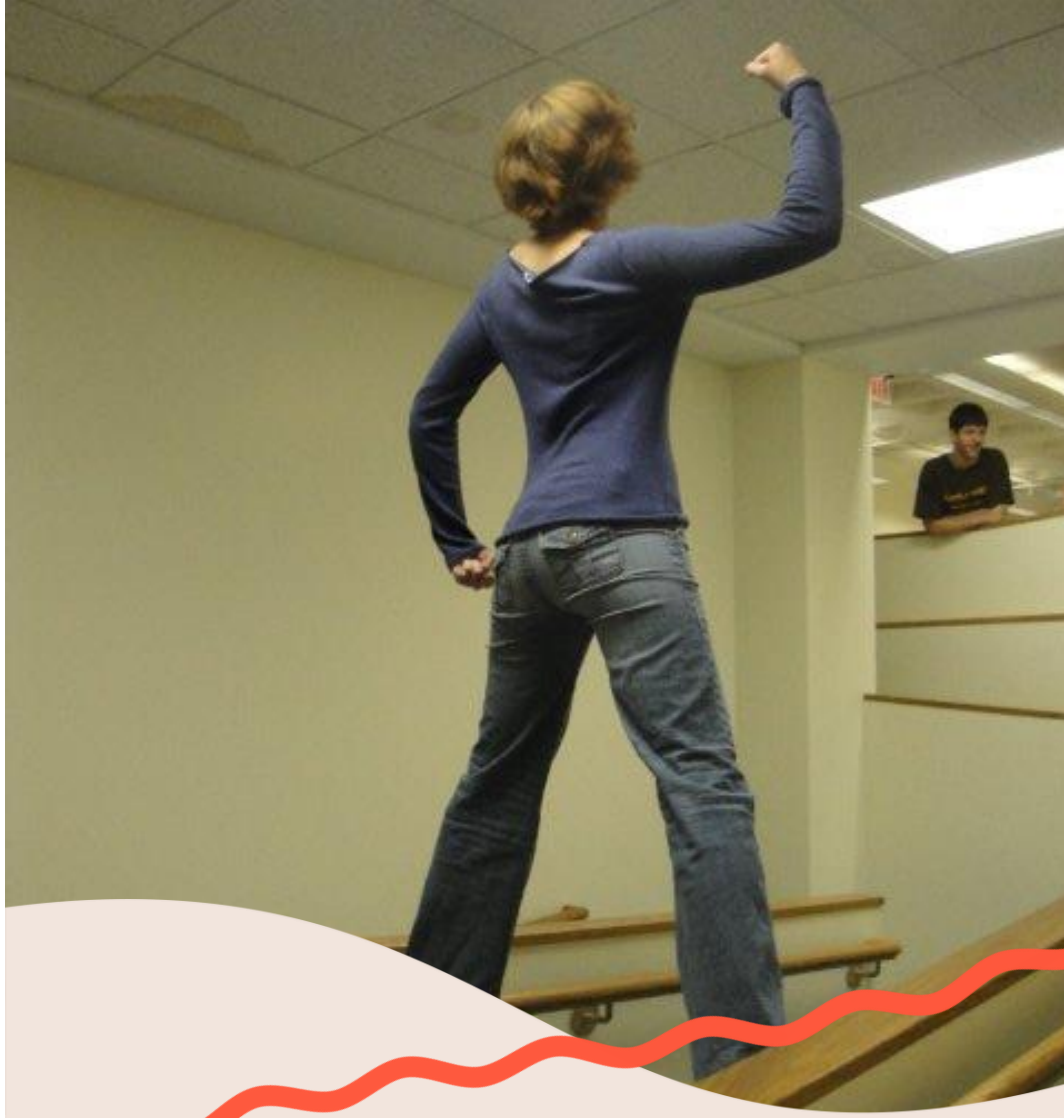
- Set off by a change in routine (quit swimming competitively)
- Burnout (anxiety and depression, perfectionism)
- Expectations outstripped skills
- Grappling with flexible and nuanced thinking (yes, philosophy did cause my depression)

Continued throughout college and after

Symptoms changed, underlying challenges remained

Motivations and Challenges

- Identity and meaning
- Sensory needs
- Black and white thinking
- Concrete method of control and success
- No autism diagnosis



Recovery

What helped?

- DBT
- An endlessly persistent therapist
- Finding social connections
- Basic psychoeducation
- Meeting sensory needs

I arrived at an autism diagnosis through sheer luck. It was life-changing.

Gender, My Eating Disorder, and Autism

Research suggests that autistic individuals are more likely to identify as LGBTQ+

Autistic individuals are 6-8 times more likely to be transgender, or gender-nonconforming than the neurotypical population

My Experience

The overlap of feeling disconnected from my body, overwhelmed by unknown sensory needs, and our of place in my gender created animosity between my mind and my body.


SETTING THE STAGE….

Eating Disorder Prevalence

GLOBALLY INCREASED FROM 3.4% TO 7.8% IN THE PERIOD 2000-2018

IN THE US APPROXIMATELY 9% OF THE POPULATION WILL SUFFER FROM A CLINICALLY SIGNIFICANT ED IN THEIR LIFETIME

Causes & Contributing Factors

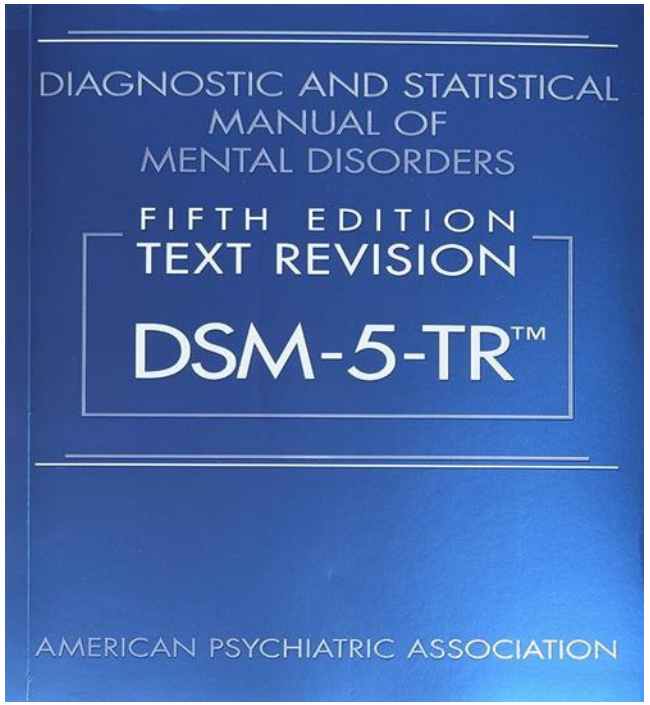
Biological

Psychological

Environmental

What Does an Eating Disorder look like?

DSM-5 Eating Disorder Diagnoses



Anorexia Nervosa

Bulimia Nervosa

Binge Eating Disorder

Avoidant Restrictive Food Intake Disorder (ARFID)

Rumination Disorder

Other Specified Feeding or Eating Disorder (OSFED)

Unspecified Feeding or Eating Disorder (UFED)

Anorexia Nervosa

Restriction of energy intake leading to significantly low weight in the context of age, sex, developmental trajectory, physical health.

Significantly low weight= a weight that is less than minimally normal or for children, less than minimally expected.

Intense fear of gaining weight or persistent behavior that interferes with weight gain. Even though at a significantly low weight.

Disturbance in the way in which one's body weight or shape is experienced, overvaluation of weight/shape on self-evaluation, or persistent lack of recognition of the seriousness of the low weight

Atypical Anorexia

All AN criteria are met except that weight remains at or above normal range

Typically seen in adolescents/young adults with history of overweight

Present with greater weight loss from higher starting point but have comparable ED symptoms both physiologically and psychologically

Often go unrecognized with delayed treatment

Avoidant/Restrictive Food Intake Disorder (ARFID)

An Eating or Feeding disturbance (apparent lack of interest in eating or food; avoidance based on sensory characteristics about food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional needs – causing 1 or more of the following:

- Significant weight loss (or failure to achieve expected weight gain)
- Significant nutritional deficiency
- Dependence on tube feeding or supplements
- Marked interference with psychosocial functioning

- Not due to lack of available food or by a culturally sanctioned practice
- The eating disturbance does not occur during the the course of AN or BN and there is no fear of weight gain or body image disturbance
- Not accounted for by a concurrent medical or psychiatric condition. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention

ARFID Presentations

Fear of Aversive Consequences

Lack of interest in food or eating

Extreme picky eating (often due to sensory sensitivity)

Binge Eating Disorder

Recurrent episodes of binge eating. Binge Eating is characterized by both:

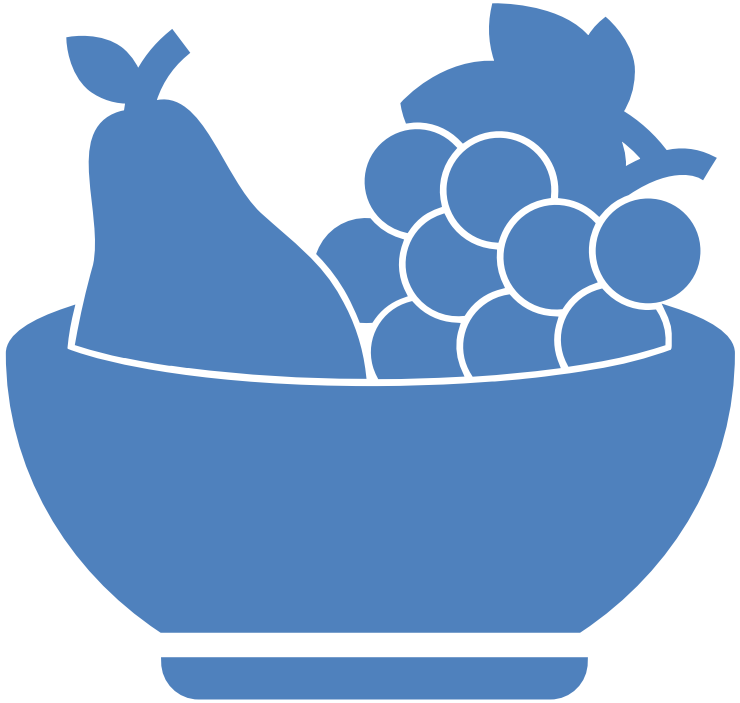
1.Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

2. Sense of lack of control over eating during the episode

The Binge eating episodes are associated with 3 or more of the following:

- much more rapidly than normal
- until feeling uncomfortably full
- when not feeling physically hungry
- Eating alone because of Feeling embarrassed by how much one is eating
- Feeling disgusted with oneself, depressed or very guilty afterward

Marked Distress regarding binge eating is present
The binge eating occurs on average at least once a week for 3 months
The Binge eating is not associated with the recurrent use of inappropriate compensatory behaviors as in BN and does not occur exclusively during the course of AN or BN



Bulimia Nervosa

- Recurrent episodes of binge eating characterized by:
  - Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
  - Sense of lack of control over eating during the episode
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, fasting or excessive exercise
- The binge eating and inappropriate compensatory behaviors both occur on average, at least once a week for 3 months
- Self-evaluation is unduly influenced by body weight and shape
- The disturbance does not occur during episodes of AN


Eating Disorders are like
Icebergs...

Medical Complications of Eating Disorders

- Low blood pressure/pulse, risk of arrhythmias
- Osteoporosis, fractures
- Brain volume loss
- Delayed gastric emptying, gastroparesis
- Muscle wasting
- Lanugo on body, loss of hair from scalp
- Decreased body temperature, hypothermia

Psychiatric Comorbidities

- 56% AN, 94.5% BN, 78.9% BED Meet criteria for another mental health disorder
- 94% of those hospitalized with Eds have another mental health disorder
- 25-35% of people with Eds also have SUD or PTSD
- In children Anxiety disorders precede onset of ED
- 20-30% of people with AN are also Autistic

What is Autism?

Autism is a brain-based developmental disability.

Autism affects the way the brain processes and uses information, impacting:

- Information Processing
- Communication
- Sensory Processing
- Emotional Regulation
- Social Behavior

Vaccines do not cause Autism.

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Diagnostic Criteria based on the DSM-5-TR

Persistent deficits in social communication and interaction:

- Deficits in social-emotional reciprocity
- Deficits in nonverbal communicative behaviors used for social interaction
- Deficits in developing, maintaining, and understanding relationships

Restricted, repetitive behaviors, interests, or activities, including two of the following:

- Stereotyped or repetitive motor movements, use of objects, or speech
- Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
- Highly restricted, fixated interests that are abnormal in intensity or focus
- Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment

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Differences, Not Deficits

Many deficits are differences in the ways that Autistic people process information, socialize, and communicate.

What is Neurodiversity?

Describes a wide range of brain-based differences including ADHD, epilepsy, dyslexia, and more.

There is no right way of thinking, learning, or acting.

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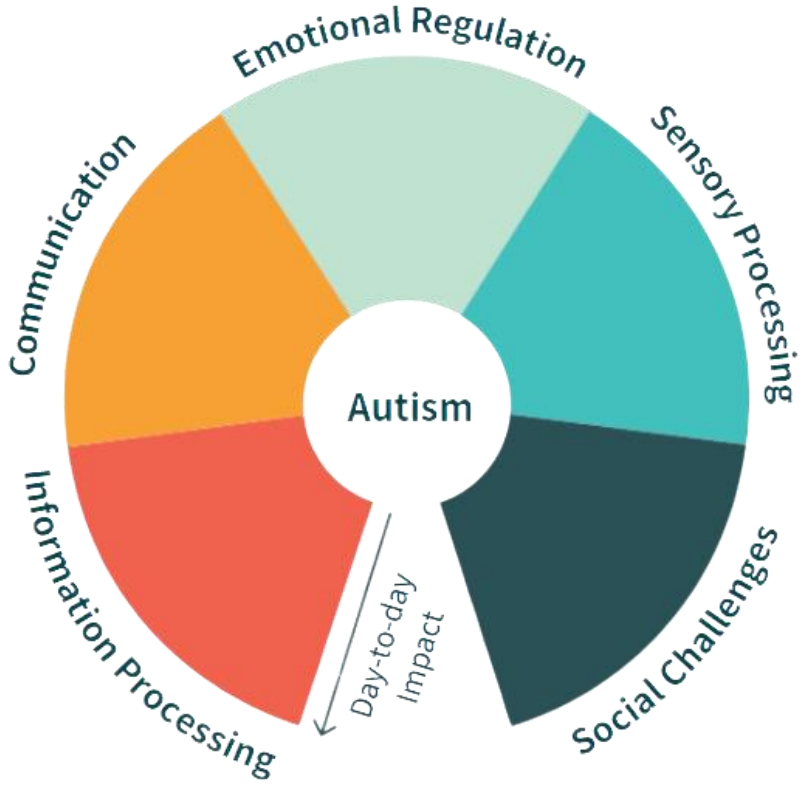

Image Source: GAO analysis of the DSM-5 I GAO-17-109

The Spectrum is not linear

- In this representation, different aspects of Autism are represented with different colors and blocks.
- Each person with Autism will exhibit a unique combination of these characteristics.

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Language

Identity First: Autistic Person

Identity-first language puts a person's condition/disability before the person. Integrates one's disability as a critical piece of a person's identity that cannot be separated.

Person-First: Person with Autism

Separates one's disability from their personhood and emphasizes the person before their disability.

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Co-Occurring Conditions

- Other Developmental Disabilities
- Medical Conditions
- Mental Health Conditions

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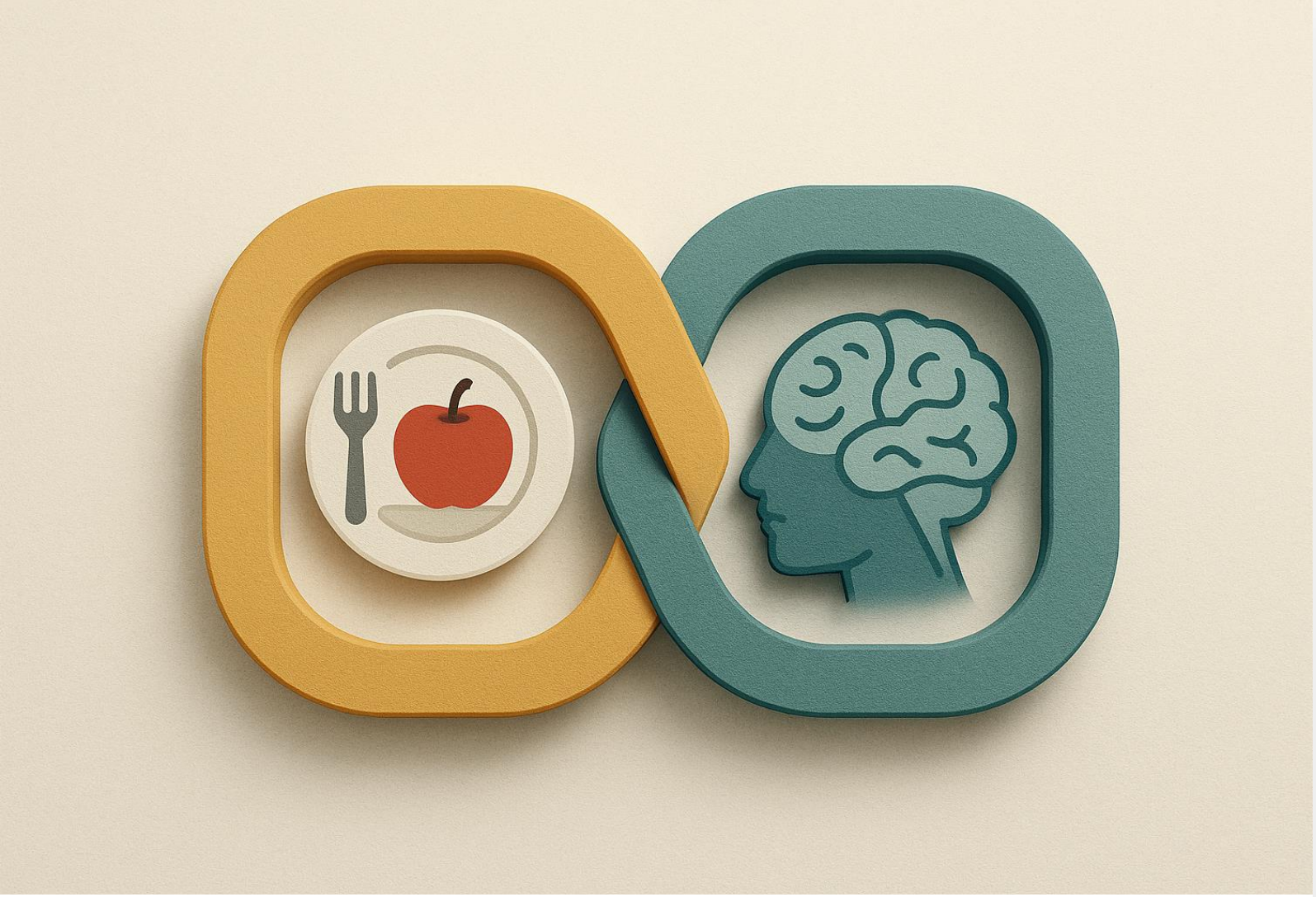
WHY THE OVERLAP?



History

- Link first noticed back in the 1980s between ASD and AN but not a lot of research and focus until the last 5-10 years.
- First noted by a Swedish child psychiatrist, Christopher Gillberg who noticed that 3 boys with Autism had female cousins with AN and hypothesized that AN was the “female” version of Autism.
- Most of the research has been done in Western Europe.
- Once thought that the Autistic traits would resolve with weight restoration and improved nutrition – that is not the case
- Autistic traits may exacerbate factors that maintain the ED rather than be a cause of Eds.
- Females with autism continue to be underdiagnosed and diagnosed later in life compared to males .

Neurodiversity & Eating Disorders

Increased risk of developing an Eating Disorder

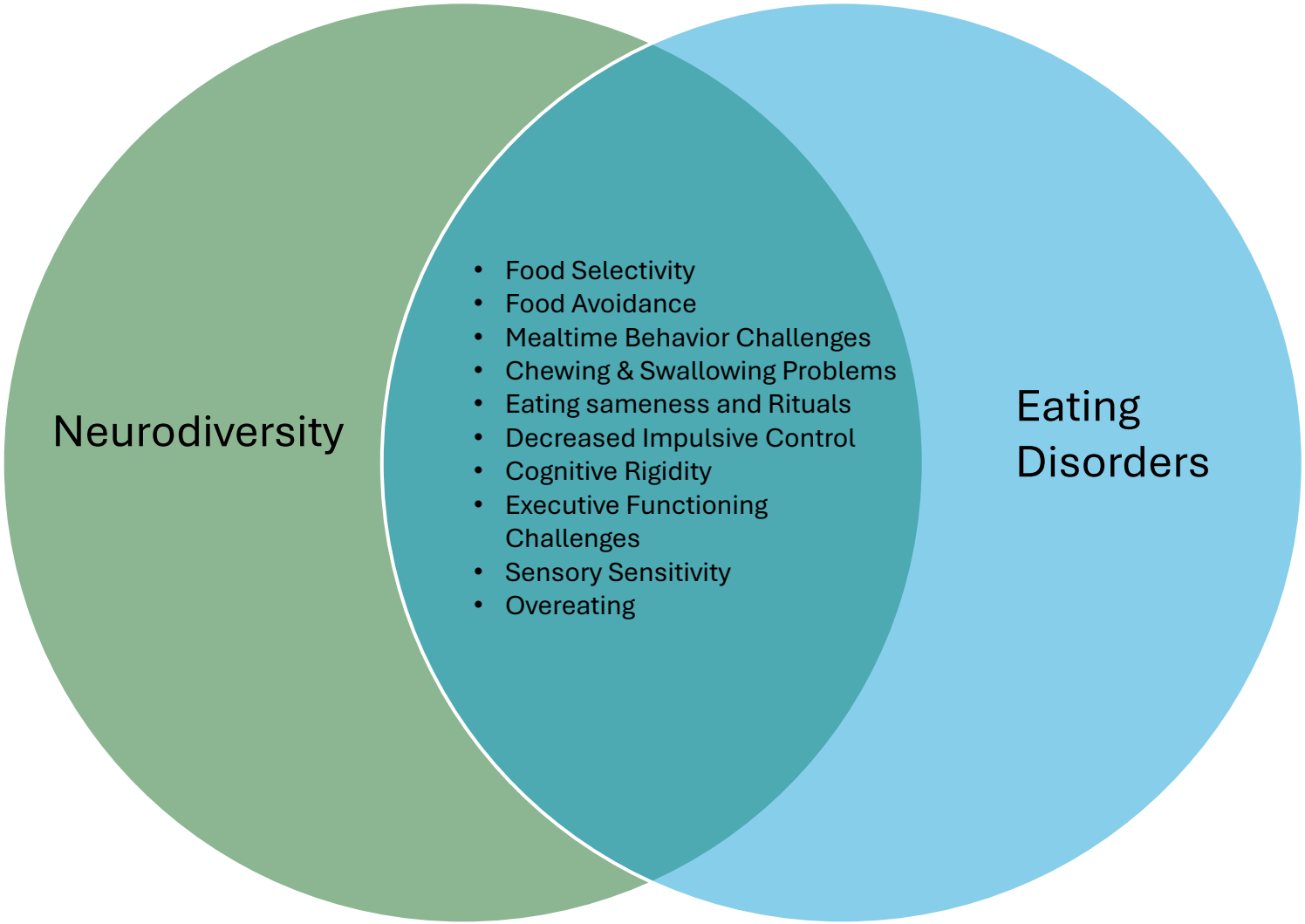
Autism

- AN – 8-37%
- Autistic traits – 20-40% of people with AN
- ARFID – 16.27% (8-54%)
- BED & BN – Limited data - overrepresented

ADHD

- BN – 15-54%
- BED – 10-36%

Overlap of Neurodiversity and EDs



Adaptive Function of ED Behaviors

Shape, weight and eating concerns

Emotional Regulation

Self-Regulation

Interpersonal Regulation

Autism Specific Mechanisms of ED Behaviors

Sensory Sensitivities

- Sensory Overload
- Food-Specific Sensory Sensitivities
- Internal Sensations

Social interaction & relationship difficulties

Poor sense of self

Difficulties with emotions

Thinking Styles

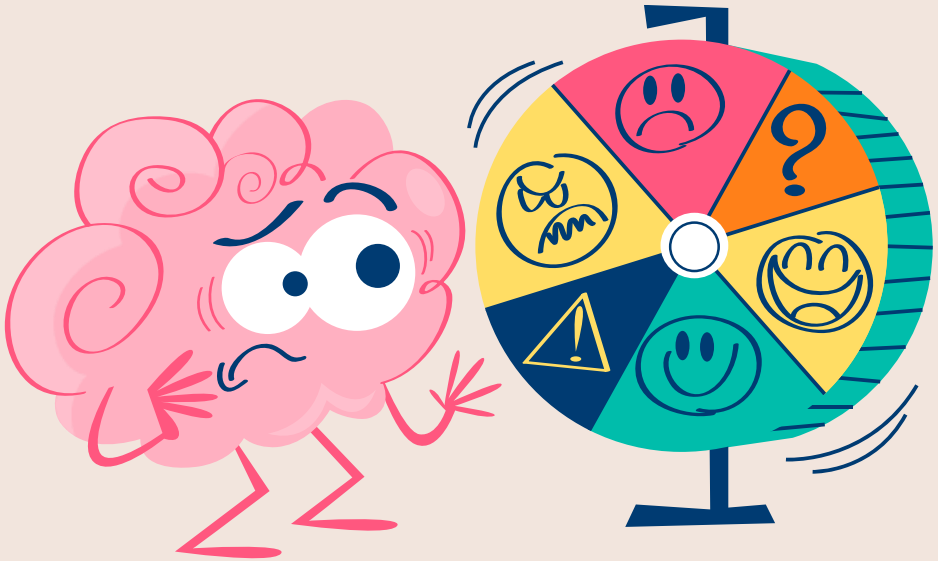
- Literal Thinking
- Intense Interests
- Rigid Thinking

Need for control and predictability

Why the Overlap:
Lived Experience

Although I didn't know it at the time, my eating disorder was a way to manage the challenges related to autism when I had no other supports (due to being undiagnosed).

Eating disorders are a very effective coping strategy...for a while. But because I struggle with change/flexibility, it grew and intensified quickly and aggressively.



My eating disorder:

- Built routines and rules that were literal and concrete
- Let me bypass interoception challenges
- Allowed me to avoid sensory sensitivities around food
- Dulled emotions, replacing emotion regulation skills I hadn’t developed

Bodies and Senses

Living in a body is hard.
Living in an autistic body is harder.

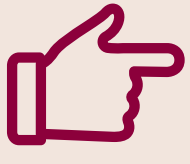
Add in challenges with self-monitoring and many autistic people feel at war with their own bodies.

Sight

Sound

Smell

Vestibular (Balance)

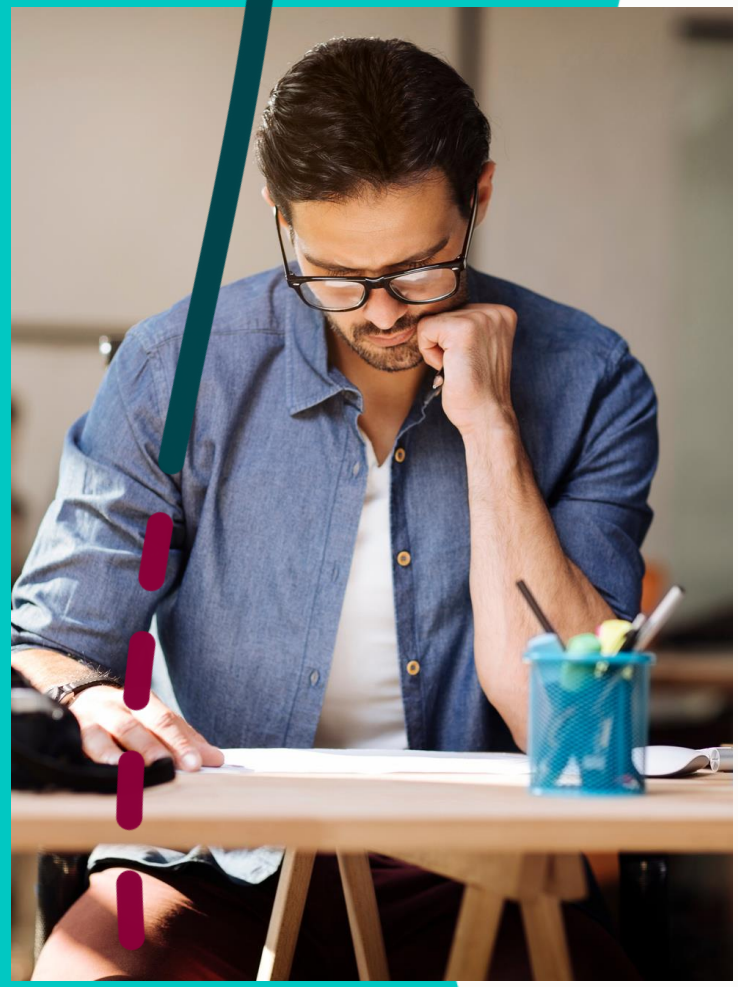


Touch

Taste

Interoception (Internal)

Proprioception (Body-Awareness)



Hyperfocus/Special Interest

Want to know who knows A LOT about eating disorders?
People with eating disorders.

Who knows A LOT about food and weight loss?
People with eating disorders.

Who is really good at becoming a deep expert with an unstoppable intensity in their interests?
Autistic people.
Now turn that hyperfocus on food and body...you get an eating disorder.

HOW EATING DISORDERS MAY PRESENT DIFFERENTLY IN AUTISTIC PEOPLE

Differences in the Whys

Differences in reasons for the eating disturbance

- Weight loss
- Masking
- Cognitive rigidity
- Manage intolerance of uncertainty
- Manage intensity of emotions
- Special interests

“I am not too much for people when I am restricting.”

Differences in Executive Functioning

- Differences in memory and processing speed
- Feeling bored by eating, not wanting to stop activity
- Difficulties with grocery shopping
- Meal preparation and planning- feeling overwhelmed
- Maintaining a schedule for meals and snacks

"It feels like too much work. It is just easier to not eat."

Differences in Interoceptive Experiences

- Hypo or Hypersensitive to internal bodily sensations
- More gastrointestinal issues → anxiety → restriction → more issues
- Lack of hunger/fullness cues → restriction or bingeing
- Prefer empty feeling in stomach → restriction
- Prefer overly full feeling → bingeing
- Enjoy chewing sensations → bingeing or rumination

“I can’t stand the full feeling of pressure in my stomach. ”

Differences in Sensory Experiences- Hypo & Hyper

- Auditory- sensitive to sounds of chewing, eating (misophonia); environment noise
- Visual- food appearance, environment
- Tactile- textures, touch, temperature of food, sensations in mouth
- Olfactory- strong smells, competing smells
- Gustatory (taste)- sour, bitter, sweet; supertasters
- Motor challenges- chewing, low muscle tone in esophagus

"I won't eat foods that taste green."

So what’s different?

Intensity and length of emotions, understanding of emotions (alexithymia)

Need for routine/rules

Sensory sensitivities (interoception)

Self-identity/meaning

So what's different?

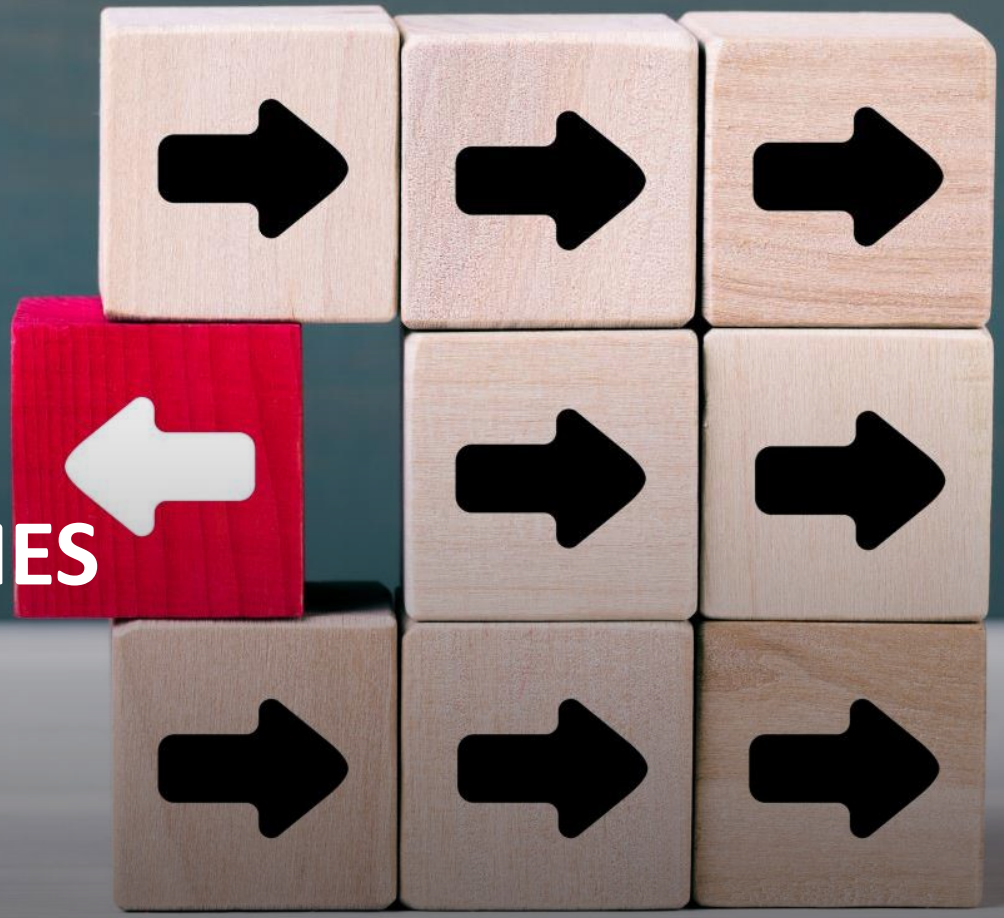
Discomfort with social eating

Communication differences

Things that look like the eating disorder may actually be autism

Different motivations, same behaviors

TREATMENT OUTCOMES



What we know

Greater illness severity

Longer lengths of stay in treatment

More frequent use of intensive treatment programs

Poorer experience in treatment

Treatment Outcomes

Treatment Programs: Higher risk of admission & longer duration of treatment

Eating Disorder Symptoms: No significant differences in ED symptoms or BMI between Autistic and Non-Autistic Individuals

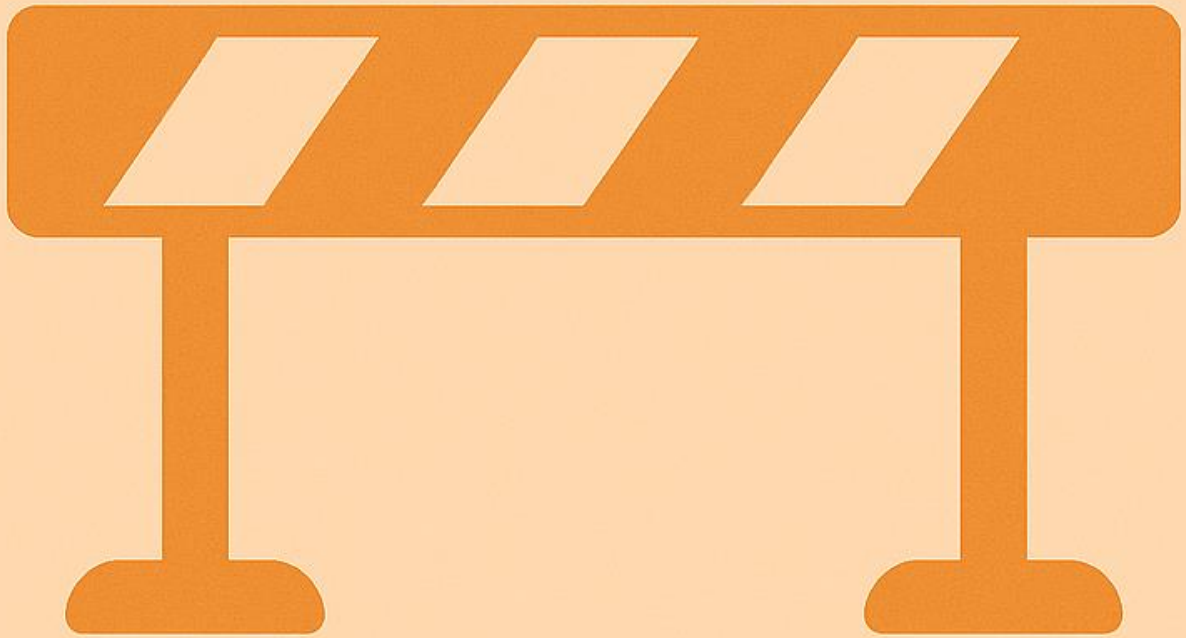
Cognitive, Socio-emotional & Psychosocial Outcomes: Emotion Focused interventions show promise. Co-occurring mental health difficulties may impact their experience of ED and treatment.

Emerging Treatments

- PEACE Pathway
- Cognitive Remediation Therapy
- Treatment Adaptations for Family Focused Treatments for adolescents with Eds.
- DBT, RO-DBT, Renfrew United Treatment Protocol for Eds, Temperament Based Therapy with Supports (TBT-S)

Future Needs

- Most Studies use Autistic Traits vs Autism
- Overreliance on quantitative vs qualitive studies looking at ED treatment outcomes in Autistic people
- No studies on the impact of ED treatment on sensory outcomes
- Lack of RCTs evaluated ED interventions for Autistic people
- Current studies are biased towards restrictive EDS
- Significant lack of diversity in research to date



BARRIERS IN CURRENT ED TREATMENT FOR AUTISTIC PEOPLE

Barriers to care for Autistic people with EDs

Lack of ED clinician understanding & training regarding autism

- Assessment/screening
- Communication & sensory differences
- Lack of confidence in delivering treatment to Autistic individuals

Lack of understanding of EDs in the Autism

- Screening & early identification

Clinician Bias – late/missed diagnosis of autism in females

Starvation effects – can complicate identification & Assessment

Treatment Barriers

ED treatment models need updating & adaptations

- One treatment doesn't fit all
- Challenges with CBT and group therapy
- Alternative therapeutic approaches

ED treatment providers misunderstand autism & Autistic traits

Adapting communication styles

Adapting service environments

- Sensory Sensitivies
- Predictability and Routine

- No autism diagnosis
  - No adjustments for sensory sensitivities (ah, tofu!)
  - Subtle communication challenges (high-masking)
- Difficulties in group
  - Very different concerns and motivations
  - Others found me off-putting
- Hard time identifying and feeling emotions (interoception)
  - Therapists were unaware of this and how to manage it
- Misunderstanding of autistic behaviors

Treatment Challenges

- Hard to trust when others promised recovery or told me to believe in the process: I felt so different from others it didn't seem like it could be true for me

- **Pace of change**
- **Takes me a long time to make changes and adjust my mindset**
- **Sheer hours of treatment: fatigue/exhaustion**

Treatment Challenges

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ADAPTING TREATMENT

Adapting Treatment Approaches

"It's me. Hi. I'm the problem, it's me."
Taylor Swift

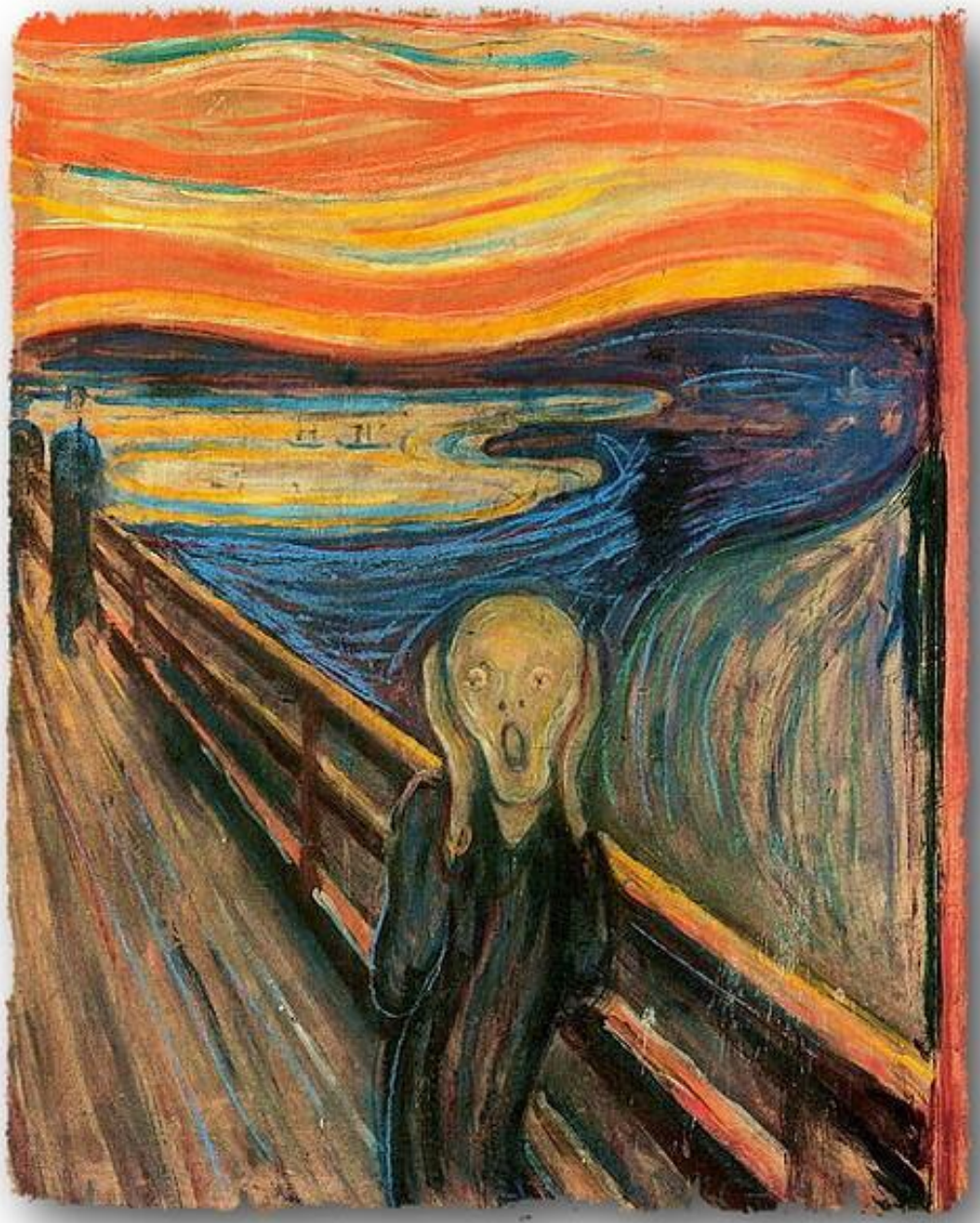
"The more I learn, the more I realize how much I don't know."
Albert Einstein

"Do the best you can until you know better. Then, when you know better, do better."
Maya Angelou

SAFETY FIRST!

- First priority- creating a safe environment
- Low vagal tone ➡ a “rigid nervous system.”
- Can’t recover quickly from threats, often in Fight, Flight, or Freeze states (hyper or hypoarousal).

- Higher level of care treatment settings can be challenging for autistics.
- Overstimulating, sensory overload, feels threatening.
- In fight or flight, appear non-compliant.
- Very important to adapt treatment.
- Neurotypical expectations lead to mislabeling behaviors and can result in treatment trauma.



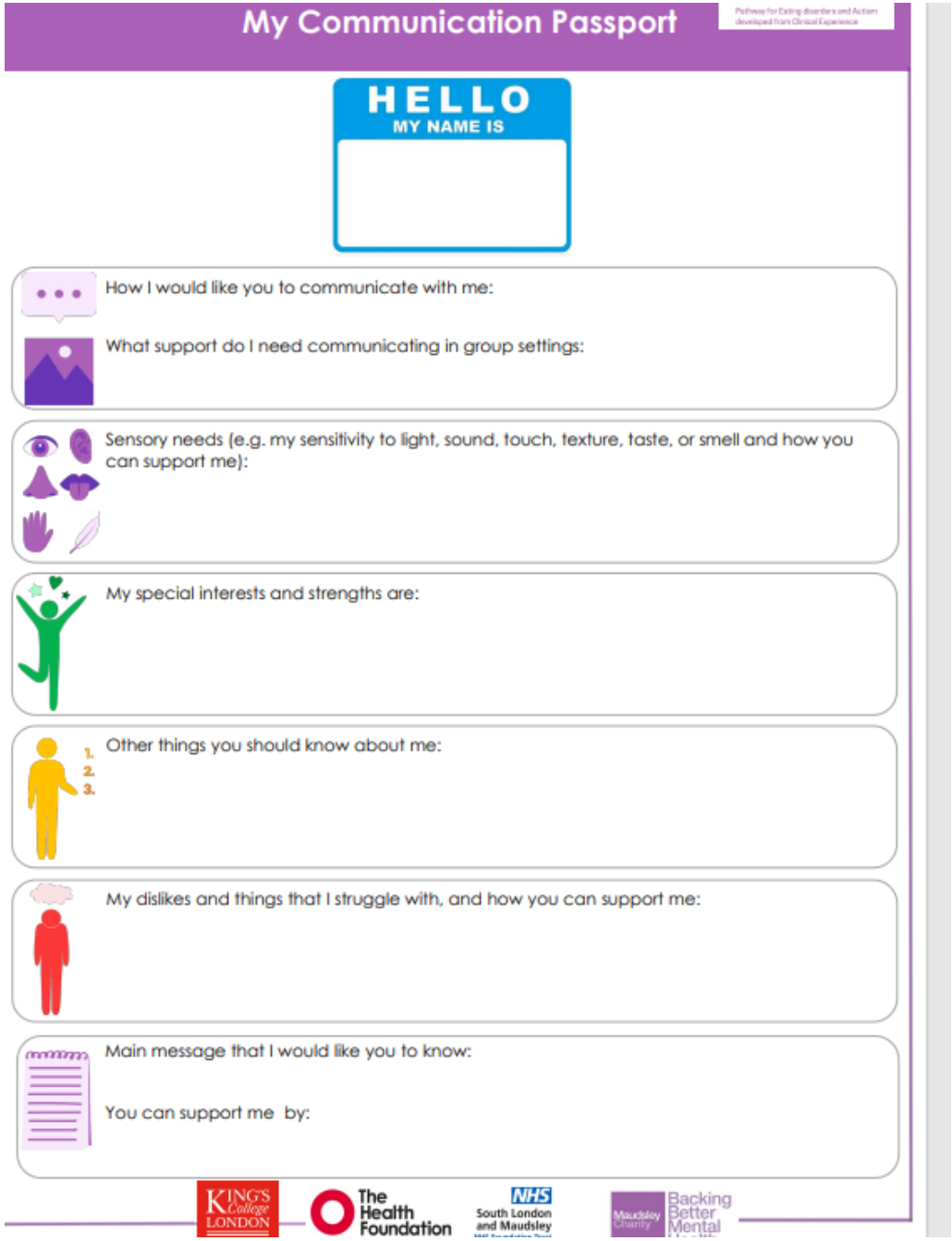
Adaptations for Inpatient, Residential, & PHP

Orient Patient to the Unit

- Pre-admission- more time prepping pt with tour, pictures, written information on rules, expectations, goals, schedule, menus.
- Meet care team members in advance.
- Longer admission session- take more time, answer questions, assign point people, introductions of staff, review routines. Take breaks during process.
- Explain reasons behind protocols

Learn about your patient…

- Assess support needs? Gather info on learning, communication styles and sensory needs.
- Assess how they regulate emotions.
- Review IEP or 504. Ask adults if they had school accommodations.
- Find out about past treatment- what was and was not helpful.
- Read their neuropsychological testing.
- Complete Sensory Assessment
- Complete Communication Passport (**peacepathway.org**) or Treatment Compass (Anxiety Institute, VA)



Adaptations for Inpatient, Residential, & PHP

Orient Unit to Patient

- Staff awareness of all plans and modifications- written copies for all team members; Communication Passport
- Assign familiar staff point person daily
- Consider placement of room- quiet place
- Single Room if possible
- **PEACE resources-** Pathway for Eating Disorders and Autism developed from Clinical Experience- from UK. **Peacepathway.org**
- Megan Neff, Ph.D Neurodivergentinsights.com

Comparison of Neurotypical and Neuroaffirming Approaches in ED HLOC

Traditional Treatment

- Set times to complete meals and snacks. Supervised group eating at meals and snacks.
- Daily multiple treatment groups.
- Limited private time. Stay in group dayroom.
- Encourage variety of foods
- No excessive movement
- Limited objects from home

Neuroaffirming Treatment Modifications

Allow more time to finish eating . Eat with small group, alone, 1:1 staff, or in quiet room.

1:1 individual appointments; fewer groups

More alone time in quiet room for sensory/calming breaks.

Safe and same foods ok if weight increasing, vitals good, hitting most nutrients. Use of kids' menu.

Allow movement breaks, stimming, rocking, sitting on yoga ball, gentle bouncing, etc.

Allow weighted blankets, sunglasses, earbuds/earplugs, chewy fidgets, scented items (essential oils)

Comparison of Neurotypical and Neuroaffirming Approaches in ED HLOC

Traditional Treatment

- Set number of therapy sessions weekly.
- No excessive use of condiments, unusual food combos, eating styles.
- Food exposures
- Exposure to discomfort
- No screens/objects at group meals
- Encouragement of mindful listening and participation in treatment groups

Neuroaffirming Treatment Modifications

Increased number of 1:1 therapy, OT, PT sessions

Eating is goal, regardless of condiments, food mixtures, etc.

Fewer food exposures. Slow them down.

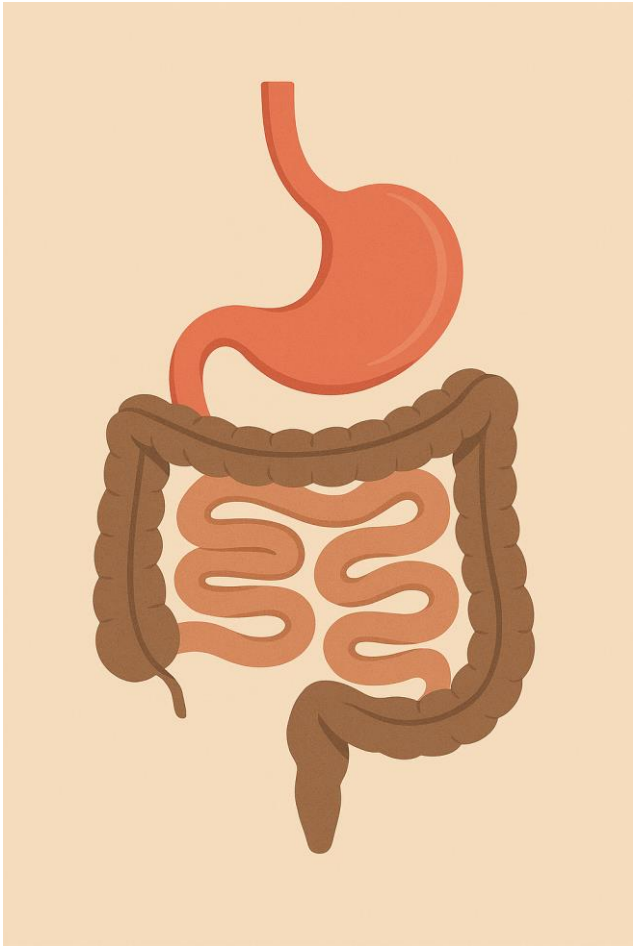
Minimize anxiety and discomfort. Habituation occurs slowly, if at all.

Use of screens, music, games to calm and minimize chewing/eating noise

Allow micromovement in groups (fidgets, knitting, coloring, rocking, gentle bouncing, jiggling)

Sensory Modifications

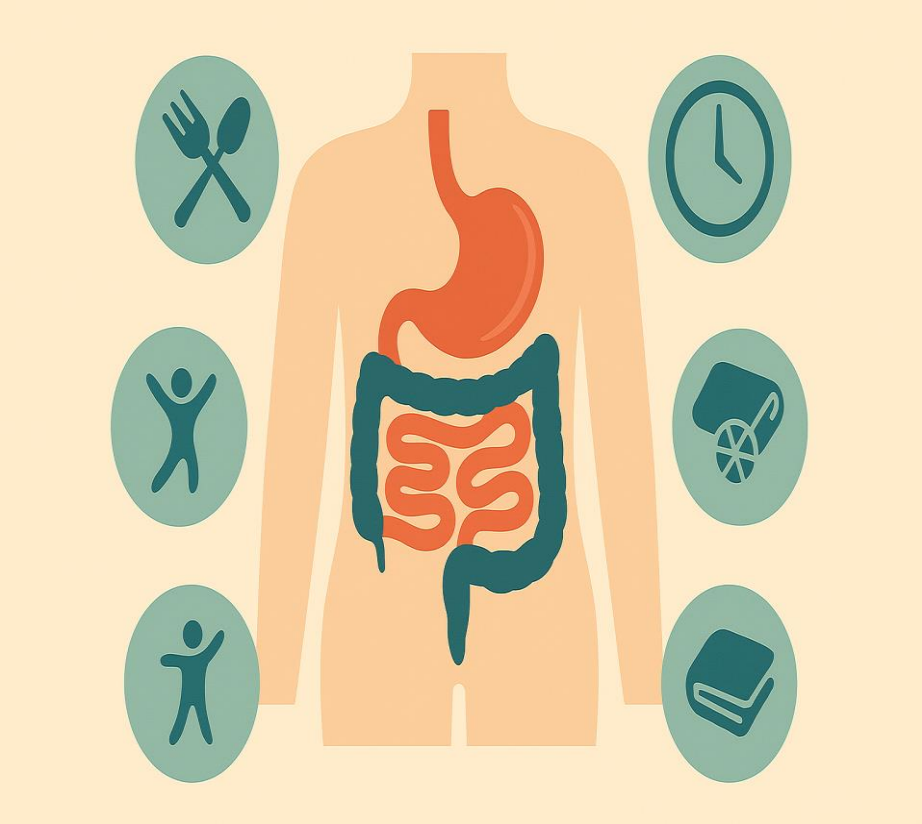
- Sensory breaks to reduce sensory overwhelm. Watch for shutdowns
- Sensory Tool Box or access to Sensory Room
- **Visual**- reminders, cards, pictures, schedules, clocks, menus, Time Timers (executive functioning + when overwhelmed and shutdown)
- **Auditory**-noise reducing headphones, music, white noise machine, ear plugs, room placement in quiet area, remove noisy clocks, turn down overhead music. Minimize number of people talking to pt at one time.
- **Olfactory**- preferred scents, essential oils for grounding or minimizing aversive food smells
- **Tactile**- textured pillows, putty, fidgets, chewy fidgets, comfy clothes with preferred textures. Modify foods to preferred textures.



Interoceptive Modifications- Hyper

Hypersensitivity to internal sensations:

- Teach discomfort does not equal danger. Calming, grounding skills, distraction, education about digestion and effects of restriction (slowed gastric emptying).
- Weighted lap pads, heat packs, stretching to help with fullness pressure
- PRN Meds (simethicone, Zofran)
- Movement Breaks- spinning, rocking, fidgeting, limited pacing, sitting on floor, bouncing slightly on yoga ball, limited standing. Stretching, pushing against wall, swinging, moving legs. (proprioception + vestibular)



Interoceptive Modifications -Hypo

- Hyposensitivity: tune in to bodily sensations of hunger and fullness by noticing body signals before and after eating. Add condiments. Mindful eating. Body scans
- Movement Breaks- spinning, rocking, fidgeting, limited pacing, sitting on floor, bouncing on yoga ball, limited standing . Stretching, pushing against wall, swinging, moving legs. (proprioception + vestibular)
- Allow bathroom breaks at “non-bathroom times” (groups, meals)- if hyposensitive may not notice need until it is urgent.
- Deep pressure (wrap self in blanket, hug from loved one)
- Gum and mints (usually not allowed)
- Do not restrict stimming

Understanding Stimming

- Stimming provides stimulation when underactivated, provides grounding when overstimulated.
- Also helps with emotion regulation, communication, pain management, stress relief, self soothes, releases tension and energy.
- Explore function of the stimming behavior
- Stimming is a communication and coping skill.
- Can be repetitive movements, staring at stimuli, or making sounds (humming, noise making)
- Stimming helps activate neurotransmitters that regulate emotions.

Treatment Modifications

- Attend to milieu to ensure inclusive, accepting environment. Shut down any potential bullying immediately. Treatment must be safe.
- Offer choice between two foods instead of an overwhelming amount of choices.
- Communication difficulties with shutdown- use of communication cards-give to staff when need particular interventions or to communicate needs.
- Alexithymia- feel bad or okay. Do not overly focus on identification of emotions.
- Coping cards- carry around skill reminder cards.
- Emotion Intensity charts- 1-5, work on decreasing affect at around a 3
- Modify traditional treatments (FBT, CBT, DBT, CBT-E) to be more neuroaffirming.

During Sessions…

- Provide a safe sensory space (hypo or hyper) and be a safe person- transparent, authentic, honest.

- Confirm understanding and adapt language. Consider using more precise, literal language, word choices.
- Provide bullet point notes of sessions and homework.
- Consider including an autistic advocate
- Be mindful of pt shutdown and overload. Make tasks more manageable.
- Research pt's special interests and incorporate into treatment. Share yours!
- Be very collaborative. Form goals and modify together.
- Allow extra time for processing. Consider longer sessions with time to "wind in" and "wind down." Treatment may be slower.
- Discourage Masking!

Sometimes it’s NOT the eating disorder- PDA

- Pathological Demand Avoidance/Persistent Drive for Autonomy
- Intuitive refusal to do something due to complete emotional or sensory overwhelm.
- Pt refuses to engage. Appears oppositional, non-compliant (externalized PDA) or completely withdrawn (internalized PDA)
- Frustrating to providers, families, and pt
- Pt does not know why they cannot engage, often cannot explain it. Intense anxiety and avoidance
- Not “I Won’t” but “I Can’t.”
- Sympathetic Nervous System in overdrive.
- Misdiagnosed as Oppositional Defiant Disorder, particularly in BIPOC

Sometimes it’s NOT the eating disorder- PDA

- Declarative statements vs questions
- Shift conversation to emphasizing pt’s autonomy and own ability to make choices in how to proceed.
- Ability for flexible schedules so can shift if feel they cannot do something
- Incongruence triggers PDA- if something is not consistent, fair, or context not congruent with what is said/appears, Fight or Flight/threat system triggered.
- Rigid expectations, compliance-based protocols do not work for Autistics with PDA. Will shut down or externalize.
- One of the main challenges when treating individuals with PDA is the conflict between their need for autonomy and the expectations of treatment interventions.
- Safety of transparent, conversational, grounding therapeutic relationship helps.
- Understanding of psychology and physiology of PDA helpful. It’s not personal.

Adaptations for Autistics with ARFID

- Goals- reduce distress, support nutrition, promote autonomy
- Respect pt goals, consent and collaboration with all aspects of treatment vital.
- Autistics habituate differently than Non-Autistics. Not goal.
- CBT-AR very helpful, but at a slower rate.
- Emphasis on curiosity and sensory exploration of foods without pressure. Educate about nutrients.
- Use of visual aids
- Sensory supports- preferred scents, textures, calming environment. “Safety mechanisms” fine.

Adaptations for Autistics with Anorexia

- Goals- reduce distress, medical stability, weight gain, reduce distress, support nutrition, promote autonomy
- Respect pt goals, consent and collaboration with all aspects of treatment vital.
- More structure with meals, snacks. Support, distractions, sensory tools.
- Staff design meal plans to help with executive functioning. Routine, sameness helpful.
- Online ordering, delivery services, recurring Amazon orders
- Specific, collaborative plans regarding weight goals and admission to HLOC
- Use of visual aids
- More OT and PT aid for interoceptive distress, executive functioning support
- Gradual changes w challenging ED rules, adding feared foods
- Slower weight restoration to tolerate internal sensations

How Families and Friends Can Help

- Keep meal times, eating less pressured, more enjoyable. Decrease intensity around eating.
- Make meal time setting sensory-friendly for pt. Use sensory tools
- Follow eating with a preferred activity
- Predictable and scheduled eating times, prepare pt if unexpected changes to times or food
- Visual and auditory reminders of eating times
- Do not moralize food (good or bad foods) or tie weight to worth.
- Don’t pressure food flexibility. Safe foods fine with getting appropriate nutrients and health.
- Allow choice and autonomy.

How Families Can Help Kids

- Advocate for your children
- You are the expert on your child. You know them the best.
- Provide copies of assessments, IEPs, 504s, accommodations
- Written copies of what helps and doesn't help.
- Ask for neuroaffirming care
- Request providers that "get autism" or are neurodivergent themselves.
- Seek out ED specialists- treatment team- therapist, dietitian, physician

Your Tools

- Advocating for Yourself
- Understanding Your Brain
- Connecting With Your Body
- Finding Your Community

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Self Advocacy

- Be picky about your therapist
- You can say no
- Write down what is helpful and share with your support people
  - You get to ask for help that is actually helpful
- Set goals that are meaningful to you
- Share what is getting in the way
- Create routines

Resources

Communications Passport

Wellbeing Passport

Sensory Wellbeing Booklet

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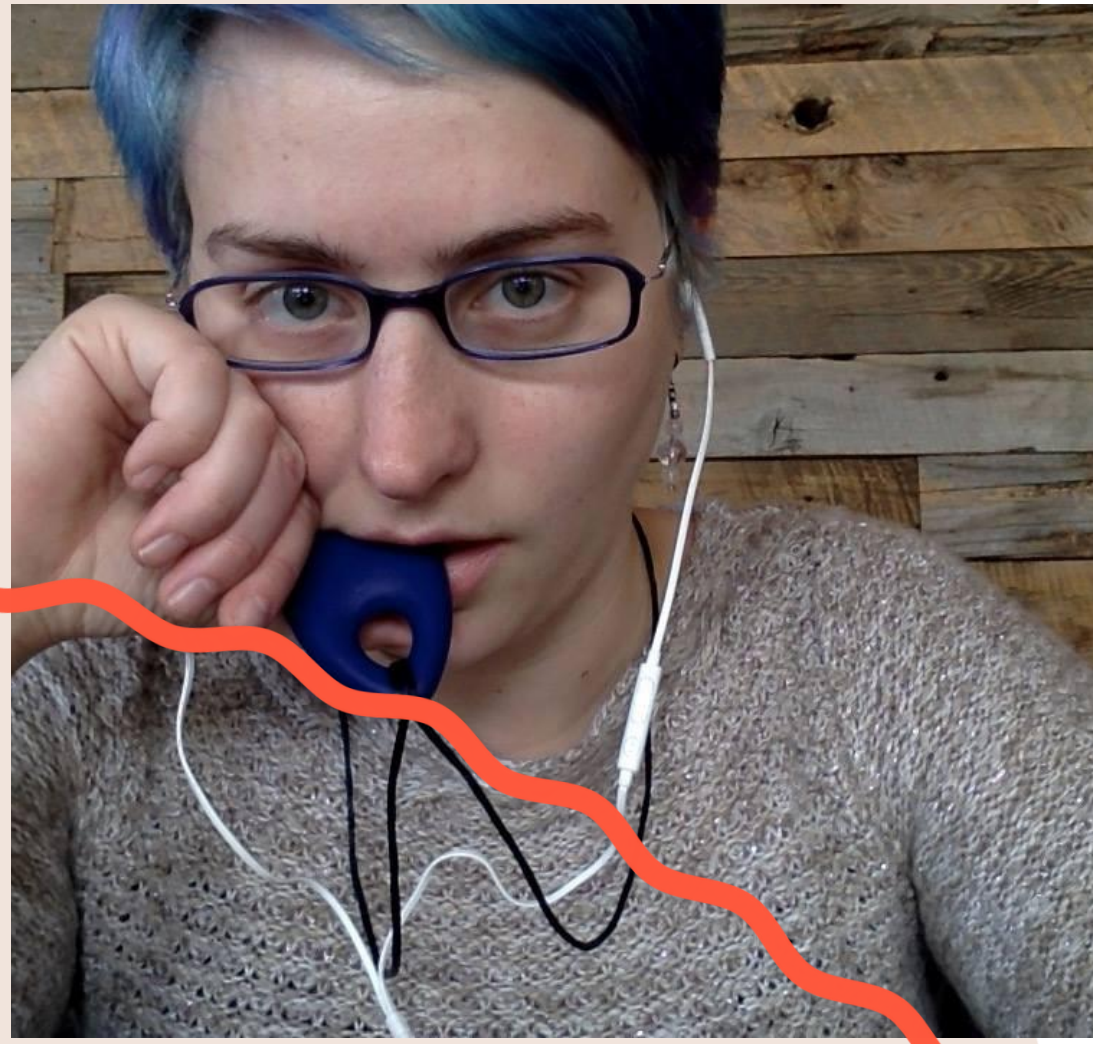
Understanding Your Brain



- Emotions are information
- You have unique sensory needs
- Predictability is key
- What purpose does your eating disorder serve?

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Connecting With Your Body

- Meet your sensory needs
- Practice interoception
- What experiences bring your body joy?
- What gets in the way of connecting with your body?

Resources

Interoception worksheets

Sensory schedule

Improving interoception

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Finding your community

- This takes a lot of trial and error: be patient!
- Community helps you unmask
- Find neurodivergent spaces
- Accept that communities will change: that’s ok.
- You may need multiple communities to meet different needs.
- Socialize the way it works for you.

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What Helped

- Acceptance
- Understanding/creating sensory supports
- Psychoeducation
- Accessible community
- Using special interests (lots of Dr. Who metaphors)
- Physical reminders (post it notes)
- Clear, reasonable expectations laid out
- Reminders and structure
- Finding my people

Recovery is possible. Even when that's hard to trust.

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Where do we go from here?

1

Broadening the scope of understanding

2

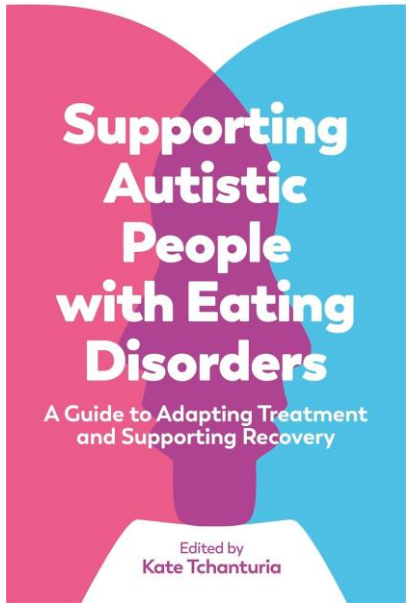
Working to better understand causal mechanisms

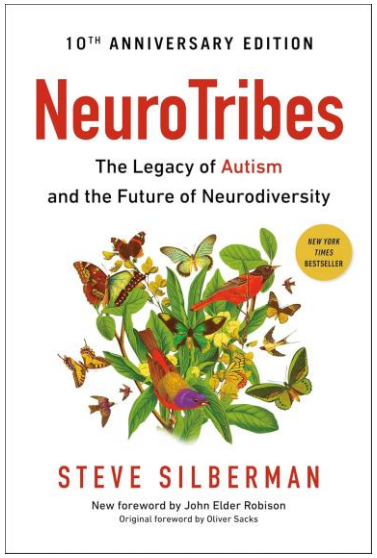
3

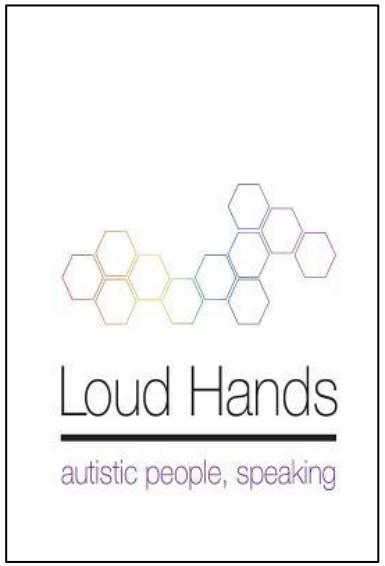
Adapting existing Eating Disorder services for Neurodivergent People

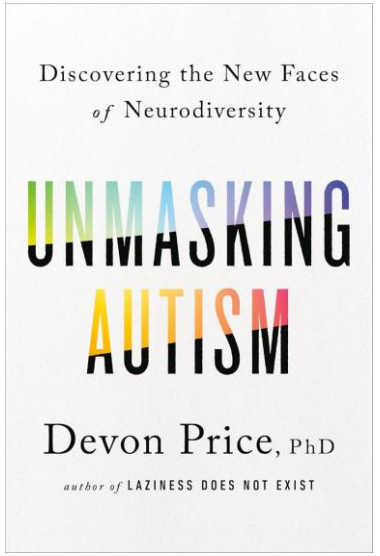
Questions

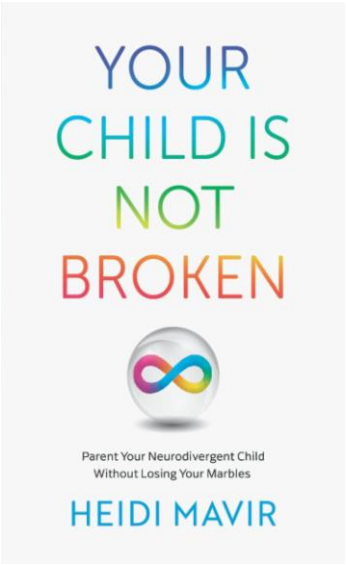
Resources











PEACE

Pathway for Eating disorders and Autism developed from Clinical Experience

https://www.peacepathway.org/

NEDA

National Eating Disorders Association