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Neurodivergence, intersectionality, and eating disorders: A lived experience-led narrative review

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NEURODIVERGENCE, INTERSECTIONALITY, AND EATING DISORDERS: A LIVED EXPERIENCE-LED NARRATIVE REVIEW [*PREPRINT*]

ABSTRACT

Autistic people and those with attention deficit hyperactivity disorder are at a high risk of developing an eating disorder. While there is limited evidence on the relationship between other forms of neurodivergence and eating disorders, research suggests associations between giftedness, intellectual disability, Tourette's syndrome, and disordered eating. Factors underlying disordered eating and/or eating disorder risk for neurodivergent people are multifaceted and complex, encompassing a wide range of intertwined psychosocial, environmental, and biological processes. Moreover, research shows that neurodivergent individuals experience poorer treatment outcomes compared to neurotypical individuals. However, there is a paucity of research in this area overall. More specifically, lived experience-led research remains rare, despite its critical role for improving individualised eating disorder care, as well as mental healthcare more broadly. Indeed, the importance of eating disorder care individuation is increasingly being recognised, particularly within the context of neurodivergence, given the heterogeneous experiences and support needs of neurodivergent people affected by disordered eating and/or eating disorders. Furthermore, despite documented overlaps between various forms of neurodivergence (e.g., co-occurring autism and attention deficit hyperactivity disorder), research looking at eating disorders in the context of neurodivergence through a transdiagnostic perspective is scarce. This lived experience-led narrative review aims to shed light on the intersectional factors underlying high disordered eating and/or eating disorder risk for neurodivergent individuals. First, an overview of prevalence data is provided, followed by a thematic framework identifying factors underlying disordered eating and/or eating disorder risk in relation to neurodivergence. A critical appraisal of current eating disorder research and care is then offered before suggestions for neurodiversity-affirming eating disorder care are made. In this view, this paper offers a foundation for future empirical work in this nascent field of inquiry by providing a lived experience-led, transdiagnostic, and intersectional account of eating disorders in the context of neurodivergence.

KEY WORDS: neurodiversity, epistemic justice, eating disorders, intersectionality, disability, human rights, gender, autism, adhd

PLAIN ENGLISH SUMMARY

Autistic people and those with attention deficit hyperactivity disorder have a high risk of developing an eating disorder. Other forms of neurodivergence, such as giftedness, intellectual disability, and Tourette's syndrome, have also been associated with disordered eating. Compared to the general eating disorder population, neurodivergent people experience eating disorder symptoms over a longer period of time and commonly experience poorer eating disorder-related treatment outcomes. Yet, there is limited research which is led by neurodivergent people with lived or living experience of eating disorders. However, it is essential to incorporate lived experience expertise in research and treatment design and implementation as this could improve understanding of the many complex and varied underlying eating disorder risk factors which may otherwise guide necessary treatment adaptation(s). Based on the perspectives of lived experience researchers and/or clinicians, this paper discusses the various mechanisms underlying disordered eating and/or eating disorder risk in the context of neurodivergence to inform future developments in eating disorder-related research and clinical practice.

1. POSITIONALITY STATEMENT

All co-authors are neurodivergent and have lived experience of an eating disorder. We are researchers and/or clinicians specialising in the field of eating disorders. We also occupy a wide range of other intersecting marginalised identities across gender, sexuality, body size, class, and neurotype; for example, some of us identify as gender diverse (e.g., transgender, gender non-binary) and/or live in larger bodies. However, we acknowledge that there remain many experiences we cannot speak to as most of us identify as white, none of us has an intellectual disability, and we are all living in Western countries (Australia and the United States of America). Our broad collective personal and professional experiences have informed our investigation of intersectional factors related to disordered eating and/or eating disorder risk, critical appraisal of current eating disorder research and therapies, and considerations for neurodiversity-affirming eating disorder care.

We take on a neurodiversity-affirming theoretical framework. Therefore, we purposefully use non-pathologising and non-stigmatising terminology in relation to neurodivergence. For example, we use terms such as ‘traits’, ‘features’, ‘characteristics’, ‘support needs’, ‘differences’, ‘atypical’, ‘challenges’, or ‘difficulties’ rather than ‘abnormal’, ‘symptoms’, ‘deficits’, ‘impairments’, ‘tantrums’, ‘attention seeking’, ‘dramatic’, ‘treatment resistant’, or ‘non-compliant’ [1-3]. We also use identity-first language (i.e., autistic person) in relation to autism as research shows this is the preference of English-speaking autistic individuals [3-4]. Additionally, we refrain from using the terms ‘low/high functioning’ as these perpetuate erroneous and monolithic stereotypes – that is, autism being a linear construct [5-6] – and fail to capture the dynamic and fluctuating nature of disability [see 7-8].

2. SCOPE AND AIMS

The associations and psychopathological mechanisms underlying eating disorders in the context of neurodivergence remain understudied and poorly understood, as illustrated by limited lived experience-led, transdiagnostic, and intersectional research in this area. With this field of inquiry still in its infancy, this paper does not seek to provide a comprehensive, systematic, review of the literature. Instead, our aim is to provide a narrative review serving as a conceptual, lived experience-led, foundation for future empirical work. In this view, this review builds on the work of Adams et al. [9] investigating the underlying mechanisms linking autism and eating disorders and Field et al.'s [10] exploration of autism-specific eating disorder treatment adaptations. However, given the documented overlapping and transdiagnostic nature of neurodivergence [11-13], our work diverges from Adams et al. [9] and Field et al. [10] as we take a wider lens to investigate neurodivergence using a neurodiversity-affirming theoretical framework. Indeed, our paper presents a holistic overview that considers intersectionality by succinctly capturing the complexity of interconnected socio-cultural and biological factors regarding neurodivergence and eating disorder risk from the perspectives of the authors’ broad professional and personal lived experience.

3. BACKGROUND

While evidence demonstrates overall lifetime prevalence of eating disorders (EDs) ranging between 0.74-2.2% for males and 2.58-8.4% for females [14], there are growing concerns over the increasing prevalence of EDs, particularly for children and adolescents [15]. However, pathophysiological mechanisms underlying the development and maintenance of

ED behaviours and cognitions remain poorly understood [16]. Furthermore, less than half of people with EDs who undergo ‘evidence-based’ treatments make a full, long-term, recovery [17]. The high relapse and mortality rates observed for EDs, even for those who can access treatment [18], have prompted an increased recognition of the need for more lived experience-led research [19] and person-centred care [20-21].

Neurodiversity refers to the diversity of human minds that naturally exists in our society [22]. Neurodivergence refers to individuals who have a neurocognitive profile that diverges from the majority (i.e., atypical), whereas neurotypical people are those whose neurocognitive profile is considered aligned with the majority (i.e., typical) [23]. There are many forms of neurodivergence, such as, but not limited to, autism, attention deficit hyperactivity disorder (ADHD), Tourette’s syndrome, giftedness, dyslexia, dyscalculia, dyspraxia, and intellectual disability (ID) [11, 24].

Neuronormativity relies on the assumptions and beliefs which uphold neurotypical privilege –an ideologically oppressive framework which views some personality and neurocognitive traits as inherently superior to and more valuable than others [25-26]. The neurodiversity paradigm, however, rejects the assumption of there being a singular ‘normal’ personality or neurocognitive profile and opposes the pathology paradigm, whereby those who do not fit within the narrow socially constructed understanding of ‘normal’ are perceived deficient, disordered, and in dire need of fixing or curing [27-29]. In this view, the neurodiversity paradigm argues that difference should not be regarded as inherently pathological and that the diversity of human minds should be accepted and accommodated for [27, 30].

Research has highlighted high co-occurrence rates between autism, ADHD, and EDs [31-32]. Preliminary research has also associated other forms of neurodivergence, such as ID [33] and

Tourette's syndrome [34-35], with disordered eating. Yet, the mechanisms underlying links between neurodivergence and EDs remain understudied and poorly understood; for instance, there is limited research on the intersectional nature of ED risk factors for neurodivergent individuals (NDI). Subsequently, NDI are shown to experience poorer ED treatment outcomes compared to neurotypical people [36-37, 87].

While there have been calls to include lived experience expertise at the core of mental health research [38], participatory and phenomenological research methods are rarely utilised in the context of EDs [19, 39-41]. With all co-authors being neurodivergent and having lived or living experience of an ED, our narrative review aims to provide a lived experience-based conceptual map to serve as a starting point for future empirical work. A high-level summary of the co-occurring prevalence rates between neurodivergence and EDs is first provided, followed by a thematic investigation of key factors underlying ED risk for NDI. Additionally, a critical appraisal of current ED research and treatments is provided before recommendations for neurodiversity-affirming (NDA) ED care are discussed.

4. METHODS AND CONTRIBUTIONS

A narrative review methodology was selected to provide a broad descriptive framework for this topic, suitable to the overall limited status of literature published to date. In addition, the narrative review is intentionally informed by the lived experiences of the authorship team, all of whom are ED researchers and/or clinicians, providing perspectives and insights with the aim of promoting further conversation and inspiring future research and clinical considerations.

For section five, two databases (PubMed and Google Scholar) were searched (11/03/2024 and 07/06/2024) for prevalence data specific to the co-occurrence discussed (e.g., autism/EDs, ADHD/EDs). Search terms involved a type of neurodivergence (e.g., autism, ADHD, Tourette's syndrome, giftedness) alongside 'eating disorder' or 'feeding disorder'. Specific subsections on prevalence were contributed by authors RE (psychosis and OCD) and LC (autism, ADHD, Tourette's Syndrome, ID, giftedness). The most recent systematic reviews and meta-analyses were selected: here, if no systematic reviews and meta-analyses were identified, the most recent studies were discussed. However, there were instances where no recent studies assessing prevalence were found, in which case it was highlighted that research evidence is limited.

Section six provides a thematic framework whereby factors underlying ED risk in relation to neurodivergence are identified. Co-authors contributed to themes that matched areas of their lived experience, interest, and/or academic expertise; for example, sexuality and gender diversity (authored by SS, with initial outlining by KS), sex diversity (co-authored by SS and KS), giftedness, systemic discrimination, and psychoneuroimmunology (author RE), and sensory processing, executive functioning, systemic discrimination, and psychoneuroimmunology (author LC). Sensory processing and executive functioning differences are discussed first due to their core overarching nature across neurodivergence. Individual characteristics, such as gender identity, sexual orientation, and giftedness follow. Intersectional factors like systemic discrimination and chronic illnesses are then investigated.

Section seven consolidates the evidence and positionality to identify current gaps in research and practice (authored by LC), while section eight provides suggestions for neurodiversity-affirming eating disorder care (co-authored by LC and AR). Furthermore, all co-authors contributed to revision and editing of this narrative review.

5. OVERVIEW OF PREVALENCE DATA

Gillberg [42] was the first to suggest an association between autism and EDs. Throughout the 1990s and early 2000s, sporadic studies have discussed the co-occurrence of EDs and neurodivergence; for example, Fisman et al. [43] found an overlap between obsessive-compulsive traits and anorexia nervosa (AN), Gravestock [44] highlighted an association between ID and binge eating disorder (BED), and Surman et al. [45] posited a link between ADHD and bulimia nervosa (BN). There has been an acceleration of research on this topic in the past decade, consistently reporting high co-occurrence rates between autism and ADHD with various ED diagnoses – namely, AN, BN, BED, and avoidant/restrictive food intake disorder (ARFID) [31-32]. Overall, there is a high degree of overlap and co-occurrence between many forms of neurodivergence [28, 46-47], however, transdiagnostic research regarding forms of neurodivergence other than autism and ADHD in relation to EDs is limited. As such, the evidence below is presented as a high-level summary within the most investigated forms of neurodivergence in relation to EDs – namely autism, ADHD, Tourette's syndrome, obsessive-compulsive disorder (OCD), psychosis, ID, and giftedness.

Despite the increased attention toward EDs in autistic and ADHD populations, there are limitations to estimating co-occurring prevalence rates. Indeed, there is accumulating evidence showing NDI assigned female at birth (AFAB) being erroneously diagnosed with borderline personality disorder [48-51]. One leading argument for such under- and/or misdiagnosis is gender biases in diagnostic instruments and practice [52-56]. Research also suggests that autism and ADHD are underdiagnosed in racially marginalised individuals due to a combination of barriers accessing assessments and ethnocentrism embedded in diagnostic measures [57-58]. Moreover, research shows that autism and ADHD are more likely to be misdiagnosed as conduct disorder, antisocial personality disorder, and/or oppositional defiant disorder in racially marginalised communities [59-64].

Relatedly, psychometric instruments commonly used for assessing eating psychopathology, as well as body image-related constructs, have not been tailored to, nor validated for, NDI [see 65-66]. Therefore, it is possible that ED measures predominantly used today, such as the Eating Disorder Examination Questionnaire or the Eating Attitudes Test, do not accurately capture EDs and body image disturbances as experienced by NDI [see 65-66]. There is also a paucity of transdiagnostic research investigating neurodivergence and EDs, despite evidenced overlaps between many forms of neurodivergence [46], such as co-occurring autism and ADHD [67], leading to a significant knowledge gap regarding ED presentation and course of illness in these populations.

5.1. Autism

Systematic and meta-analytic reviews have consistently highlighted a strong link between autism and AN: Huke et al. [68] found the prevalence of autism among those with AN varying between 8-37% while Boltri & Sapuppo [69] identified a prevalence range between 8.8-24.5%. Additionally, between 8.2-54.8% of children with ARFID are autistic [31], while 21% of autistic people are deemed at risk of developing ARFID based on a genome-wide association study [70]. Furthermore, undiagnosed ARFID in autistic children represents a risk factor for malnutrition and death [71], highlighting the urgent need for systematic ED screening in autistic children. Between 14-36% of autistic children also show pica behaviours [72-73]. Although research has so far focused mostly on dietary restriction in relation to autism, there is emerging evidence linking autistic traits with all forms of disordered eating, including bingeing behaviours [74-75].

5.2. Attention Deficit Hyperactivity Disorder

There is a significant association between ADHD and EDs. Indeed, in a recent review which included five cross-sectional studies, Villa et al. [32] found that 31.37% of children and adolescent patients with an ADHD diagnosis presented with BED, 19.23% with BN, and 9.38% with AN. Additionally, a meta-analysis found that the prevalence of ADHD in adults with EDs was 3-16.2% for AN, 9-34.9% for BN, and 19.8% for BED [76]. Here, ADHD traits were also found to predict binge eating and bulimic symptoms' severity, even after controlling for anxiety and depression [76]. Moreover, in a study involving 1165 adults diagnosed with an ED, Svedlund et al. [37] found that 37% of individuals with AN and 35% of those with BN scored above the cut-off on the Adult ADHD Self-Report Scale [77]. While prevalence has not been established, research suggests that children with ADHD present an increased risk of loss of control of eating compared to children without ADHD [32, 78]. High incidence of ADHD has also been observed in adolescents [79] and adults [80] seeking weight management surgery.

5.3. Intellectual Disability

There is limited research investigating ID in relation to EDs, in part driven by the lack of adapted ED assessment tools in the context of ID [see 81]. Additionally, there is high heterogeneity, with differing reported ED incidences between people with ID living in the community (1-19%) compared to those who reside in care institutions (3-42%) [44]. Another study showed that 27% of people with ID had an ED, with BED being the most prevalent [82]. In a study of children with ID, Gal, Hardal-Nasser, and Engel-Yeger [33] found that 97% of participants had at least one eating or feeding problem (i.e., food refusal, food selectivity, dysphagia, rumination, binge eating). Furthermore, a systematic review highlighted a high incidence of swallowing problems (e.g., aspiration, dysphagia) contributing to malnutrition in adults with ID [83].

5.4. Tourette's Syndrome, Obsessive Compulsive Disorder, Psychosis, and Giftedness

There is limited data regarding the co-occurrence of Tourette's syndrome and EDs. However, one study estimated that the lifetime prevalence for EDs was 2% for those with Tourette's, with females (7%) more at risk than males (0.3%) [84]. Furthermore, studies have highlighted a high incidence of disordered eating and feeding challenges for children with Tourette's syndrome [34-35]. For obsessive-compulsive disorder (OCD), meta-analytic prevalence estimates report co-occurrence of OCD in EDs being 13.9 –18%, with greater frequency in AN [85-86]. In comparison to neurotypical individuals experiencing an ED, individuals with OCD or those with elevated OCD traits are at greater risk of more severe ED symptomatology and poorer ED treatment outcomes [87]. Research on the co-occurrence rates of psychotic spectrum disorders and EDs is also limited; however, higher levels of co-occurrence between these two diagnostic groups have been indicated compared to the general population [88]. Indeed, a systematic review showed higher rates of disordered eating compared to controls in individuals with schizophrenia, with disordered eating behaviours observed in 10-41.5% of patients [89]. Moreover, transient psychosis occurs in EDs secondary to malnutrition, electrolyte imbalance, metabolic disturbance, and re-nutrition [90-91] and incidence of transient psychosis among ED patients has been estimated to be 10-15% [91]. Lastly, some studies have suggested a link between giftedness and EDs, with gifted individuals thought to be at a high risk of developing EDs; however, there is no prevalence data available [92-98].

5.5. Conclusion

While clear associations between autism, ADHD, and EDs have been highlighted, more investigations are needed with regards to other forms of neurodivergence. Additionally, despite many forms of neurodivergence overlapping and co-occurring, there is limited transdiagnostic research investigating neurodivergence and EDs. Nonetheless, estimating prevalence remains challenging due to issues such as NDI being misdiagnosed with personality disorders and lack of ED-focused psychometric instruments tailored to, and validated for, NDI.

6. NEURODIVERGENCE, INTERSECTIONALITY, AND EATING DISORDERS

The reasons underlying NDI being at a high risk of disordered eating and/or EDs are varied, complex, and multifaceted, and encompass a wide range of interconnected environmental, psychosocial, and biological factors. NDI experience the world differently in a myriad of ways, as illustrated by differences in sensory processing, communication and socialising (e.g., the double empathy problem), thinking and learning styles (e.g., monotropism, inertia), gender identity, sexual orientation, sex diversity, and executive functioning [99-101]. Together, these differences may contribute, either directly or indirectly, to a wide array of pathways potentially contributing to the development of disordered eating, EDs, and/or body image disturbances for NDI [9, 19, 101-103].

The section below outlines several common neurodivergent experiences that may contribute to elevated ED risk. The available evidence has been integrated with the lived and living experiences of the authorship team to provide a framework for future work on this emerging topic within the ED field.

6.1. Sensory Processing

Sensory processing differences encompassing exteroception (related to external stimuli such as sounds or tastes), interoception (related to internal stimuli such as thirst, pain, or hunger), and alexithymia (the ability to recognise and/or describe affective states and associated physiological sensations) are core overarching characteristics associated with neurodivergence [104-112]. Collectively, atypical sensory processing patterns are linked to EDs as well as body image disturbances, irrespective of neurotype [113-115]. Additionally, research shows that atypical sensory processing, as experienced by autistic people more specifically, is strongly associated with disordered eating [116-118].

Exteroception and interoception influence cognitive processes such as goal-directed behaviours (e.g., eating, drinking), motor control and coordination, memory, learning, motivation, self-perception, and emotional awareness and responsiveness, and are tied to neurobiological systems, particularly thalamo-cortical connectivity [119-121]. The thalamus is located at the centre of the brain and has historically been perceived as a passive relay centre for sensory information, including interoception and exteroception (except for olfaction, which is routed through the olfactory bulb) [122]. However, a growing body of evidence shows that the thalamus plays a more active and important role in many cognitive functions than previously thought, including regarding memory and attentional control [123-124], executive functioning [125], and emotional processing (e.g., thalamo-limbic connectivity) [126]. More recently, neuroscience research has suggested the thalamus to be involved in a wide range of psychiatric conditions (e.g., depression, anxiety, bipolar disorder, post-traumatic stress disorder, substance abuse) [127-129], including EDs [130-132]. Atypical sensory processing likely underlies differences in eating processes and habits as well as vulnerability to ED development [see 133, pp. 22-23].

There are different ways in which atypical sensory processing may lead to eating difficulties and/or disorders. Exteroception may contribute to dietary restriction resulting from aversions whereas sensory seeking and associated cravings tied to specific tastes or textures may underlie bingeing [113]. Heightened exteroception (e.g., hyperacusis, misophonia) may also be contributing to the preference for eating alone to avoid sensory overwhelm [134-135]. Moreover, interoception may impact eating through the modulation of hunger and satiety; for instance, feeling full after consuming small amounts of food may underlie restriction whereas delayed satiety may promote bingeing and/or eating in the absence of hunger [113]. Interoception further plays an important role in body image and has been associated with body image disturbances [102, 136-137]. Research has also associated alexithymia, which is connected to interoception, with binge eating behaviours (often referred to as ‘emotional eating) [138-139]. Specifically, Vuillier et al. [140] found that alexithymia could partially explain the high prevalence of EDs in autistic people.

Eating a restricted range of foods is often framed as an ED symptom. While this phenomenon may reflect psychopathology for some, qualitative research shows that, for autistic people, it may be an adaptive and self-regulatory mechanism to prevent sensory distress, cognitive overwhelm, and mealtime anxiety [103, 141-142]. Indeed, research suggests that autistic people do not habituate to sensory stimuli in the same ways as non-autistic people [143-144]. In the context of such reduced habituation, coercing autistic people to eat aversive foods may be experienced as traumatic and unintentionally exacerbate feeding difficulties (e.g., food phobia) [145]. It is therefore critical to take the different ways NDI experience eating and feeding from a sensory perspective into account for ED identification, care, and recovery [9, 10, 19, 36].

6.2. Executive Functioning

Executive functioning differences (e.g., task initiation, memory, demand avoidance) are influenced by sensory processing patterns [146] and are observed in many NDI [147]. Executive functioning differences are also linked to EDs [148-149]; for example, executive functioning differences may contribute to difficulties related to remembering to eat, grocery shopping, meal preparation, consistently following a meal plan, and/or choosing what to eat [113, 101, 141]. Such difficulties may promote restrict-binge cycles, whereby forgetting to eat or being unable to organise meal preparation leads to prolonged periods of time without eating, which may be followed by compensatory bingeing episodes [101]. Additionally, given that many autistic people have a literal, or concrete, thinking style [23, 150], dichotomous portrayals of ‘healthy’ or ‘good’ versus ‘unhealthy’ or ‘bad’ foods associated with diet culture and public health messages may contribute to fixations towards foods considered ‘healthy’ (e.g., orthorexia) [101, 151-152].

6.3. Gender, Sexuality, and Sex-Diversity

People with a diverse sex, sexuality, and/or gender identity are more likely to be autistic and/or have ADHD [153-159] and face a high risk of EDs and body image disturbances [160-161]. Factors contributing to the increased risk of EDs among neurotypical sex, sexuality, and gender diverse people include gender dysphoria, internalised cis-heterosexist ideals, and minority stress [133, 160, 162-168]. In contrast, identity pride, community connectedness, and gender-affirming healthcare can be protective factors [133, 160, 166, 169].

Trans people experience disproportionate rates of EDs compared to cisgender individuals [162-164, 170]. EDs, in this context, may function as a way to manage gender dysphoria; for instance, restrictive eating can delay the onset of puberty or minimise the appearance of secondary sex characteristics [162-164]. ED risk for trans people is further exacerbated by minority stressors, including discrimination and social exclusion, which can lead to heightened body dissatisfaction and increased engagement in ED behaviours [171]. Additionally, high levels of gender dysphoria are observed in the autistic population, partially mediated by atypical sensory processing, contributing to greater difficulties in coping with gender incongruence and body image disturbances [157, 172-174].

Variations of sex characteristics (VSC) – otherwise referred to as intersex– are differences in innate sex characteristics that differ from social and medical norms [175]. In a study of 1022 people with VSC, 8.8% had a diagnosis of autism, 9.1% had high autistic traits, and 4.1% screened positive for ADHD [155]. Higher autistic trait scores were associated with lower self-esteem in participants with Turner Syndrome, Klinefelter Syndrome, and female participants with 46XY variations with and without androgenisation [155]. Additionally, higher ADHD trait scores were associated with poorer body image in participants with Turner Syndrome, female participants 46XY variations with and without androgenisation, and male participants with 46XY variations [155]. ED diagnoses were reported in 11.1% of the overall sample (3.7 times higher than the general population); however, stratified data of ED diagnoses for autistic intersex people and those with ADHD were not provided [155].

Intersectionality plays a crucial role in understanding elevated ED risk for NDI who are also members of the LGBTQIA+ community, highlighting the need for targeted interventions and support systems that address the unique intersections of neurodivergent and LGBTQIA+ identities [153, 161]; for example, by acknowledging that dietary restriction may stem from different motivations in this population (e.g., sensory and gender dysphoria-based), underscoring the importance of neurodiversity-affirming ED care also being gender-affirming.

6.4. Giftedness and Twice-Exceptionality

Giftedness, which refers to outstanding intellectual and/or creative potential [176], may represent a risk for ED development through perfectionism, low self-esteem, striving to achieve social acceptance, and avoiding ostracization and rejection [177-179]. Obsessive perfectionism may develop in gifted people within the context of interpersonal trauma and marginalisation, wherein an individual pursues creative and/or intellectual achievements as a survival process to protect autonomy, identity and individuality, and to anesthetise psychological pain [180-182]. High academic and/or creative achievement in the context of giftedness may be an asset to accepting uniqueness and social difference; however, this may become a burden when an individual's emotional vulnerability and associated need for support are not recognised and addressed [183]. Twice-exceptional people (i.e., people who are both disabled and gifted, such as those with co-occurring giftedness and dyslexia and/or ADHD) may also experience psychosocial vulnerability and imposter syndrome due to asynchrony – referring to disparities between ones' chronological and developmental trajectories, belongingness with peers, and expectations [177]. Perfectionism and disordered eating may be an attempt to cope with the psychosocial distress [see 184] associated with such asynchrony [97, 177, 185]. Twice-exceptionality may also present a social and identity threat, due to experience of being 'twice different' [186]; thereby, disordered eating may serve as a social survival strategy to fit in with peers through striving toward societal body ideals [177] and alleviate the existential angst that may accompany fears of failure and/or imposter syndrome [187].

6.5. Systemic Discrimination, Inequity, and Trauma

NDI commonly experience systemic oppression and discrimination across varying settings and contexts (e.g., education, healthcare, employment) [188-195]. Such forms of systemic discrimination increase the likelihood of unemployment [196], houselessness [197], and food and nutrition insecurity [198-199], therefore contributing to psychosocial distress and mental ill-health [200], including EDs [201]. Indeed, high rates of houselessness and unemployment have been reported for NDI [196, 198, 202-205]. The risk for autistic people to be food insecure is four times greater compared to non-autistic people [198]. Moreover, a systematic review highlighted that between 10-40% of adults with ID experienced houselessness [206]. Food insecurity is a known ED risk factor, particularly for BN [207-209].

Rejection and stigmatisation are common experiences for NDI, and negatively impact on self-esteem and psychosocial wellbeing [210-212]. Rejection and stigmatisation are often rooted in deficit-based and dehumanising stereotypes, such as that autistic people ‘lack empathy’ and ‘social skills’ [213-216] or that those with ADHD are ‘lazy’ and ‘attention seeking’ [217-218]. Resultantly, NDI are prone to internalise such stigma and may hide their authentic selves to avoid being rejected and bullied – a phenomenon referred to as *masking* or *camouflaging* [219]. Masking is associated with loss of sense of self and identity confusion [220], which are known risk factors for EDs [221]. Furthermore, substantive evidence supports the link between masking and poor mental health outcomes in autistic people, such as anxiety, self-harm, suicide [222-225], and risk of EDs [151, 226].

NDI have been found to experience higher rates of interpersonal victimisation, including domestic abuse and sexual violence, compared to neurotypical individuals [227-231]. For example, nine out of ten autistic women [232] or those with an ID [233] report having been sexually assaulted, which is three times more than neurotypical women. Additionally, a systematic review suggested that those with ADHD were more likely to have experienced childhood sexual abuse compared to those without ADHD [234]. Such experiences of victimisation are relevant as interpersonal trauma, including sexual abuse, have been found to substantially increase the risk of EDs [201, 235-237].

There is emerging evidence suggesting that autistic people experience post-traumatic stress triggered by factors not currently conceptualised within psychiatric nosology as inherently traumatic [238-241]; for example, some autistic people may experience post-traumatic stress resulting from repeated exposures to aversive sensory input (e.g., sounds, smells, tastes, textures) [145]. It is estimated that up to 60% of autistic people suffer from post-traumatic stress disorder in their lifetime [241], with many thought to be misdiagnosed (e.g., borderline personality disorder) and not receiving the trauma-informed care they need [49-50, 239]. Since post-traumatic stress disorder is a known contributor to the development of EDs [242], the delayed identification and delivery of compassionate treatment of trauma may therefore exacerbate the vulnerability towards developing EDs for autistic people.

Intersecting experiences of marginalisation and structural oppression (i.e., racism and ethnocentrism, ableism, gender binarism, sexism, cis-heterosexism, and sizeism) may compound ED risk [237, 243-244]. Indeed, in Nelson et al.’s [237] longitudinal study involving 331 undergraduate students, different forms of discrimination such as racism, weight stigma, and sexism all predicted body image dissatisfaction and disordered eating. The patterns of disordered eating were different depending on the type(s) of discrimination experienced [237], highlighting the importance of considering the influence of intersecting factors of identity, oppressive power structures, and trauma experiences in ED development and recovery, irrespective of neurotype [20].

6.6. Chronic Illness and Psychoneuroimmunology

NDI experience chronic medical illnesses at higher rates than neurotypicals [245-247]. The range of such medical conditions include, but are not limited to, Ehlers-Danlos syndrome, postural tachycardia syndrome [248], diabetes type 2 [249], polycystic ovarian syndrome [250], endometriosis [251], asthma, dermatitis, food allergies [252-253], gut microbiome dysbiosis [254-255], and gastrointestinal disorders [256-257]. There is emerging evidence suggesting a bidirectional relationship between the aforementioned conditions and EDs; indeed, experiencing one of the conditions listed above may increase the risk of developing an ED later in life, while having an ED may increase the risk of developing one of the aforementioned conditions later in life [258-263].

Furthermore, there is growing evidence from the field of psychoneuroimmunology suggesting that psychological stressors, including in relation to systemic discrimination, interpersonal victimisation, and childhood trauma, may be a key factor in immune and gut-brain dysregulation [264-267]. It has been suggested that the link between psychological stress and gut-brain and immune dysregulation is rooted in the mechanism whereby stress activates corticotropin releasing hormone (CRH) which, in turn, triggers the degranulation of mast cells [268-270]. More specifically, research points to a bidirectional relationship between the immune system, particularly mast cells and histamine [271-272], and a wide range of psychiatric disorders [273-274], including EDs [262, 275-277]. Some research also posits that this relationship may be mediated by histamine playing a role in the modulation of dopamine neurons' firing rates in the brain [278], particularly in the thalamic region [279-280]. Histamine further influences glucose and lipid metabolism [281], leptin and ghrelin activity (i.e., appetite, fullness) [282], digestion [283], and control of arousal and energy expenditure (i.e., homeostasis), including propensity towards exercising [284-286]. As noted by Keeler et al. [287], “infections, autoimmune diseases, and stress-related alterations in the immune system influence brain circuits and neurotransmitters involved in appetite and mood regulation”.

6.7. Conclusion

There are many intersectional factors underlying NDI being at a high risk of experiencing disordered eating and/or developing EDs. This underscores the importance of investigating ED risk through a holistic, intersectional, and lived experience-led lens. Taking these intertwined factors into account in treatment formulation is also of great importance to improve ED care individuation.

7. GAPS IN RESEARCH AND PRACTICE

EDs are psychiatric disorders with significant negative consequences on psychosocial wellbeing and physical health [288]. Despite this, our current understanding of mechanisms for ED risk, development, maintenance, and relapse remain poorly understood, irrespective of neurotype [18, 289].

While manualised psycho-behavioural mental health approaches, such as cognitive-behavioural therapy (CBT), are often promoted as first-line ‘evidence-based’ treatments for most mental illnesses, including EDs [17-18], there are a range of issues that impact the generalisability of such broad claims [290]. Identified issues include publication bias [291-293], selective reporting [294-295], undisclosed conflicts of interest [296-297, see 298], under-reporting of adverse effects [299-301], lack of long-term follow-up studies [18, 302], and lack of participatory, lived experience-led, research [39, 41, 303].

Indeed, psycho-behavioural treatments considered as the ‘gold standard’ in the context of EDs – namely, CBT (for adults) and family-based therapy (FBT; for young people) – have consistently been shown to lead to less than half of people with EDs reaching long-term recovery overall [17-18, 304]. There is also emergent evidence showing that NDI, more specifically, have poorer ED treatment experiences and outcomes compared to neurotypical individuals [87, 305-310].

7.1. Reporting of adverse effects and risk assessments

Insight into both intervention efficacy and risk of harm is essential to the practice of evidence-based medicine; indeed, as noted by Junqueira et al. [311], “treatment decisions rely on accurate knowledge of both efficacy and harms”. However, adverse effects related to psycho-behavioural treatments for mental ill-health frequently lack systematic assessment and transparent reporting in research, subsequently skewing evidence regarding risk-benefit ratio [299-300, 312-315]. For example, in a systematic meta-review of meta-analyses of ED treatments, adverse events were only acknowledged in the context of pharmacology [316]. Furthermore, Linardon et al. [317] conducted a systematic review and meta-analysis to assess the efficacy of CBT for treating EDs where they deemed CBT to be efficacious despite omitting to discuss measures of short and long-term harms. Iatrogenesis, that is, harm resulting from healthcare practices, may not manifest immediately and be delayed [299], in which case it would only be captured in long-term follow up studies. Late onset iatrogenic harm is therefore missed by the lack of long-term follow-up studies in ED research [see 18]. Subsequently, lack of reported iatrogenic harm in the literature is mistakenly interpreted as evidence of no harm [see 301], leading mental health practitioners under-resourced to recognise and address iatrogenesis from psycho-behavioural treatments [see 300, 318], including in the context of neurodivergence [36, 319-321].

There is an increasing number of community resources where NDI with lived experience of EDs report having experienced iatrogenic harm from ED treatments, including psychological trauma [322-326]. Unfortunately, such narratives are seldom reflected in published mental health clinical trials and meta-analyses. Biases undervaluing qualitative, phenomenological, and lived experience-led research have been suggested to contribute to such narratives not being adequately discussed in mental health research [327-328]. Nonetheless, there is growing recognition that psycho-behavioural treatments can be harmful to NDI [318-319, 329], including in the context of EDs [19, 309, 330-331].

7.2. Neurodivergent Leadership and Representation: Who is Creating The ‘Evidence’ and Who is the ‘Evidence’ For?

According to Curnow et al.’s [332] umbrella review investigating the overall suitability of currently available mental health therapies in the context of autism, no existing mental health framework can claim to be NDA; a conclusion that has also be highlighted in the ED context [10, 36, 309]. There are two main factors, discussed below, playing into this: namely, the lack of representation of NDI in mental health research and the lack of non-tokenistic, lived experience-led, participatory research. Indeed, “inclusive research practice characterized by the involvement of neurodivergent people in meaningful roles has been described as a ‘requirement of excellence’ in neurodiversity research” [333].

Participatory research methods which are led by individuals with lived experience are rarely utilised in ED research [39-41] or in mental health research more broadly [334-337, pp. 179-180]. It has been suggested that participatory research methods have potential to improve overall mental health outcomes for NDI [336, 338-340], including in relation to EDs [19, 40]. Indeed, participatory research methods have been shown to facilitate the translation of findings into real-world contexts and ensure that the research yields relevant and meaningful benefits for the community [340].

The neurodivergent community, and other marginalised communities (e.g., gender diverse folks) [341], are not adequately represented in ED research [10, 19, 40]. The lack of neurodivergent representation is not limited to EDs; for example, Jubenville-Wood et al. [303] noted that “limited research exists that examines the experiences of autistic individuals in psychotherapy.” The neglect of intersectionality in ED research further extends to co-occurring mental illnesses, despite a majority of those with an ED also being diagnosed with another psychiatric condition [342]. This is particularly relevant in the context of neurodivergence as NDI are shown to experience mental illnesses, including other than EDs, at significantly higher rates compared to neurotypical individuals [343-347].

A greater focus on participatory research that takes an intersectional lens is indicated to better understand the connections between neurodivergence and EDs and improve ED prevention efforts and treatment outcomes for NDI [10, 40, 174, 264, 331].

7.3. One Size Does Not Fit All

The indiscriminate use of a narrow range of manualised therapies, assessment tools, and public health campaigns for different demographic groups, such as NDI, gender and/or sexually diverse people, and racially marginalised individuals, is problematic, as each group experiences unique underlying factors to the development of EDs and may require different, sometimes conflicting or opposing, forms of support and formulations to recover [see 10, 174, 348-349]. As outlined in section six, NDI, as well as those with other minority and/or marginalised identities, have been found to have divergent feeding, eating, and ED experiences. However, hegemonic conceptualisations of feeding, eating, and EDs do not incorporate such diversity of lived experiences, a limitation that impacts all stages of ED care [see 10, 174, 348-349].

Evidence-based medicine requires that clinicians consider research evidence, clinical expertise, and patient preferences when deciding on a course of action [350]. Indeed, ED clinical guidelines identify a narrow range of ‘evidence-based’ ED interventions, many of which are manualised, whilst also acknowledging the important role of person-centred approaches to ED care [351-352]. This is a realistic goal when the manualised treatments are informed by diverse and representative samples that adequately capture divergent experiences and account for them. However, given the traditional misrepresentation of authentic and inherently adaptive neurodivergent eating and feeding experiences as pathological, and the historical and ongoing legacy of epistemic injustice silencing neurodivergent (and other marginalised) voices in ED research [see 19, 40, 164, 174, 348-349], it appears that oppressive and unequal power dynamics have contributed to the lack of more affirming, innovative, and inclusive conceptualisations of and interventions for EDs, setting the scene for the monopolisation of ED research by a limited number of manualised interventions (e.g., CBT, FBT), despite their lacklustre success rates [see 17-18, 304].

Importantly, this legacy of epistemic injustice places ED clinicians who are attempting to translate research evidence into clinical practice in a double bind: on the one hand, clinicians must practice in accordance with ED clinical guidelines which identify a narrow range of suitable ED treatment approaches, typically manualised, that they can choose from, whilst simultaneously being asked to practice person-centred care that, if followed, is not likely to fit neatly into the prescribed formulation and treatment plan laid out in the approved manualised interventions.

The RAVES model (an acronym representing regular eating, adequacy, variety, enjoyment, and social eating) is a clinical tool that is commonly used by dietitians [353]. Whilst the intervention targets identified in this clinical tool appear logical when framing eating through a neuronormative lens, they do not align with lived-experience informed conceptualisations of adaptive neurodivergent feeding and eating experiences, such as preference for sameness [142], sensory-related food variety constraints [see 9, 40, 151], and preference to eat alone [134], and risks invalidating authentic and adaptive neurodivergent feeding and eating support needs and preferences if applied indiscriminately [101].

Food-related exposure-based techniques, typically used in tandem with psycho-behavioural ED treatments such as FBT and CBT [see 354], risk causing sensory overwhelm, distress, or even sensory trauma when they fail to account for and accommodate divergent sensory processing profiles [see 142, 145], particularly in light of the evidence showing that sensory habituation is attenuated amongst autistic individuals [143, 355-356].

Research demonstrates that those with atypical AN experience similar psychopathology, illness severity, and medical risks to those with typical AN, regardless of weight status [357-359]. The current weight-centric conceptualisation of AN recovery is thus problematic, particularly for autistic people who report that weight is not the most predominant factor contributing to their food restriction [9, 10, 141, 151, 174, 309]. Indeed, research investigating treatments for AN, including CBT, mainly focuses on weight gain as a main indicator of recovery and a primary outcome measure for treatment effectiveness [36-361], despite growing evidence that weight does not measure recovery and that focusing on weight in this manner contributes to weight stigma (e.g., being turned away from health services due to being perceived as ‘not being sick enough’) [362-364] and iatrogenic harm [365]. Furthermore, qualitative research shows that people with lived experience commonly emphasise the importance of supportive interpersonal connections, strengths-based sense of identity, finding meaning and purpose in life, and orienting towards self-compassion as central factors supporting ED recovery, more so than weight [21].

7.4. Conclusion

Current psycho-behavioural frameworks for treating EDs, such as FBT and CBT, are often broadly promoted as effective and ‘evidence-based’, despite meta-analytic evidence consistently demonstrating only less than half of people who access these treatments experience long-term recovery, irrespective of neurotype. Additionally, evidence shows that autistic people and those with ADHD experience poorer treatment outcomes compared to neurotypical people; unfortunately, there is a paucity of empirical evidence for other types of neurodivergence. Issues relating to lack of long-term follow-up data, limited assessment and reporting of iatrogenesis, undisclosed conflicts of interest, and protocol and publication biases, have been identified as factors to consider when interpreting efficacy claims in this context. More specifically, participatory research methods are seldom used in ED research and NDI are rarely represented or taken into consideration in treatments’ design and implementation, as are other marginalised communities, thus significantly undermining the validity of ‘evidence-based’ mental healthcare for a more diverse range of people. Furthermore, ED research rarely takes a holistic lens that acknowledges intersectional factors, as outlined in section six, needing to be considered in treatment formulations, leading to gross oversimplifications in manualised treatment frameworks that do not account for the fact that different people and communities have different, and sometimes conflicting, support needs.

8. WHAT DOES NEURODIVERSITY-AFFIRMING EATING DISORDER CARE ENTAIL?

The concept of NDA care is grounded in the principles of the neurodiversity paradigm which views neurodiversity as a natural and valuable form of human diversity, rejecting the idea that there is a singular ‘normal’ personality and neurocognitive profile that all humans should universally aspire to and emulate [22]. An NDA mental healthcare framework, therefore, is a holistic and person-centred framework rooted in the principles of phenomenology, epistemic justice, and cultural humility [339, 366-371]. NDA ED care requires that ED clinicians engage in ongoing self-reflection to challenge biases and neuronormative assumptions, social norms, beliefs, and goals that further perpetuate the pathologisation and systemic oppression of NDI [40, 101, 174, 264]. Crucially, NDA ED care necessitates clinicians be able to differentiate neurodivergent traits from ED symptoms, understand the underlying reasons and adaptive mechanisms of neurodivergent traits, and validate and accommodate the individualised support needs of NDI, such as with regards to sensory processing, communication, and executive functioning, rather than attempt to ‘fix’ these at the expense of overall wellbeing and self-determination [see 40, 101, 174, 264, 372].

8.1. Overview of currently available neurodivergent-specific psychometric assessments and treatment adaptations

Specific assessment tools have been developed to improve the identification of feeding and eating difficulties, and related psychopathology, amongst autistic individuals (Swedish Eating Assessment for Autism spectrum disorders [373]; Body Appreciation Scale 2 for Autistic Adults [65]; Autism Eating Questionnaire [374]; Brief Autism Mealtime Inventory Assessment [375-376]. To the authors’ knowledge, no assessment tools have been developed or adapted to target eating or body image psychopathology associated with other forms of neurodivergence.

Suggestions have also been made to tailor treatments for NDI [10, 377-378]. However, except for the Body Appreciation Scale 2 for Autistic Adults [65], none of the adaptations to either identification or treatment discussed in this section have been explicitly identified by their authors as having been developed through lived experience-led research. It is also important to note that while care adaptations discussed below have been developed with the intention of improving treatment outcomes for NDI, this does not necessarily guarantee that they will be experienced as NDA by NDI with EDs or helpful in practice [see 379]. Empirical evidence led by NDI with ED lived experience is required to provide insight on whether these ED care adaptations are experienced as helpful, harmful, or neutral.

An ED inpatient care pathway tailored for autistic people, the PEACE Pathway, has been implemented in the United Kingdom [377]. The PEACE Pathway outlines the need for individualised sensory processing accommodations and includes training for clinicians to assist in making autism-specific adjustments to ED care and psychoeducation [380]. A preliminary evaluation of the PEACE pathway found that it reduced treatment duration and resulted in admission cost savings [380]. The PEACE pathway researchers examined the feasibility of implementing Cognitive Remediation Therapy (CRT) amongst individuals with an ED, comparing efficacy between those with low and high autistic traits, and found CRT supported improvements in cognitive flexibility and central coherence in both groups [381]. However, across studies, results are heterogeneous, with Saure et al.'s [115] narrative review concluding that individuals with AN with high autistic traits appear to benefit less from CRT (as well as from cognitive remediation and emotion skills training interventions) compared to those with low autistic traits.

Drawing on available research and clinical experience of supporting autistic children and young people with AN, Loomes and Bryant-Waugh [382] identified a range of autism-specific modifications for family-based interventions for AN. The suggested adaptations target four domains: sensory processing considerations, cognitive and behavioural factors, difficulties with social communication and relationships, and challenges relating to emotion processing [382]. The authors recognise that the suggested adaptations are conceptual and thus require empirical assessment before we can determine their acceptability and efficacy.

Field and colleagues [10] undertook a similar project, identifying ways in which ED services could better meet the needs of autistic women via a Delphi Study. Fifty-six consensus statements reached agreement in the final round, relating to the need to support the unique experiences of autistic women, separating autistic features from the ED, and the importance of staff being experienced in supporting autistic individuals [10].

A single case report detailed adaptations to CBT to meet the needs of an individual with ID experiencing difficulties with binge eating [383]. Adaptations included a focus on regularity and predictability of appointments, the use of images to aid with understanding, adapted use of language, and sensory considerations. The authors reported that the participant’s self-regulation associated with loss of control eating improved as a result of the intervention [383].

8.2. Human Rights, Cultural Humility, and Epistemic Justice

An NDA approach to mental healthcare is a human rights-based approach rooted in the social model of disability and existential-humanistic psychology [339, 366-368, 384]. As such, NDA mental healthcare is inherently gender-affirming and trauma-informed [339, 366]. This requires the rejection of compliance and exposure-based behavioural approaches (e.g., operant conditioning, contingency management) that are imposed rather than self-determined and client-led as these have been associated with iatrogenesis, including learned helplessness and psychological trauma [225, 339, 385-389]. Instead, the priority must be on supporting self-determination, self-advocacy, and self-efficacy, and incorporating a person-centred, compassionate, and strengths-based approach to care that is informed by lived experience expertise [19, 337, pp. 179-180, 366, 390-393].

It is imperative that all NDA mental health interventions aim to support the development of a positive and authentic neurodivergent identity, as this has been associated with benefits to overall psychosocial wellbeing and increased self-compassion [394-395]. The benefits of a positive neurodivergent identity have also been noted in relation to supporting ED recovery specifically [10, 19, 151, 174]. Such an approach echoes the recent call to action released in a joint statement by the United Nation and the World Health Organization that urges mental health practitioners and researchers to focus on the social determinants of mental health, epistemic justice, harm reduction, and human rights-based mental healthcare [396].

8.3. Reasonable Adjustments

Founding members of Autistic Doctors International have created SPACE; an autistic-led framework for autism-specific accommodations aimed at improving accessibility of healthcare services for autistic individuals [370]. The SPACE framework identifies key reasonable adjustments across core support needs for autistic people, such as sensory, predictability, acceptance, communication, and empathy, as well as across three main domains of experience: physical space, processing space, and emotional space [370]. As noted in section six, NDI have unique sensory, communication, cognitive, and emotional needs that have been identified as important to understand, validate, and accommodate as part of NDA ED care, and as such, SPACE has potential utility as a tool to support more neurodiversity-affirming ED service delivery [see 9, 10, 101]. For example, some autistic people may be non-speaking, while others may be partially speaking (e.g., situational mutism), and allowing communication in ways that feel comfortable is likely to improve trust between patient and clinician [370]. Additionally, adapting the consulting room to meet the sensory needs of autistic patients may also assist in building trust, self-regulation, and safety (e.g., noise, temperature, smells, lights) [370]. On the other hand, some autistic patients may prefer to remain standing or sit on the floor during the consultation, and these differences in proprioception should also be accommodated [370].

Research exploring general mental health has highlighted empirical evidence supporting the benefits of sensory-based approaches in the general population, where the physical environment is tailored to the sensory processing characteristics of an individual [397-401]. Sensory-based approaches can include strategies such as adjusting the room’s lighting and/or colours, providing access to weighted blankets, fidget tools, rocking chairs, and/or noise-cancelling headsets to reduce sensory stimulation. Sensory-based mental health approaches have been shown to create a sense of safety and control, increase self-regulation, reduce distress and anxiety, improve self-perception, and help with stabilising (or ‘grounding’) acute arousal [399, 401]. There is also emerging evidence suggesting that sensory-based approaches in inpatient mental health facilities may contribute to improvements in autistic individuals’ wellbeing and self-regulation [372, 402-403], giving further weight to the argument in support of ED services attending to the unique sensory needs of NDI.

8.4. Conclusion

NDA care involves respecting and validating different personality and neurocognitive profiles instead of de facto pathologising divergence and trying to 'fix' differences rather than celebrating diversity and accommodating specific support needs. Promoting self-determination and a positive, authentic, sense of self are critical to NDA care. In the context of EDs, NDA care requires that researchers and clinicians engage in epistemic justice and remain curious towards the different ways NDI engage with eating, self-perception and expression, and conceptualise recovery. Indeed, distinguishing between ED symptoms and adaptive ND traits is key to NDA ED care and the prevention of iatrogenesis. Additionally, while further empirical research is required, the SPACE framework and sensory-based approaches may be useful in the context of ED care for NDI.

9. CONCLUSIONS

Prevalence data highlights that autistic people and those with ADHD are at an increased risk of developing EDs compared to those who are neurotypical. The limited research on other forms of neurodivergence (e.g., giftedness, intellectual disability, Tourette's syndrome) and eating psychopathology has found them to be associated with high incidences of disordered eating, highlighting a need for more research. It is possible that the real co-occurrence rates between neurodivergence and EDs are much higher as issues such as the underdiagnosis and/or misdiagnosis of autism and ADHD in AFABs and racially marginalised populations, lack of tailored psychometric instruments, and limited research despite documented overlaps between various forms of neurodivergence potentially lead to under-identification of true prevalence rates. Improvements in the accessibility of neurodivergent assessments and the development of lived experience-led ED screening and diagnostic tools are likely to support early identification for NDI. In addition, given the overrepresentation of neurodivergence in ED populations, it is ideal for ED clinicians to screen for autism and ADHD to improve ED care individuation.

There are a wide range of interwoven factors underlying ED risk for NDI, ranging from atypical sensory processing, executive functioning, social communication, emotional processing, and a higher likelihood of experiencing chronic illnesses and systemic discrimination. Therefore, it is important that future investigations into ED risk in the context of neurodivergence take an intersectional approach. Transdiagnostic research factoring in the overlaps between varied forms of neurodivergence is also warranted given that co-occurring forms of neurodivergence appear to have an impact on ED presentations and the nature of support needs. Future empirical work should be participatory, non-tokenistic, and ideally lived experience-led, and acknowledge power structures associated with discrimination and trauma to better achieve epistemic justice and better translate to cultural humility in ED care.

10. STRENGTHS AND LIMITATIONS

While our work did not entail a comprehensive systematic review of the literature due to the nascent nature of this specific area of inquiry, this narrative review allows for scoping of the literature available to date whilst providing a lived experience-led framework for discussion and an initial conceptual map for future empirical work.

Additionally, this review can only draw from the strength of the evidence that is available. Although an extensive narrative review, research is still limited, and this can only be improved with funding and support. Furthermore, most of the literature to date focuses on either autism or ADHD in relation to EDs. Therefore, there is limited data relevant to other forms of neurodivergence to draw upon.

This paper was written exclusively by NDI with lived or living experience of an ED, which may influence reflexivity. However, the importance of lived experience-led mental health research has been consistently highlighted, particularly with regards to translation and implementation.

LIST OF ABBREVIATIONS

ADHD: attention deficit/hyperactivity disorder

AFAB: assigned female at birth

AMAB: assigned male at birth

AN: anorexia nervosa

ARFID: avoidant/restrictive food intake disorder

BN: bulimia nervosa

BED: binge eating disorder

CBT: cognitive behavioural therapy

CRH: corticotropin releasing hormone

CRT: cognitive remediation therapy

ED: eating disorder; EDs: eating disorders

FBT: family-based therapy

ID: intellectual disability

NDI: neurodivergent individuals

OCD: obsessive compulsive disorder

VSC: variations of sex characteristics

DECLARATIONS

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N/A

Consent for publication:

N/A

Availability of data and materials:

All data generated or analysed during this study are included in this published article.

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