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Eating disorder or disordered eating? Eating patterns in autism

When Phoebe (aged 14) started her GCSEs she became very anxious and began obsessively counting calories. Libby (aged 16) stopped eating some of her favourite foods after learning about healthy eating at school. Both young women (names and details have been changed) have a diagnosis of autism spectrum disorder (ASD) and both were suspected of having developed an 'eating disorder' following weight loss.

Eating a limited diet is commonly reported in autism (Shea, 2015). In clinical practice young people can present with complex patterns of food refusal. For some, this contains elements of two diagnostic classifications: 'Avoidant and Restrictive Food Intake Disorder' (ARFID) and 'Anorexia Nervosa' (AN) (American Psychiatric Association, 2013). This article describes some of the differences between these two eating patterns.

Eating patterns

The diagnostic category of ARFID (Appendix 1, figure 1) replaces the previous and more general term 'Childhood Feeding Disorders' (American Psychiatric Association, 1993) and the many terms used to describe children (and adults) with certain common characteristics in their eating and drinking.

ARFID typically includes restriction of foods based on sensory properties and concern about the aversive consequences of eating. This can include fears of choking, vomiting or extreme contamination/disgust. Weight loss and/or nutritional deficiency can also be present as a result of these restrictions, along with disruption in the individual's daily psychological or social functioning.

Anorexia Nervosa (Appendix 1, figure 2) is characterised by a restriction in calorie intake due to a desire to control weight and an intense fear of becoming fat. This is combined with a disturbance in the way in which one's body weight or shape is experienced.

Whilst there are a number of clinical tools for the assessment of AN, as yet there is no published equivalent for ARFID. Diagnosis depends on the careful exploration of eating behaviour.

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Phoebe had complex and lengthy rituals and routines around food preparation and eating. This included eating foods in multiples of 4, a number she described as being 'safe'. Libby mostly ate plain, 'beige carbohydrate' foods and was very particular about how foods looked, including an adherence to specific packaging, and how they were cooked. Both young women became very anxious if they were given new or unfamiliar foods.

Since its introduction there is a growing body of literature on the clinical presentation of ARFID, including comparisons with AN. Similarities across the two groups include low weights, high levels of anxiety and bullying as a common trigger (Norris et al., 2014). The differences between the groups are that:

- there are more males in the ARFID group
- presentation starts at a younger age
- there is a higher risk of pervasive developmental disorder(s) than in those with AN (Kenny & Walsh, 2013) (Fisher et al., 2014)

Interestingly, in one study, a percentage of children with ARFID, whilst not expressing fears about weight or body shape, did worry about developing illnesses due to their eating pattern (Niceley et. al., 2014).

Links between anorexia and autism

We know that the ARFID pattern of eating is common in individuals with autism and that sensory sensitivity is likely to be one of the underlying causes. Is there, however, evidence that anorexia and autism are similarly connected?

Researchers have found links between autism and anorexia, particularly in the cognitive or thinking profiles of these two groups (Oldershaw et. al., 2011). Similarly, Simon Baron-Cohen and colleagues found female adolescents with anorexia to have 'elevated autistic traits'. These include a 'systemising' of food, weight or body shape similar to the 'special interests' that develop in autism (Baron-Cohen et. al., 2013).

This does not mean of course that everyone with autism who has eating problems will develop anorexia. However, there is some evidence that females on the spectrum may be more at risk (Kalyva, 2009). This may be because girls and women are more able to restrict their intake or are more susceptible to social and cultural norms and pressures about eating, weight and body shape. When Libby began to diet it was not because she had a fear of being fat, but because she wanted to be more like her friends who "were dieting too".

So it does appear that both these patterns of eating overlap in that there is restriction of intake and therefore potential for weight loss. However, the defining differences seem to be ones of motive. Particularly the need to control weight in anorexia using 'healthy' or low-calorie foods versus the adherence to certain foods in ARFID because of their sensory properties. Phoebe (who spent some time in an eating disorder unit) described the difference between what she called 'autistic' and 'anorexic' thinking.

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"After breakfast I had to wash my hands as I couldn't stand them being sticky with jam. Other girls did the same because they were worried that they would lick the extra calories from their fingers."

Increased understanding of these two eating patterns in autism is essential. It is crucial we recognise that many young people with autism and ARFID will restrict their intake during periods of stress and anxiety, but that this does not represent a desire to be thinner or reflect a distortion about the way they look. We must also not overlook the risks of anorexia, particularly where the individual's social-communication differences may make it difficult to verbalise any body shape or weight concerns.

Careful assessment is therefore recommended, taking into account age, developmental stage, learning and risk factors such as gender or bullying. As our knowledge grows it is likely that we will have better clinical tools. This will reduce the risk of misdiagnosis and increase our ability to successfully support individuals with autism to eat well.

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Appendices

Appendix 1: DSM 5 Diagnostic Criteria for Anorexia Nervosa & Avoidant and Restrictive Food Intake Disorder (American Psychiatric Association, 2013)

Figure 1: Diagnostic criteria for Avoidant & Restrictive Food Intake Disorder

A. Eating or feeding disturbance (including but not limited to apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; or concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:

1. Significant weight loss (or failure to gain weight or faltering growth in children)
2. Significant nutritional deficiency
3. Dependence on enteral feeding
4. Marked interference with psychosocial functioning.

B. There is no evidence that lack of available food or an associated culturally sanctioned practice is sufficient to account alone for the disorder.

C. The eating disturbance does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa, and there is no evidence of a disturbance in the way of which one's body weight or shape is experienced.

D. If the eating disturbance occurs in the context of a medical condition or another mental disorder, it is sufficiently severe to warrant independent clinical attention.

Figure 2: Diagnostic criteria for Anorexia Nervosa

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

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Restricting Type: During the last three months, the person has not engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).