Assessment toolkit – Autism and Eating Disorders

The Assessment toolkit is designed as a follow-up to a standard eating disorder assessment if an individual scores over 6 or above on an AQ-10 screener. **The aim of this assessment is not to further assess autism, but instead to explore whether autism-specific mechanisms may influence their eating disorder experience.** A parent or caregiver perspective is welcome where possible, especially as part of a historical assessment of the individual's presentation to support differentiating between long-term Autistic traits and symptoms which have developed because of the eating disorder.

To support this assessment, we would first encourage clinicians to complete a PEACE sensory assessment as a gentle introduction to senses before moving on to the Assessment Toolkit, which more directly assesses eating behaviour. We encourage the use of PEACE resources (e.g. a communication passport and collaborative formulation document) on completion of this assessment. The Assessment Toolkit aims to cover a range of domains known to be important in the **development and maintenance of eating disorders** in individuals with higher Autistic traits. It is also designed **to identify Autistic strengths** that can be harnessed to support recovery from an eating disorder (e.g. a preference for routine) which can be built into treatment planning. These domains include:

Sensory Processing

Exteroception refers to external stimuli such as taste or sound. This can lead to dietary avoidance due to sensory aversions and/or sensory seeking, leading individuals to seek out specific tastes or textures. Exteroception may also lead to preferences to eating alone to avoid sensory overwhelm (e.g. sounds, smells etc). ***Interoception*** refers to the body's ability to identify and process internal sensations such as hunger, thirst, and pain etc. This can lead to hypersensitivity (for example, acute awareness of fullness sensations or bloating, leading to avoidance of food) or hyposensitivity where it is more difficult to identify and process this information (for example a lack of hunger cues leading to missing meals, or lack of cues of fullness leading to increased risk of bingeing). It may also lead to a sense of disconnection from the body and body image distortions. ***Proprioception*** refers to the ability to sense your own body's movement, positioning in space and action, which can lead to differences in body awareness and body image, as well as physical difficulties with eating and differences in mealtime behaviours. ***Vestibular processing*** refers to the body's ability to detect movement, balance and spatial orientation and helps regulate posture and co-ordination. This can lead to engaging in stimming or rocking behaviours, such as leg shaking or tapping, which may be mistaken for engaging in calorie-burning behaviours.

Identification and expression of emotion

Alexithymia refers to the ability to identify and communicate your own emotions. Alexithymia has been linked to negative or confused experiences of body image, as well as different eating behaviours, including restrictive eating, binge eating and emotional eating. Alexithymia is also

closely linked to ***interoception***, as people with poor alexithymia struggle to distinguish between emotional states and physical sensations. ***Emotion recognition*** refers to the ability to identify and understand emotions in others. It is an important part of emotion regulation, as well as interpersonal interactions. ***Emotion regulation*** refers to how an individual understands and manages emotions. Disordered eating behaviours, such as binge eating or restricting/avoiding eating, can be used as a way of coping with negative emotions.

Motor skills. This includes **fine motor skills** necessary to pick up cutlery and bring food to your mouth. This can present as a preference for specific cutlery, or eating with fingers, behaviours that can be misattributed to disordered eating. This can also include **oral motor skills** that may impact eating behaviours, such as difficulty chewing or swallowing, co-ordination or strength of lips, tongue or jaw, or gag reflex issues.

Gastrointestinal issues (GI). GI issues are highly prevalent in Autistic people and may impact eating in several ways. Examples of common issues are constipation, diarrhoea, reflux, bloating, food intolerances and sensitivities. These behaviours can be mistakenly attributed to being driven by weight and shape concerns, such as purging (following discomfort) or restrictive eating (to avoid certain textures or abdominal pain), as well as leading to increased anxiety or vigilance over food.

Social. This includes differences in social communication, interactions and relationships, evidenced across inter- and intra-personal contexts. ***Camouflaging (sometimes also referred to as masking)*** refers to when an individual consciously or unconsciously changes or inhibits their behaviour to fit in with societal expectations. Within individuals with eating disorders, we can see some individuals adopting diet culture or taking part in weight and shape talk amongst peers. It can also involve repressing stimming behaviours or forcing eye contact, leading to high levels of distress. Camouflaging behaviours can be hard to see, but they often put a significant burden on the individual and only become apparent when they are completely overwhelmed. ***Rejection sensitivity*** refers to an intense emotional response to perceived or real rejection, criticism from others or exclusion. This may make the individual more susceptible to societal pressures and fear of judgement from others. It is important when approaching these social differences to consider them within the broader context of stigma or discrimination often experienced by Autistic people.

Executive functioning. This refers to a set of cognitive processes that help with problem solving, goal-orientated behaviours and self-regulation. ***Attention*** refers to the ability to focus on certain information whilst filtering out non-relevant information. This may look like focused attention or hyperfocus on certain parts of their body/eating disorder-based cognitions or on preferred interests, which may make shifting between tasks more difficult. A closely related concept is ***monotropism,*** which is an autism-led theory for the Autistic ability to deeply immerse themselves and their attention in specific tasks. ***Routines*** refer to structured habits or tasks that serve to increase predictability and reduce cognitive load. Routines can serve to manage daily life and minimize uncertainty. This can help reduce anxiety and serve as structured reminders to complete certain tasks. This is linked to ***preference for sameness,*** doing certain things the same way, which can help reduce uncertainty. ***Demand avoidance*** refers to a strong need to avoid doing something that is expected or requested of you. The individual may want to do what is asked of them but avoid doing so due to anxiety or overwhelm.

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Name and DOB:

Clinician:

Date/time of assessment:

Area	**Question(s)**	**How is this being experienced currently?**	**How was this experienced before the eating disorder and/or as a child?**
Sensory	Do you have any sensory-based eating habits (e.g., avoiding or seeking out food based on taste, texture, smell, sound or sight preferences)?		
	Do you feel aware of internal sensations (e.g., hungry, full, thirsty, dehydrated, temperature)? Do you feel able to identify what these sensations are?		
	Do you feel aware of where your body (e.g., your limbs) are in space, and how they move in space?		
	Do you have any preferences for specific brands of food and drink?		
	Do you ever eat inedible things, like soil?		
Emotion	Do you feel able to identify or communicate your own emotions? Do you feel able to identify other people's emotions?		
	How do you cope with strong emotions, such as feeling excited or distressed?		
Motor	Do you have difficulties with moving your body or		

	limbs to perform certain tasks, such as lifting? Do you have any difficulties with chewing or swallowing?		
GI	Do you have any stomach or digestion issues (e.g., abdominal pain, constipation or diarrhoea)) Do you have any allergies or food intolerances).		
Social	How do you experience eating around other people? For example, do you prefer to eating around other people or struggle with this?		
	How do you experience your social relationships and interactions? For example, what does your support network look like? How do you like to socialise with others (e.g., do you have any preferred socialising activities)?		
	Do you ever copy or mimic other people's behaviours to fit in (e.g., copying eating habits, learning food or body ideals from other people or from the TV, etc.)?		
	Do you ever feel like you have to hide parts of who you are during social interactions?		
Rejection sensitivity	How do you react to rejection from other people? (can be real or perceived)		
Attention	Do you have any intense interests? Are any of these related to your eating behaviours?		
Routines	Do you have any routines or rules around eating? What is the purpose of these routines? For example, does it help you reduce feelings of anxiety?		

Need for predictability	Do you prefer the same seat when eating, or to use the same plates or cutlery? Are there any other things you prefer being the same or being predictable to reduce uncertainty?		
Demand avoidance	Do you tend to avoid demands made of you, such as sleeping, or going to school/work? These can be direct demands (brush your teeth) or implied demands (paying a bill).		

Collaboratively identify three things from above that might impact ED treatment and recovery (e.g., unpredictability or uncertainty around appointments):

1.
2.
3.

Collaboratively identify three things from above that might support ED treatment and recovery (e.g., routines etc):

1.
2.
3.

Additional considerations – these are factors which may be helpful to consider in more detail in autistic individuals

Area	**Notes**
Co-occurring considerations Any co-occurring neurodivergent (e.g., ADHD), mental health (e.g., OCD) or physical (e.g., autoimmune) conditions? The impact of these will need to be considered within the formulation	
Demographics and intersectionality (consider gender, ethnicity and sexuality)	
Environmental considerations	

Ask about any immediate changes to the clinical environment that can be made t (e.g., removing ticking clocks, alternative seating, light control)?	
Language preference (for this with a diagnosis or who self-identify already) Do you have any preferences in language (e.g., I am Autistic or person with autism)?	