

Supporting Someone with Eating Disorders & Neurodivergence

A practical, compassionate guide for parents, partners, families, friends and carers

Supporting someone with an eating disorder can feel complicated. When the person is also autistic, has ADHD, or experiences other neurodivergent differences, well-meaning advice can miss what makes eating and daily life genuinely difficult. The most helpful starting point is curiosity: what is happening for *this* person, and what support actually makes things more manageable?

This article is relevant across anorexia nervosa (including atypical anorexia), bulimia nervosa, binge eating disorder, ARFID, OSFED/UFED and other feeding or eating difficulties. It does not assume that all experiences share the same cause, or that a particular body size reveals how unwell someone is.

1 | See the whole person, not only the food

An eating disorder is not a choice, a lack of willpower or simply a problem with meals. Neurodivergence can affect sensory processing, routines, emotional regulation, executive functioning, interoception (recognising internal body signals) and communication. An eating disorder may develop alongside these differences, and some difficulties can reinforce each other.

- **Autism:** sensory discomfort, predictability, change, communication style, social demands and burnout may affect food experiences.
- **ADHD:** planning, initiation, timing, distractibility, impulsivity and inconsistent awareness of hunger may interfere with eating routines.
- **Other differences:** dyslexia, dyspraxia, learning differences, tic disorders or processing difficulties may affect how information, care and mealtimes are experienced.

Do not attribute every symptom to neurodivergence. New restriction, purging, binge eating, compulsive exercise, rapid changes in intake or physical deterioration need appropriate assessment, even when a person has longstanding sensory or routine-related difficulties.

2 | Understand what food may represent

For one person, eating may trigger fears about weight, shape or control. For another, texture, smell, temperature or unpredictable ingredients may provoke distress. Someone with ARFID may avoid food because of sensory properties, low interest in eating or fear of consequences such as choking or vomiting; weight or shape concerns are not its defining mechanism. More than one difficulty can be present.

Ask open questions outside a stressful mealtime: *“Is it the food itself, how it feels, what might happen afterwards, the environment, or something else?”* The answer may be “I don’t know”. That is useful information too.

3 | Communication that reduces pressure

- Use clear, literal language; avoid hints, sarcasm and ambiguous instructions when these increase confusion.
- Offer time to process. One question at a time may be easier than repeated requests for explanations.

- Ask whether speaking, texting, writing, visual choices or a communication aid is most accessible.
- Validate the experience without agreeing with harmful eating-disorder rules: “I can see this feels frightening. I want to help you stay safe.”
- Avoid remarks about weight, appearance, portion size, “good” or “bad” foods, or praise for eating less.
- Agree what privacy means. Do not discuss the person’s eating with others without a clear reason, consent where possible, or a safeguarding need.

“Would you prefer me to sit with you, talk about something else, or give you quiet company?”

4 | Make the environment easier, not the person smaller

Practical adjustments can reduce overload without turning recovery into avoidance. Discuss adaptations with the person and, where relevant, their treatment team.

- **Sensory:** softer lighting, reduced cooking smells, familiar crockery, quieter seating and manageable food presentation.
- **Predictability:** advance notice of meals, ingredient information, written routines and a plan for changes.
- **Executive support:** reminders, shared shopping lists, simple preparation steps, accessible food storage and support with meal preparation.
- **Interoception:** predictable opportunities to eat and drink may help when hunger cues are unreliable; follow any agreed clinical meal plan.
- **Social eating:** allow flexible seating or communication breaks while keeping the agreed nutrition and safety needs in view.

5 | Supporting without becoming the food police

Pressure, arguments, threats and surprise changes often increase shame and distress. On the other hand, stepping away from every difficulty can leave someone without necessary support. The middle ground is compassionate, collaborative consistency, especially where medical or specialist guidance sets essential nutritional goals.

- Agree roles in calmer moments: who shops, prepares food, provides company, checks in, or contacts clinicians?
- Offer genuine choices *within* the agreed care plan, rather than asking the person to negotiate basic safety in crisis.
- Notice when you are slipping into surveillance, bargaining or repeated reassurance; ask the treating team for guidance.
- Celebrate communication, accepting help and recovery-oriented steps without making praise contingent on body or appearance.

Important: for children and young people, family involvement can be an important part of evidence-based treatment. Do not replace a specialist eating-disorder plan with independent exposure exercises, food substitutions or negotiated restrictions.

6 | Respond to common difficult moments

“I cannot eat that; it feels wrong.” Try: “Can you tell me which part feels difficult—texture, smell, uncertainty, or a fear? We can work out the next step with your support plan.” Avoid disguising ingredients or forcing a surprise taste.

“Stop asking me about food.” Try: “I won’t keep questioning you. We still need a way to help you stay safe. Would a written check-in work better?”

After a binge or purge: remain calm and non-judgemental. Do not moralise, prescribe punishment or suggest compensation. Encourage appropriate medical review and following the person’s treatment or safety plan.

Meltdown, shutdown or overwhelm: reduce demands and stimuli, communicate simply, offer space when safe, and revisit decisions once the person can process them. Distress does not remove medical urgency.

7 | Different diagnoses need different support

Anorexia / atypical anorexia: restriction and fear or overvaluation related to weight or shape may coexist with rigid routines or sensory needs. Atypical anorexia can be medically serious at any weight. Specialist treatment and medical monitoring matter.

Bulimia / purging disorder: purging can cause significant medical complications regardless of weight; privacy, shame and repetitive cycles may hide symptoms.

Binge eating disorder: avoid blame or weight-focused advice. Support regular care, a reduction in shame and access to evidence-based treatment.

ARFID: assess sensory, fear-based and low-interest pathways individually. Accommodations and specialist-supported gradual change may both be relevant.

OSFED, rumination-regurgitation, pica, night eating and T1DE/diabulimia: presentations differ substantially. Seek tailored assessment; for insulin omission or manipulation in diabetes, diabetes and eating-disorder clinicians should work together.

8 | Boundaries are part of compassionate care

Carers can be loving and dependable without being endlessly available or responsible for providing treatment. A boundary is clearer when it describes what *you* can do, not a threat about what the other person must do.

- “I can talk for twenty minutes now, and we can make a plan for the next check-in.”
- “I will not comment on your body or argue about calories. I can help you contact your clinician.”
- “If I am concerned about immediate safety, I will seek urgent medical advice even if this is uncomfortable.”

Avoid making the person responsible for your fear or exhaustion. Seek your own support from trusted people, carer organisations or a professional, without making private details public.

9 | Recognise when more help is needed

Arrange a GP or eating-disorder service assessment as early as possible if eating, weight, exercise, purging, distress or physical health is changing. Do not rely on BMI alone. Medical risks can occur across diagnoses and body sizes.

Seek **urgent medical help** for fainting, chest pain, serious dehydration, confusion, pronounced weakness, blood in vomit, repeated purging with concerning symptoms, or rapid physical deterioration. In the UK call **999** for an immediate life-threatening emergency, or **NHS 111** for urgent medical advice when it is not an emergency. If there is immediate risk of self-harm or suicide, seek emergency help.

If the person has diabetes and is restricting or manipulating insulin, contact their diabetes team urgently; this can become dangerous quickly.

10 | A calmer plan to agree together

- **Notice:** What usually happens before things become difficult? Include sensory, emotional, social and physical signals.
- **Communicate:** How should someone check in? What words and formats help? What makes it worse?
- **Support:** Who is responsible for practical help and how does it fit the clinical plan?
- **Safety:** What signs mean contacting the GP, eating-disorder team, NHS 111 or emergency services?
- **Review:** When will everyone revisit the plan? What has the person found more manageable?

A final thought for families and carers

You do not have to understand every sensory experience or every thought to take it seriously. Support works best when it combines respect for neurodivergent needs with timely, evidence-based eating-disorder care. A person deserves safety, autonomy, dignity and hope—not pressure to look or behave “normal”.

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For further reading: NICE guideline NG69, *Eating disorders: recognition and treatment* (nice.org.uk/guidance/ng69); NHS eating-disorder information and support (nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/eating-disorders/).

Educational information only. This resource does not replace individual medical assessment, eating-disorder treatment or emergency advice.