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RESEARCH

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Re-imagining connection: the role of late autism diagnosis in eating disorder recovery and social support

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Abstract
This paper explores the complex relationship between autism, social connection, and eating disorder recovery, drawing on the lived experiences of two late-diagnosed autistic adults with histories of longstanding and severe eating disorders. Using narrative and autoethnographic methods, we examine how delayed autism diagnosis intersects with the social dimensions of illness, and the process of treatment and recovery. We identify unique barriers autistic individuals with eating disorders face in building meaningful social connections, navigating support systems, and accessing appropriate care. By integrating personal insights with existing research, we advocate for earlier autism screening and neurodiversity-affirming treatment approaches that embrace and value autistic differences, including the strengths inherent in neurodivergence. This requires a shift in how social support is conceptualised within eating disorder care, prioritising the creation of meaningful connections that address the unique social and emotional needs of autistic individuals. We argue for clinical practices that not only recognise the challenges faced by neurodivergent individuals but also embrace the strengths they bring, fostering environments where autistic individuals can engage authentically in their recovery process. This approach ultimately benefits patients and treatment providers alike, promoting more inclusive, empathetic, and effective care for all.

Keywords Eating disorders, Autism, Neurodiversity, Social support, Lived experience, Co-production, Qualitative research, Recovery

Plain English Summary
This article is written by two individuals who have lived with longstanding and severe eating disorders and were diagnosed as autistic in adulthood. Using stories from their lives, the authors explore how delayed or missed autism diagnoses affected their mental health, social lives, and experiences of treatment. They describe how feeling misunderstood and unsupported made their eating disorders worse, especially before being diagnosed. Receiving an autism diagnosis later in life helped them reframe their struggles, reduce shame, and begin building more meaningful and supportive connections. The authors show the value of recognising and supporting autistic differences, rather than seeing them as problems to fix, and how this can support recovery in ways that feel more respectful and authentic. They also highlight that social support can look very different for autistic people, and

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caution against one-size-fits-all approaches in treatment. Drawing on both lived experience and research, the paper makes recommendations for how eating disorder services can become more inclusive and responsive to autistic people's needs. This includes earlier autism screening, flexible support options, and working alongside people with lived experience to design better, more compassionate care.

Introduction

Untangling the overlap between autism and eating disorders

The intersection of autism and eating disorders (EDs) has become a recent focus within clinical research, with studies highlighting a high prevalence of autistic traits and autism diagnosis amongst individuals with anorexia nervosa (AN) and avoidant/restrictive food intake disorder (ARFID) in particular [1–4]. While some studies have suggested that the cognitive effects of starvation and/or ED psychopathology may present as 'pseudo-autistic features' [5, 6], more recent research has found no significant difference in the prevalence of autistic traits among individuals with AN before and after weight restoration or recovery [7, 8]. This finding suggests that the overlap between autism and EDs is more than a byproduct of starvation.

Further evidence for a substantive link comes from longitudinal studies such as Solmi et al. (2021) [9], which found that childhood autistic traits significantly predicted disordered eating behaviours in adolescence, indicating that neurodevelopmental features may precede and contribute to ED onset. Additionally, while much of the literature has focused on restrictive presentations, elevated rates of autistic traits and autism diagnosis have been reported in individuals with non-restrictive EDs, including bulimia nervosa (BN) and binge eating disorder (BED) [10], suggesting that the association between autism and EDs may be broader and more complex than previously assumed. Together, these findings strengthen the argument that autism and EDs share overlapping developmental, cognitive, and behavioural mechanisms, rather than being incidentally or artefactually related.

The need for adapted treatment

Characteristics such as sensory sensitivities, cognitive rigidity, and perfectionism, which are commonly observed in both autistic individuals and those with EDs, have prompted the development of more accommodating treatment frameworks which offer adaptations that affirm rather than undermine neurodivergent identities [11–13]. For example, the Pathway for Eating Disorders and Autism (PEACE) pathway [14] has been designed to tailor inpatient ED treatment to the needs of autistic individuals by creating more sensory-friendly environments, individualising communication strategies (such as providing information in written format), and adopting more flexible therapeutic approaches (for example, offering a wider range of menu options) [14].

Social connection and neurotypical norms

Social connection and support are widely recognised as critical to recovery from EDs, with relational interventions often addressing the isolation and secrecy that perpetuate these conditions [15]. Such support can come from a range of sources, including family members, peers, friends, teachers, and therapeutic or community groups, each offering different forms of connection and understanding. However, for autistic individuals, differences in communication, sensory processing, social-emotional reciprocity, and/or a preference for solitude can make it challenging to engage with conventional support systems, which are often designed with neurotypical individuals in mind [16–18]. Treatment that fails to recognise or validate autistic traits may leave autistic adults feeling 'lost' within the support system [19], mirroring disconnection and loneliness encountered in the wider social world [20, 21].

Late diagnosis and the need to expand affirmative models

Although neurodiversity-affirming approaches to treatment such as PEACE have gained ground, they may fail to fully account for the specific social challenges faced by late-diagnosed autistic individuals. The lack of early autism screening and historical biases in diagnosing autism mean that many individuals with EDs remain undiagnosed, with their autistic traits frequently attributed to other causes, such as personality 'disorders', trauma, or the ED itself [8, 22]. Late-diagnosed autistic adults may have depended on 'camouflaging' or 'masking' their autistic traits in order to appear more neurotypical, which can contribute to significant psychological distress [23, 24]. Notably, social camouflaging has also been identified as a strong predictor of more severe ED symptoms [25]. This suggests a potentially self-reinforcing cycle, where the pressure to camouflage exacerbates disordered eating, which in turn may further intensify the need to conceal one's difficulties.

Despite these challenges, a late autism diagnosis can offer a transformative shift in perspective, allowing individuals to reinterpret their lifelong social difficulties and better understand their experiences [24, 26]. In the context of ED treatment, supporting this reframing could help late-diagnosed individuals by fostering self-compassion, reducing stigma, and opening new pathways to social support in the process of recovery [27].

Methods and philosophical stance

This paper adopts a qualitative, autoethnographic, and narrative inquiry approach to explore the intersection of neurodivergence and ED recovery, blending our personal experiences with empirical research findings and the broader social and clinical contexts ofthese issues. Both authors, diagnosed with autism in adulthood and navigating ongoing recovery from EDs, use our lived experiences (LE) to investigate how a late autism diagnosis can influence social connection and recovery trajectories.

We employ autoethnographic and narrative inquiry as complementary methods to explore the intricate social realities of navigating both EDs and autism. These approaches are grounded in the belief that personal narratives are not only a tool for self-reflection but also a means of illuminating broader social phenomena. According to Clandinin and Connelly (2012) [28], narrative inquiry is particularly suited to understanding how individuals construct meaning through storytelling, providing rich insights into how personal experiences interelate with the societal contexts in which they take place. Similarly, autoethnography allows us to combine personal experiences with broader cultural and social analysis, making it particularly valuable for exploring the intersection of individual identity and broader social structures [29]. Together, autoethnography and narrative inquiry enable us to centre our voices as meaning-making and knowledge-creating subjects, rather than objects of study, thus offering insights that may not be captured through more conventional research methods.

Our approach also takes a dialectical philosophical perspective [30, 31], which allows for the exploration of opposing tensions within our experiences of EDs and neurodivergence, acknowledging how different dimensions of identity both conflict and coalesce. For example, we recognise the challenges we have experienced as autistic people with EDs are not simply something to be pathologised, but a distinctive way of engaging with the world that impacts how we experience recovery.

Our methods also embrace reflexivity, where we have critically reflected on our positionality, biases, and the influence of our subjective LE on the research process [32–34]. To achieve this, we engaged in iterative writing sessions, discussing and critiquing each other's reflections to ensure our perspectives were represented accurately and meaningfully. We actively sought to make explicit the subjective, non-generalisable nature of our individual experiences and interpretations, whilst retaining an ability to analyse these critically in relation to what they may say more broadly about the systems of care and societal structures we have found ourselves in. Importantly, we challenged one another on the identities and experiences we *cannot* claim to represent as qualitative researchers [35], including in relation to our privileges as white, educated individuals from wealthy, Western countries.

Additionally, this work is grounded in the principle of epistemic justice [36], which in mental health research relates to the fair representation and inclusion of diverse perspectives in the creation of knowledge, particularly those from marginalised groups [37–40]. Co-producing knowledge with people with LE is especially important to countering the historic marginalisation of autistic people as valid 'knowers' in both ED and autism research - something which is changing in recent years with a greater number of examples of co-produced research with autistic people, including those with EDs [41–43]. By integrating our LE with scholarly discourse, we aim to provide a more comprehensive understanding of the social dimensions of EDs autistic individuals, highlighting the need for more inclusive and nuanced clinical practices that acknowledge the intersections of neurodivergence, identity, and ED recovery. Overall, these principles were not merely abstract ideals but active, dynamic tools that fundamentally shaped the way we conducted and interpreted our work.

Focus of research

In keeping with the aims of the Journal of Eating Disorders' Special Collection, *"Lending a hand: The role of social support in the management of eating disorders"*, we discussed the need to focus our narratives and critical reflections on our experiences of social support in relation to EDs. Specific knowledge and treatment gaps we have encountered through personal experience - mirrored in published research literature - motivated our decision to focus specifically on how we have experienced social support as late-diagnosed autistic ED patients. We identified four key shared features of our narratives which we used as subjects to explore in more depth through autoethnographic writing, namely: (1) experiences of social support when undiagnosed; (2) the process of diagnosis itself; (3) reflections on ED treatment experiences; and (4) the role of social support in autistic ED recovery.

We wanted to approach the subject with an appreciation of the challenges of connection, isolation, and miscommunication that arise when neurodivergent[1] needs

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[1] Neurodivergent refers to an individual with a neurodevelopmental condition such as autism, attention-deficit/hyperactivity disorder, or dyslexia

are not fully recognised or understood by social networks and support systems. However, it was equally important to us to be able to identify positive elements of our experiences or treatment and recovery, and to use the process of writing this paper as an opportunity in itself to re-story our experiences (i.e. reinterpret our histories) in a way that supports each of our ongoing recoveries.

Findings

1) The social dimensions of illness when undiagnosed

Narrative insights

MA *When I was 13, I started seventh grade at a new school. On the first day at this new school, all the students gathered in the gymnasium… I was overcome by the bright LED lights and the basketball court's reflection. There were at least 100 students in the gymnasium, most older than me. I was equally overwhelmed by how the laughter and loud voices echoed around me. It was this year that my eating disorder started, and I turned my increasing anxiety and feelings of isolation inward, making athletics and exercise my passion, the "special interest" I was focussed on becoming the "best" at. Within a year, I began to think of my eating disorder as a friend. Something that was always there, something predictable that gave me a sense of identity. I had many cycles in and out of the hospital for my eating disorder.*

JD *A big part of my experience of the social world was shaped by a sense of 'not knowing'. Not knowing why I found it so difficult to do things that other people seemingly were able to join in with. Not knowing what the rules were of how to take part or take my turn. Not knowing how to cope with constantly feeling overstimulated on a sensory level, whilst at the same time being under-stimulated intellectually. Not having others know how and why I was struggling so much. I was always readily able to make friends, but found it difficult to sustain friendships - to realise what the other person wanted from me, or what was realistic for me to give of myself. This got me into some very difficult situations where I didn't know what healthy boundaries were, and was at risk of being exploited.*

The time before I was diagnosed with autism and ADHD felt like spending my life on the outside looking in at the kind of life that I wanted to have. Sometimes this was literal - being on the outside of rooms that I couldn't enter, or on the outside of social groups that I wanted to join but didn't feel that I could. I found a very effective way of being able to cope with my distress in social environments was to dial down the intensity with which I was feeling everything. That meant numbing my senses and suppressing the vehicle for feeling - my body. That's where my eating difficulties really began.

Critical reflections

Our experiences highlight the critical role that social support - or the lack thereof - can play in the development of EDs. This may involve specific challenges for neurodivergent individuals, especially when undiagnosed. For both of us, the absence of social support was not merely a backdrop to our experiences; it was a central force that shaped our illness trajectories. The lack of recognition for our neurodivergence created environments in which our struggles were misunderstood or overlooked, in turn compounding our sense of isolation.

This absence of understanding also profoundly shaped how we came to see ourselves - both in private and in relation to others. Without external affirmation, our sense of self became increasingly defined by difference, deficiency, or failure to meet unspoken social expectations. This tension between internal self-identity and the perceived demands of social identity contributed to a deepening disconnect, making it harder to seek or accept support, and easier to retreat into the rigid safety of our ED behaviours. For MA, this manifested in a growing sense of alienation and the eventual turning inward to the ED as a means of coping. The ED provided a false sense of comfort and companionship, but it also reinforced a cycle of isolation, as she increasingly withdrew from social interactions and engaged more intensely with the ED. The lack of social support also meant that there were few opportunities for MA to express her distress in ways that could be recognised and responded to. She depended instead on behaviours that perpetuated her illness.

For JD, his sense of exclusion was also deeply tied to social isolation. Difficulties in understanding social cues, maintaining friendships, and setting healthy boundaries were significant, but remained entirely hidden from others. This brought about a feeling of being "on the outside looking in" at social spaces and relationships, but not knowing why. The lack of an explanation as to why social support was so difficult to access led to a sense of alienation and increased reliance on maladaptive coping mechanisms, including a restrictive ED.

This analysis highlights the cyclical nature of isolation when social support is lacking. During our struggles with unrecognised neurodivergence, we both experienced a reinforcing loop: a lack of social understanding led to feelings of being misunderstood and disconnected, which in turn exacerbated ED behaviours. The key issue here is that isolation, when left unchecked, can become self-perpetuating. Without understanding and informed social support systems in place - whether from family, friends, or clinicians - neurodivergent individuals can

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while neurodiverse refers to a group of people with neurodevelopmental conditions and/or a variety of neurodevelopmental differences (e.g., alexithymia).

find themselves trapped in a cycle of illness and disconnection which can precipitate and be further reinforced by a sense of personal blame and shame.

Together we reflected on how social support networks may have been better equipped to recognise and respond to our needs as autistic individuals. Early identification of our neurodivergence may have served as a protective factor from developing EDs in the first place, or helped us to exit cycles of isolation and maladaptive coping sooner via more timely, individualised treatment. Whilst we can't change our pasts, we acknowledge a mutual desire for a reality where early intervention and prevention strategies focus not only on EDs themselves, but also on fostering inclusion and connection in social contexts for at-risk individuals, irrespective of their differences.

2) Treatment experiences when undiagnosed

Narrative insights

MA *When I became sick with AN, I would leave my home environment and be admitted to the ED program 6 h away. It took days to adjust to the unit schedule, rules, other patients, and the physical structure of the unit. Paradoxically, I later found solace in the schedule and rules. Day after day, I knew what to expect. The physically and relationally contained treatment environment helped me connect with others although I often still felt like the 'weird' patient. The predictable way of existing that treatment provided was upended when I was discharged. The drastic change in environment, support, and routine caused severe anxiety and a sense of chaos. I soon returned to my eating disorder 'friend' and the predictability it provided.*

JD *Looking back, I can see how my eating difficulties arose within a context where my differences - whether in sensory experiences or communication styles - led to exclusion from social support, a lack of belonging, and marginalisation from understanding, both from others and myself. Instead of helping me untangle these challenges, treatment only reinforced my sense of invalidity by failing to provide the insights I now have about my experiences and needs as an autistic individual with co-occurring neurodevelopmental, psychiatric, and physical conditions.*

In treatment, I went from not knowing why I was struggling so much to being given explanations that didn't fit - explanations that seemed more like stereotypes than reflections of my reality. I wonder whether this was due to a lack of curiosity or simply clinicians being unaware of the diverse experiences that receive more attention today. By the time I reached treatment, my ability to mask my differences was so ingrained that even the experts couldn't perceive them.

The false explanations - that I must hate my body or be driven by a desire to lose weight - only compounded my confusion and deepened my sense of disconnection. This was disillusioning, as I had hoped the experts would understand. It took many years before I received a diagnosis and, with it, a doorway to self-understanding and a better ability to meet my needs in recovery.

Critical reflections

Our accounts reveal a profound disconnect between the realities of our experiences and the frameworks we encountered within ED treatment. While these frameworks aimed to support recovery, they were often ill-equipped to address the unique challenges posed by undiagnosed neurodivergence. Instead of fostering understanding or offering pathways to meaningful healing, the treatments we encountered frequently perpetuated feelings of misunderstanding, exclusion, and frustration.

For MA, the regimented structure of inpatient treatment provided a rare sense of predictability and stability, offering a temporary reprieve from the sensory and emotional chaos they experienced outside the unit. This structure facilitated a degree of relational connection with others in treatment, even as she continued to feel different and isolated as the "weird" patient. However, the abrupt removal of this stability upon discharge left MA disoriented and anxious, pulling her back toward the ED as a familiar and controllable constant. This dynamic reveals the tension between the comfort provided by predictable environments and the difficulty of navigating less accommodating real-world settings, and the transitions between these settings.

For JD, treatment deepened feelings of invalidation and disconnection. Despite seeking understanding, he often felt as though his struggles were explained away using reductive narratives that did not align with his lived experiences. Misattributions about the drivers of his illness caused further alienation, and failed to account for the complex interplay of sensory, cognitive, and emotional factors which could have proved effective treatment targets if identified sooner.

3) The process of diagnosis

Narrative insights

MA *I pursued an autism assessment because my major depressive disorder and ED did not seem to account for all of the challenges I faced. I attributed difficulty relating to others as just low self-esteem when in reality, it was autism. It was hard to get an autism assessment. There is one clinic nearby that accepts insurance for adult autism assessments. After I had the assessment and was informed that I had the diagnosis, it was enlightening to reflect on how connected autism was to my ED. I think the onset of my AN was, in part, a strategy to deal with the overwhelming transition from childhood to adolescence. Eventually,* *AN became part of me, something I was interested in and had to 'perfect.'*

JD *I was diagnosed with autism in my early thirties, shortly after receiving an ADHD diagnosis. This period of discovery felt like a puzzle finally coming together, providing clarity about struggles that had long felt inexplicable. At the same time, it was a destabilising process that challenged my self-concept. It felt almost like grieving - not only for the parts of myself that had been misunderstood or overlooked by others but also for the opportunities I had missed because I hadn't fully understood or accommodated my needs.*

Out of this grief, however, came a greater understanding and sense of empowerment. The diagnosis gave me a language to describe and communicate my experiences in ways I hadn't been able to before. It allowed me to re-story my life, reframing my differences as expressions of neurodivergence rather than failures.

Critical reflections

Our experiences demonstrate the profound psychosocial implications of receiving an autism diagnosis in adulthood, particularly for individuals with EDs. Both accounts emphasise the transformative potential of diagnosis, as a means of understanding neurodivergence, and as a way to reframe past experiences in order to navigate life and ED recovery with greater self-awareness and authenticity.

For MA, autism diagnosis offered clarity about the link between autism and her ED, shifting her understanding of restrictive eating. Rather than being a maladaptive behaviour, it could be understood as a strategy developed in response to the overwhelming developmental transitions from childhood to adolescence. This reframing reflects the importance of distinguishing between disordered behaviours - such as rigid dietary control - and neurodivergent differences, such as sensory sensitivities or a need for predictability. Without this lens, these behaviours might be (mis)understood in ways that overlook their adaptive origins.

Similarly, JD's narrative highlights the process and power of 're-storying' experiences, i.e. using their new diagnosis as a framework to reinterpret challenges and social difficulties as manifestations of neurodivergence rather than personal failures. This realisation helped him cultivate greater self-compassion and align his recovery efforts with a more authentic sense of self. The concept of grieving, present in both accounts, also illustrates the emotional complexity of late diagnosis. MA reflects on the gate-keeping of autism assessment and the societal gaps in recognising neurodivergence, while JD expresses grief for missed opportunities and the misunderstandings that shaped his self-concept. Both narratives reveal how diagnosis can challenge long-held internalised beliefs, acting as a double-edged sword of enlightenment and emotional upheaval.

4) The role of social support in autistic ED recovery

Narrative insights

MA*Forming relationships with people I've initially met through online platforms has been valuable. I've connected with friends and colleagues with similar passions, whereas navigating that for the first time in person can feel impossible or irrelevant. Another integral part of support has been my close relationships with animals. My dog helped me through the worst of my mental health. At times, I became emotionally exhausted, and I would lie in bed for hours. My dog, who I loved so much, sensed I was hurting and refused to leave my side. My experience of social support might be different, not disordered.*

JD *Understanding I am autistic has enabled me to work with my differences, seeing them not as weaknesses but as variations that could exist alongside meaningful participation in social activities and relationships. I no longer feel compelled to be the same as everyone else or to mask constantly in an effort to fit in. Instead, I can see how I have performed inauthentically in relationships and social situations in ways which often haven't been supportive of my recovery. Greater self-awareness has enabled me to become more interpersonally effective, balancing my individually-unique needs with the norms of the social world I've always struggled to navigate.*

Being autistic doesn't mean I should opt-out of social engagement or don't need to find a sense of community and belonging. Rather, I've been able to seek out more authentic connections, including with friends who were also autistic. I have been able to learn from peers who also navigate multiple struggles including with their health and social experiences. Ultimately, being able to find belonging, experience reciprocal caring relationships, and feel valued and understood for who I am has been a profoundly reparative and healing process which has challenged the deep-set ideas about myself that entrapped me in my ED in the first place.

Critical reflections

Our narratives demonstrate a shift in interpersonal dynamics following autism diagnosis, and provide evidence for the unique and varied ways in which social support can contribute to recovery for autistic individuals with EDs. MA's benefit from online communities and close relationships with animals reflects how alternative forms of support, outside conventional social frameworks, can provide vital connection and emotional sustenance. JD's journey highlights the transformative power of embracing neurodivergent identity in creating more authentic relationships. Moving away from masking and striving for neurotypical standards allowed him to build connections with like-minded peers, reinforcing a sense of belonging and countering the isolation that had perpetuated his ED. This demonstrates the importance of finding spaces where individual differences are valued, and where reciprocal, meaningful relationships can flourish.

Both accounts point to the impact of stigma and internalised shame on social support. These factors often led to feelings of disconnection and self-isolation, but our narratives also show how understanding and accepting our neurodivergence opened pathways to recovery through reconceptualised forms of connection. The themes of reframing social relationships and finding tailored support networks are central to both experiences, showing the dynamic and adaptive nature of social support in autistic ED recovery.

Discussion

Our experiences of social support among late-diagnosed autistic adults with EDs reveal the interconnected nature of social, psychological, and treatment needs. They also illustrate the central role of identity in shaping how individuals engage with support systems, and how diagnostic recognition can influence self-understanding and access to appropriate care. These findings align with and expand upon existing literature on autism, EDs, and social support, highlighting the need for further research and innovation to inform more inclusive, neurodiversity-affirming approaches within clinical and social contexts.

Reframing past experiences of illness and treatment

Analysis of our personal experiences highlights how autistic traits can be misinterpreted as symptoms of EDs and/or other psychiatric and physical illnesses. This demonstrates the important role of normative narratives of illness (including stereotypes) and hermeneutics (interpretation) in shaping the way individuals with EDs are understood and treated by others [44]. For example, we have illustrated the potential for 'diagnostic overshadowing' to occur, i.e. where true nature and causes of symptoms are overlooked in favour of other more immediately obvious or familiar conditions [45–47]. This phenomenon is particularly salient in the context of both autism and EDs, where co-occurring conditions are commonplace and overlapping symptoms are often unclear in origin [48–50].

Research demonstrates the presence of a hermeneutic (interpretive) bias towards explaining a range of symptoms solely through the lens of an ED diagnosis, across biopsychosocial domains [51, 52]. Examples exist of patients' physiological symptoms first being attributed to an ED, but later being identified as involving major gastrointestinal, hypermobile, and endocrine disorders, or even cancer [51, 53–55]. These experiences suggest that neurodivergent individuals with EDs face a dual risk whereby they are more predisposed to co-occurring physical conditions [56–57], yet may be less likely to have them fully comprehended and treated. Our own experiences confirm how health conditions and disabilities that affect mobility, physical health, and mental and emotional readiness to participate in social activities can reinforce loneliness and isolation, especially when untreated.

Similarly, psychological distress around food and eating might be misinterpreted - as seen in our own accounts - as the sole product of ED psychopathology, rather than also stemming from neurodivergent differences such as sensory aversions and preference for sameness [6]. Our social challenges - be they in the context of treatment or wider community settings - have been explained to each of us as disordered features of our *personalities*, rather than appreciated as neurodivergent differences. Other published LE accounts mirror our experiences [22, 27], whereby we were denied opportunities to identify our preferences in relation to social connection and belonging because of an disproportionate focus on our difficulties.

Being misunderstood in such ways is an example of the 'double empathy problem', whereby bidirectional misunderstandings between autistic and neurotypical individuals arise not from difficulties in communication solely located within the autistic individual, but a reciprocal mismatch in cognitive and social expectations between autistic and neurotypical people [58]. This notion in turn relates to theories of mentalisation - i.e. the ability to understand and interpret each other's thoughts, feelings, and intentions [59]. In light of the double empathy problem, research that has traditionally focussed on 'deficits' or 'impaired' mentalisation amongst those with EDs and autism [60, 61] may benefit from seeing psychological disconnection as a shared - rather than particularly neurodivergent - concern.

Bridging the gap between misunderstanding and unique social needs

The possibility for social support to play a positive role in ED recovery for autistic people is a source of great therapeutic optimism. However, this requires the social and relational components of existing, neurotypically-designed support models to become more flexible and inclusive. Group therapy, for instance, often relies on high levels of social reciprocity and verbal communication, which can feel inaccessible or unhelpful for autistic individuals [62]. As such, more flexible forms of participation and clear communication regarding the structure and expectations involved within therapeutic group settings may be advantageous, in addition to exploring options such as peer support within neurodivergent-led spaces.

In our own experiences of treatment, sometimes very simple steps have helped make 1–1 and group therapy engagement more accessible. These have included reassurance about there being no expectation for eye contact, being encouraged to position our bodies in ways that feels comfortable to us, and being permitted to use fidget toys, take notes, or create visual summaries. Clinical staff initiating these discussions (i.e. about what may help make engagement with others an easier process for us) has reduced the emotional burden of having to ask for adjustments. Welcoming our differences has also helped minimised shame - ultimately creating more space for connection. Predictability and routine are well-documented preferences for many autistic individuals [63], meaning a structured approach to treatment with clear expectations can be beneficial. However, we recognise that this may also pose significant challenges for those disruptions to routine which are inevitable in clinical settings and when transitioning between different levels of care, including discharge from treatment. Whilst the specifics of successfully navigating these transitions are beyond the scope of this paper, we advocate providing graded, structured, and clearly-communicated transitions rather than abrupt changes where possible.

Outside of clinical settings, recognition that social reconnection for autistic patients may take different forms aligns with emerging evidence on the benefits of autistic-specific social networks and peer-led interventions (often online), which can serve as valuable sources of belonging that may enhance ED recovery outcomes [64]. These networks and relationships with the natural world, animals, and other non-human companions, offer alternative forms of connection that are often more accessible and aligned with autistic needs and values, promoting wellbeing [65, 66].

Community-based settings such as schools, workplaces, and family environments, offer further opportunities to support neurodivergent people with EDs. For example, research in the field of Occupational Therapy demonstrates how schools can create more inclusive learning environments by making adaptations that meet the needs of autistic students - such as reducing sensory and social pressures and allowing students to develop social skills at their own pace [67, 68]. Peer support initiatives, where autistic students are paired with others who share and/or understand their experiences, have also been shown to reduce isolation by providing positive and affirming role models [69, 70]. Extending the neuro-affirmative models that are already found to be effective within educational settings to more actively include differences and concerns around body image, eating, and exercise, could support efforts towards ED prevention and early intervention for this vulnerable group. Similarly, whilst strengthening caregiving/family relationships can create a more supportive home environment for recovery, specific education for caregivers about autism and the ways EDs may present differently remains lacking [71]. Across community groups and organisations more broadly, greater adoption of neuro-affirmative practices that provide safer, lower-stress opportunities for participation and social connection can support social change towards greater justice and wellbeing for neurodivergent people [72], within which those who navigate the additional challenges of EDs will face a lesser burden.

Future research is needed to explore how these unique support systems can be integrated into formal ED treatment frameworks as part of a broader paradigm shift in how social support is conceptualised and delivered in ED care. This will be of benefit not only for neurodivergent individuals, but for any groups of patients who may require a more expansive and inclusive approach. In the here-and-now, it is important for clinicians and caregivers to listen intently to the experiences of patients themselves in order to help them identify sources of meaningful connectedness on their own terms.

Re-imagining recovery

The experiences we have shared demonstrate the potential of an autism diagnosis in adulthood to transform one's relationship with their experience of illness, self, and recovery. Recognising autistic traits as intrinsic rather than pathological factors can support an intrapersonal process of moving from self-blame to self-understanding. This aligns with literature on self-acceptance in neurodivergent individuals [73], which may have a role in reducing ED psychopathology by bolstering self-esteem and self-compassion [74–76]. Researchers with LE have also advocated the therapeutic potential of 're-storying' experiences of illness in light of new information, such as diagnosis with a neurodivergent condition [44, 77]. Space may also be needed for ideas about ED recovery itself to adapt and change, in light of emerging evidence that highlights differences in how autistic and non-autistic individuals may define the process and outcomes of recovery [78, 79].

Using narrative methods within this study has helped us construct meaningful recovery narratives and develop a more integrated understanding of our past experiences as individuals, whilst connecting with one another in a mutually supportive way that honours shared experiences as well as difference [80]. It has been particularly meaningful for us to have agency in authoring our own stories and making sense of our experiences on our own terms - acting contrary to hierarchical frameworks of knowledge which do not value the phenomenology of LE as an equitable source of data [81, 82]. We suggest therefore that creative approaches to knowledge generation can help foster greater 'epistemic justice' in the field of EDs, with promising examples of participatory approaches using narrative videos, movement and dance, poetry, and other experiential and expressive methods [83–86].

Creating greater equity in knowledge and understanding by valuing the sense-making potential of those with LE is a central component of progressing the field of EDs, especially for those who diverge from expected norms such as autistic patients. The transformative potential of including LE expertise applies beyond self-discovery - it is recommended in order to construct more precise approaches to assessment, formulation, and treatment - approaches that we and so many others can benefit from [87, 88]. Thus, co-production must be embedded across all developments in research and practice - from developing screening tools and more nuanced approaches to assessment, to generating evidence for treatment adaptations and the ways in which we define recovery itself.

Further intersectional considerations

When analysing the social dimension of our experiences as autistic individuals with EDs, it quickly became apparent that their co-occurrence do not exist in isolation. Rather, neurodivergence and EDs intersect with other aspects of our social identities, including (but not confined to) sex, gender, sexual orientation, race, religion, and physical disabilities. This highlights both the complexity of EDs, and the need for a broad-based approach to the social dimensions of illness, treatment, and recovery. Adopting a dialectical approach to social identity - i.e. one where multiple intersecting identities and truths can co-exist without erasing one another - can help embrace the complex dimensionality of individual lives, avoiding emphasising binary categories of pathology on the one hand, and normative, rigidly-defined conceptualisations of recovery on the other [89, 90].

Notably, autism intersects with other neurodevelopmental conditions, such as Attention Deficit Hyperactivity Disorder (ADHD), as experienced by author JD. Traits associated with ADHD, such as impulsivity and difficulty with executive functioning, often overlap with ED behaviours like compulsive exercise or disorganised eating patterns [91]. This complicates diagnosis and treatment, as it may be unclear whether symptoms are primarily neurodivergent traits, ED symptoms, or a combination of both [6]. For example, ADHD-related impulsivity may intensify restrictive behaviours or binge eating episodes, while autism can contribute to rigid routines and struggles with social eating. An expansive approach is therefore required to address all neurodivergence concurrently alongside ED symptoms.

Experiences of gender identity, sex, and sexual orientation in autistic individuals can also complicate social experiences of EDs. For example, gay men face societal pressures that often define masculinity through emotional restraint, which may create a double bind for individuals who express traits considered more feminine, such as emotional openness or attention to appearance. Neurodivergent individuals, especially those who mask, (i.e., suppress) these feminine traits to meet societal expectations, can experience increased stress which exacerbates their ED symptoms, as was the case for author JD. Rather than reinforcing rigid binaries of masculinity and femininity, a more nuanced approach is needed, especially in clinical settings where stereotypical gender norms often dominate. Among intersex individuals (i.e., people with innate variations in sex characteristics [92], sociomedical framings of intersex as pathological can cause feelings of self-disgust and an internalised view of oneself as 'freakish' [93, 94]. In author MA's experience, this internalisation positioned her body dissatisfaction and ED behaviors as a comparatively 'good pathology', which was difficult for others to understand.

A range of additional sociocultural factors shape how autistic individuals with EDs may access and experience social support. For example, religious practices, such as fasting, dietary restrictions, or ascetic ideals, may exacerbate or mimic ED symptoms, especially for those who already have a complex relationship with food and body image [95, 96]. Adherence to recovery-oriented behaviours may conflict with culturally imposed/religious rules, creating tension between personal identity and communal practices in ways which can be experienced as exclusionary [96]. Such experiences can potentially cut off valued sources of support that such communities can provide [97], complicating recovery. This has been the case in JD's personal experience within religious communities, whereby ED cognitions and behaviours created barriers to participation in what were previously sites of belonging.

Strengths and weaknesses of the study

This study provides novel insights into the intersections of autism, EDs, and social support - an area that remains critically underexplored in the literature. By centering the narratives of late-diagnosed autistic adults, it highlights unique perspectives on the social dimensions of illness, the transformative impact of diagnosis, and the role of neurodivergent-specific social support in recovery. These findings contribute to a growing body of work that challenges neurotypically-centered ED treatment and advocates for neurodiversity-affirming care. In particular, we hope our work provides an example of how LE-led research can add rich insights into both obstacles and pathways to recovery that might otherwise be overlooked. The methodology of integrating personal narratives with existing research adds nuance and depth of

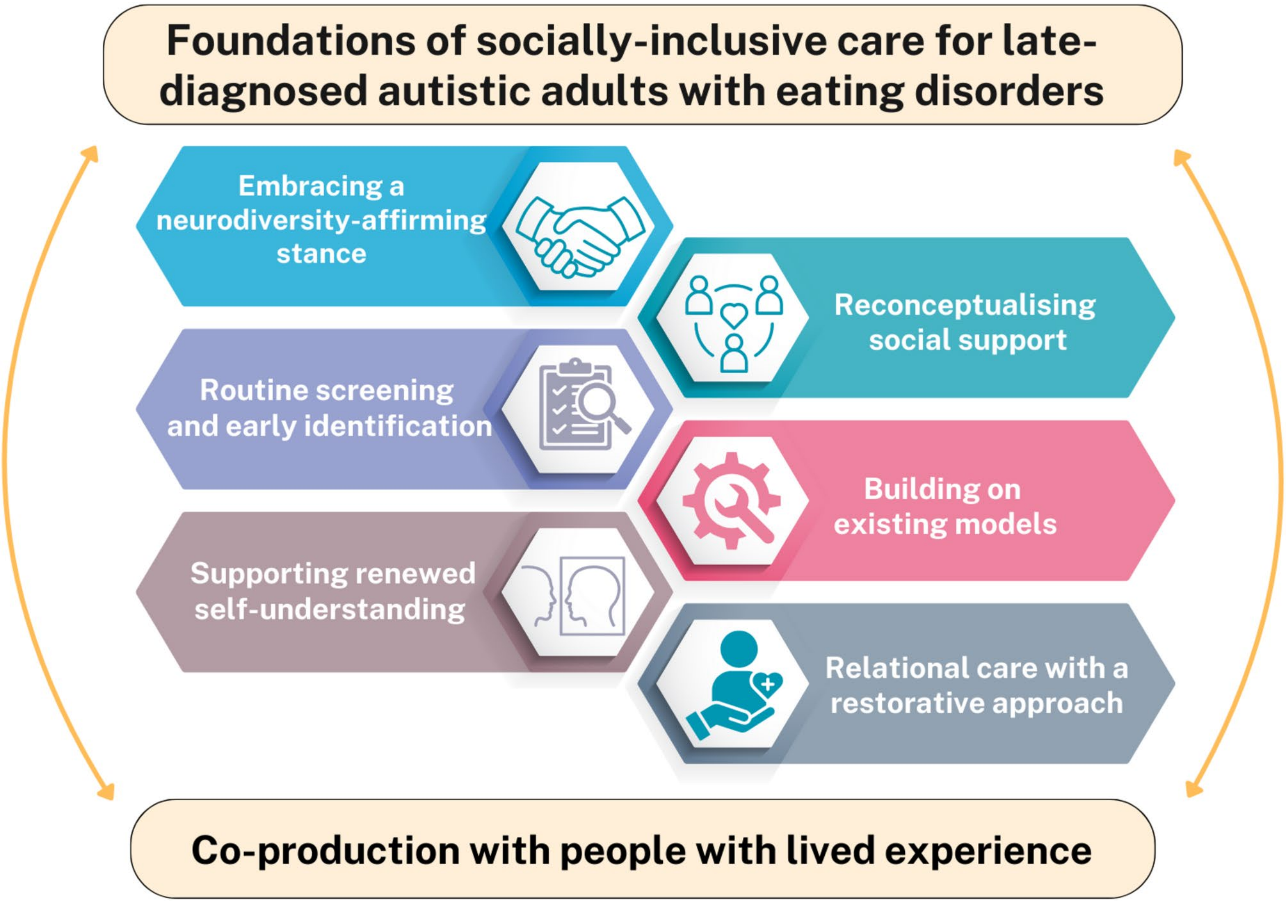

Fig. 1 Foundations of socially-inclusive care for late-diagnosed autistic adults with EDs

understanding to investigating the complex topics we have considered.

However, there are also notable limitations to our work. Whilst our approach centres on subjective LE, there are many dimensions of social support that we were unable to explore comprehensively within our topics of focus, or from our specific identities and experiences. For instance, intersectional factors such as racial and cultural identities remain under-examined in our analysis. Emerging evidence suggests significant differences in how EDs manifest, are understood, and are treated across racial and cultural groups [98–100]. Autistic people from non-white racial or non-Western cultural backgrounds therefore face unique inequities that exist at the intersection of systemic racism, cultural stigma, and ableism [101–104]. Considering experiences of exclusion and discrimination are associated with more severe ED symptoms [105], addressing these research gaps is essential to developing more inclusive models of care that respond to the diverse needs of autistic individuals across all backgrounds.

Recruiting diverse samples and applying participatory, co-produced research methods could ensure that a greater number of marginalised voices are included in future [106]. Co-producing research with autistic people with EDs may involve specific ethical and practical challenges [43], some of which may mirror barriers and harms we have discussed in this paper, and therefore must be undertaken with care. Lastly, significant developments are required within academic publishing if the field of EDs is to benefit from the knowledge obtained from LE - knowledge that is equally valid alongside traditional research methods, yet is hindered by multiply-exclusionary processes for people with lived expertise of EDs and/or neurodivergent conditions.

Clinical implications and recommendations

This section outlines some key clinical implications arising from our work. Together they aim to assist service providers to better identify and support the social needs of late-diagnosed neurodivergent individuals with EDs in their treatment and recovery. As a visual tool, these elements have been summarised in Fig. 1. below:

Routine screening and early identification

Considering the risks of missed diagnosis, which we have illustrated in detail, it is clear that improving care for autistic individuals with EDs requires including autism screening in standard ED assessments. Clinicians should be particularly attentive to signs of autism in individuals with sensory sensitivities, rigid thinking patterns, and/or significant communication differences which may make navigating healthcare settings and the wider social world more challenging. Appropriate training is also needed to ensure ED clinicians can effectively administer existing autism screening tools and further develop diagnostic measures which more precisely identify the etiological underpinnings of similarly-presenting clinical phenomena.

Embracing a neurodiversity-affirming stance

Embracing a neurodiversity-affirming stance involves considering the broader cultural and institutional factors which shape the care provided within clinical settings. We encourage treatment providers to reflect on their values and approach to working with autistic individuals, and to recognise that the difficulties patients face are not solely their responsibility to overcome. The 'double empathy problem' suggests that these challenges are bidirectional, requiring mutual understanding and adjustment from both the clinician and the patient. A shift in clinical culture, where clinicians are open to distinguishing between behaviours that are symptomatic of a disorder, and those that reflect neurodivergent differences, may enable more confidence in adapting treatments to specific individual needs, minimising any fear of colluding with patients' ED psychopathology.

Relational care with a restorative approach

Clinicians need to be equipped to actively recognise and respond to the unique social and emotional needs of autistic individuals. Offering more nuanced, empathetic support - that acknowledges differences in communication styles, emotional processing, and social interaction - may be especially important in promoting engagement with treatment and establishing the strength of therapeutic alliance required to carry the challenging work of treatment and recovery.

Our personal accounts highlight the need for treatment providers to recognise that late-diagnosed individuals may have endured significant adversity within social and healthcare contexts, too. In these cases, a trauma-informed approach to re-engaging individuals in treatment may be beneficial and can include practices such as giving time to discuss past experiences and promoting opportunities to rebuild trust with providers.

Building on the existing models

Implementing neurodiversity-affirming care models is an essential step to making treatment more acceptable and relevant for autistic patients, including those diagnosed as adults. Whilst the PEACE pathway focuses on adaptations within inpatient settings, its principles and practices can be extended to other care environments. Evidence suggests that these adaptations not only improve engagement and outcomes for autistic patients but also enhance the therapeutic experience for all patients and staff. Co-creating further developments aimed at making treatment more inclusive needs to be done alongside people with LE themselves, in order to reflect the needs and motivations of the patients who need them.

Reconceptualising social support

Whilst the importance of social support in the recovery process cannot be overstated, how this looks for autistic individuals with EDs may need to be reconceptualised. Based on our own experiences, we think it would under-serve patients like us to either assume we cannot benefit from group-based approaches in treatment at all, or to mandate participation in groups that do not feel accommodating. Instead, the development of LE-led and autism-specific groups for active treatment provision and/or peer support could be widely beneficial, especially where these groups focus on creating an environment characterised by acceptance, belonging, and mutual understanding, without the pressure to conform to neurotypical expectations.

Beyond clinical settings, treatment can focus on identifying and exploring forms of belonging, community, and connection that align with each individual's needs and preferences. Social rehabilitation should not necessarily aim to return individuals to how they were before, nor pressure them to conform to mainstream social norms. Rather, it needs to support patients in defining and pursuing their own goals for meaningful social engagement and connection.

Supporting renewed self-understanding

We have seen personally how empowering self-understanding can be in recovery. For autistic individuals like ourselves, receiving a late diagnosis may be a profound moment of clarity, offering a new lens through which we can view our past struggles. There can also be challenges in this, with complex emotions such as grief and loss being evoked, and changes to the way in which we are perceived and treated by others. The magnitude of this shift is not something to go through alone, and maximising the therapeutic opportunities of diagnosis requires support - be that from clinicians, peer-supporters, carers and/or other professionals.

We believe that our work offers one example of how creative methods can be particularly beneficial in this process, as they can provide individually-led and non-threatening ways to engage with complex emotions, promoting healing without the imposition of external rules and hierarchies that limit choice. Approaches might include narrative inquiry and storytelling, as we have used in this paper, or may draw from other expressive and artistic ways of 'making sense' and (re)creating self-knowledge.

Co-production with lived experience

Cutting across all these recommendations is the principle of co-production with individuals who have LE of both autism and EDs. Including neurodivergent voices in the design, delivery, and evaluation of services ensures that interventions are not only evidence-based but also authentically responsive to the needs of those they aim to serve. Such an approach aligns with the broader movement toward participatory healthcare and the transformative potential of LE in shaping inclusive and effective clinical practices.

Conclusion

This paper has explored the critical intersection of autism, EDs, and social support through the lens of late diagnosis and recovery experiences. Our narratives and analysis illustrate the profound impact that a neurodivergence-affirming approach can have in reimagining care for individuals navigating these complexities. Recognising the nuanced interplay between autistic traits, social challenges, and ED psychopathology is an essential part of creating more inclusive and effective treatment environments.

A late autism diagnosis, while challenging, offers opportunities for reframing one's experiences, fostering self-compassion, and re-establishing pathways to recovery that prioritise authenticity and belonging. By acknowledging the unique needs and strengths of autistic individuals, we can transform the clinical landscape to support meaningful social connection and recovery outcomes. This requires embracing neurodiversity-affirming practices, addressing systemic barriers to care, and broadening the scope of how we conceptualise social support and inclusion in treatment frameworks.

Ultimately, the integration of LE into research and clinical practice can illuminate hidden dimensions of recovery and drive innovation in care. Moving forward, we must continue to champion the voices of neurodivergent individuals, ensuring that their stories and insights guide the creation of more compassionate, adaptive, and empowering systems of support. In doing so, we can establish approaches to treatment that not only accommodate difference but celebrate it as a foundation for more authentic and sustainable recoveries.

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JD led the conceptualisition of the paper, created a first draft and prepared figure 1. MA also contributed to conceptualisation and drafting. Both authors contributed narrative accounts, conducted collaborative reflective analysis, collated research literature, and contributed to finalising the content and presentation of the paper.

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