EXTENDED SUMMARY:

AUTISTIC SPECTRUM DISORDER IN ANOREXIA NERVOSA: INVISIBLE ONES IN FRONT OF THE MIRROR

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Abstract

The relationship between Autism Spectrum Disorder (ASD) and Anorexia Nervosa (AN) has raised a growing interest given the high comorbidity rates and the need to adapt existing treatment to this population, since they present worse results in standard treatments for eating disorders. In this article, a descriptive review of different aspects related to ASD and AN is carried out, trying to offer a perspective on the topic that may be useful for clinical practice. It covers epidemiological aspects and neuropsychological profiles, deepens the particularities of the diagnosis in these cases and presents treatment proposal.

Keywords: *Autistic spectrum disorder, Anorexia, Eating disorders, Asperger Syndrome, Cognitive remediation therapy.*

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Anorexia Nervosa (AN) is classified in the DSM-5 as one of the eating and food intake disorders while Autism Spectrum Disorder is a neurodevelopmental disorder of childhood onset. Apparently they seem very different, but they have more aspects in common than it seems at first sight. In the 80s Gillberg raised the possibility that there could be an underlying ASD in some cases of AN based on the similarities in their cognitive profiles. From then until now there has been a growing interest in the scientific literature to understand the relationship between these two disorders given the high presence of ASD in AN and the underlying difficulties shared in cognitive, social and emotional functioning. ASD seems to be overrepresented in a population with eating disorders with prevalence data of 22.9%, this comorbidity is associated with poorer prognosis and worse response to treatment.

People diagnosed with ASD often have disordered eating that may be a risk factor for future eating disorders. Some of these characteristics are similar to those presented in the cases of Food Avoidance / Restriction Disorder, another of the eating disorders categorized in the DSM-5. The prevalence of food avoidance / restriction disorder is significantly higher in ASD children than in their peers. People with food avoidance / restriction disorder differ from people with AN in that the former do not have body image alterations or fear of gaining weight. When there are suspicions of ASD and eating alterations of any type are observed, the first step would be to make a thorough differential diagnosis. Likewise, some authors propose that it could be beneficial to systematically perform a screening in search of a possible ASD in people who are being treated for an eating disorder.

The neuropsychological profile of eating disorders has been studied in recent decades, with weaknesses in central coherence and cognitive stiffness being the most consensual characteristics. More recently, the focus of research on socio-emotional difficulties has also been put through studies of social cognition. AN and ASD share behavioural similarities (for example, rituals with food or difficulties in eating with other people in social settings), difficulties on an emotional level such as alexithymia and could be that they also share some neurological characteristics such as: weak central coherence (difficulties in seeing globality instead of details), problems with set shifting (the ability to change from one task to another fluidly, aspect related to stiffness cognitive) and difficulties with the theory of the mind (the ability to attribute mental states).

Eating disorders are more frequent in women, and ASD in men, so the diagnosis of ASD in women is usually delayed due to, among other factors, a gender bias: the existing diagnostic criteria are based on men. This makes autistic women vulnerable to developing secondary mental disorders, including AN.

The diagnosis of ASD in women presents additional difficulties, since they tend to show greater social motivation, less stereotypy and less restrictive interests than men and often their interests are more aligned with gender stereotypes, so they are more difficult to detect. In addition they analyze the social behaviours of others and

find ways to mask their autism: but these attempts to camouflage their condition can also bring other difficulties such as identity problems ("I don't know who I really am"), high levels of anxiety and a huge fatigue, which often makes them prefer or need to be alone because they feel overwhelmed. A diagnosis in time would work as a protective factor, relieving their internal struggle, and allowing a therapeutic process to accompany them to get to know themselves better, as well as to find ways to adapt to a normotypic world, which they find complicated and confusing. Sometimes we will find an undiagnosed ASD in people who come asking for help with an eating disorder. It is important that we know how to recognize this type of profile in order to make a correct diagnosis and adjust the intervention to their needs. The diagnosis is complicated for several reasons: on the one hand, the symptoms of AN can mask the ASD when they manifest with extreme rigidity and obsessions focused on the calculation of calories, weight control or exercise and on the other hand some people without ASD can show behaviours associated with it during the acute phases of anorexia due to the psychological consequences of starvation. It is therefore essential to distinguish if the food symptoms presented by someone who ask for help are part of the underlying diagnosis of ASD (problems with food are another manifestation of the nuclear symptoms of ASD) or if there is a clear comorbidity, since they meet diagnostic criteria for both disorders.

The comorbidity between ASD and AN is associated with a worse prognosis, a worse response to treatment as well as the need for more intensive treatments since the rigidity and difficulties of introspection and communication characteristic of ASD make it difficult to respond to traditional therapeutic programs for eating disorders. The presence of acute ASD features in people with AN are associated with more severe symptoms, worse prognosis and worse treatment outcomes, so it is essential to adapt the treatments to the needs and peculiarities of ASD people. The underlying difficulties related to central coherence can broaden the perfectionist and obsessive-compulsive traits of people with AN, making it difficult to adhere to treatments that emphasize behavioural change, so treatments may need to focus first on the characteristics Cognitive characteristic of this type of patients. To respond to these difficulties, interest in cognitive remediation therapy arises as a possible approach in these cases: it addresses characteristics shared by both diagnoses (cognitive rigidity and central coherence problems) and has been proven effective in cases of AN. It addresses cognitive processes (how the person thinks) rather than the content of the thoughts (what the person thinks). The goal of CRT is for patients to reflect through guided discovery about their own thinking styles and how they affect them in their daily lives.

It is therefore essential that clinicians can see beyond the symptoms, it is a challenge to make ASD women feel finally seen: it is estimated that 70% of ASD people could have a comorbid mental disorder and the current reality is that they often go through different mental health consultations receiving diagnoses only of their associated pathologies, while the ASD remains invisible. Diagnosing in time

is not only prevention in the case of ASD girls and adolescents, but is also the key to adjust the treatments to the needs of this population.