



ORIGINAL ARTICLE

A Neurodiversity-Affirming Perspective on Eating Disorders

Shira Collings¹ & Laura Yakas²

¹*Thread and Threshold Psychotherapy*, ²*University of Michigan*

Abstract

In this essay we apply the neurodiversity paradigm to the topic of eating disorders. We begin by defining several important concepts, and then we build toward our main argument: because of our anti-fat culture, traits associated with eating disorder recovery, such as unrestricted eating and fat acceptance, are often more pathologized than traits associated with eating disorders; in particular, restrictive eating and anti-fat biases are normalized and even valorized in our society. We argue that eating disorder recovery can therefore be conceptualized as “neurodivergence,” given that unrestricted eating and fat acceptance are pathologized and deemed “abnormal” in our culture. Neurodivergence refers to thoughts, feelings, and behaviors that diverge from what society deems “normal” and are pathologized, and we assert that recovery paradoxically meets this definition. Finally, we end with ideas for mad/neurodiversity-affirming and fat-affirming eating disorder care. Rather than conventional models that aim to restore “normality” and “functioning,” we explore a treatment paradigm that celebrates divergence from all oppressive social norms, that creates opportunities for cross-movement solidarity and positive neurodivergent and fat identity, and which supports people on a path of personal and collective healing and liberation from oppression.

Keywords

Eating disorders, Mad Pride, neurodiversity, anti-fatness, saneism, ableism, anti-saneism, mad/neurodiversity-affirming practice, fat-affirming practice, critical eating disorder studies

History

Received 30 June 2024
Revised n/a
Accepted day month yr

Introduction: what have we written, and why?

In this essay we apply the neurodiversity paradigm to the topic of disordered eating in hopes of highlighting valuable nuances and takeaway lessons for mad studies theorists and for eating disorder clinicians who wish to adopt neurodiversity-affirming strategies. This essay is a passion project, and we are so grateful that our journeys have brought us to a

place where we can write this together, incorporating our personal expertise as proudly mad/neurodivergent people with histories of disordered eating and recovery¹, and our professional expertise as a neurodiversity-affirming eating disorder therapist (Shira) and an educator of future neurodiversity-affirming therapists (Laura).

Definitions of relevant neurodiversity paradigm concepts

The neurodiversity paradigm is becoming increasingly embraced in mainstream culture, which we see as a blessing and a curse. We are glad that more people are interested in these ideas, yet we also see these ideas being co-opted and deradicalized in ways that reinforce saneism instead of challenging it (Crosman, 2020; Meadows, 2021; Roberts, 2021). To avoid assuming all readers share the same background knowledge, and because we expect this to be used by clinicians-in-training who may not have as much exposure to the neurodiversity paradigm (or who may have been exposed to a deradicalized version), we begin our essay by defining relevant terminology.

We cite a few individuals whose work has educated us, but we also acknowledge that much of our knowledge is collective wisdom absorbed unconsciously over decades of immersion in mad and disability studies, and in the social justice movements of Mad Pride, neurodiversity and fat liberation. A similar sentiment was expressed in a recent article reminding readers that the neurodiversity paradigm and movement are the result of generations of collective effort, and cannot be attributed to any specific individuals (Botha et al., 2024). So, while we cannot name *everyone* who has impacted our growth, we *can* take a moment to express heartfelt gratitude to any and all ancestors and peers who have participated!

So taking what we've learned from some specific neurodiversity theorists and activists (e.g., Walker, 2021; Asasumasu 2021; Price, 2022; Chapman, 2023) and mad studies theorists and activists (e.g., Chamberlin, 1978; LeFrançois et al., 2013; Russo & Sweeney, 2016; Hoffman, 2019; Beresford & Russo, 2022; Rashed, 2023; Lewis, Ali & Russell, 2024), as well as the collective wisdom of many unnameable ancestors and peers, we now present to you our understanding of the neurodiversity paradigm and the system of oppression (saneism) that it evolved to resist.

Neurodiversity refers to the inherent and natural diversity in the ways that humans think, feel, learn, and process information, and how these differences influence behavior. For example; some people have a more sensitive nervous system than others, and are therefore

¹ When we discuss "recovery" from disordered eating, we are not referring to remediating an individual pathology, we are referring to liberating ourselves from the culturally imposed system of oppression called anti-fatness and healing from the trauma caused by that internalized oppression. We also want to clarify that we view "healing" and "recovery" as synonymous terms to describe the process whereby interventions are employed in order to lessen undesired or painful traits, and we use these terms interchangeably – but we recognize and embrace that others may view these as distinct concepts.

more prone to dysregulation; some people have more/less neural connectivity than others, which impacts sensory experience, perception and behavior (see Engelbrecht & Silvertant, 2023); some people are more bottom-up thinkers and others are more top-down thinkers; some people can smell colors and taste sounds; etc.

Building upon this, **neurodivergence** refers to ways of thinking, feeling, learning, processing and behaving that have been framed as “abnormal” in a given society, and pathologized using terms like “mental illness/disorder” or “psychiatric disability” – it is synonymous with the concept of **madness** as it is defined within mad studies and Mad Pride activism (the social justice movement by which the term “mad” got reclaimed). This is why we use these terms interchangeably and sometimes combined as “madness/neurodivergence,” or when describing people, “mad/neurodivergent².” We also sometimes use the acronym MNPD, or “mad, neurodivergent, and/or psychiatrically disabled” (DeWolfe et al., 2019) to capture the varying ways people may choose to relate to these terms, similar to the term c/s/x (for “consumer/survivor/ex-patient”) used in the early mad movement (Venter, 2019). And we acknowledge and embrace the fact that such terminologies will likely continue to evolve!

Neurodiversity happens in the interplay between biology and culture – it is both natural and nurtured, to use that common phrasing. We therefore appreciate the distinction some make between innate neurodivergence and acquired neurodivergence. **Innate neurodivergence** refers to pathologized traits that are mostly rooted in genetics and exist regardless of culture and life experience, such as the neural hyperconnectivity associated with autism. **Acquired neurodivergence** refers to pathologized traits that have been influenced or created by life experience, such as when stress and trauma impact a person’s nervous system and lead to traits like anxiety and dissociation.

Though some people misunderstand this, especially if they’ve learned co-opted or oversimplified versions of neurodiversity paradigm concepts, neurodivergence does not mean “mentally/behaviorally different from what is normal.” In fact, the neurodiversity paradigm rejects the idea that there is a “normal” to be different from! In alignment with other social justice perspectives, neurodiversity paradigm proponents view the concepts of “normal” and “abnormal” as ever-changing social constructs that are often leveraged to further oppression. Along these lines, **neurotypical** does not mean “mentally/behaviorally normal.” It simply describes people whose thoughts, feelings and behaviors have *not* been pathologized by society (thus far!) because they (for now!) conform to what society views as normal. On social media, we are seeing increasing use of the term **neuroconforming** instead of neurotypical, as the word “typical” can imply that one *does* mean “normal,” whereas the word “conforming” more clearly implies that one means “conforms to what society views as

² We generally use identity-first language (e.g., “I am a mad person”) because it aligns with our perspective that madness/neurodivergence is an oppressed identity worthy of pride, though we embrace that others may prefer person-first language (e.g., “I am a person experiencing madness”) and we acknowledge that both can be valid depending on context.

normal.” And though it is not a common term, we also use **non-mad** as another synonym, which is a variation of the term “non-disabled” that is promoted by some disability justice activists to signal those whose bodyminds³ have not (yet!) been pathologized.

The **neurodiversity paradigm** refers to an ideological paradigm shift that challenges the dominant “medical model” (or pathology paradigm) in our culture, which asserts that there is a right/wrong or normal/abnormal way to think, feel and behave, and frames what our culture views as “wrong” or “abnormal” as disease or disorder. With the neurodiversity paradigm, neurodivergence is no longer pathologized, but is instead affirmed, accommodated, and when it is consensual and possible (e.g., for some neurodivergence that is acquired due to trauma), healed or recovered from. Proponents of this paradigm strive for a world where we stop framing *any* thoughts, feelings, or behaviors as inherently “abnormal” or “wrong;” where we seek the deeper root causes of thoughts, feelings, and behaviors that are deemed harmful; where we allow harmless neurodivergence (e.g., whether or not a person makes eye contact) to exist as a valid way of being human; and where we stop allowing the medical-industrial complex to enforce what social scientists, activists and radical mental health professionals call “psychiatric hegemony” (Diamond, 2013; Cohen, 2016; Femia, 2022) through coercive interventions that aim to “treat” and therefore eradicate madness/neurodivergence. In other words, the neurodiversity paradigm is the ideological framework underlying the social justice movement to resist saneism.

Saneism (or sanism) is the system of oppression whereby a society idealizes neuroconformity and pathologizes, oppresses, and aims to eradicate madness/neurodivergence (for a thorough treatise on saneism, see Yakas, 2023). We view saneism as a variant of **ableism**, a system of oppression whereby a society pathologizes certain bodyminds as “abnormal” (usually those that are less productive to capitalism) and creates structural conditions that are inaccessible and violent towards pathologized people⁴. The term **neuronormativity** can be used synonymously with saneism, similar to how heteronormativity and heterosexism refer to the same system of oppression.

Finally, we want to define **anti-saneist clinical practice**, which can also be called **neurodiversity-affirming** or **mad-affirming clinical practice** (we will henceforth refer to it as mad/neurodiversity-affirming), as we hope our essay will support more clinicians in adopting these practices! In brief, mad/neurodiversity-affirming clinical practice entails supporting clients in (1) learning to **embrace, affirm, and thrive in their neurodivergence** and (2) **moving toward personal and collective liberation and healing from trauma and oppression, especially saneism**. In embracing and affirming neurodivergence, the implication is that the person (or more specifically, their neurodivergent traits) does not

³ The term bodymind comes from disability studies and disability justice activism, and is used to reject the notion that body and mind are separate/separable (Price, 2015).

⁴ With gratitude to our ancestors and peers who have contributed to defining and resisting ableism, such as: Sins Invalid, 2020; Clare, 2017; Mingus, 2018; Lewis, 2022.

change, instead, the environment around them changes. For example, appropriately educating an autistic child's community may spare the child from the pressure to begin "masking," which is Devon Price's (2022) term for performing neuronormative behaviors to conform to social norms, a practice that can be debilitating and thus lead to more acquired neurodivergence. In moving toward personal and collective liberation from trauma and oppression/saneism, the implication is that not only are we changing the environment, but also changing the person. For example: through liberating from internalized saneism, someone may begin "unmasking" and thus become more visibly mad/neurodivergent; through healing someone's nervous system, their neurodivergent traits like anxiety may abate.

Regardless of what changes occur, we acknowledge their inevitable complexity. At the individual level, **how do we balance the benefits of unmasking with the risks**, recognizing that becoming more visibly mad/neurodivergent may be empowering but also unsafe, especially for folks with multiple oppressed identities? And **how do we determine which of our neurodivergent traits to embrace and affirm, and which to heal and potentially abate?** How do we balance the political goal of liberation from saneism (and its assumption that there are wrong/abnormal ways of thinking, feeling, and behaving) with personal goals for abating thoughts, feelings, or behaviors that bring us pain? As an example, I (Laura) have struggled immensely with these questions – because healing my nervous system has made me less anxious, and that has made me less visibly mad, does this mean my healing journey has been saneist? Was it selfish and saneist of me to prioritize experiencing less pain over political representation? **Would I reflect Mad Pride better if I had decided *not* to heal because anxious voices have an important role in our world?** There are no simple answers to such questions, but we believe it is important that mad/neurodivergent folks explore and answer these questions for themselves – although we acknowledge that most people don't do it *by* themselves, but in community with others.

And at the societal level, **how do we as a society decide which neurodivergent traits are "harmless differences" that we should embrace, and which are "harmful differences" that we should not?** After all, in our current legal and criminal justice system, people can use "mental disorder" as a defense against charges of violent crimes, and along these lines, we do not want to live in a world where violent behavior is viewed as valid neurodivergence to embrace and affirm, even when the behavior is rooted in trauma and can appropriately be called acquired neurodivergence⁵. **So, where is the line between "different" and "violent"? Between "violent" and "damaged by violence"? And how do we respond to violent behavior whilst holding space for the anti-saneist principle that there are no inherently "wrong" behaviors?** Again, there are no simple answers to such questions, but we believe

⁵ We acknowledge that most violent behavior is, at its root, a *reaction* to the violence and unmet needs that people and their ancestors may have experienced, a point that is captured well in the aphorism "hurt people hurt people."

that reckoning with them thoughtfully as a society would lead us toward anti-saneism better than continuing on the current trajectory of how our culture responds to violence.

Along these lines we are seeing a worrying trend as the neurodiversity paradigm is becoming adopted (and at times co-opted, as we noted earlier) by clinicians – the creation of a binary where “innate neurodivergence” is viewed as the “right/good” kind of neurodivergence, and “acquired by trauma” as the “wrong/bad” kind. For example, a clinician claiming to be neurodiversity-affirming may encourage unmasking of autistic traits that are viewed as innate, but when it comes to traits like anxiety or dissociation, they may instead see these as acquired by trauma and encourage healing or recovery that eradicates those traits. Of course, when healing or recovery is consensual and in-no-way coerced by saneism, we endorse it (we have ourselves engaged in it!). But because it is so deeply ingrained, and has been for so very long, we understand that it is very easy to reinforce saneism without meaning to, and this new binary that “neurodivergence acquired by trauma” is less valid than “innate neurodivergence” is worrying to us.

Implications for eating disorders

As noted in the introduction, the aim of this essay is to apply the above neurodiversity paradigm concepts to what our society calls “eating disorders.” Eating disorders are defined as mental illnesses/psychiatric disabilities in our culture, as evidenced by their inclusion in medical texts such as the ICD and DSM (World Health Organization, 2019; American Psychiatric Association, 2022). And we believe that applying the neurodiversity paradigm to eating disorders takes us to a very interesting and paradoxical place: eating disorders are relatively unusual amongst our society’s defined mental illnesses in that they are simultaneously **pathologized**, **normalized**, and often even **valorized**. The very same behaviors that texts like the DSM and ICD frame as pathological, such as restrictive eating, calorie counting, and an impassioned drive for thinness, are not only *normal* (in the sense that they are common, everyday behaviors), but are actively *encouraged*. And they are not only encouraged by mainstream culture, for example, by diet culture/the diet industry (Gordon, 2023; Taylor, 2018), but also by the healthcare system. We see evidence of this in the adoption and use of a deeply flawed Body Mass Index/BMI that is racially biased (Stern, 2021; Vasquez, 2023; Wind, 2022) and uncritically equates fatness/high weight with unhealthiness (Harrison, 2019; Kinavey & Sturtevant, 2022; Gordon, 2023), and in the frequent use of food restriction diets as “treatment” (Harrop, 2020; Gaudiani, 2018).

Many eating disorders are characterized by a compulsion to pursue weight loss and/or restrict food intake⁶. We feel that while there are varying degrees of this for different

⁶ We acknowledge that there are also many people labeled with eating disorders whose relationships with food and their bodies are not characterized by a compulsion to pursue weight loss or eat a minimal amount of food in order to conform to societal norms. People may struggle with their relationship with food due to

people, this compulsion is a cultural norm – even a cultural *mandate*, or “eating order,” to use the language of this special issue – rather than a deviation from cultural norms. We are constantly told by the media, by the medical field, and by our communities that it is not only beneficial to pursue weight loss and limit our food intake, but that it is our moral obligation to do so, and it is commonplace to see people praised for food restriction and weight loss and shamed for unrestricted eating and weight gain. **This anti-fat ideology that is so pervasive in our culture is one of the most well-known environmental contributors to the development of eating disorders** (Ekern, 2024). And we want to make it explicit that like saneism, **anti-fatness is a system of oppression**, also known as fatphobia, weight stigma, fatmisia, and sizeism, that pathologizes fatness and idealizes thinness (Gordon, 2020; Taylor, 2018). We view both anti-fatness and saneism as variants of ableism, as they both involve pathologizing and oppressing bodymind diversity, and are deeply intertwined.

As a culture, we do not only associate weight loss and food restriction with being more physically healthy, we associate it with being more mentally healthy – more self-disciplined and hardworking, better able to take care of oneself, more responsible, more competent, more empowered, more sane, etc. And we associate weight gain and unrestricted eating with the opposite – being lazy, lacking self-discipline, not taking care of oneself properly, being mentally unstable, being incompetent, etc. Fat people commonly face discrimination in educational and workplace contexts as well as the medical and mental health system due to being perceived as incompetent and irresponsible (Täuber, Mulder, & Flint, 2018; Gordon, 2020; Brown, Flint, & Batterham, 2022). And it’s important to note that **anti-fatness intersects with all other oppressions, such as white supremacy and cisheteropatriarchy**, and that people of color, women, LGBTQIA+ people, and mad/neurodivergent people are disproportionately impacted by these anti-fat biases (Strings, 2019; Taylor, 2018).

Do these perceptions of irresponsibility and incompetence sound familiar? As we noted earlier, we see many similarities between the ways that weight gain, fatness, and unrestricted eating are conceptualized within our culture and the ways that neurodivergence is conceptualized. And we believe that the definition of neurodivergence (i.e., mental/behavioral traits that are pathologized in our society) paradoxically applies more to the traits and experiences of *recovery* than to many eating disorders. Recovery from many eating disorders entails letting go of control over one’s weight, and accepting the weight that one naturally gravitates to when one is eating an adequate amount and not restricting any foods that one likes. This applies to people of all sizes – for many people in recovery, the weight they need to be at in order to function is a higher weight than the BMI categorizes as “normal.” Recovery often involves unconditional permission to exist in any

sensory issues with foods, low appetite due to physiological or psychological reasons, executive functioning issues with preparing food, etc. (e.g., people with the diagnosis of Avoidant/Restrictive Food Intake Disorder/ARFID). It is important to accommodate these food-related differences, as pathologizing them often leads to a more disordered relationship with food.

body size, and to eat and rest, rejecting the idea that food and rest need to be earned or are dependent on weight, and rejecting the categorization of foods as “healthy/good” or “unhealthy/bad” and instead recognizing the value in all foods.

As noted above, **we argue that although it sounds paradoxical, eating disorder recovery is often more pathologized and abnormalized in our culture, and therefore more clearly meets criteria for the term “neurodivergence,” than many eating disorders do!** In our anti-fat society, it is just as (if not more) likely that someone will be shamed and pathologized for unrestricted eating and fat acceptance (i.e., recovery) than for restrictive dieting and anti-fatness (i.e., disordered eating).

Although I (Shira) am a person with straight-sized privilege, I have experienced a great deal of shaming due to the unrestricted eating I engage in as part of my recovery. I have been called “lazy” for eating fast and frozen foods when cooking has been a struggle (in part due to other forms of neurodivergence I experience), “impulsive” due to eating in response to emotions rather than solely during times that I am physically hungry, and “self-indulgent” due to eating sugary foods that bring me pleasure. And I have been told that I am “delusional” for believing all of this to be part of a healthy relationship with food and an aspect of my recovery from disordered eating. The words in quotes reflect sanist prejudice and discrimination. Words like “lazy,” “impulsive,” “self-indulgent,” and “delusional” are commonly utilized to characterize mad/neurodivergent people in a negative way. Counterintuitively, my healing and recovery have resulted in being subjected to *more* saneism, not less. It has been utilized to categorize me as *more* divergent from what is considered “mentally healthy” or “normal,” not less. **I was mad when I had an eating disorder, but somehow even madder when I began to recover!** And I recognize that the shaming I have experienced pales in comparison to those in larger bodies, who face many more assumptions of mental incompetence and experience structural violence on this basis.

Although fatness and unrestricted eating⁷ are not in the DSM, we would argue that the dominant narrative within the mental health field approaches and conceptualizes these as mental illness – as “symptoms” (i.e., pathological traits) that need treatment. It is a standard part of many mental health professionals’ education and training to learn how to utilize the various therapeutic modalities available to “help” clients lose weight and eat “healthier” (i.e., more restrictively). I (Shira) have attended several trainings in which the example patients were people in larger bodies who did not want to eat restrictively or lose weight, and they were often framed as patients who “lacked motivation” and needed to have their “irrational thoughts” challenged. Many mental health professionals are also taught that

⁷ A common misconception is that Binge Eating Disorder/BED constitutes unrestricted eating. In reality, restriction plays a major role in binge eating, and BED is a restrictive eating disorder. In fact, bingeing is often a healthy and life-saving response to food deprivation. The fact that there is much more focus on addressing bingeing and very little recognition of the need to address restriction among people with BED in our culture, is further evidence of the ways that disordered eating is normalized and accepted.

fatness is a result of trauma (Millner, 2023; Matz, 2022), and therefore, treating trauma can and should “melt away” people’s “excess fat.” Mental health professionals who receive training in addiction are frequently told that sugar and food are addictive, and that they should encourage clients who are “addicted” to food to participate in addiction treatments that frame food restriction as sobriety.

This is drastically different from other forms of neurodivergence. Mental health professionals are not taught to utilize therapeutic modalities to encourage clients to become more anxious, to hear more voices, to experience themselves as more plural, to learn and communicate more differently from other people, etc. They *are* taught to utilize these modalities to encourage clients to have a more disordered relationship with food – even if they are not conceptualizing it this way or intentionally carrying out that goal.

We therefore feel that **mad/neurodiversity-affirming eating disorder care means acknowledging that eating disorder recovery is pathologized significantly more than disordered eating is in our society.** I (Shira) remember that during my own healing and recovery from disordered eating, I told my therapist that I felt that my disordered relationship with food and my body was “the most normal thing about me.” I felt very different as a result of being multiply neurodivergent and other marginalized identities I have, and I sometimes felt that my pursuit of weight loss and food restriction were the one thing that made me feel like I was the same as everyone else and afforded me some neurotypical privilege. While this thought process was not completely accurate, it was true that I was often praised, validated, and told how self-disciplined and hardworking I was for my disordered eating. And I was never praised or validated for any of my other neurodivergent traits – in fact, it was the reverse, I was more often judged as “lazy,” “needy,” and “irresponsible” for those traits (e.g., needing more support and time to accomplish some tasks than others). When I pursued recovery from disordered eating, I not only felt that these judgments were amplified, but as I said earlier, I was also subjected to additional saneism for my recovery. I know that I am not alone in experiencing my relationship between disordered eating, recovery, and neurodivergence in this way, as I have heard similar experiences from others, including Laura. So, to us, a mad/neurodiversity-affirming approach to eating disorder recovery means recognizing the ways in which recovery diverges from social norms (and is therefore pathologized), and the ways in which recovery may amplify saneism, especially for people who have multiple forms of neurodivergence. We need to acknowledge this as a real barrier to recovery and **validate the incredibly challenging nature of recovering in a culture that is not only anti-fat but ascribes saneist judgements to unrestricted eating and weight restoration.**

To reduce such barriers, we need to advocate for the de-pathologization of unrestricted eating and fatness (Fox et al., 2023) and support clients in advocating for accommodations that will make recovery more accessible. Just as we can support autistic clients in embracing this as an aspect of their identity to accept and accommodate, we can support clients in

eating disorder recovery in developing a positive sense of identity around this and in developing strategies to reduce barriers in their environment. For example, people in recovery from eating disorders may benefit from curating their social media such that they're exposed to fat-affirming content rather than the default anti-fat content that pervades. People in recovery from eating disorders also often thrive better in environments where fat talk/diet talk is minimized, and we often share resources to help people ask for these accommodations, such as the following social media post with tips to avoid and reframe fat/diet talk on feasting holidays.

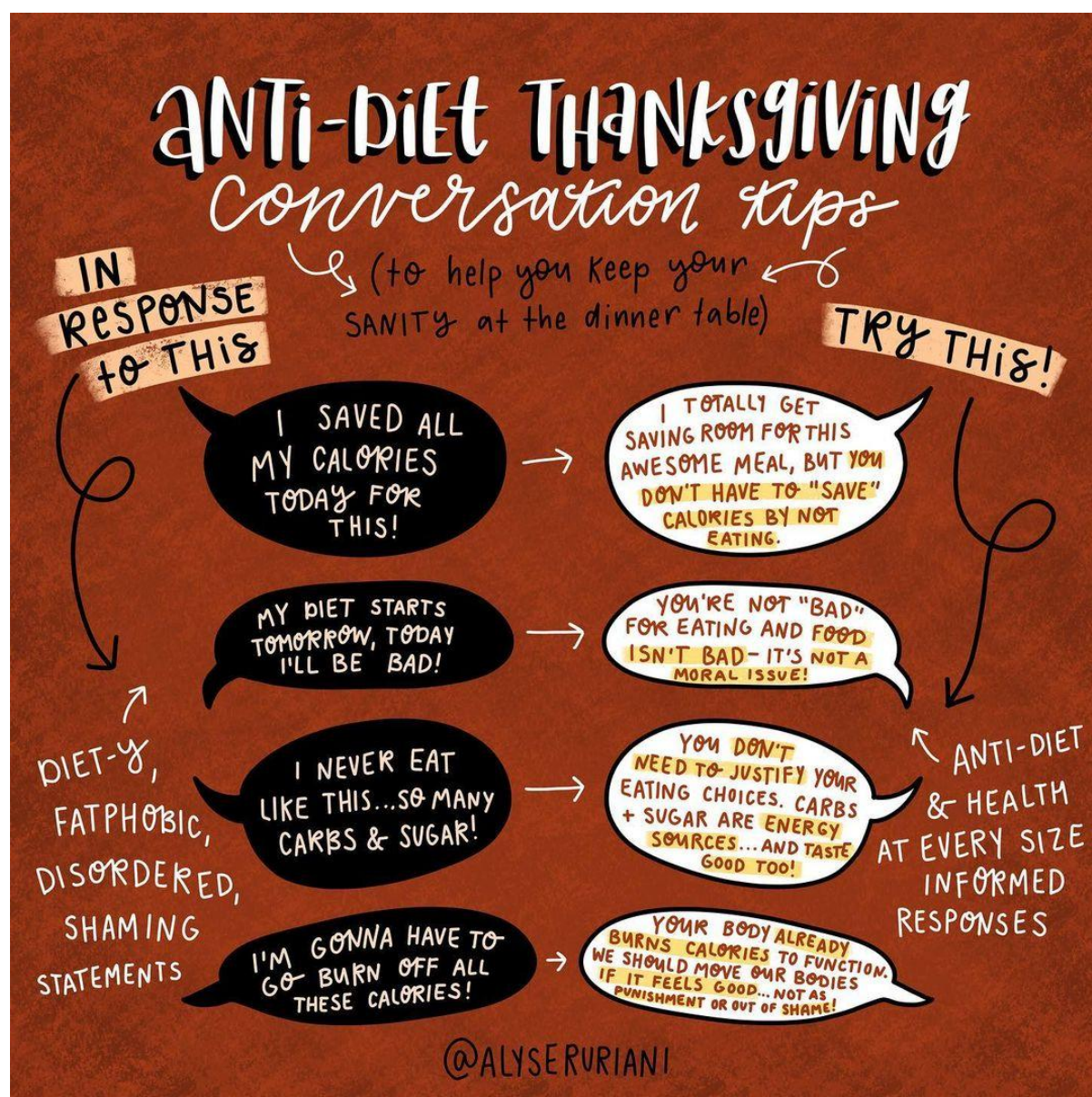


Image sourced from Ruriani (2021). We acknowledge that while we think this resource is valuable in terms of its challenge to diet culture, we might use different

language than “keep your sanity” to align with anti-saneism, for example, we could phrase it as “protect your mental health” instead.

Image Description - The graphic is titled “Anti-Diet Thanksgiving Conversation Tips.” The subtitle says, “(to help you keep your sanity at the dinner table).”

The graphic is divided into two main columns:

- The left column is labeled “In Response to This” and contains speech bubbles with common diet-y, fatphobic, disordered, shaming statements often heard during holiday meals.
- The right column is labeled “Try This!” and offers anti-diet & Health at Every Size (HAES)-informed responses to those comments.

Each statement-response pair is connected with a curved arrow, showing how to redirect the conversation compassionately.

Here are the four pairs shown:

1. Statement: “I saved all my calories today for this!”

Response: “I totally get saving room for this awesome meal, but you don’t have to ‘save’ calories by not eating.”

2. Statement: “My diet starts tomorrow, today I’ll be bad!”

Response: “You’re not ‘bad’ for eating and food isn’t bad – it’s not a moral issue!”

3. Statement: “I never eat like this... so many carbs & sugar!”

Response: “You don’t need to justify your eating choices. Carbs & sugar are energy sources... and taste good too!”

4. Statement: “I’m gonna have to go burn off all these calories!”

Response: “Your body already burns calories to function! We should move our bodies if it feels good... not as punishment or out of shame!”

At the bottom, the creator is credited: @alyseruriani.

Currently, the aim of conventional eating disorder treatment models is to restore individuals to functioning and to remediate “symptoms” of any “mental disorder.” This is often framed as bringing people closer to neurotypicality/neuroconformity – for example, improving physical health so that individuals can be productive to capitalism by working full-time, and reducing behaviors perceived as “extreme” so they can better fit in and have access to the social capital that neurotypical people have. Underpinning these aims is saneism – the idealization of neurotypicality/neuroconformity and devaluing of madness/neurodivergence. **We believe that mad/neurodiversity-affirming eating disorder care means *celebrating* divergence from oppressive norms rather than reinforcing them.** The goal of mad/neurodiversity-affirming care is personal and collective liberation rather than “symptom” remediation. **Eating disorder recovery is conceptualized not as recovery from individual pathology or abnormality, but as a rebellion and divergence from our anti-fat culture’s normalization and idealization of eating disorders.**

Through this lens, it is clear to us that **mad/neurodiversity-affirming eating disorder care must also be fat-affirming**, and include exploring all forms of internalized oppression and how they play a role in individuals' lives. Clinicians can support clients in understanding and unpacking harmful societal messages they've internalized about food and body size, and moving toward recovery as an inherently political rebellion against anti-fatness. Clinicians can also support clients in recognizing the intersections between anti-fatness and saneism, and engaging in acts of resistance against both forms of oppression. This may involve exploring ideas that clients have internalized about how it is and is not okay to think, feel, and act, not only around food and weight but in all areas of their lives. Therapy could be a space to explore ways to unmask neurodivergent traits, to build community with people who affirm fatness and neurodivergence, and to advocate for accommodations to make their environment more accessible. **In framing recovery as a form of neurodivergence, clinicians could empower clients to resist the internalized saneism and anti-fatness that often affects people who are in recovery**; instead of viewing unrestricted eating and unconditional body acceptance in a negative light, clients could instead feel liberated because they are diverging from oppressive norms, and develop a sense of neurodivergent pride in being a person in recovery, and when relevant, a sense of fat pride⁸ – though we do acknowledge that liberation from internalized oppression is rarely “complete” and that healing and recovery are more about “moving toward” than “arriving at!”. They could also see their recovery as an opportunity for connection and cross-movement solidarity⁹ with those who resist anti-fatness, saneism, and all other forms of oppression.

And rather than making assumptions about which forms of neurodivergence should be accepted and accommodated versus which should be healed or recovered from, we propose that mad/neurodiversity-affirming therapy is about giving clients space to explore and discover for themselves what feels most true and authentic. Rather than identifying “symptoms” and providing strategies to overcome them, the role of the mad/neurodiversity-affirming clinician is to hold space for clients' exploration of their *own* definition of a good and meaningful life and steps they can take to move toward that. As we mentioned earlier, this often involves developing self-advocacy skills and finding a community that can help cultivate mad/neurodivergent pride and positive identity. It may also involve implementing methods to heal from, recover, or reduce traits that cause distress or harm, as in Laura's example shared earlier (about healing her nervous system to reduce anxiety). However, **underpinning mad/neurodiversity-affirming care is the foundational idea that mad/neurodivergent people are whole, complete, and deserving of**

⁸ We recognize that mad/neurodivergent pride and fat pride are controversial. Not everyone who identifies as mad/neurodivergent or fat believes that pride in these identities is appropriate or beneficial. We do – we feel mad pride ourselves, and we have seen mad pride and fat pride make others' lives better. But we recognize and embrace that the mad liberation and fat liberation movements encompass a diversity of perspectives.

⁹ Cross-movement solidarity is one of the key tenets of the intersectional disability justice movement, which emphasizes interdependence and mutual liberation from all interconnected systems of oppression in our society (Sins Invalid, 2020).

all the same rights and opportunities as neurotypical people, regardless of what traits they do or do not heal or recover from. Without this foundation, healing and recovery cannot be truly consensual.

As a mad/neurodiversity-affirming eating disorder therapist, I (Shira) work to support people in recovery, not from a place of wanting them to be more neurotypical by eliminating “symptoms,” but rather from a place of believing in the inherent value of being compassionate and nourishing toward ourselves despite living in a culture that tells us to do otherwise. This means acknowledging the bitter realities of saneism and anti-fatness while also making space for all the ways that diverging from cultural mandates and norms can bring us more joy and enhance our quality of life. To me, a mad/neurodiversity-affirming approach to eating disorder recovery is about celebrating the value of neurodivergence and building solidarity among those who are resisting the pressure to conform to oppressive (e.g., racist, sexist, anti-fat, cisheteronormative, classist, saneist, etc.) norms of all kinds.

Follow-up resources for interested readers

In addition to our references section (below), we have created this list of resources for further education and support, and we also welcome readers to connect with us by email for further discussion and community!

For continued education:

- RDs for Neurodiversity: <https://www.rdsforneurodiversity.com>
- Eating Disorders Neurodiversity Australia: <https://www.edneuroaus.com>
- The Therapist Neurodiversity Collective: <https://therapistndc.org/>
- The Association for Size Diversity and Health, and the Health At Every Size framework: <https://asdah.org/haes/>
- [Critical Eating Dis/Order Studies Collective: https://www.criticaleatingdisorderstudies.com/](https://www.criticaleatingdisorderstudies.com/)
- [National Association to Advance Fat Acceptance: https://naafa.org/](https://naafa.org/)
- [Center for Body Trust: https://centerforbodytrust.com/](https://centerforbodytrust.com/)

For mad/neurodiversity-affirming care:

- These are a few directories of neurodiversity-affirming providers:
 - <https://therapistndc.org/therapist-directory/>
 - <https://neurodivergentpractitioners.org/>
 - <https://ndtherapists.com/>
 - <https://www.neuroaffirm.com/>
- Mad/neurodiversity-affirming eating disorder support group through Liberating Jasper (facilitated by Shira): <https://rachelmillnertherapy.com/>
- Eating Disorder Foundation support groups: <https://www.eatingdisorderfoundation.org/get-help/support-groups/>

References

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
- Asasumasu, K. (2021). What Your Daughter Deserves: Love, Safety, and the Truth. In Autistic Women and Nonbinary Network (Ed.). *Sincerely, Your Autistic Child: What People on the Autism Spectrum Wish Their Parents Knew About Growing Up, Acceptance, and Identity* (pp. 21–26). Beacon Press.
- Beresford, P. & Russo, J. (2022). *The Routledge International Handbook of Mad Studies*. Routledge.
- Botha, M., Chapman, R., Giwa Onaiwu, M., Kapp, S.K., Stannard, A., & Walker, N. (2024). The neurodiversity concept was developed collectively: An overdue correction on the origins of neurodiversity theory. *Autism*, 28(6), 1591-1594.
- Brown, A., Flint, S.W., & Batterham, R.L. (2022). Pervasiveness, impact and implications of weight stigma. *EClinicalMedicine*, 47.
- Chamberlin, J. (1978). *On our own: patient-controlled alternatives to the mental health system*. New York: Hawthorn Books.
- Chapman, R. (2023). *Empire of Normality: Neurodiversity and Capitalism*. Pluto Press.
- Clare, E. (2017). *Brilliant Imperfection: Grappling with Cure*. Duke University Press.
- Cohen, B. (2016). *Psychiatric Hegemony: A Marxist Theory of Mental Illness*. Palgrave Macmillan.
- Crosman, C. (2020). *Is Autism Speaks capable of change?* In the Loop About Neurodiversity. [Blog]. <https://intheloopaboutneurodiversity.wordpress.com/2020/02/24/is-autism-speaks-capable-of-change/>
- DeWolfe, K., Perry, M., Stohlmann-Rainey, J., & Collings, A. (2019). *28 Ways to Make the World Less Hostile to Mad, Neurodivergent, and Psychiatrically Disabled People*. Radical Abolitionist. [Blog]. <https://radicalabolitionist.org/2019-2-15-26-ways-to-make-the-world-less-hostile-to-mad-neurodivergent-and-psychiatrically-disabled-people/>
- Diamond, S. (2013). What Makes Us a Community? Reflections on Building Solidarity in Anti-Sanist Praxis. In B.A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad Matters: A Critical Reader in Canadian Mad Studies* (pp. 64–78). Toronto: Canadian Scholars' Press.

- Ekern, B. (2024) *A culture of dieting and how it can perpetuate eating disorders*. Eating Disorder Hope [Blog]. <https://www.eatingdisorderhope.com/blog/culture-dieting-perpetuate-ed>
- Engelbrecht, N., & Silvertant, M. (2018). *Autistic brain differences: Connectivity*. Embrace Autism. [Blog]. <https://embrace-autism.com/autistic-brain-differences-connectivity/>.
- Femia, J. (2022). *How can social work be a part of liberation from the psychiatric hegemony?* The Social Lens: A Social Work Action Blog. [Blog]. <https://socialwork.ubc.ca/news/how-can-social-work-be-a-part-of-liberation-from-the-psychiatric-hegemony/>
- Fox, R., Park, K., Hildebrand-Chupp, R., & Vo, A.T. (2023). Working toward eradicating weight stigma by combating pathologization: A qualitative pilot study using direct contact and narrative medicine. *Journal of Applied Social Psychology*, 53(3), 171-184.
- Gaudiani, J.L. (2018). *Sick enough: A guide to the medical complications of eating disorders*. Routledge.
- Gordon, A. (2020). *What we don't talk about when we talk about fat*. Beacon Press.
- Gordon, A. (2023). *"You Just Need to Lose Weight": And 19 Other Myths about Fat People*. Beacon Press.
- Harrison, C. (2019). *Anti-diet: Reclaim your time, money, well-being, and happiness through intuitive eating*. Hachette UK.
- Harrop, E.N. (2020). *"Maybe I Really Am Too Fat to Have an Eating Disorder": A Mixed Methods Study of Weight Stigma and Healthcare Experiences in a Diverse Sample of Patients with Atypical Anorexia*. University of Washington.
- Hoffman, G.A. (2019). Public mental health without the health? Challenges and contributions from the Mad Pride and neurodiversity paradigms. In K. Cratsley & J. Radden (Eds.). *Developments in neuroethics and bioethics* (Vol. 2, pp. 289-326). Academic Press.
- Kinavey, H., & Sturtevant, D. (2022). *Reclaiming Body Trust: A Path to Healing & Liberation*. Penguin.
- LeFrançois, B.A., Menzies, R. & Reaume, G. (Eds.). (2013). *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto: Canadian Scholars' Press.
- Lewis, B., Ali, A., & Russell, J. (Eds.). (2024). *Mad Studies Reader: Interdisciplinary*

Innovations in Mental Health (1st ed.). Routledge.

Lewis, T. (2022). *Working definition of Ableism*. Talila. A. Lewis. [Blog].
<https://www.talilalewis.com/blog/working-definition-of-ableism-january-2022-update>

Matz, J. (2022) *Unlearning weight stigma*. Psychotherapy Networker.
<https://www.psychotherapynetworker.org/article/unlearning-weight-stigma/>

Meadows, J. (2021). *You're Using the Word "Neurodiversity" Wrong*. Medium.
<https://jessemeadows.medium.com/youre-using-the-word-neurodiversity-wrong-e579ffa816a8>

Millner, R. (2023) *A letter to all therapists about weight stigma in the trauma field*. Rachel Millner Therapy. <https://www.rachelmillnertherapy.com/blog/1007548-a-letter-to-all-therapists-about-weight-stigma-in-the-trauma-field>

Mingus, M. (2018). *"Disability Justice" is Simply Another Term for Love*. Leaving Evidence. [Blog]. <https://leavingevidence.wordpress.com/2018/11/03/disability-justice-is-simply-another-term-for-love/>

Price, D. (2022). *Unmasking Autism. The Power of Embracing Our Hidden Neurodiversity*. Monoray.

Price, M. (2015). The Bodymind Problem and the Possibilities of Pain. *Hypatia*, 30(1), 268–284.

Rashed, M.A. (2023). Mad pride and the creation of culture. *Royal Institute of Philosophy Supplements*, 94, 201-217.

Roberts, J. (2021). *Performative Neurodiversity – the appropriation and watering down of a Human Rights Movement for profit*. Therapist Neurodiversity Collective.
<https://therapistndc.org/performative-neurodiversity-the-appropriation-and-watering-down-of-a-human-rights-movement-for-profit/>

Russo, J., & Sweeney, A. (Eds.). (2016). *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*. PCCS Books.

Ruriani, A. (2021). *Anti-diet Thanksgiving conversation tips*. Facebook post.
<https://www.facebook.com/alyseruriani/posts/4600794283297262/>

Sins Invalid (2020). *What is Disability Justice?*
<https://www.sinsinvalid.org/news-1/2020/6/16/what-is-disability-justice>

Stern, C. (2021) *Why BMI is a flawed health standard, especially for people of color*.

The Washington Post.

https://www.washingtonpost.com/lifestyle/wellness/healthy-bmi-obesity-race-/2021/05/04/655390f0-ad0d-11eb-acd3-24b44a57093a_story.html

Strings, S. (2019). *Fearing the black body: The racial origins of fat phobia*. New York University Press.

Täuber, S., Mulder, L.B., & Flint, S.W. (2018). The impact of workplace health promotion programs emphasizing individual responsibility on weight stigma and discrimination. *Frontiers in psychology*, 9, 414476.

Taylor, S. (2018). *The body is not an apology: The Power of Radical Self-Love*. Berrett-Koehler.

Vasquez, I. (2023) *BMI is BS. Here's why*. Your Latina Nutritionist. [Blog].

<https://yourlatinanutritionist.com/blog/bmi-is-bs>

Venter, C. (2019). *Origins of the csx movement*. Mindfreedom.

<https://mindfreedom.org/kb/voices-for-choices/origins-of-the-c-s-x-movement-voices-for-choices/>

Walker, N. (2021) *Neuroqueer heresies: Notes on the neurodiversity paradigm, autistic empowerment, and postnormal possibilities*. Fort Worth, TX: Autonomous Press.

Wind, K. (2022) *Why I no longer prescribe weight loss, calculate BMI, or use the term 'obesity'*. This Changed My Practice (TCMP) by UBC CPD.

<https://thischangedmypractice.com/why-i-no-longer-prescribe-weight-loss/>

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). <https://icd.who.int/>

Yakas, L. (2023). "Love is merely a madness": Sexuality and Madness in a cisheteropatriarchal culture. In S.K. Kattari (ed.). *Exploring sexuality and Disability: A Guide for Academics and Health and Human Service Professionals* (pp. 108-123). Routledge.

Your Fat Friend (2019): *The Bizarre and Racist History of the BMI: Body Mass Index has been used in recent decades as a referendum on individual health. But it was never meant to be*. Medium. <https://elemental.medium.com/the-bizarre-and-racist-history-of-the-bmi-7d8dc2aa33bb>