



ASSOCIATION OF SUPPORT LEVEL WITH FOOD SELECTIVITY AND FOOD NEOPHOBIA IN UNIVERSITY STUDENTS WITH AUTISM SPECTRUM DISORDER

ASSOCIAÇÃO DO NÍVEL DE SUPORTE À SELETIVIDADE E NEOFOBIA ALIMENTAR EM UNIVERSITÁRIOS COM TRANSTORNO DO ESPECTRO AUTISTA

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ABSTRACT: OBJECTIVE: To evaluate food selectivity and neophobia in university students with and without a diagnosis of ASD, correlating them with the level of support required. METHODS: Cross-sectional study conducted with students from the Federal University of Ouro Preto (UFOP), using online questionnaires: *Autism Spectrum Quotient* (autistic traits), *Food Neophobia Scale* (food neophobia) and *Adult Picky Eating Questionnaire* (food selectivity). Data analysis was performed using STATA version 15.0. RESULTS: A total of 102 responses were analyzed, 17 of which were from individuals with ASD. The mean age was 26 years. Most participants were single (89.2%), financially dependent (76.4%), lived with a family member or in a shared apartment (84.3%), were eutrophic (54.9%) and had other health-related diagnoses (63.7%). Individuals with ASD showed greater food selectivity in all subscales, while neophobia did not differ significantly between groups. CONCLUSION: Students diagnosed with ASD show greater food selectivity in all parameters evaluated compared to normotypical students.

KEYWORDS: Autism. Eating behavior. University students.

RESUMO: OBJETIVO: To evaluate food selectivity and neophobia among university students with and without an autism spectrum disorder (ASD) diagnosis, correlating these traits with the level of support required. METHODS: A cross-sectional study was conducted with students from the Federal University of Ouro Preto (UFOP), using online questionnaires: the *Autism Spectrum Quotient* (autistic traits), the *Food Neophobia Scale* (food neophobia), and the *Adult Picky Eating Questionnaire* (food selectivity). Data analysis was performed using STATA version 15.0. RESULTS: A total of 102 responses were analyzed, including 17 from individuals with ASD. The average age was 26 years. Most participants were single (89.2%), financially dependent (76.4%), lived with family members or in shared housing (84.3%), were eutrophic (54.9%), and had other health-related diagnoses (63.7%). Individuals with ASD exhibited greater food selectivity across all subscales, while food neophobia did not differ significantly between groups. CONCLUSION: Students diagnosed with ASD demonstrated greater food selectivity in all parameters evaluated compared to neurotypical individuals.

PALAVRAS-CHAVE: Autism. Eating behavior. University students.

INTRODUCTION

The term autism began to be used vehemently in the 1940s, when pediatrician Hans Asperger described it with characteristics of compulsiveness, social limitations and general motor skills ¹. Today, according to the 2019 International Classification of Diseases (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) ^{2,3}, it is called Autism Spectrum Disorder (ASD), encompassing its various clinical manifestations, which vary by age, degree and level of development ⁴. Symptomatically, the disorder is characterized by the impairment of three areas, manifesting early in early childhood: 1. Social skills; 2. Deficits in communicative skills, verbal or non-verbal; and 3. Repetitive and stereotyped behaviors. These symptoms have repercussions on the individual's social, personal, academic and professional functioning, resulting in "severe impairments in social interaction, severe difficulties in both verbal and non-verbal communication, and absence of imaginative activities, replaced by repetitive and stereotyped behaviors" ¹.

The term "spectrum," which encompasses all the diversity found in this disorder, relates to the three possible levels of support that individuals fall into: intense support (level 3), major support (level 2), and light support (level 1). The levels of support are defined according to the level of support that individuals may need, depending on the degree of their limitations ⁵.

Its prevalence has increased dramatically worldwide, validating its current clinical relevance, since recent research shows that 1 in 36 8-year-old children in the United States is affected by the syndrome, according to a study by the *Centers for Disease Control and Prevention* ⁶, which has been tracking the number of autistic children in the country for two decades. This study also points out that in addition to more diagnoses, they are being made later, and many children are only diagnosed at school age, which compromises the prognosis ⁷.

From a neuroscience perspective, the specific causes of ASD are still under investigation, but it is already known that there is an important genetic basis. In general, it is a global disturbance of brain function that affects different parts of the central nervous system and manifests itself differently in each individual ⁸. This disorder involves neuronal disorganization and irregular production of cytokines, which also affect neighboring cells and their receptors, which impairs the development of different brain regions ⁹. In addition to these factors, most individuals with ASD have Sensory Processing Dysfunction (SPD), a failure in the neurophysiological process of sensory integration to interpret, process and modulate sensory stimuli ¹⁰. As a result, the social and motor behavior of the person with ASD can be compromised at different levels, resulting in the main manifestations observed in the disorder, such as little social interaction and the repetition of stereotyped movements.

In the nutritional context, these individuals are more susceptible to developing comorbidities associated with eating disorders, with food selectivity and neophobia standing out ¹¹. Food selectivity is defined by food refusal, low appetite and lack of interest in food, especially in preschool children ¹². During their first contact with food, it is natural for children to explore food with their senses, using touch, smell, taste and sight to acquire knowledge about the new food. In children with ASD, this selectivity occurs physiologically due to the sensory limitation caused by SPD ¹³, creating problems in exploring food and difficulty in accepting it, contributing to a limited food repertoire based on its sensory characteristics, such as texture, color and shape, and this behavior often continues throughout life ¹¹. Associated with this issue, food neophobia is another typical behavior of individuals with ASD, defined by the reluctance to consume or try new foods, which increases the problematization of contact and food acceptance, since in ASD it is common to have difficulty tolerating changes in relation to textures, aromas and flavors ¹⁴. In this sense, the association of dysfunctional behaviors at mealtime amplifies the

range of negative consequences generated by the low intake of some micro and macro nutrients, compromising the nutritional quality of the diet of this group of individuals ¹⁵.

Studies on food selectivity and neophobia in adults highlight the relevance of these behaviors. A study conducted in Poland with 309 adults found prevalence rates of 15.2% for food selectivity and 19.4% for high risk of neophobia, using instruments such as the Food Neophobia Scale ¹⁶. Although this study did not include comparisons with individuals diagnosed with autism spectrum disorder (ASD), a group with a high prevalence of eating disorders ¹¹, its results reinforce the importance of investigating these aspects, especially in the context of ASD. Food selectivity in autism spectrum disorder can be effectively addressed with educational interventions involving tasting sessions and multidisciplinary programs, including psychology, speech therapy, and nutrition ¹⁷. These strategies help to expand food choices and promote health, highlighting the urgency of directing public policies towards nutritional education in this group.

In this sense, the Ministry of Health, through the Guidelines for Rehabilitation Care for People with Autism Spectrum Disorder ¹⁸, defines that the Unified Health System guarantees comprehensive care in its various aspects to the population diagnosed with ASD, with the support of a multidisciplinary team that, regardless of the type and degree of diagnosis, must have their biopsychosocial aspects considered in their therapeutic plan, including nutritional monitoring. However, although it is well established that individuals with ASD may have a diet that is not very varied and have greater difficulty in introducing new foods into their habits, little is known about whether food selectivity and neophobia increase with the level of support required by these individuals, especially in adults. Understanding this relationship can favor a more assertive nutritional intervention, so that it is considered not only based on the diagnosis of ASD, but also on the degree of autistic behaviors.

In view of the above, this study seeks to evaluate food selectivity and neophobia in university students with and without a diagnosis of Autism Spectrum Disorder, in addition to the correlation of these behaviors with the level of support required.

METHODOLOGY

This is a cross-sectional study, carried out with adult undergraduate students from the Federal University of Ouro Preto (UFOP), through online questionnaires. The form invitation was sent to all students enrolled at UFOP in the second semester of 2023, totaling 10,287 emails sent.

Students from the Federal University of Ouro Preto enrolled during the period in question, who agreed to participate, through the virtual Free and Informed Consent Form, and were between 19 and 59 years old were included; and those who did not completely complete the online form were excluded.

The previously structured online questionnaire contained socioeconomic and demographic questions, lifestyle and health conditions, as well as adapted versions of an autistic spectrum quotient test, a questionnaire for the analysis of food neophobia and a food selectivity questionnaire for adults. Anthropometric data (weight and height) were self-reported in the online questionnaire. The questionnaire included a question about the diagnosis of ASD or Asperger's Syndrome, which was categorized as "yes" or "no".

Among the sociodemographic variables, questions were asked about age, sex, marital status, level of education of the closest person responsible for health care, family income and the number of financial dependents on this same income and, finally, housing. Questions were also asked about the clinical condition of the interviewee: weight, height, diagnoses of other diseases, such as diabetes,

hypertension and depression, in addition to questions about the presence or absence of the diagnosis of ASD. With the data “weight” and “height”, BMI (weight/height x height) was calculated and subsequently the results obtained were classified as underweight < 18.5, eutrophic ≥ 18.5 and < 25.0 and overweight ≥ 25 .

EXPRESSION OF AUTISM SPECTRUM TRAITS

To assess the expression of Autism Spectrum traits (assessed as a predictor of the level of support) on an individual basis, the *Autism Spectrum Quotient* (AQ) was used, adapted into a Portuguese version, with 50 items related to the usual behaviors of individuals with ASD. This method uses a 4-point Likert scale for its assessment, ranging from strongly disagree to strongly agree. Each of the listed items counts for 1 point if the interviewee records abnormal or autistic-like behavior, mildly or strongly, and the higher the score, the greater the degree of support required (Baron-Cohen et al, 2001). Only individuals who reported a previous medical diagnosis of ASD responded to this scale.

FOOD NEOPHOBIA

To estimate the level of food neophobia, the *Food Neophobia Scale* (FNS) was used, adapted into a Portuguese version, which has 12 items related to the taste and/or desire to try foods unknown to the individual. This method uses a 7-point Likert scale for its assessment, ranging from strongly disagree to strongly agree. The resulting score can vary between 10 and 70 points and can be classified into the following categories: food neophilia (score ≤ 23.4), neutral (score between 23.4 and 53.4) and food neophobia (≥ 53.4). These categories were developed using two cut-off points (23.4 and 53.4), calculated using the Mean Score $\pm$ Standard Deviation, with neophilia being someone who has a tendency to try new foods, neophobic being someone who is resistant to innovation and neutral being someone who does not fit into either of the two extremes (PLINER, 1992).

FOOD SELECTIVITY

To assess food selectivity, the *Adult Picky Eating Questionnaire* (APEQ), translated into Portuguese, was used. It has 20 items that address food choices and preferences, categorized into common aspects in the practice of food selectivity: rigidity in meal presentation or preparation (Meal Presentation), little dietary variety and reluctance to try new foods (Food Variety), disinterest and avoidance of meals (Meal Disinterest), and rejection of bitter and acidic foods (Taste Aversion). This method uses a 5-point Likert scale for its assessment, ranging from never = 1 point to always = 5 points. Through this questionnaire, the aim is to judge and measure selective eating behavior. The overall and subscale scores were calculated by averaging the items, with higher values indicating greater tendencies of food selectivity. The resulting score has a range of 20 to 100 points and must be divided by the total number of items, in order to produce an overall average and by domain/subscale, which in turn can vary from 1 to 5. The higher the value, the greater the intensity of selective behaviors (MENGHI, 2022).

ETHICAL ASPECTS

Volunteers were informed about the objectives and impacts of the study in an online Informed Consent Form and were only included if they agreed to participate. This study was approved by the Research Ethics Committee of the Federal University of Ouro Preto (CAAE: 70711923.4.0000.5150).

STATISTICAL ANALYSIS

The data obtained were tabulated and validated in Microsoft Excel, and analyzed in STATA version 15.0. Continuous variables were assessed for normality by the Shapiro-Wilk test and described as mean $\pm$ standard deviation if normal, or median (minimum and maximum) if non-normal. Categorical variables were described as absolute and relative frequency. Differences between groups were assessed by the t-test or Mann-Whitney test, depending on the normality of the data. The relationships between categorical variables were assessed by the chi-square method. Correlations between continuous variables were performed by Pearson's or Spearman's correlation tests, depending on the normality of the data. All analyses were conducted at a significance level of 5%.

RESULTS

The responses of 102 participants were analyzed, all enrolled in the second semester of 2023 at UFOP, 17 of whom had a previous diagnosis of ASD (16.6% of participants). Of the participants interviewed, 68.6% were female, with females also predominating among those diagnosed with ASD (71.7%). The average age of the individuals analyzed was 26 years, ranging from 19 to 54 years. The vast majority of interviewees indicated their marital status as single (89.2%), and the education level of the closest family member was predominantly complete or incomplete higher education (61.7%). The sample was also predominantly financially dependent (76.4%) on a guardian, lived with a family member or in a shared apartment (84.3%), were eutrophic, for the most part, according to the BMI classification (54.9%), and had some other diagnosis related to their health condition (63.7%), such as depression, high blood pressure, and diabetes.

Among the individuals belonging to the spectrum, the *Autism Spectrum Quotient* (AQ) questionnaire was applied, which assesses the degree of support needed by each individual. For the sample, the average score found was 34.2.

Socioeconomic, demographic, lifestyle and health condition aspects of the sample were analyzed and compared regarding the presence or absence of an ASD diagnosis (Table 1); however, none of the results obtained were significantly related to the ASD diagnosis.

The sample was also assessed on the food neophobia scale (Table 2), in relation to the diagnosis of ASD and those without the diagnosis. There was no statistically significant difference in the proportions of neophilic, neophobic or neutral individuals in relation to the diagnosis of ASD.

Regarding the assessment of food selectivity in relation to the diagnosis of ASD, there was a higher overall score and a higher score on all selectivity subscales in individuals diagnosed with ASD (Table 3).

Finally, it was not possible to evaluate the neophobia and selectivity scales according to the degree of autism support because the number of individuals diagnosed with ASD was small, but when

evaluating the autistic behavior scores in relation to the selectivity and neophobia scores, there was no correlation between any of the variables evaluated (Table 4) .

The analyses and interpretations duly supported by the data, concepts and information presented in the development should be inserted here. This is the topic in which the results achieved in the research should be explained. Verification and comparison with the state of the art of the theoretical basis can be carried out.

FIGURES AND TABLES

Table 1 - Characterization of the sample in relation to the presence or absence of the diagnosis of Autism Spectrum Disorder. Ouro Preto, 2024 (n = 102).

VARIABLES	TOTAL	TEA NO	TEA YES	p
AGE*	102	24(19-64)	25 (20-48)	0.325
SEX- FEMALE	70(68.6%)	61(71.76%)	9(52.94%)	0.127
SEX - MALE	32(31.3%)	24(28.24%)	8(47.06%)	
MARITAL STATUS - SINGLE	91(89.2%)	76(89.41%)	15(88.24%)	0.886
MARITAL STATUS - MARRIED	11(10.7)	9(10.59%)	2(11.76%)	
SCHOOLING-ILLITERATES	1(0.0%)	1(1.18%)	0 (0.00%)	0.849
EDUCATION - ELEMENTARY SCHOOL	16(15.6%)	14 (16.47%)	2 (11.76%)	
EDUCATION - SECONDARY SCHOOL	22(21.5%)	19 (22.35%)	3 (17.65%)	
EDUCATION - HIGHER EDUCATION	63(61.7%)	51 (60.00%)	12 (70.59%)	
INCOME UP TO 3 SALARIES	49(48.0%)	40 (47.06%)	9 (52.94%)	0.658
INCOME > 3 SALARIES	53(51.9%)	45 (52.94%)	8 (47.06%)	
C/FINANCIAL DEPENDENCE	78(76.4%)	67 (78.82%)	11 (64.71%)	0.210
WITHOUT FINANCIAL DEPENDENCE	24(23.5%)	18 (21.18%)	6 (35.29%)	
LIVES ALONE	16(15.6%)	13 (15.29%)	3 (17.65%)	0.904
LIVES WITH FAMILY	47(46.0%)	40 (47.06%)	7 (41.18%)	
LIVE REPUBLIC	39(38.2%)	32 (37.65%)	7 (41, 18%)	
BMI - LOW WEIGHT	6(0.05%)	5 (5.88%)	1 (5.88%)	0.934
BMI - EUTROPHIC	56(0.54%)	46 (54.12%)	10 (58.82%)	
BMI- OVERWEIGHT	40(39.2%)	34 (40.00%)	3 (35.29%)	
WITH OTHERS ILLNESSES	65(63.7%)	51(60.00%)	14(82.35)	0.080
WITHOUT OTHER DISEASES	37(36.2%)	34 (40.00%)	3 (17.65%)	

*Represented as median, and assessed using the Mann-Whitney test. Other variables were analyzed using the chi-square test. For the BMI classification, underweight was considered <18.5, eutrophic ≥18.5 and <25.0, and overweight ≥25.0. For the income range, the value of the minimum wage in force in Brazil in the year 2024 was considered. The significance value adopted was P<0.05. ASD = Autism Spectrum Disorder.

Table 2- Frequency of food neophobia in relation to the diagnosis of Autism Spectrum Disorder. Ouro Preto, 2024 (n = 102).

<i>Food neophobia</i>	TOTAL	TEA NO	TEA YES	p
NEOPHILIC	20 (19.60%)	18(21.1%)	2(11.7%)	0.668
NEUTRAL	61(59.80%)	50(58.8%)	11(64.7%)	
NEOPHOBIC	21 (20.50%)	17(20%)	4(23.5%)	
TOTAL	102	85	17	-

Chi-square test. The classification into neophilic, neutral and neophobic was made according to the FNS test, with cut-off points respectively of ≤ 23.4 ; between 23.4 and 53.4 and ≥ 53.4 , calculated by means of the Mean Score $\pm$ Standard Deviation. The significance value adopted was $P < 0.05$. ASD = Autism Spectrum Disorder.

Table 3- Food selectivity scores in relation to the diagnosis of Autism Spectrum Disorder. Ouro Preto, 2024 (n = 102).

<i>Food Selectivity</i>	TOTAL	TEA NO	TEA YES	p
TOTAL SCORE*	2.4 (1.15-4)	2.31 $\pm$ 0.68	3.04 $\pm$ 0.58	0.0001
MEAL PRESENTATION	2.28 (1-4.57)	2.28 (1- 4.57)	2.28 (2-4.28)	0.0007
FOOD VARIETY	2.25 (1-4.75)	2.25 (1-4.75)	3(1-4.75)	0.0417
DISINTEREST IN THE MEAL	2.33(1-5)	2 (1-5)	3 (2.3- 4.3)	0.0001
TASTE AVERSION *	2.41(1-4.5)	2.3 $\pm$ 0.70	3.0 $\pm$ 0.8	0.002

*Student's t-test. The other variables were analyzed using the Mann-Whitney test. The significance level adopted was $P < 0.05$. ASD = Autism Spectrum Disorder.

Table 4- Correlation between scores of autistic behaviors, selectivity and food neophobia (n = 17).

	TEA SCORE	
	r	p
TOTAL FOOD SELECTION SCORE*	0.198	0.446
MEAL PRESENTATION	0.024	0.926
FOOD VARIETY	0.193	0.456
DISINTEREST IN THE MEAL	0.061	0.456
TASTE AVERSION*	0.201	0.439
FOOD NEOPHOBIA SCORE	0.361	0.153

* Pearson correlation. For the others, Spearman correlation was adopted. The significance value adopted was $P < 0.05$. ASD = Autism Spectrum Disorder. r: Rho Pearson and Spearman correlation.

DISCUSSION

In the context studied, no statistical significance was found for the socioeconomic, demographic, lifestyle and health conditions data of the sample, compared to the presence or absence of a diagnosis of ASD, nor was there any difference in relation to food neophobia and the correlation between autistic behavior scores in relation to selectivity and neophobia scores. However, the selectivity score was higher

in individuals diagnosed with ASD in all aspects: total score, meal presentation, food variety, disinterest in the meal and taste aversion. In addition, among individuals belonging to the spectrum, the average score found was 34.2 points, which according to BARON-COHEN et al. (2001)¹⁹ exceeds the expected cut-off point for autistic individuals, which would be 32 points.

Individuals with ASD have impaired processing of sensory flows and adaptive responses, which is called Sensory Processing Dysfunction (SPD), a failure in the neurophysiological process of sensory integration to interpret, process and modulate visual, olfactory, gustatory, tactile and auditory sensory stimuli¹⁰. As a result, SPD makes it difficult for individuals with ASD to inhabit their own bodies²⁰, leading to impaired physical and social development, since the construction of learning and memory necessarily involves the sensory systems. Among the consequences of SPD is the eating factor, which is often impaired in this group, resulting in greater susceptibility to developing comorbidities associated with eating disorders, atypical nutritional patterns, disruptive behaviors and food selectivity²¹.

During their first contact with food, it is natural for children to explore food with their senses, using touch, smell, taste and sight to acquire knowledge about the new food. In children with ASD, this selectivity occurs physiologically due to the sensory limitation caused by SPD, creating problems in exploring food and difficulties with acceptance that can remain throughout life¹³. The dysfunction is present in around 60 to 90% of children with ASD, showing responses that can vary from hyper- to hyposensitiveness to sensory stimuli, with difficulties in regulating responses to stimuli that can compensate their neurological threshold for more or less²⁰.

Thus, the results of the research show that, in fact, people on the spectrum tend to be more selective when it comes to food than the control population, which can be explained by the sensory limitation that permeates the group and is directly reflected in the scales assessed: presentation of the meal, food variety, lack of interest in the meal and aversion to taste, all connected to the sensory perception involved in the neurological processing of nutritional stimuli. In these cases, food refusal can be considered an adaptive behavioral response, since information overload in the form of smells, colors, presentations and textures can lead to erratic physiological neuronal responses²². In addition, when there are no verifiable organic factors, food selectivity can also be justified by the manifestation of restricted interests, typical of rigid autistic behavior²³.

Although food selectivity is not an exclusive characteristic of people with neurodevelopmental disorders, it can affect up to 80% of these individuals²⁴ and this tendency can regress over the years, which means that most research focuses on children, even though recent studies have shown that selective behaviors continue beyond childhood²⁵. As a result, few researchers have assessed how this food refusal is followed up, especially among university students with ASD, which the analysis carried out in this study indicates may remain with significant levels of selectivity, requiring specialized monitoring.

Research has shown that 90% of children with ASD are selective because they do not process sensory information, particularly related to touch, smell, sight and hearing, in the same way as their peers with typical development²⁶. Williams et al. (2000)²⁷ found that 67% of family members complain that their children have food selectivity, with the following factors: texture (69%), appearance (58%), taste (45%), smell (36%), and temperature (22%), as well as reluctance to try new foods (69%) and a small repertoire of accepted foods (60%). Six years later, Schreck et al. (2006)²⁸ found that food is rejected mainly because of its presentation, with the use of different cutlery or utensils or the presence of different types of food on the same plate.

In addition, Kauer et al. (2015)²⁹ concluded that people with picky eating habits were more likely to adopt rejection behaviors based on sensory characteristics such as taste, color and texture. These

data, combined with the findings of this study, indicate that even at an older age (from 19 to 54 according to the sample studied), the criteria found in selectivity in terms of presentation, variety, disinterest and aversion to taste can remain and negatively impact the adult life of individuals with ASD.

As for food neophobia, it was expected, according to the literature, that it would be higher in individuals with ASD. Schreck et al. (2006)²⁸ found that 72% of the children surveyed had a limited repertoire of foods. Whiteley et al (2000)³⁰ found even more significant results, with 83% of family members reporting that their children only ate a limited amount of food. Another study³¹ concluded that self-reported picky eating is related to less varied diets, especially in fruit and vegetables, when compared to a non-picky population. This dietary inflexibility harms the individual's overall health as fewer nutrients, vitamins and minerals are incorporated into the diet. In addition, individuals classified as neophobic tend to have a higher BMI and a greater propensity to make unhealthy food choices compared to neophiliacs, who have a lower BMI and consume more fruit and vegetables³².

However, the small number of responses obtained in the questionnaire sent out in this study may have influenced the values found in the statistical analysis, as neophobia may be a parameter which, unlike selectivity, decreases with age. In addition, the sample studied was a university student, and it is known that at this stage of life the restriction of resources and options, as well as the need to be responsible for their own meals, can force individuals to change their food choices, for example, having to eat in university restaurants, where there is a pre-established menu^{33,34,35}.

The limitations of this study include the low number of responses to the questionnaire (102 responses), with an even lower percentage of respondents on the autistic spectrum (16.6%), which makes it difficult to characterize the sample and statistically extrapolate the responses obtained. The low number of forms filled in by individuals with ASD, the study's target audience, may be due to the low number of students with the disorder entering public universities³⁶ or to late diagnosis. According to the Centers for Disease Control and Prevention⁶, the prevalence of ASD diagnoses has increased year on year, from 1 in 150 children in the early 2000s to 1 in ³⁶ children in 2020 in the USA. However, even with a greater number of diagnoses, they still happen late, due to lack of preparation on the part of the professional team, misinformation on the part of those responsible or the ineffectiveness of public health policies, which makes it difficult for interventions to be effective and guarantee the individual's full development³⁷. Thus, some people can live with the disorder even without a firm diagnosis, with little or no support for their needs.

On the other hand, as strengths, this study is innovative in addressing eating behavior in individuals with ASD in the university population, characterizing the sample and obtaining relevant data on food selectivity, which can raise the debate about the need for nutritional support for the group. Given that the diagnosis of ASD has increased in recent years and that many university students enter adulthood and university without a correct diagnosis and without proper nutritional guidance regarding dysfunctional eating behaviors, understanding such behaviors can help in a more assertive and effective intervention, minimizing the nutritional impacts on this population. Thus, by understanding the profile of university students with ASD, it is possible to seek health promotion measures aimed at their specific needs, addressing food selectivity in this group according to age group, type of housing and income, providing therapeutic behaviors that fit into the academic context and that aim, above all, to increase the dietary variability of these individuals, in order to avoid the development of comorbidities and chronic diseases.

CONCLUSION

It is therefore concluded that students diagnosed with Autism Spectrum Disorder are more selective in terms of food when compared to neurotypical students in all aspects evaluated (total score, meal presentation, food variety, lack of interest in the meal and aversion to taste). However, there was no difference in relation to food neophobia, and these behaviors were not correlated with the degree of autistic behaviors.

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