THE SAGE HANDBOOK OF COUNSELLING & PSYCHOTHERAPY

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LESLEY DOUGAN

OVERVIEW AND KEY POINTS

My experience as a Neurodivergent therapist, client and educator informs this chapter. I begin by defining some of the key terms before considering how therapy can be impacted when either the therapist or client (or both) are Neurodivergent (ND**)**. I will use '*Identity-first language*' (i.e., referring to Neurodivergent clients or therapists, as opposed to clients or therapists who are neurodivergent) throughout the chapter as advocated by the Human Rights Model of Disability, developed following the United Nations (UN) *Convention on the Rights of Persons with Disabilities* (United Nations, 2006). Identity-first language is essential because being neurodivergent 'informs every facet of a person's development, embodiment, cognition, and experience, in ways that are pervasive and inseparable from the person's overall being' (Walker, 2021: 87).

The chapter covers:

- neurodiversity, neurodivergence and neurotypicality.
- neurodivergence in relation to the different models of disability.
- neurodivergence in the context of counselling and psychotherapy.
- common experiences of neurodivergent people.
- neurodivergent affirming therapy.

INTRODUCTION

WHAT IS NEURODIVERSITY?

Neurocognitive functioning, both between and within individuals in any given society varies considerably (Doyle, 2020; Kapp et al., 2013). The term 'neurodiversity' encompasses the infinite differences within and between human minds **(**Singer, 1998). People whose processing fits within any society's concept of normalcy are Neurotypical (NT), whereas those whose processing diverges from the socially constructed 'norm' in any way are 'Neurodivergent' (ND). While having a different neurotype is not synonymous with a disability, many neurodivergent people face similar challenges and may be disabled by their neurotype (or society's responses to their neurotype). Neurodivergence manifests in many ways, which may not always be apparent to either the individual or to others. Some examples of ND processing include (but are not restricted to): ADHD, Autism, dyslexia, dyspraxia, dyscalculia, Tourette's syndrome, neurofibromatosis, synaesthesia, alexithymia, sensory processing sensitivity, rejection sensitive dysphoria.

MODELS OF DISABILITY

Given the association between neurodiversity and disability, and the discrimination faced by ND people, it is important to consider how we understand 'disability'. There are various models of disability. The Human Rights Model (sometimes referred to as the Empowerment Model) is contrasted here with the more commonly known Social, Medical, and Charity Models of disability.

The Human Rights Model (United Nations, 2006) of disability recognises that:

- Disability is a natural part of human diversity that must be respected and supported in all its forms.
- People with disabilities have the same rights as everyone else in society.
- Impairment must not be used as an excuse to deny or restrict people's rights.

The Medical Model centres the 'problem' with the individual, and what they can or cannot do because of their health condition, rather than society being centred around the needs of non-disabled people. Further, the Medical Model can be used to restrict the rights of disabled people, for example, the blanket 'Do Not Resuscitate Orders' placed on people with Learning Disabilities during the Covid-19 pandemic (Bloomer, 2021).

The Charity Model is a 'moralistic extension' of the Medical Model (Withers, 2012). Developed by

non-disabled people, it frames disabled people as tragic and in need of support, while simultaneously highlighting 'inspirational individuals' who achieve 'despite' their disability. The false binary at the heart of the Charity Model enables non-disabled people to 'feel bad for disabled people's limited life chances and choose to help them – thereby making them 'good people' – and to be inspired by disabled people and realise how much more potential they have as someone who doesn't face the same limitations' (Ralph, 2017, n.p.). Both the Medical and Charity Models of disability are inconsistent with Human Rights (Degener, 2016).

The Social Model of disability is preferable to either the Medical or Charity Models. However, it is not without its faults. Namely:

- It advocates '*person-first*' rather than '*identity-first*' language.
- Many disabled people consider the Social Model of disability as ableist because it fails to see disabled people as the experts in their own lives, thereby enabling discrimination in favour of non-disabled people.
- Social Model interventions often fail to acknowledge the real impact of impairment on the lives of individuals (probably because of the insistence of '*person-first*' language).
- It tends to treat all disabilities the same.
- Its focus on society's barriers assumes that disabled people will access the services they need once the obstacles are removed.

RELEVANCE TO COUNSELLING AND PSYCHOTHERAPY

FROM PATHOLOGY TO NEURODIVERSITY: A PARADIGMATIC SHIFT

Historically, westernised socio-cultural-economic systems have been structured and developed around the needs of those in power, i.e., NT, able-bodied, white, cisgender men. The mechanisms of power frame NT as the *'natural*', *'universally desirable human condition*' (Davies, 2016: 136). Normative counselling and psychotherapy practice has an implicit disablist attitudinal stance, i.e., it discriminates against disabled people (Moors, 2022). ND presentations are 'othered' or framed as 'difficulties' or 'deficits' by systems built around the needs of the NT majority. It is also worth remembering that other intersections of a neurodivergent person's identity, such as race, faith, gender identity, disability, age, socio-economic standing, sexuality, and relationships, add additional layers of oppression or marginalisation (see Turner – Chapter 2.1, this volume).

WHY IS CLARITY OF LANGUAGE IMPORTANT?

'Clarity of language supports clarity of understanding' (Walker, 2021: 31). Nevertheless, neurodiversity discourse is frequently misused and misunderstood, resulting in ND people being 'othered' by their NT peers. The image in Figure 2.6.1, explaining divergent, diverse and typical using shapes, is reproduced with the permission of Sonny Hallet, and communicates the nuances of neurodivergence so clearly.

NEURODIVERGENT MINDS – DIFFERENT NEUROTYPES

There is enormous variation in the way individuals experience and understand their ND; in the same way, there is considerable variation in the way individuals experience and understand their neurotypicality. For example:

- Some ND people will have received a formal neurodevelopmental diagnosis in childhood.
- Others go through life unaware that they are ND; some only realise after their child is diagnosed with a neurodevelopmental condition.
- Despite always knowing they have a neurogenetic condition, others, like myself, never (or take a long time to) connect the dots to realise they are ND.
- Some will recognise that they are ND without ever receiving a formal diagnosis from a professional.

All are valid.

ND people are a neurological minority or 'neurominority', whose processing and presentation diverge from the NT majority. ND people are disadvantaged across various life outcomes, including education, employment, relationships and health care (Doyle and McDowell, 2021), due to the fact that societal structures are largely designed by and for the needs of the NT, for example, hot-desking at work, artificial lighting at school or in the office, limited access to quiet space, assuming you need to sit still and give eye contact to be concentrating or listening, etc. Further, the recent emergence of Radulski's 'Critical Neuro Theory', which combines the concept of neurodiversity with critical disability approaches (including the Human Rights Model of disability) and Minority Group Model of Neurodiversity

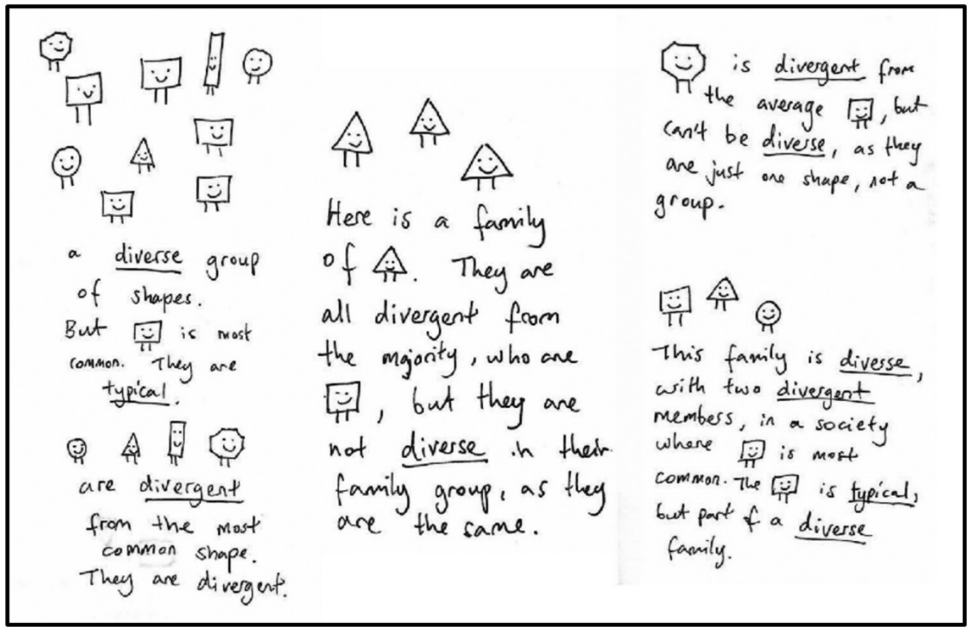

Figure 2.6.1 Divergent, diverse and typical

(Radulski, 2022), will play pivotal role in shifting the neurodiversity paradigm in the counselling profession.

An organismic psychological perspective is particularly helpful. When we permit ourselves to acknowledge the existence of a multiplicity of neurotypes and neurocognitive functioning in society (Goodley, 2016), we change our perspective to view neurodiversity through a similar lens to the one we use to make sense of flora and fauna in the context of biodiversity. Wynter (2003) refers to the 'archipelago of Human Otherness': just as a plant's ability to thrive is dependent on environmental conditions, the conditions which facilitate an individual to thrive (or actualise) will also vary considerably. Taking such an organismic perspective allows us to consider the equal importance of both homonomy and autonomy (Angyal, 1941; Tudor and Worrall, 2006) for ND trainees, therapists and clients, and the opportunity to view counselling and psychotherapy through a different lens.

COUNSELLOR CORE TRAINING AND CONTINUING PROFESSIONAL DEVELOPMENT

It is likely that your counselling training was 'normative' and did not cover neurodivergence, or perhaps it was covered in a tokenistic way, from a NT perspective, highlighting 'deficits' and emphasising the 'challenges' when working with ND people. The tutor team were probably all NT, and the training designed around NT norms and a 'right' 'way of being'. It is likely that neurodivergent trainees were on the receiving end of microaggressions, including being told they would not be good counsellors because of their idiosyncrasies, and perhaps experienced minority stress as a result (Meyer, 2003). Trainees who feel misunderstood by both tutors and peers may withdraw from training before qualifying.

Historically, continuing professional development (CPD) for working with ND clients (particularly Autistic clients) has emphasised the 'complexity' of such work. Understandably, some therapists may be reluctant to work with a ND person, feeling they lack competency (Raffensperger, 2009). If you are in the position of looking for CPD in this area, I would encourage you to do the following:

- Check whether ND trainers are delivering CPD on neurodiversity and counselling ND clients.
- Be wary of training that represents ND people as 'complex' (we are not).
- Be open to the fact that you may need to suspend NT viewpoints to enter the world of a ND client.

UNIVERSAL DESIGN WILL LEAD TO INCLUSIVE PRACTICE

The following section, informed by the lived experiences of ND therapists and clients, applies to all clients – ND or NT – and may alleviate some anxiety, while challenging therapy's 'neuro-normativity' (Huijg, 2020).

> We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know. (Rogers, 1980: 116)

When therapists are facilitative in 'acceptantly understanding the inner world of the other' (Rogers, 1977, cited in Kirschenbaum and Henderson, 1989: 382), the rest should fall into place. However, ND clients often report the opposite, with therapists invalidating minimising, misunderstanding, misrepresenting or denying their experience (Moors, 2022). Remember, the client ***is*** the expert on their own experience, regardless of whether they are NT or ND.

Common experiences of ND people include the following:

- Negative experiences of education (primary, secondary, FE or HE).
- Teachers or lecturers not appreciating their view on the world.
- Frequently feeling misunderstood.
- Difficulty fitting in with NT peers.
- Struggle with implicit social cues, especially when others use ambiguous language and either do not say what they mean or do not mean what they say.
- Processing/understanding information styles that differ from that of NT people.
- May have learned to people-please (or appease NT people to their own detriment).
- Plain speaking, which can come across as rude or abrupt by NT people.
- Sensory Perceptual Differences, which can appear to NT people as them 'over-reacting' to situations.
- Experiencing the emotions of others as if they are their own (echoemotica).
- Excessive neuronal activity leads to information overload and possible 'shut down', sometimes referred to as 'Intense World Syndrome'.
- Alexithymia (not being able to identify emotions experienced).
- Highly creative.
- Either appear to be a rule follower because conforming to rules reduces anxiety; or alternatively challenge the injustices of a NT status quo and are therefore less likely to conform.
- Passionate about social justice.
- Good at solving problems due to the ability of seeing patterns.
- The terms 'masking' and 'camouflaging' are often used interchangeably. However, they are, in fact, two distinct concepts focusing on internal and external processes (Radulski, 2022):
    - Masking refers being aware of your *internal* neurodivergent traits and concealing them.
    - Camouflaging refers to the way ND people attempt to adopt the NT norms.
- Having their way of being invalidated.
- Most people (both ND and NT) 'stim'. However, it is more frequent in the ND population and is unlikely to be conceptualised as stimming in the NT population.

To stim is to engage in any action that falls outside the boundaries of the social performance of normativity, and that provides some form of sensory stimulation in order to facilitate, intentionally or otherwise, some particular cognitive or sensorimotor process, or access to some particular state or capacity of consciousness or sensorimotor experience. (Walker, 2021: 102)

- Stimming can include (but this list is not exhaustive):
    - Bouncing your leg
    - Biting nails
    - Twirling hair
    - Clicking pens
    - Cracking knuckles
    - Whistling
    - Flapping hands
    - Rocking
    - Walking on tip toes
    - Twisting on an office chair
    - Repeating words or phrases of others (echolalia) or self-generated sounds (palilalia).

CONCLUSION

We can never know with certainty the neurotype of a new client, even if they have received a formal diagnosis (and does that even matter?). However, being

responsive to all clients and their processing styles can make a considerable difference in clients feeling heard and understood. The following list is not prescriptive, but could be a useful starting point:

In your practice, consider:

- Adding details about you and the way you practise to your website using clean, unambiguous language. An up-to-date profile picture is essential.
- Let clients know that there is no expectation for eye contact and ask if they have a preferred way to be in the room. The view that eye contact conveys 'availability for psychological contact' (Stafford and Bond, 2020: 30) is an ableist misnomer.
- Adapting the pace of your speech depending on the individual client (my own internal metronome pace is 'andante', i.e., moderately slow).
- Speaking in short sentences rather than long monologues or leaving pauses between sentences to allow clients to process information.
- Adjusting the environment of the therapy space:
    - Can the lighting be dimmed?
    - Can the client access sunglasses or similar?
    - Does the therapy room have blinds or similar (to reduce distractions from outside)?
    - Are your clocks 'silent'? (Many clients are distracted by ticking clocks.)
    - Could outside noises interfere with sessions? (Many ND people experience gestalt auditory processing and have difficulty filtering relevant speech if the environment outside the therapy room is noisy.)
    - Do you have sensory items available to enable clients to 'stim'?
    - Do you have a blanket or throw for your clients if they need it (weighted or otherwise)?
    - Is there space in the room if a client needs to stand up, stretch or pace?
    - Minimise strong fragrances.
    - Is your therapy room close to a toilet? A potential combination of noise and smell may be distracting.

Most, if not all, clients thrive when there is consistency for their therapy, e.g., the room, the day, the time, their therapist, etc. After all, predictability can help to reduce anxiety.

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RECOMMENDED READING

Association of Neurodivergent Therapists (ANDT), https://neurodivergenttherapists.com/ (established in 2021, ANDT is a group for ND therapists).

Although based in the UK, ANDT has a global reach. They organise monthly informal support for fellow ND therapists and trainees, facilitate structured discussions and organise training events.

Stark, E., Ali, D., Ayre, A., Schneider, N., Parveen, S., Marais, K., Holmes, N. and Pender, R. (2021) *Psychological Therapy for Autistic Adults* [online]. Oxford: Authentistic Research Collective. Available at https://www.authentistic.uk/ (retrieved 24 February 2021).

This is an exceptionally useful resource, written from lived experience. It contains a wealth of important information to consider when working therapeutically with neurodivergent people.

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Nick describes herself as a queer, transgender, flamingly autistic author and educator. Her work is challenging, informative and, as ND person, I find her writing deeply affirmative.