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# Neurodiversity affirming practice: The next frontier in culturally responsive practice?

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# Acknowledgement of Country

We acknowledge the unceded sovereignty of the Wiradyuri people, who are the traditional custodians of the unceded lands on which we live and work.

We acknowledge the traditional custodians of the lands on which we meet today and the traditional custodians of the lands from which you all have travelled.

We acknowledge the unbroken survival of 2000 generations of knowledge, traditions and culture.

We extend this acknowledgment to oppressed, displaced and dispossessed Indigenous people around the world

We pay respect to their Elders past and present.

**Lu**
**Autism, Anxiety, ARFID, Endometriosis, PMDD, Cleft lip and palate and Hearing impairment**

**Sarah**
**AuDHD, CFS/ME, ARFID, Autoimmune Disorders**

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# What is cultural responsiveness?

## What it is

- An understanding of, and respect for, cultural and linguistic differences among individuals
- Knowing how to respond in a culturally sensitive and appropriate manner when working with children and families

## What it is not

- Comprehensive knowledge of every culture and language in the world
- An endpoint – it is an ongoing journey

# What is cultural responsiveness?

"A culturally responsive professional is not someone who has achieved a state of competency but rather is someone who continually working towards competency through:

(1) Awareness of their own culture and how it impacts upon their thoughts, actions and interpretation of the world;

(2) A willingness to actively listen and learn about the cultures, perspectives and experiences of others and to adapt their practice accordingly;

(3) Acknowledgment that they don't know what they don't know; and

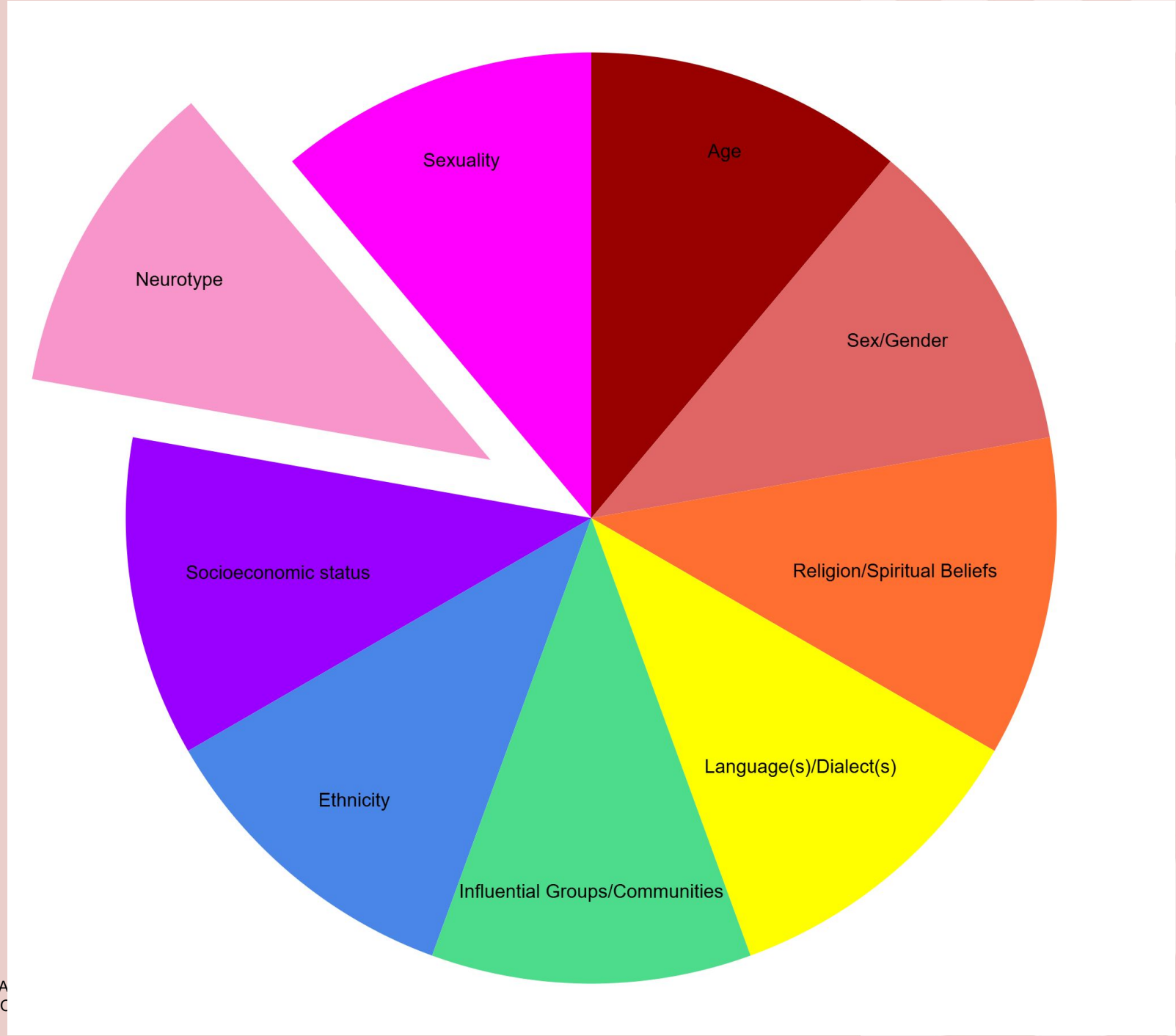
(4) An ongoing process of learning, questioning and re- evaluating their world view."

Verdon 2020

# So how does neurodiversity affirming practice relate to culturally responsive practice?

Because we are no longer viewing neurodiversity from a deficit lens, but rather we are seeing it as a form of diversity, in the same way that a person's language, gender, age and beliefs combine to form their identity, so too does the way their brain is wired

# What is culture?



# EBP4

# What is neurodiversity?

- The range of differences in individual brain function and behavioural traits, regarded as part of normal variation in the human population
- Yet the neurodiversity framework distinguishes between two main types;
  ***Neurotypical*** refers to an individual whose brain and cognitive development falls w
  the typical range.
  ***Neurodivergent*** refers to an individual whose brain and cognitive development falls outside (or 'diverges' from) the typical range (Goldberg, 2023)

- Despite the neurodiversity movement striving to move aware from a deficit approach, we still end up with binary categories of "normal" vs "non normal" brains with these 2 terms, albeit unintentionally
- Types of neurodiversity include – autism, ADHD, dyslexia, dyscalculia, dysgraphia, and Tourette's syndrome.



A must read! Goldberg, H. (2023). Unraveling neurodiversity: Insights from neuroscientific perspectives. Encyclopedia, 3(3), 972-980.

# Neurodiversity affirming practice

- A strengths-based approach that view types of neurodiversity such as Autism as a form of diversity rather than a disability.
- Neurodiversity-affirming practice acknowledges that autism, attention deficit/hyperactivity disorder (ADHD), dyslexia, Tourette's syndrome (TS), dyspraxia, dyslexia, dysgraphia, dyscalculia etc. aren't problems to be cured or fixed, but individual neurotypes with unique strengths, needs, and challenges.
- The neurodiversity movement is a shift away from the idea that brains that are not "typical" are "disordered."


From @reframingautism on Instagram

# Different forms of neurodiversity often co-occur!

e.g.,

- AuDHD = A brain in constant battle and opposition with itself!
  - 50-70% of autistic people also have ADHD
- Many autistic people are dyslexic or hyperlexic
- Non-speaking autism can be associated with dyspraxia (i.e., CAS)
- Tourette's syndrome can present as repetitive/stimming movements in autism

Cabral, C., & Fernandes, F. (2021). Correlations between autism spectrum disorders and childhood apraxia of speech. *European Psychiatry*, *64*(S1), S209-S209.
Moore, J., Boyle, J., & Namasivayam, A. K. (2024). Neurodiversity-affirming motor speech intervention for autistic individuals with co-existing childhood apraxia of speech: a tutorial. *Int. J. Autism Relat. Disabil.*, *7*, 168.

# Language matters: Using neurodiversity affirming language

Neurodiversity: describes the variety of ways people think, learn, and behave

Neurodivergence: refers to people whose brains process information differently from neurotypicals - the threshold of what classifies “divergence” is difficult to define

## Some affirming label alternatives:

- Autism Spectrum Disorder vs Autism/Autistic
- Attention Deficit Hyperactivity Disorder vs Attention Dysregulation, Hyperfocus Driven
- Pathological Demand Avoidance vs Pervasive Desire for Autonomy
- Sensory Processing Disorder vs Sensory preferences
- Auditory Processing Disorder vs Auditory Processing Differences

## Helpful readings:

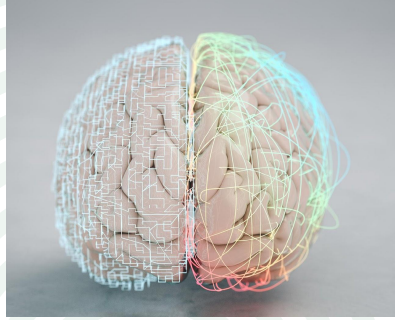
Dwyer, P., Williams, Z. J., Lawson, W. B., & Rivera, S. M. (2024). A trans-diagnostic investigation of attention, hyper-focus, and monotropism in autism, attention dysregulation hyperactivity development, and the general population. *Neurodiversity*, *2*. 10.1177/27546330241237883

Bottema-Beutel, K., Kapp, S. K., Lester, J. N., Sasson, N. J., & Hand, B. N. (2021). Avoiding ableist language: Suggestions for autism researchers. *Autism in Adulthood*. *3*, 1. 10.1089/aut.2020.001418

# What do we know about neurodivergence?

1. Mainly stems from biological and genetic factors
2. It’s hereditary
3. It's no one’s fault
4. It can't be “cured”
5. It doesn’t need to be cured – just understood
6. It can present very similarly to trauma (and frequently co-occurs)

# The neuroscience of neurodiversity: An evolutionary perspective?

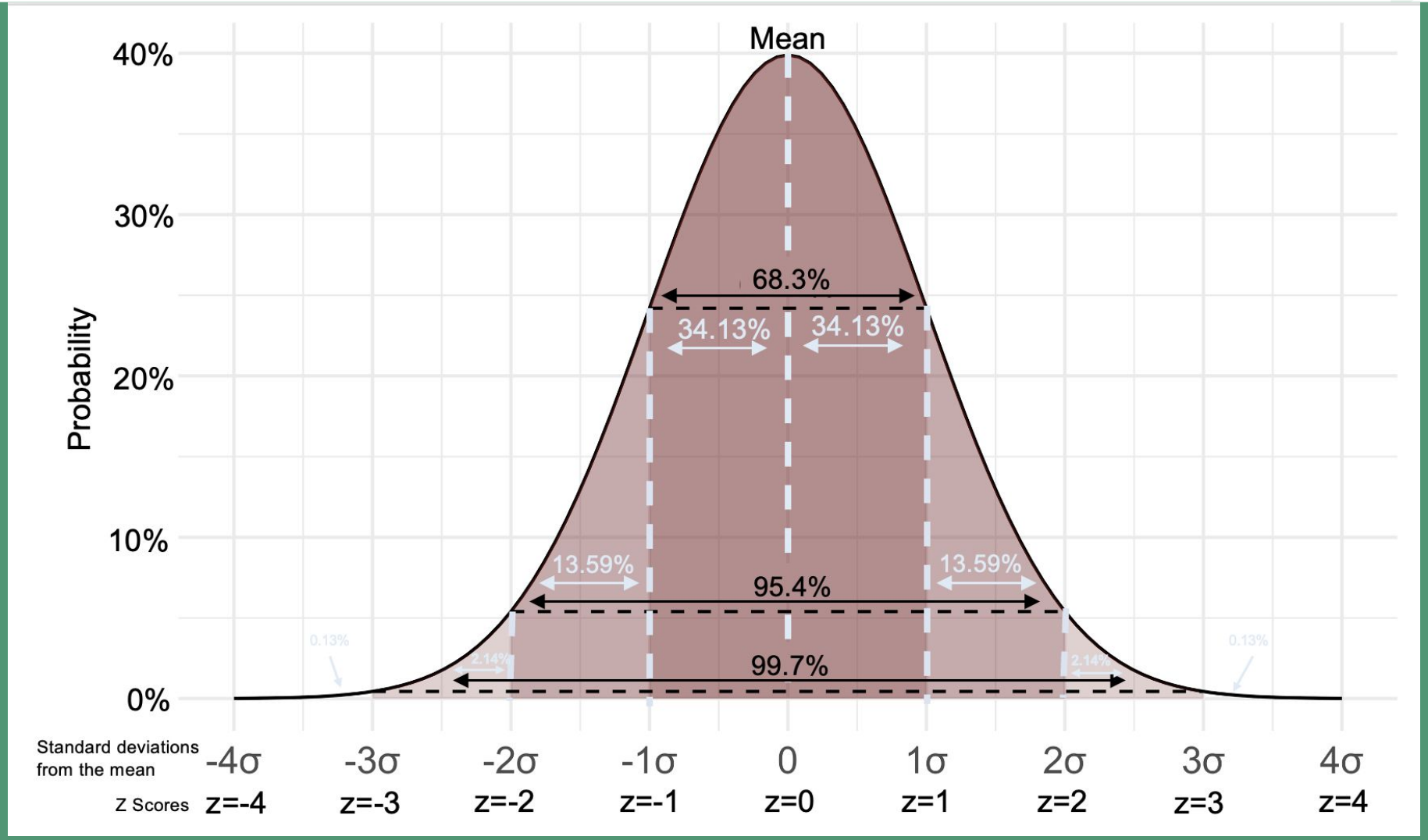


Neurodiversity is attributed to both nature and nurture factors

We know that environment (nurture) can affect genes (nature), so these two causes are intertwined.

- Variability (neurodiversity) is correlated to evolutionary cortical expansion.
- The highest variability was found in frontal, temporal, and parietal association cortex areas - late-developing regions which are essential to complex, human-specific cognitive functions like reasoning, attention control, and language.
- This finding suggests that neurodiversity reflects human individualization; brain systems that facilitate high-order survival functions (such as self-reflection, social processing, and complex decision-making)
- It's not as rare as we think

# Let’s think about “normal distribution” in relation to neurodivergence




*About a fifth of the human population is considered neurodivergent*
(Goldberg, 2023)

# SOME EXAMPLE SCORING PATTERNS AND WHAT THEY MIGHT MEAN

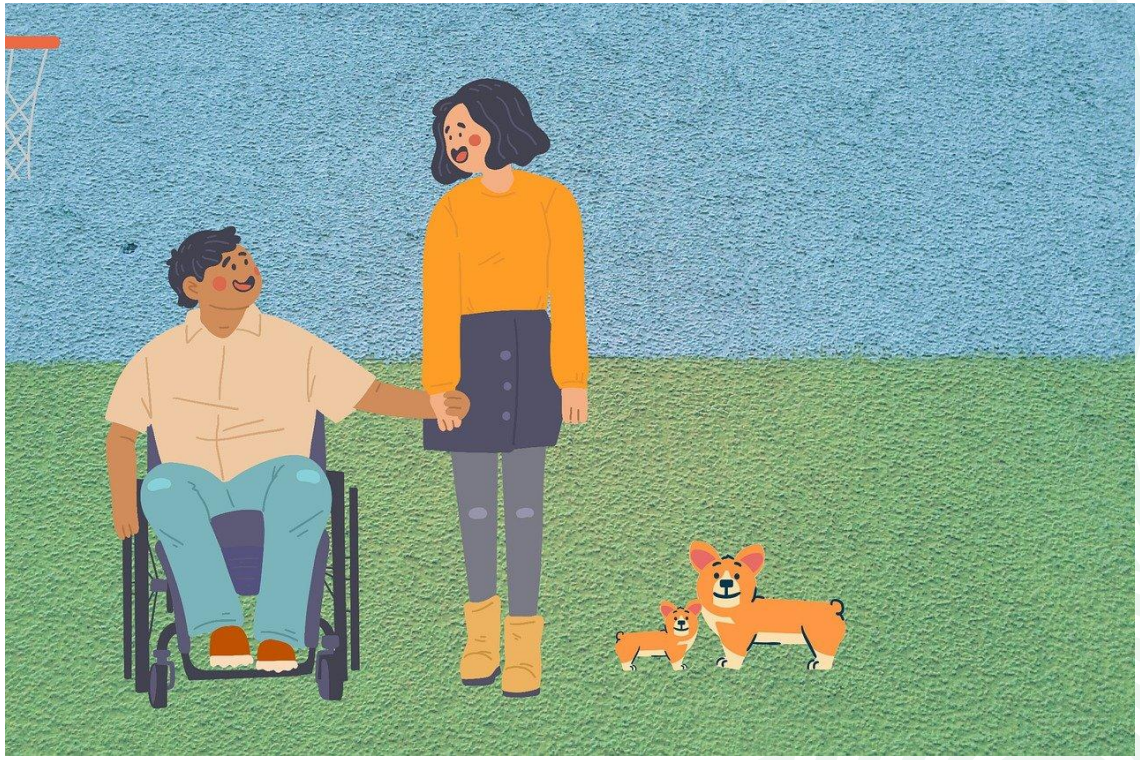
| *Receptive language score* | *Expressive language score* | *Core language score* | *Pragmatics profile* | *Hypothesis* |
|---|---|---|---|---|
| Average | Average | Average | Average | Typically developing |
| Borderline/at risk | Low to very low | Low to very low | Typical | DLD |
| Low to very low | Low to very low | Low to very low | Typical | DLD |
| Low to very low | Average | Average | Atypical | ASD |
| Above Average | Average | Average | Atypical | ASD |
| | | | | |

# *So is it actually a disability?*

It depends who you ask,
and how they define disability…

- Level 1 and 2 autistics often have more capacity to share their experiences, which can lead to bias in what is known about the lived experience
- It depends on co-occurring conditions
- It depends on the accommodations available
- Beware the toxic positivity! Sometimes it's great, sometimes it's really hard, both can be true
- Social vs medical model of disability

(either way it still deserves funding!)



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# So how do we break through all the myths surrounding neurodiversity?

# Neurodiversity has been misunderstood for a long time: Where do these myths come from?

- Outdated stereotypes
- Misrepresentation/narrow representation in media
- Gender bias in research – male presentation is most commonly depicted, female traits of neurodiversity are less understood
- Research conducted by neurotypical researchers/without consultation with neurodiverse community has led to false assumptions and beliefs and unhelpful practices

**Source:** https://reacho.in/discover/young-sheldon-trailer-the-big-bang-theory-spin-off

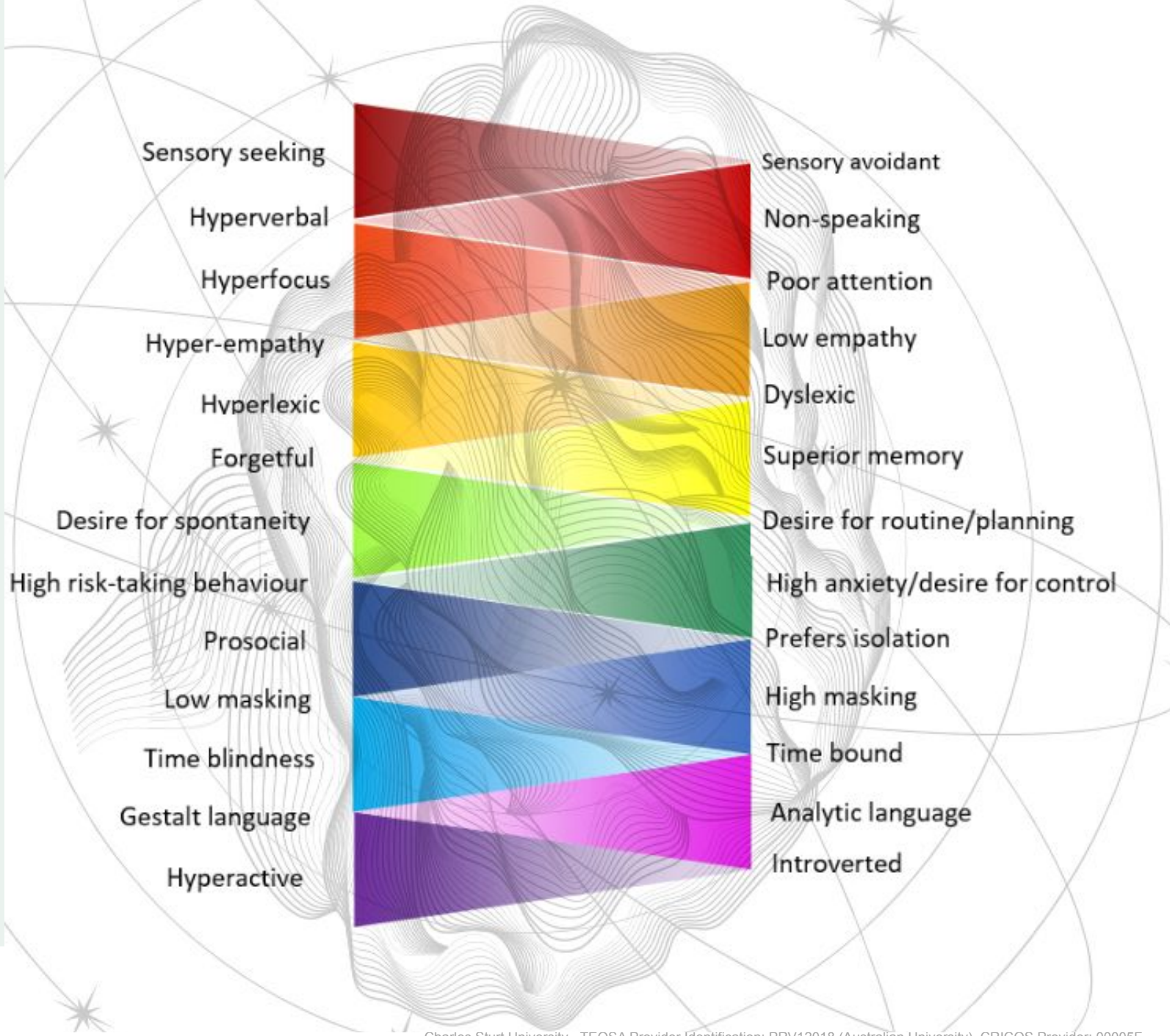
# Myths about neurodivergence

## Myth 1: All autistic people have the same traits
## Myth 2: Neurodivergent Individuals Lack Empathy
## Myth 3: Neurodiversity Is a Problem to Be Fixed
## Myth 4: Neurodiversity is new
## Myth 5: Dyslexia Equals Low Intelligence
## Myth 6: Neurodiversity Is Rare

See Sarah's TedX talk for more: https://www.youtube.com/watch?v=zxOFXiwmpsE

# Features of Neurodiversity

# The spectrum of neurodiversity

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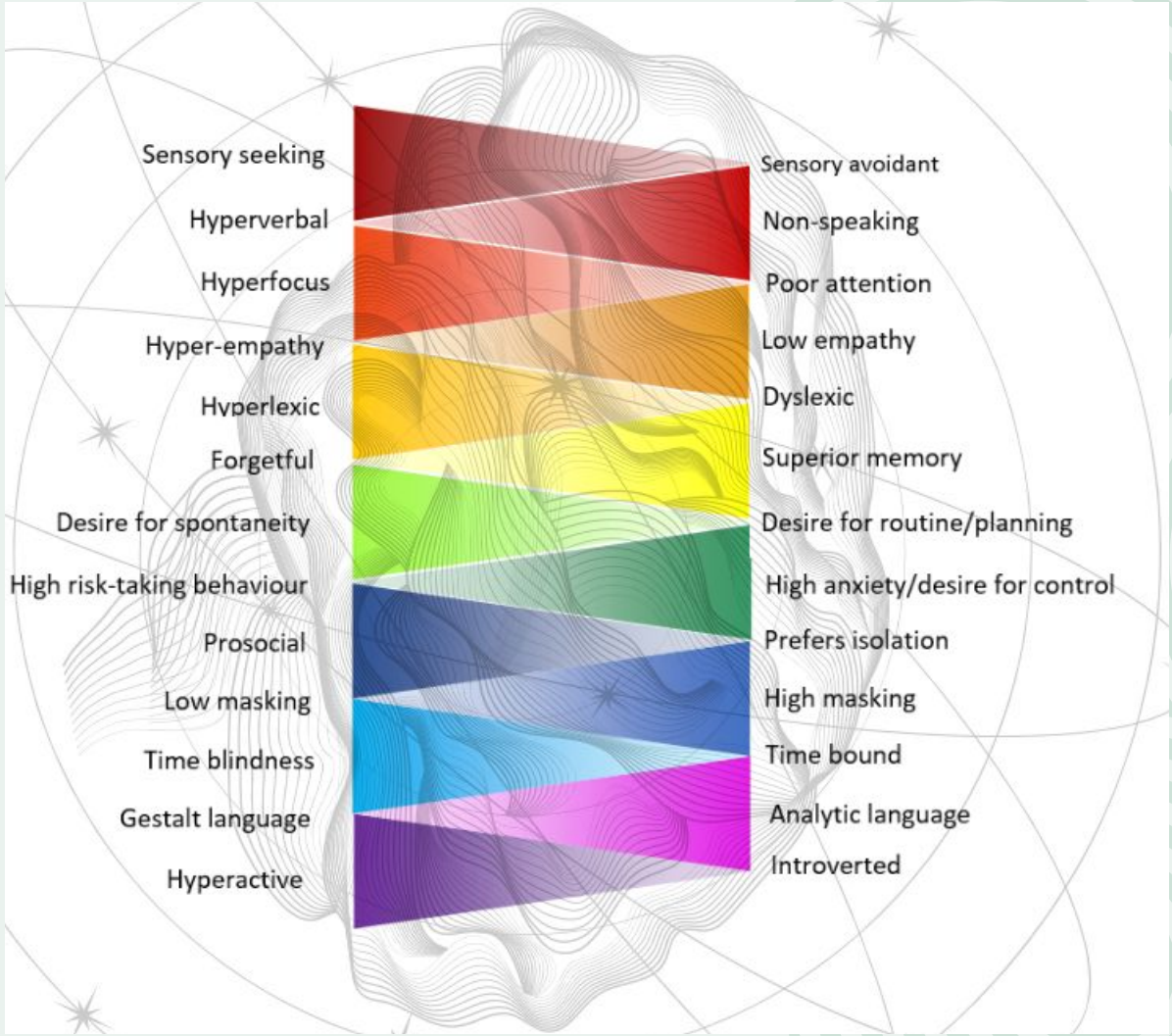
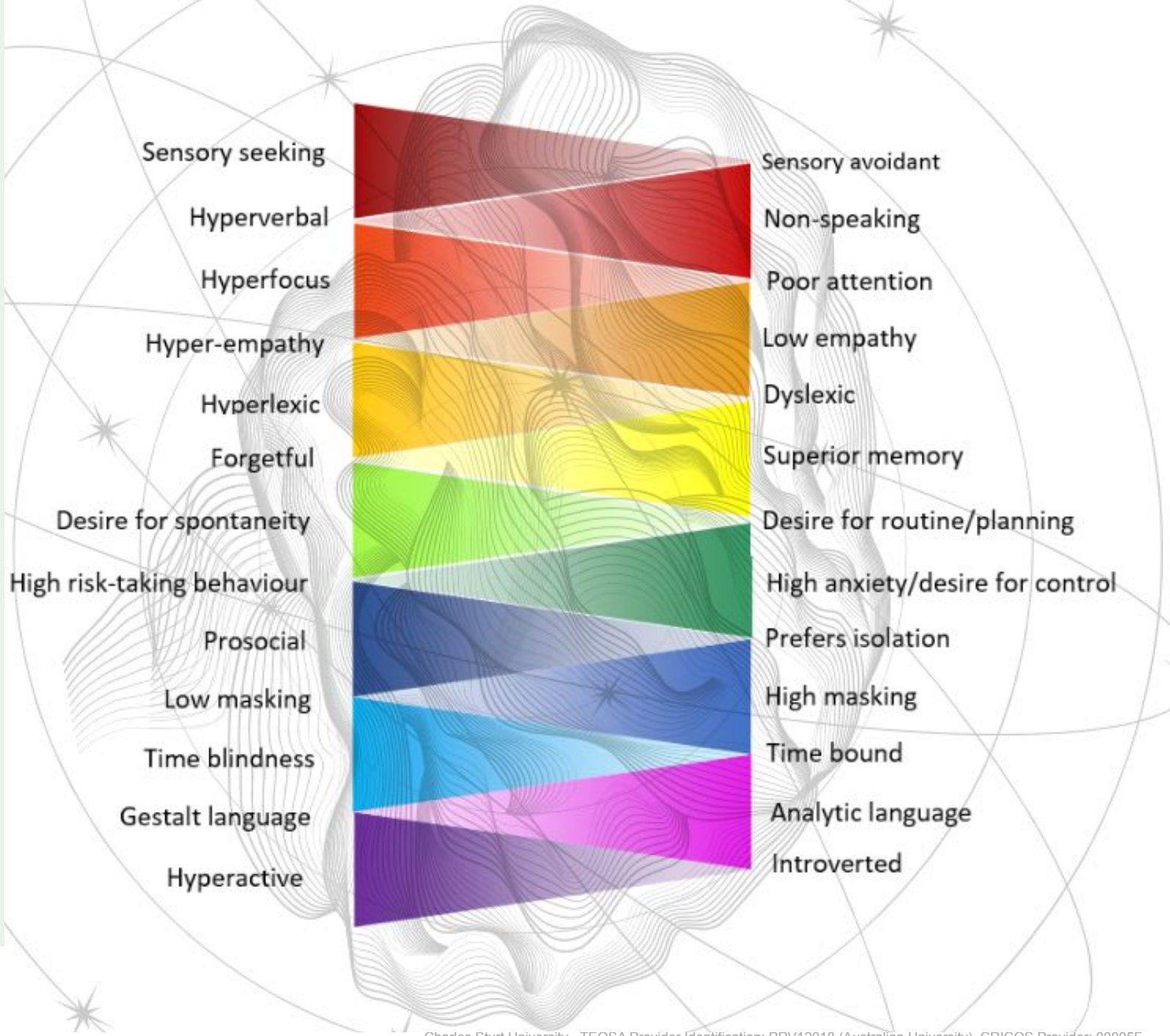
# Features of neurodiversity

- Each of these features are typical aspects of human functioning.
- The differences between people represents the full spectrum of human neurodiversity.
- Neurodivergence occurs when there is a pattern of features that occur of the extreme end of the spectrum of these features
- Not all features will be affected in all neurodivergent people
- Every neurodivergent brain is unique



# Activity: Let's map your brain!

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# Sensory needs

Neurodivergent people experience sensory information differently they may perceive too much (leading to sensory avoidance) or too little (leading to sensory seeking)

These sensory preferences and behaviours are designed to regulate the nervous system of a neurodivergent person

Preferences can vary between senses

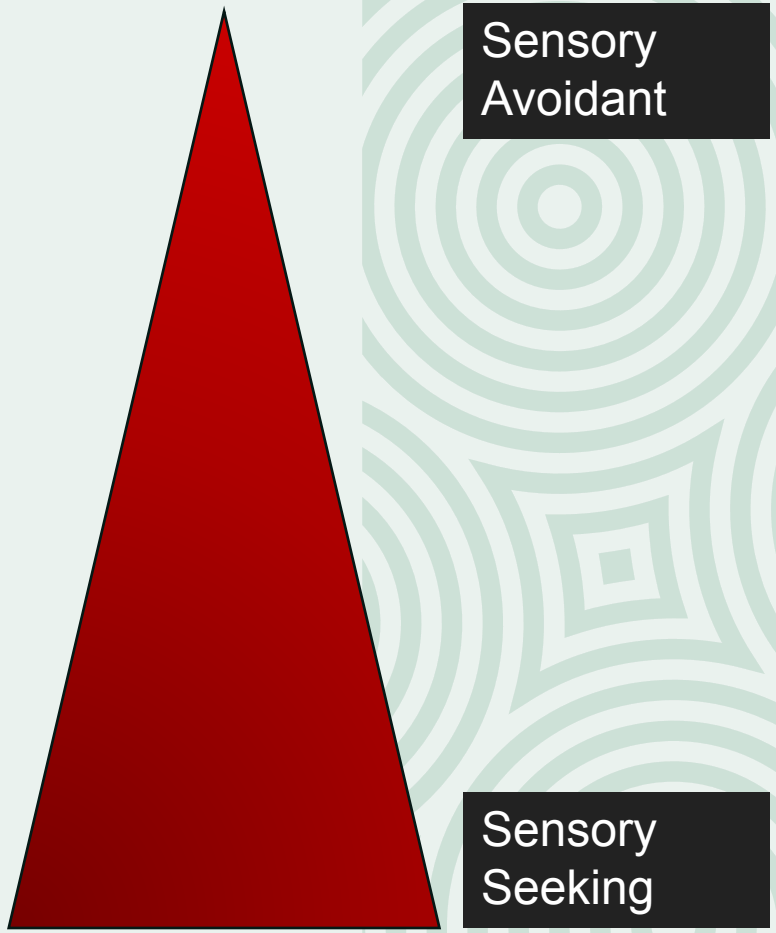
Touch – e.g., seeking deep pressure to feel calm (weighted blankets, tight hugs), excessive touching of items/people

Taste – e.g., picky eating, avoidance of certain textures/colours of food

Sight – e.g., preference for low lighting, wearing sunglasses, holding lights up to eyes

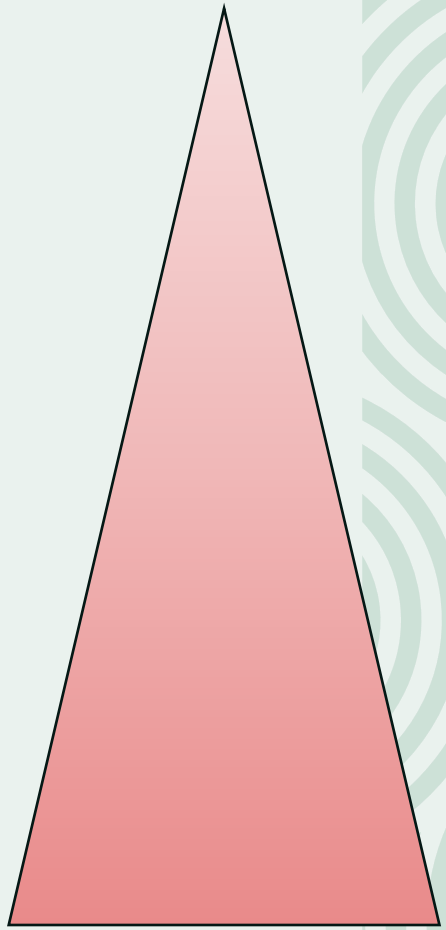
Hearing – e.g., hands over ears, wearing noise cancelling headphones

Smell – e.g., acute sense of smell, dislike of strong smells such as perfume, sniffing objects



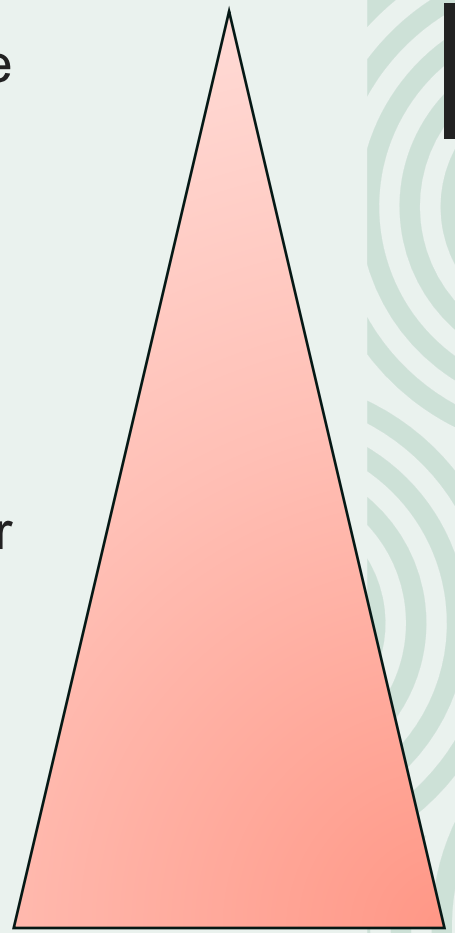
# Use of verbal speech

- Neurodivergent people vary in their use of verbal speech
- This can be context specific (i.e., situational/selective mutism)
- Non-speaking does reflect intelligence or language ability
- Non-speaking children may communicate through other forms such as AAC – sign, pictures, electronic devices
- Hyperverbal children are often missed in early diagnosis as they do not have “speech concerns”



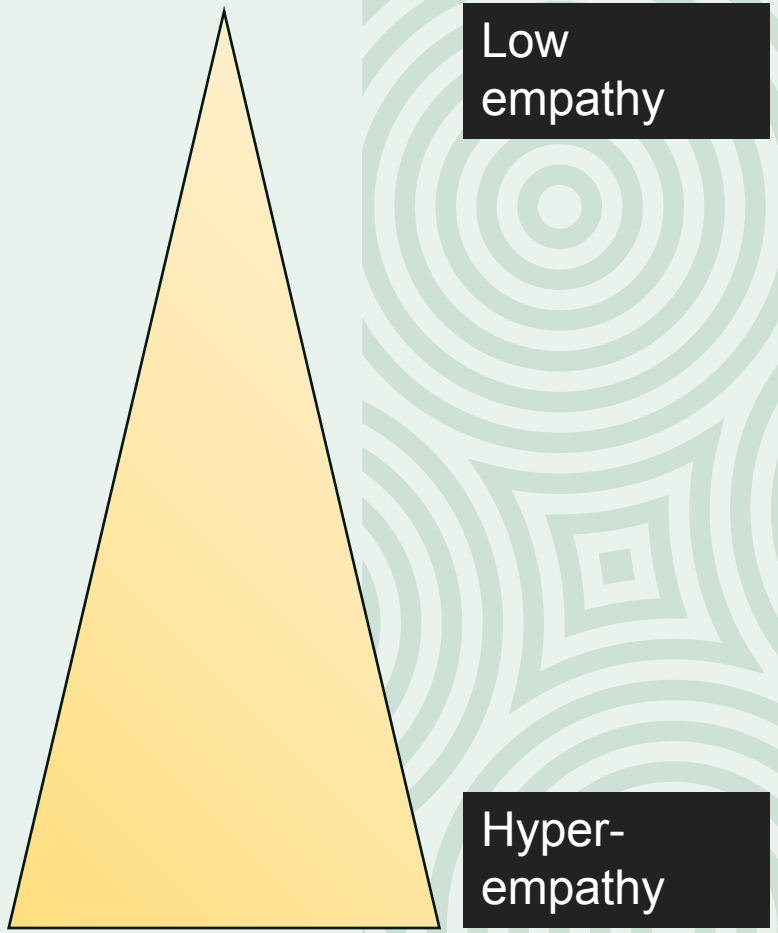
# Attention and focus

- Neurodivergent people vary in their ability to maintain and regulate their attention
- This is usually situationally dependent – i.e., the level of interest drives level of attention
- Dopamine seeking – medication can help to regulate attention
- Very common among children with ADHD, AuDHD
- When hyperfocused, attention to detail can be far superior to that of a neurotypical so the concept of “attention deficit” is a misnomer
- Hyperfocus is closely related to special interests



# Empathy and perspective taking

- Outdated stereotypes often state that Autistic people do not experience empathy.
- While some struggle with understanding other people's emotions and points of view, others are hyper aware and hypervigilant and can take on those emotions themselves.
- Some have excellent theory of mind which leads them to respond differently to neurotypical people in social interactions.
- Two main ways to categorise empathy:
  - Emotional
  - Cognitive



# Memory

## Working memory

- A type of short-term memory that lasts only seconds
- Used to hold information while performing other tasks
- A common issue in children with language disorders
- A common challenge for people with ADHD

## Long-term memory

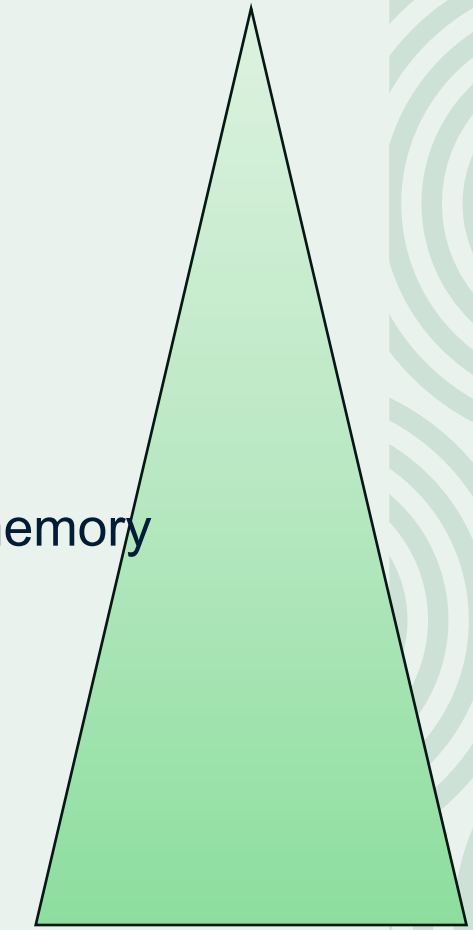
- A mostly permanent storage space for information
- Can be divided into implicit (unconscious) and explicit (conscious) memory

### Implicit memory

- Unconscious memories that help with everyday tasks
- Examples include procedural memory, priming, and conditioning
- For example, riding a boke or driving a car

### Explicit memory

- Conscious memories that can be recalled
- Examples include episodic memory
- Autistics often have excellent recall of facts, events and details especially hyperfixations

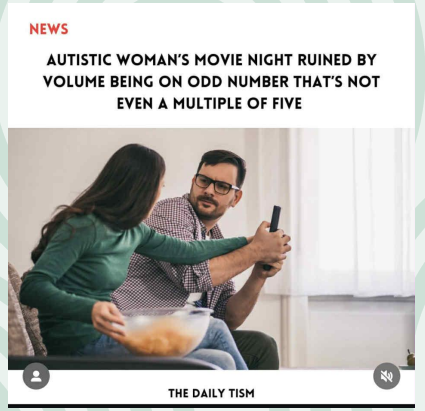


# Routine, rigidity and flexibility

Autistics – often prefer predictability and rigid adherence to routine, can thrive in a well structures, clearly routine environment

ADHDer – Need novelty and spontaneity to maintain interest and focus

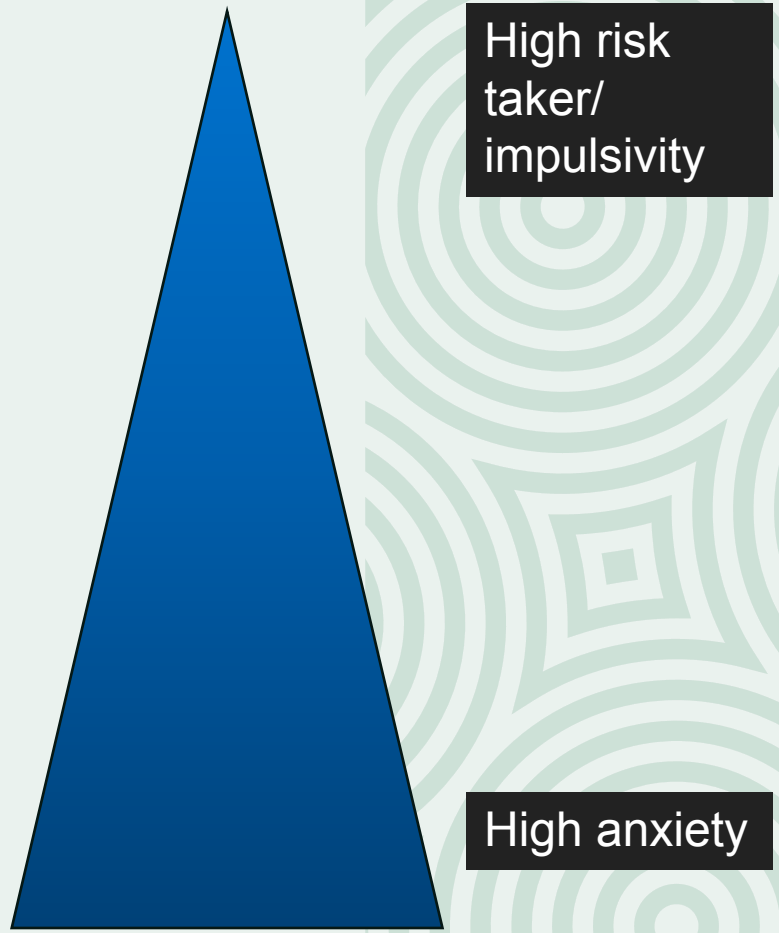
AuDHD – oscillate between the 2 extremes to stay regulated

# Risk taking and avoidance

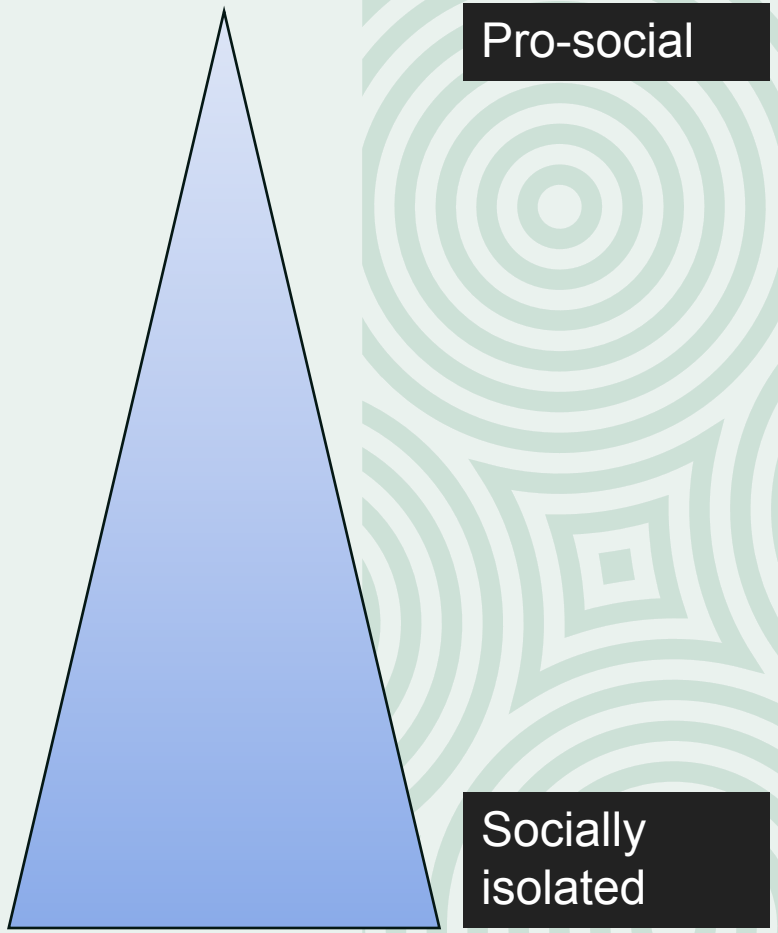
Autism – often high anxiety, particularly around new tasks, fear of failure and fear of making a mistake (can lead to perfectionism)

ADHD – Can be very impulsive, not think through risks and consequences before acting, always seeking adventure and novelty which could at times be risky



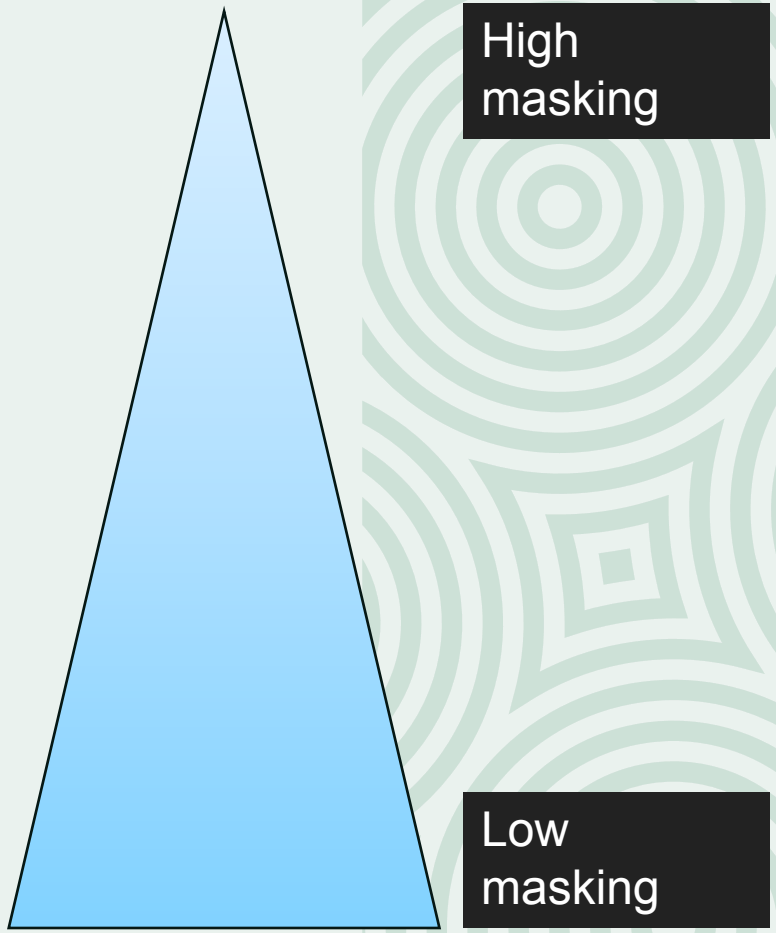
# Desire for social interaction

- A huge myth is that neurodivergent people do not want or seek social interactions or relationships
- Often this are highly desired but difficult to initiate and maintain
- Often seek or prefer solitude because of overstimulation, social anxiety or difficulties with emotional regulation, rather than a lack of interest in other people



# Masking

- Masking = hiding features of neurodivergent in order to fit in with society
- High masking neurodivergents are often later diagnosed and can be highly affected by mental health issues
- Often experience meltdowns or burnout at the end of the day from having to mask all day
- A very common feature in autistic girls, who are often excellent at observations and pattern recognition so can mimic expected social behaviours but find them extremely taxing

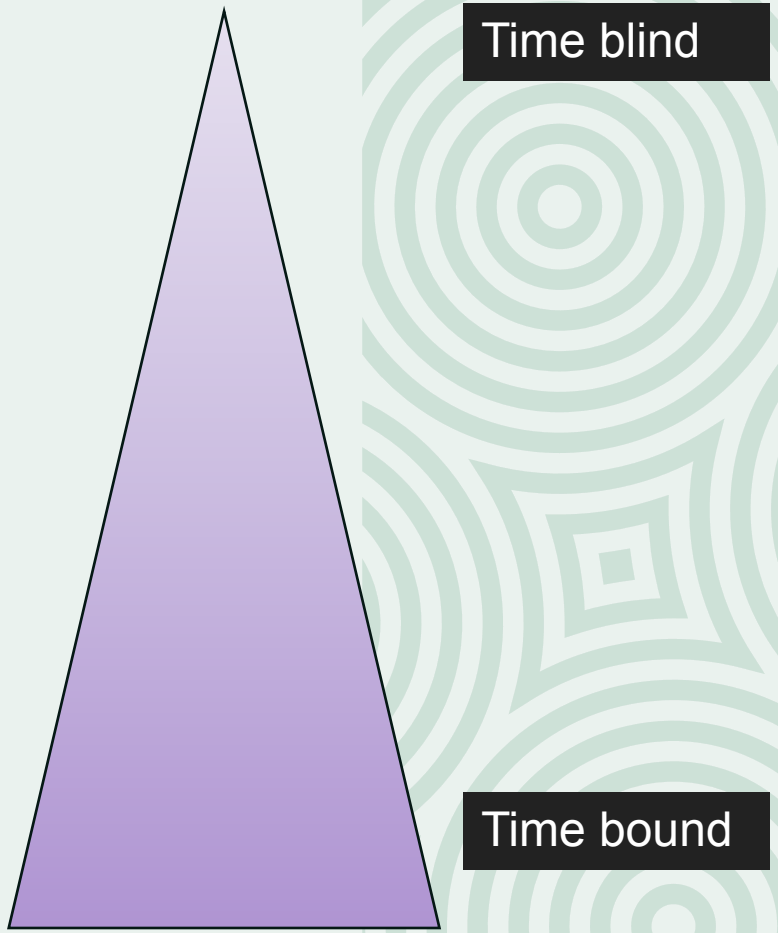


# Relationship with time

Autistics – often very time bound, expect things to run on time

ADHDers – often have difficulties perceiving how much time a task will take and will run late because of their difficulties conceptualising time

AuDHDers – try really hard to be on time and get stressed about being late but are late anyway due to time blindness

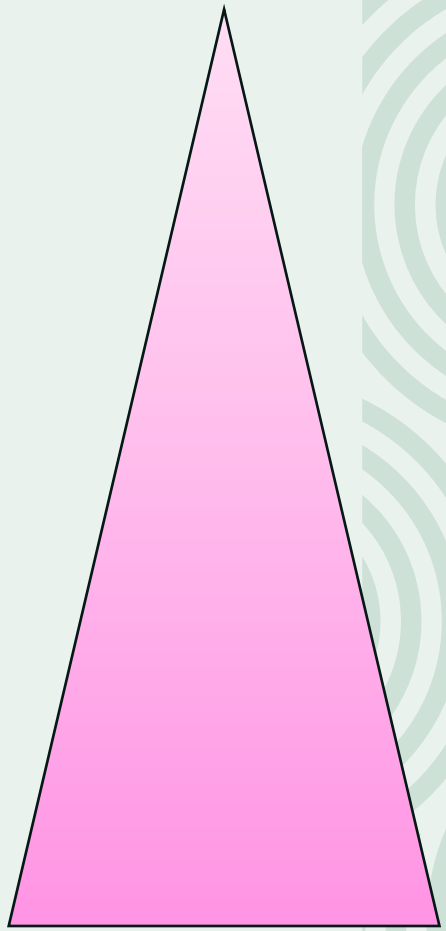


# Interoception

Level of awareness around:

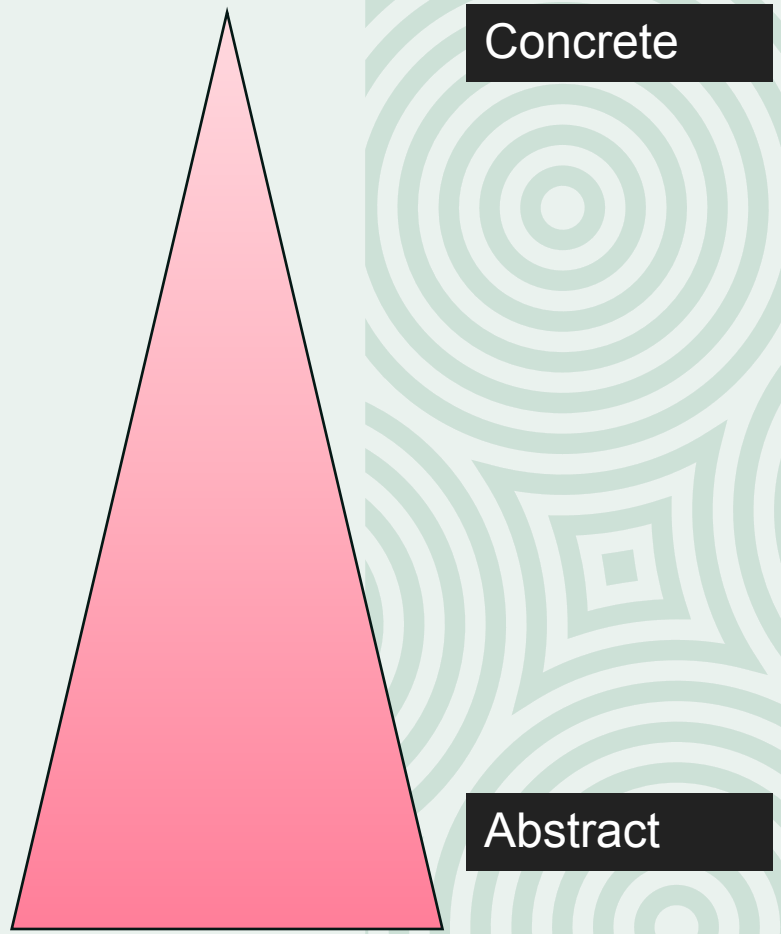
- Temperature
- Pain
- Emotions
- Hunger
- Toileting

Interoception is linked to emotion regulation and mental and physical health. People with high interoception are better able to feel their bodily states and regulate their emotions.



# Language development

- Top down (echolalic) vs bottom up language acquisition (more neurotypical)
- Gestalt vs. Analytic language processing
- Literal interpretations
- Understanding abstract concepts
- Understanding idioms, sarcasm, jokes etc.



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# Reflection: 5 minutes

- What did you discover about yourself and how your brain works?
- Did any of this resonate with your clients / people in your life?
- How can you apply this model into your future practice?

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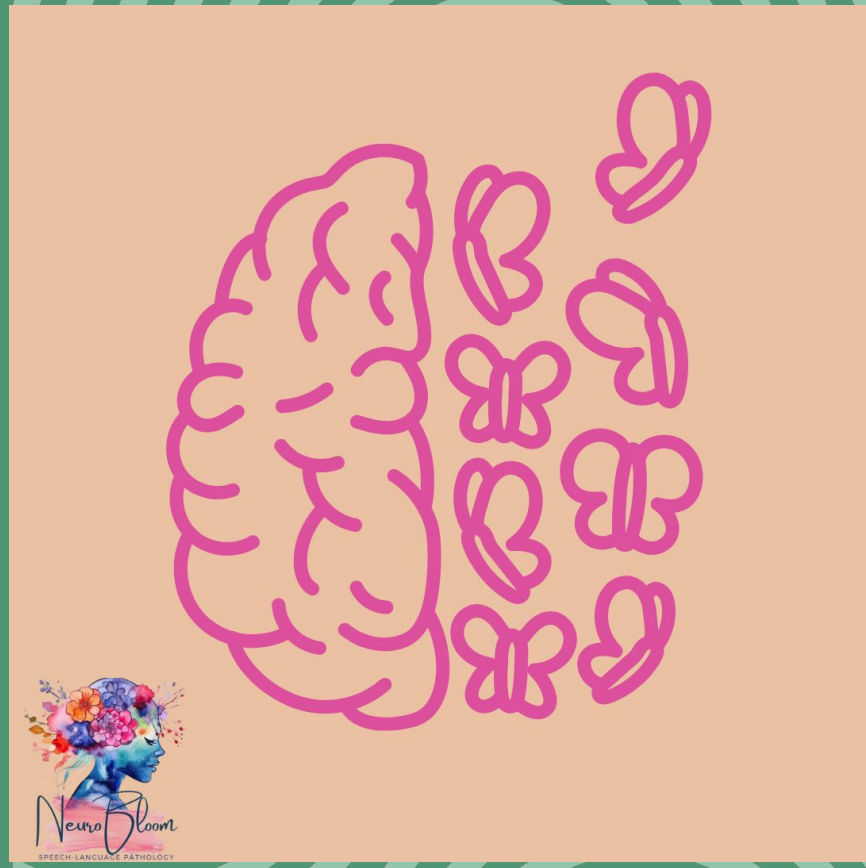
# Sensory preferences

## EXTERNAL INPUT

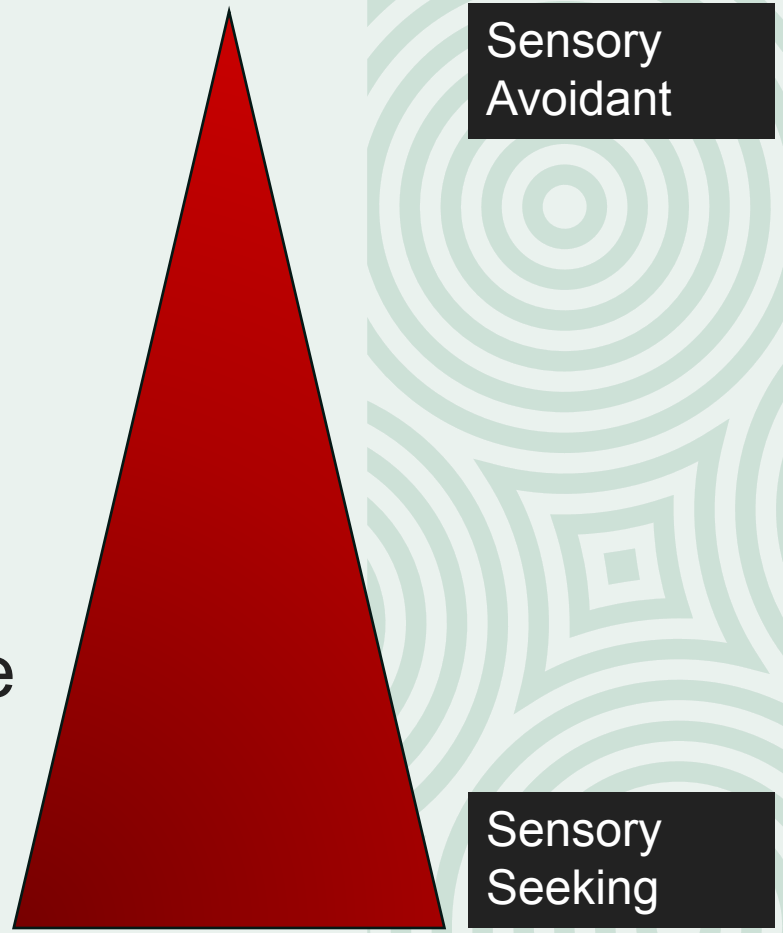


# Sensory needs and preferences

Neurodivergent people experience sensory information differently they may perceive too much (leading to sensory avoidance) or too little (leading to sensory seeking)

These sensory preferences and associated behaviours are designed to regulate the nervous system of a neurodivergent person

Preferences can vary between senses, with some being seeking and others avoidant



# Stimming

Self-stimulatory behaviour or “stimming” is repetitive behaviours often used by neurodivergent people (often unconsciously) to regulate their nervous system by balancing out an unmet sensory need.

Common examples include:

- Rocking
- Flapping
- Spinning
- Cracking joints
- Blinking
- Flicking fingers

# *Should we encourage stimming or try to prevent it?*

- Stimming has some great benefits as long as it is safe for the individual and those around them!
- Stimming can help people to feel **less anxious, more regulated, support attention and focus and feel joyful**
- Despite frequently being a positive experience, Autistic adults report purposefully suppressing stimming (“masking”), which was done almost exclusively for extrinsic reasons (e.g. to avoid judgment from others)”
- Provide options for various inputs e.g. breaks for stimming; going on a swing, jumping on trampoline, heavy work, various fidgets available
- Work with the individual to find the input or combination of inputs that work the best for them

Charlton, R. A., Entecott, T., Belova, E., & Nwaordu, G. (2021). “It feels like holding back something you need to say”: Autistic and non-autistic adults' accounts of sensory experiences and stimming. Research in Autism Spectrum Disorders, 89, 101864. https://doi.org/10.1016/j.rasd.2021.101864
Kapp, S. K., Steward, R., Crane, L., Elliott, D., Elphick, C., Pellicano, E., & Russell, G. (2019). ‘People should be allowed to do what they like’: Autistic adults’ views and experiences of stimming. *Autism*, *23*(7), 1782-1792.
Morris, I. F., Sykes, J. R., Paulus, E. R., Dameh, A., Razzaque, A., Esch, L. V., Gruenig, J., & Zelazo, P. D. (2025). Beyond self-regulation: Autistic experiences and perceptions of stimming. *Neurodiversity*, *3*

# The sense of touch/pressure/proprioceptive input

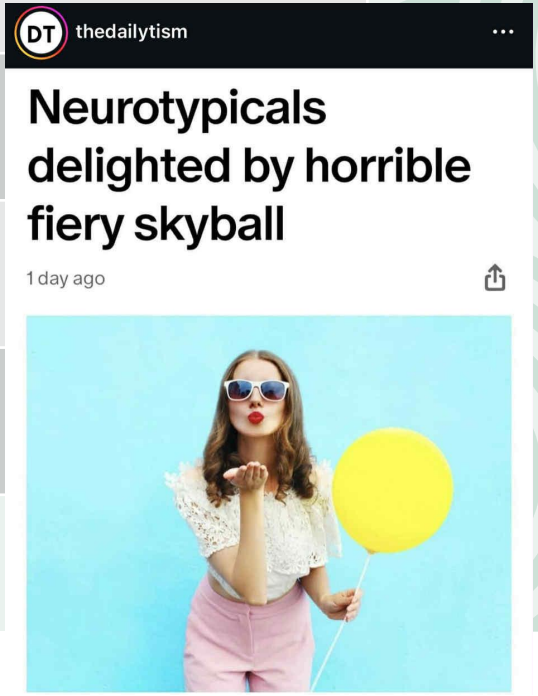
| Seeking | Avoiding |
|---|---|
| Tight hugs | Disliking hugs |
| Weighted blankets | Aversion to clothing/shoes |
| Touching / stroking  fabrics | Need to cut tags off clothing |
| Touching other people | Dislike of self care tasks such as showering and hair brushing |
| Kicking objects | Disliking seatbelt |
| Hitting others | Disliking the feeling of being wet |

# The sense of taste/oral sensory needs

| Seeking | Avoiding |
|---|---|
| Placing non-food items in mouth | Restricted diet (ARFID) |
| Chewing on clothes, collar, tie, necklace | Avoiding certain textures of food |
| Biting nails | Avoiding certain colours of food |
| Vocal stimming (making loud or repetitive noises) | Gagging when items/food enters mouth |
| Chewing on hair | Only liking a specific cup, bottle, dummy, spoon etc. |
| Chewing on pens | Disliking brushing teeth |
| Eating non-food items | |
| Licking windows | |

# The sense of sight/visual sensory needs

| Seeking | Avoiding |
|---|---|
| Staring or gazing at objects, such as ceiling fans or lights | Disliking the “big light” |
| Moving fingers in front of the eyes | Disliking sunny days/needing sunglasses |
| Repetitive blinking or turning lights on and off | Preferring warm white lights, not fluorescent |
| Eye tracking or peering from the corners of the eyes | Disliking flashing/bright lights |
| Object placement, such as lining up objects | |

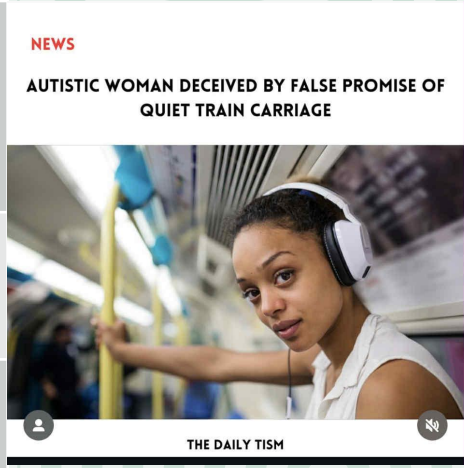


# The sense of smell

| Seeking | Avoiding |
| --- | --- |
| Sniffing objects | Disliking perfume |
| Sniffing people | Avoiding places because of the smell |
| Enjoying strong smells such as petrol and nail polish | Experiencing headaches/migraines from smells |
| Being able to smell what others can't | Refusing certain foods that have a strong smell |
| Craving specific scents | Refusing to use products such as soap that have a strong smell |

# The sense of hearing/auditory input

| Seeking | Avoiding |
|---|---|
| Listening to very loud music | Hands over ears |
| Making loud repetitive noises | Avoidant of busy/crowded places |
| Clapping, humming, tapping | Disliking group settings such as the classroom |
| Blocking ears repetitively | Preferring to wear noise cancelling earphones |
| Seeking constant background noise | Preferring to control auditory input |
| Saying the same sound or phrase over and over | |



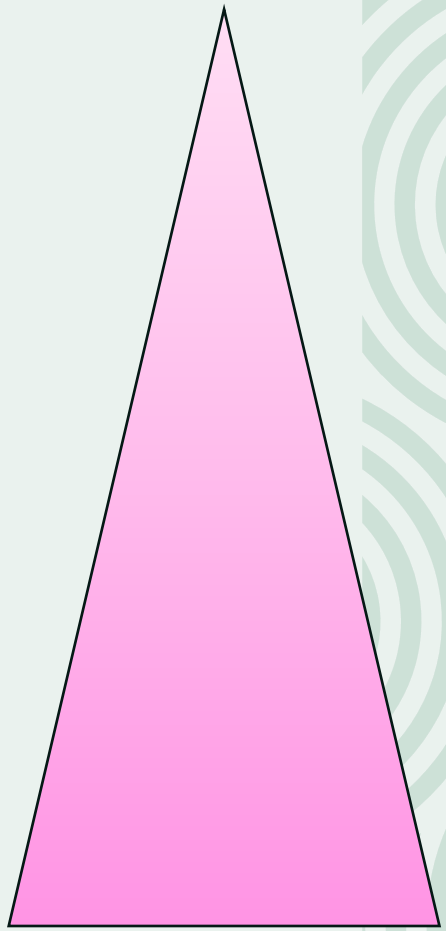
# Interoception

## Internal input

# Interoception

The body's perception of its own internal states
Level of awareness around:

- Temperature
- Pain
- Emotions
- Hunger
- Toileting




Lawson, W. B. (2025). Interoception and Relationship to Monotropism. In *Autism and Being Monotropic: What Medical and Other Practitioners Need to Know* (pp. 67-72). Singapore: Springer Nature Singapore.

# Interoception strategies

- Interoception is designed to keep us safe and meet our bodily needs.
- Interoception is linked to emotion regulation and mental and physical health.
- People with high interoception are better able to feel their bodily states and regulate their emotions.
- People with low interoception may need help or prompting to meet these needs (e.g., a daily schedule, a support worker)
- Autistic people tend to have lower interoception compared with non-autistic people

DuBois, D., Ameis, S. H., Lai, M. C., Casanova, M. F., & Desarkar, P. (2016). Interoception in autism spectrum disorder: A review. *International journal of developmental neuroscience*, *52*, 104-111.

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# Reflection: 5 minutes

- What did you discover about yourself and how your brain works?
- Did any of this resonate with your clients / people in your life?
- How can you apply this model into your future practice?

# How can we support sensory differences and preferences?

- Get to know a person's preferences, map them out sense by sense
- Observe interoception, do they know when its cold, or when they are hungry?
- Identify how they like to regulate these differences
- Support and encourage safe stimming behaviours
- Promote understanding of stimming to reduce stigma

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# Pathological Demand Avoidance

AKA (NEURODIVERSITY AFFIRMING TERMS)
PERSISTENT DRIVE FOR AUTONOMY
OR
PERVASIVE DESIRE FOR AUTONOMY

# *What is PDA?*


## How it presents:

- Always needing to be in control
- Can't be told no
- Needs to get their own way
- Can do things if they are told to do it

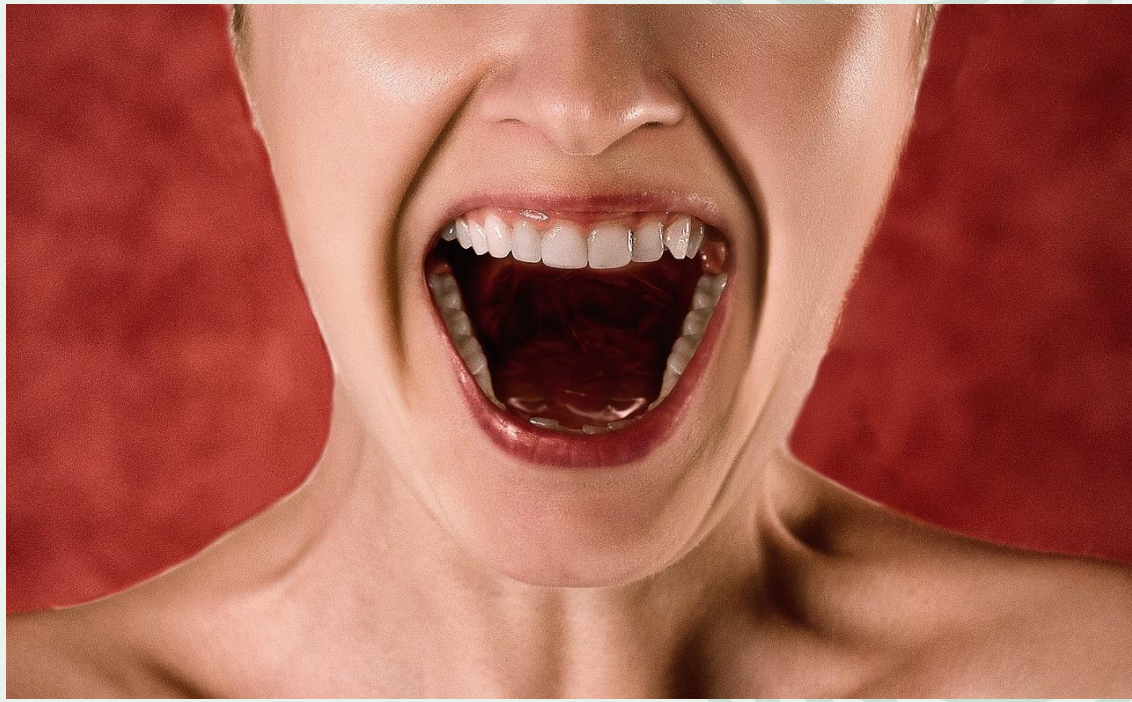
## What it actually is:

- A survival drive for autonomy which overrides other instincts. May override needs like; sleep, eating, hygiene and safety.
- When autonomy is perceived to be impacted it triggers the fight or flight response. This can happen immediately or accumulate over time and then lead to nervous system burnout aka freeze.
- Happens on a subconscious level.
- PDA can be considered “externalised” or “internalised”.

# Equalising behaviours

Things that people may do to get back to feeling like they are in control:

- Breaking things
- Yelling
- Talking over people
- Hitting oneself
- Hitting head against the wall
- Self harm
- Staying up late
- Controlling eating
- Messing hair after it is brushed



# High Masking Autism + PDA

- PDA children often have two different "versions" of themselves depending on context.
- For example, ‘fine’ at school and ‘explosive’ or ‘meltdowns’ at home.
- PDA children are often "high masking" autistics.
- They often imitate or follow neurotypical social norms and override

their threat response at school or with certain people.

- When they come home or to their safe space, they may show completely different behaviour and appear like a different child.

**This is because they are finally safe to express how they really feel!**

# Constant need for autonomic nervous system co-regulation

- PDA children may need constant co-regulation and undivided attention or they will become dysregulated and experience an internal nervous system response, even if it isn't outwardly obvious
- They can seem very demanding, particularly to their “safe person” whom they rely on to regulate them
- The PDA child needs to consistently receive signals of safety so that their nervous system doesn't go into fight, flight, freeze or fawn throughout the day.
- Co-regulation can be provided by a safe person who is regulated and can signal safety with tone, facial expression, body movement, and physical proximity
- This may present differently for introverted expressions of PDA

# Unpredictable Nature of Dysregulation and Meltdowns

- Dysregulation and meltdowns for the PDA child often "appear out of nowhere."
- It is important to realize that the final particular stimuli is often the "straw that breaks the camel's back" and the response can appear "disproportionate."
- Dysregulation, equalizing behaviour, shutdown, and meltdowns are often in response to an accumulation of stress from the PDA child spending a significant amount of time (days, weeks, months) overriding their threat response by masking consistently in an environment outside of the home (at school, with grandparents. etc.).

# PDA is common in autistic adults too!

Often more internalised than externalised.

**Quiet or withdrawn behaviour**

When triggered by a demand, an individual with internalized PDA might become quiet, shut down, or withdraw from interaction

**Social strategies to avoid demands**

They may use subtle social cues or tactics to avoid being asked to do something, or they may create an illusion of compliance to avoid the perceived threat of a demand.

**Perfectionistic compliance**

To neutralize the threat of a demand, they may comply in a perfectionistic manner, over-exerting themselves or becoming excessively concerned with details.

**Avoidance of triggers**

They might experience avoidance behaviours when triggered by internal decisions or demands, such as avoiding tasks or situations that feel too overwhelming

# Accommodations

- Often involves trial and error and ‘data gathering’ to observe whether it helps the client or not
- Remember that we cannot do therapy with a dysregulated client
- Allowing freedom and choice where possible
- Creating a sense of equality e.g. in speech we both say the target words
- Using declarative language without expecting a response; “I wonder...”, “You can”, “We can”, “I notice....”
- Laughter and play is therapeutic in nature for PDA clients – sometimes being light-hearted is the best way to break the stress response if you have a good relationship
- Incorporating novelty
- Allowing for sensory seeking behaviours
- Flipping the power dynamic

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# Rejection Sensitivity Dysphoria

# What is RSD?

- RSD or rejection sensitivity dysphoria is an increased intensity of emotions when reacting to rejection.
- The brain is wired to interpret neutral stimuli as negative, discount positive stimuli and amplifies negative stimuli.
- Can be perceived or actual rejection.
- Rejection isn't always someone just saying "no", can also be regarding feedback .
- Can look like anxiety, sadness, rage, extreme embarrassment or self consciousness.
- Impacts self perception and romantic relationships.
- Linked with ASD and ADHD.
- Linked with other personality and mood diagnoses.
- Can be misdiagnosed as social anxiety.
- For women can be more prominent with certain hormonal changes during cycle.

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# How to reduce the impact of RSD

- Be really clear in your communication – don’t make them guess how you're feeling
- Reassure if you think the person is second guessing themselves
- Discuss worst case scenario
- Name it
- Seek psychological support
- Educate about RSD
- Discuss triggers with key people in their life

RSD can lead to people pleasing – which can put neurodivergent people into unsafe situations

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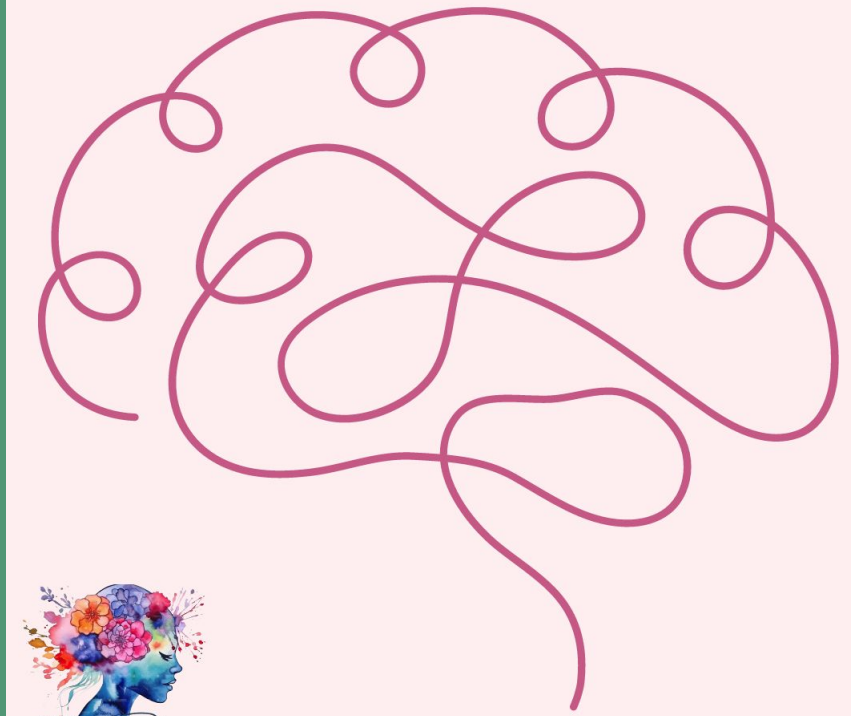
# Neurodivergence and mental health



# What is the relationship between neurodivergence and mental health concerns ?

- **Over 35% of children who are autistic experience suicidality**
- **Misdiagnosis or missed-diagnosed especially in girls / females**
- **40% of autism at least one other DSM-5 anxiety disorder**
- **Eating disorders 3 x more likely in ADHD**
- **70% of autistic children demonstrated 'atypical' eating behaviours**
- **17.5% of autistic children have PTSD**
- **90% of Autistic females have experienced sexual assault**
- Autistic adults also have a **higher prevalence of loneliness** which is associated with poorer health outcomes
- Loneliness can occur when our desired relationships e.g. friendship or romantic isn't aligned with our reality can include; quality, quantity and specific experiences
- **Societal pressures to be neurotypical;** social exclusion, traumatic experiences, gaslighting, lack of accessible supports and difficulty processing or expressing emotions


Douglas, S., & Sedgewick, F. (2023). Experiences of interpersonal victimization and abuse among autistic people. *Autism*, 13623613231205630. https://doi.org/10.1177/1362361323120563

Edelson, M. G. (2010). Sexual abuse of children with autism: Factors that increase risk and interfere with recognition of abuse. *Disability Studies Quarterly*, *30*(1). https://doi.org/10.18061/dsq.v30i1.1058

Hedley, D., Uljarević, M., Foley, K. R., Richdale, A., & Trollor, J. (2018). Risk and protective factors underlying depression and suicidal ideation in autism spectrum disorder. *Depression and anxiety*, *35*(7), 648-657. https://doi.org/10.1002/da.22759

Simpson, K., Adams, D., Wheeley, E., & Keen, D. (2020). Parent perspectives on the presentation, triggers, impact, and support of anxiety in young children on the autism spectrum. *Journal of Child and Family Studies*, *29*, 572-582. https://doi.org/10.1007/s10826-019-01576-5

Syriopoulou-Delli, C. K., Polychronopoulou, S. A., Kolaitis, G. A., & Antoniou, A. S. G. (2019). Views of teachers on anxiety symptoms in students with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, *49*, 704-720. https://doi.org/10.1007/s10803-018-3752-1

# How can we support mental health for neurodivergent people?

- Raising awareness of the prevalence
- Screening clients + referring to help (Suicidal thoughts and urges questionnaires: STUQ)
- Training mental health clinicians to support neurodivergent people
- Starting consent education at a young age
- Strategies to facilitate engagement for autistic people; wording, timing, formatting, various ways to respond, choices, in person or online format, support person if needed, sensory tools and fidgets, lowering noise or lighting,

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# Co-occuring conditions

# Conditions that commonly co-occur with neurodivergence

- 80% of autistic people have sleep disorders or disturbances
- GI problems occur in 46% to 84% of Autism population
- 1.6 times more likely to have eczema or skin allergies
- 1.8 times more likely to have asthma and food allergy
- 2.1 times more likely to have frequent ear infections
- 2.2 times more likely to have severe headaches
- 3.5 times more likely to have diarrhoea or colitis
- 7 times more likely to report gastrointestinal (GI) problems
- Approximately 30% of children with autism have anxiety related to toileting
- Approximately 25% of children with ASD have immune deficiency and dysfunction (i.e., dysautonomia, POTS MCAS etc.)

Al-Beltagi M. (2021). Autism medical comorbidities. *World Journal of Clinical Pediatrics, 10*(3), 15–28. https://doi.org/10.5409/wjcp.v10.i3.15

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# Avoidant Restrictive Food Intake Disorder (ARFID)

# Not just a fussy eater!

- ARFID or avoidant restricted food intake disorder is characterised by persistent difficulties meeting nutritional needs and can occur across the lifespan.
- ARFID is not due to gastrointestinal complications or body image diagnoses such anorexia or bulimia.
- ARFID can occur due to a variety of factors which can also co-occur such as; lack of interest in food, aversion to sensory properties of foods and averse and traumatic experiences with food such as choking.
- ARFID commonly occurs with neurodivergent individuals.

For literature on ARFID:
https://svp-slp.com/wp-content/uploads/2024/10/arfid-key-literature.pdf

# How can we support people with ARFID?

## Intervention

- Addressing existing nutritional deficiencies with relevant medical professionals such as; dietician, pediatrician or general practitioner.
- Reducing anxiety around eating and mealtimes. Chaining from preferred or 'safe foods'.
- Exploring food based activities such as cooking classes.

## CHAINING

### What is chaining?

Chaining is an evidence based strategy which supports children / people with ARFID to try new foods. This strategy begins with identifying 'safe' or preferred foods and what the features of the safe foods are e.g. colour, texture, flavour. From here you can identify foods which are similar which you can aim to work towards by gradually changing features of the foods.

**For the latest ARFID intervention literature:**

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# Intervention

- We never force them to eat! This just makes the anxiety around meal times so much worse
- Any food is better than no food at all
- Don’t make negative comments about food choices.
- Start safe and chain to more nutritional options
- This can take a long time!

**Listen to our two podcast episodes on ARFID:**

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# Monotropic thinking and object permanence

## OUT OF SIGHT, OUT OF MIND

# What does monotropism actually look like?

- Difficulty discussing other topics with people
- Trouble transitioning to other tasks from preferred task
- Focused on singular task for extended period of time but forgot to eat, have water, go to the bathroom
- Wanting to focus on and discuss detailed aspects of topic rather than surface level
- Becoming frustrated if other people don't know a topic as well as you or if something inaccurate is said
- Not doing study or work tasks but being focused on something else completely unrelated or that isn't due for weeks


Lawson, W. B. (2025). Looking at Monotropism as a Strength-Based Cognitive Theory. In *Autism and Being Monotropic: What Medical and Other Practitioners Need to Know* (pp. 73-80). Singapore: Springer Nature Singapore.

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# Girl-tism


# Neurodivergence in girls / females

- Gender bias in research
- Neurodivergent people are more likely to identify as gender diverse
- Underdiagnosed - boys 4 times more likely to be diagnosed
- Often later diagnosed, mis-diagnosed or missed-diagnosis
- Stereotypes about neurodivergence *generally* don't apply to girl-tism e.g., lacking empathy, not wanting friendships or social interaction and lacking imagination
- Internalised presentation
- Often very good at masking and mimicking the behaviours of others, often over analyzing social situations
- Excellent pattern recognition

Brickhill, R., Atherton, G., Piovesan, A., & Cross, L. (2023). Autism, thy name is man: Exploring implicit and explicit gender bias in autism perceptions. *PloS one*, *18*(8), e0284013.

**Listen to our podcast episode on Girl-tism:**

# Female autistic characters

**Wednesday Addams**
**From ‘Wednesday’**

**Casey Gardiner**
**From ‘Atypical’**

**Bernadette**
**From ‘The Big Bang Theory’**


**Elphaba**
**From ‘Wicked’**

Craddock, E. (2024). Raising the voices of AuDHD women and girls: Exploring the co-occurring conditions of autism and ADHD. *Disability & Society*, *39*(8), 2161-2165.

# What about the strengths?

Double empathy theory - birds of a feather flock together

## Extending Double Empathy: Effects of Neurotype-Matching on Communication Success in an Expository Context

**Authors**: Morgan Oates, Allison Bean, Rachel Kickbusch, and Sam Sauer | AUTHORS INFO & AFFILIATIONS

**Publication**: American Journal of Speech-Language Pathology • Volume 33, Number 5 • Pages 2364-2377
https://doi.org/10.1044/2024_AJSLP-23-00393

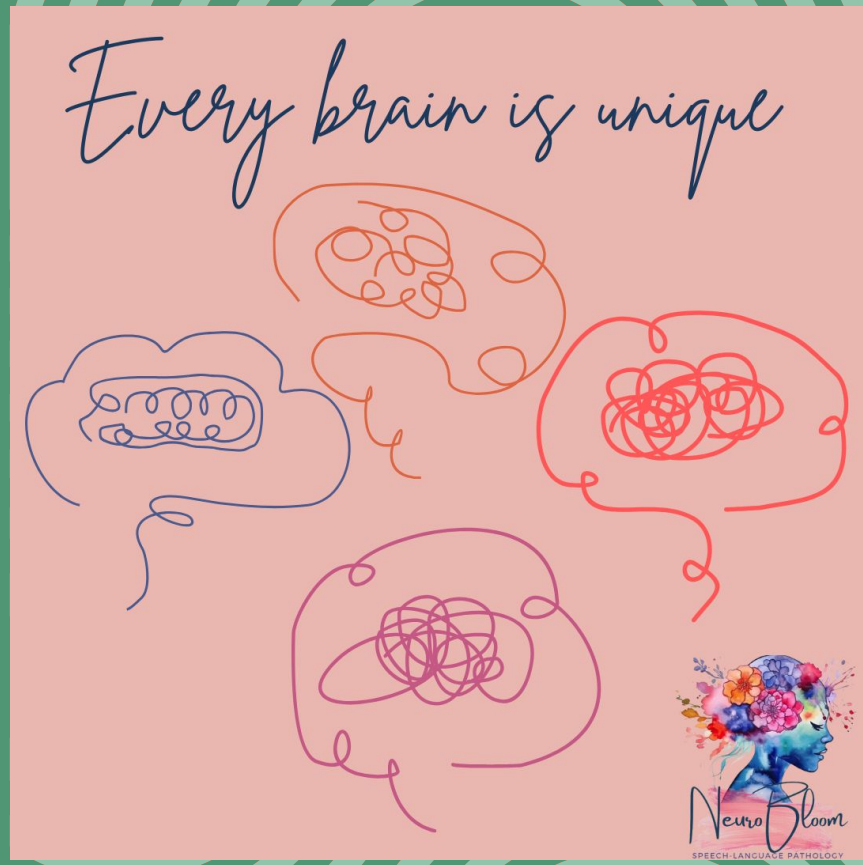
"The traditional, clinical view of autism has focused on deficits, particularly in sociocommunicative areas. However, evolving perspectives driven by the neurodiversity movement and greater inclusion of autistic voices are reshaping this understanding. Evidence now emerges that suggests that social difficulties in autism may at least partially arise from mismatches in interaction styles between autistic and neurotypical individuals."

Matyjek, M., Dziobek, I., Hamilton, A., & Wheatley, T. *Social Interaction Style in Autism: A critical review of social behaviours and outcomes in autistic and neurotypical interactions.*

# Case Studies

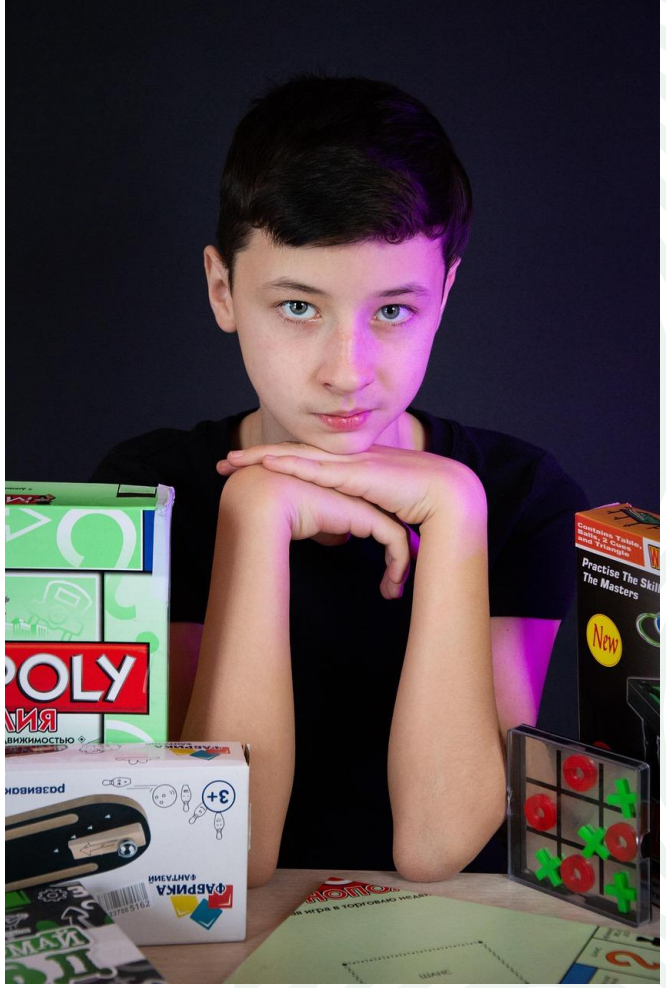
"Allowing a student with a hidden disability (ADHD, Anxiety, Dyslexia) to struggle academically or socially when all that is needed for success are appropriate accomodations and explicit instruction, is no different than failing to provide a ramp for a person in a wheelchair ".

@neurominds_



# Let’s meet Lincoln

- 15 years old (Year 9)
- AuDHD profile (diagnosed age 6)
- PDA presentation
- Sensory seeker (tapping feet, clicking pen, verbal stims)
- Works with an Occupational Therapist fortnightly
- Loves playing sports
- His special interest is board games, footy stats and his local teams
- Lincoln is a very competitive player and finds it difficult to lose
- Struggles to process written information
- Loves listening to music and podcasts



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# How can we support Lincoln in a neuroaffirming way?

# How do we best support Lincoln?

- Fidgets allowed in class to assist with regulation
- Texts for school provided in audiobooks or podcasts as Lincoln has trouble with written texts but does well with auditory information
- Social communication - ask what he actually wants, not what his parents or the teachers or the SLP what
- Extra time in exams for movement breaks to regulate nerves and provide movement input
- Reader for exams to activate auditory pathway and assist with understanding the questions
- Check-ins for understanding with assessment tasks
- Extra support for organization / executive functioning

# Let’s meet Rory

- 9 years old (Year 3)
- Diagnosed with a moderate intellectual disability at age 3
- Rory’s Dad is an amputee, he uses a wheelchair and has his own support worker
- Rory loves sports (cricket, athletics and swimming)
- Handover from previous speech pathologist said he was “non-verbal”. However, he attempts to communicate verbally
- He has a liberator device with LAMP software (this is often not taken out of his school bag and not charged)
- Sensory avoidant (afraid of loud noises, large crowds, bright lights and popping games)
- Struggles with hygiene such as; handwashing, teeth brushing, showering and toileting
- Rory has trouble with buttons, zippers and holding cutlery
- Refuses to attend doctors or dentist appointments (hides under chairs or runs away

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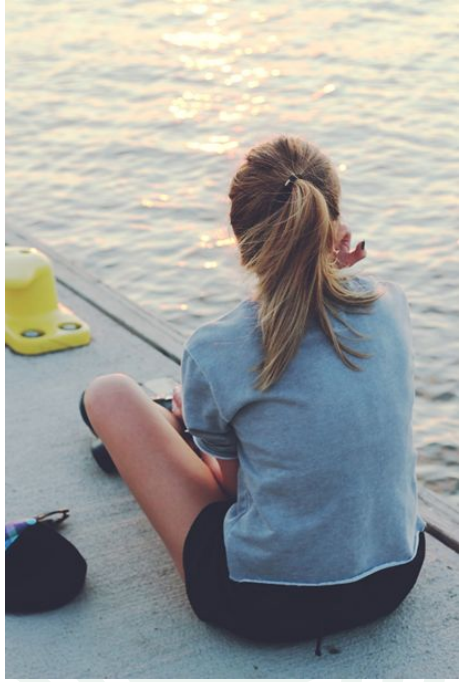
# How can we support Rory in a neuroaffirming way?

# How do we best support Rory?

- Comprehensive exploration and diagnosis of neurodivergence
- Visuals for morning routine, evening routine, handwashing, teeth brushing, showering and using the toilet
- Comprehensive speech sound assessment to determine his inventory to build on verbal communication
- Comprehensive language assessment to explore his receptive language
- Sessions with parents and teachers to support use of his AAC device
- Ongoing speech pathology support
- Regular Occupational Therapy to support self care and fine motor skill development

# Let’s meet Layla



- 13 years old (Year 7)
- Autism and anxiety diagnoses
- Rejection sensitivity dysphoria
- Sensory averse (does not like loud noises or bright lights)
- She loves reading especially Harry Potter, Lord of the Rings and other fantasy
- She experiences social anxiety and sometimes has anxiety attacks
- Layla does NOT like public speaking
- She can often struggle with making friends and maintaining friendships long term
- Layla has ARFID and only eats a small variety of foods
- Her preferred foods are; pasta, chicken nuggets, cheese toasties and potato wedges
- Layla attends fortnightly psychology appointments via telehealth

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# How can we support Layla in a neuroaffirming way?

# How do we best support Layla?

- Layla can wear noise cancelling earbuds during independent work
- Layla is able to pre-record presentations rather than presenting in front of peers
- Layla's teacher does subtle check ins with her to ensure understanding e.g. thumbs up if understood instructions, thumbs down if unsure
- A quiet room for exams to prevent sensory discomfort
- Availability to chat with school counsellor for feelings of anxiety
- 5 minute time out passes to get a drink or do breathing exercises, which can be handed to the teacher at any time
- Layla has fortnightly check  ins with teachers for 5 mins after class
- Exploring food and cooking in a fun and affirming way e.g. cake decorating class, finding the ‘ultimate’ hot chocolate

# Let’s meet Heather

- Age 6 (Year 1)
- Undiagnosed Autism
- English is her second language
- Cantonese is her first language
- Heather loves watching Bluey, she has seen every episode (several times)
- Her special interests are space and drawing and she is very knowledgeable on these topics
- She really wants to have friendships but doesn’t know how to make them

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# How can we support Heather in a neuroaffirming way?

# How do we best support Heather?

- Heather is academically gifted, she doesn't need intervention for speech and language
- Her speech “errors” are actually cross-linguistic influence from her first language, resulting in accented/different BUT not disordered speech production
- Grammatical differences are a result of bilingualism
- Educate family about traits of autism in girls
- Undiagnosed Autism - support diagnosis for funding and understanding
- Embrace special interests
- Support social goals by linking with children with similar interests

# For more information:

Lots of episodes available on neurodiversity to continue your learning!

https://open.spotify.com/show/5UMZgIvsD96fTa3jaAEhKT

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