The UK's increase in neurodivergent diagnoses presents opportunities and challenges for therapists to navigate alongside their clients

It is estimated that around one in seven people in the UK (more than 15%) are neurodivergent,[1] yet we are a long way from a consensus on how neurodivergence might present, or the most effective ways of working with it.

Amid soaring diagnoses, today the conversation around working therapeutically with the neurodivergent community is widening, which necessarily begins with understanding how to speak about it.

'Neurodiversity is the natural range of human neurotypes – we are all neurodiverse!' says Clare Ward, a therapist with Special Networks, a multidisciplinary team offering neuroaffirmative therapy. 'Neurodivergent means any neurotype that diverges from this idea of "normal".'

The broad spectrum that the term 'neurodivergent' covers includes attention deficit hyperactivity disorder (ADHD), autism, Tourette's, dyslexia, dyspraxia and cognitive functioning difficulties. This feature will focus on working with people who present as experiencing ADHD and autism.

A British study found a 787% rise in the number of autism diagnoses between 1998 and 2018, while current NHS waiting lists for autism assessments have reached unsustainable levels. Moreover, there has been an estimated 400% increase in the number of adults seeking a diagnosis of ADHD since 2020.[2]

These exponential rises come amid myriad headlines about dubious private clinics making diagnoses. Experts remain undecided about whether there may be overdiagnosis or more people are neurodivergent.

What is clear is that the growth in diagnoses underlines the urgent need for all therapists to develop greater knowledge of best practice to adequately support the needs of the neurodivergent community – whether diagnosed or not.

For Ward, a diagnosis is 'not the most important piece of information' when starting therapy. 'In fact, I often forget who has which label – or any label – once the work has begun,' she says. 'Knowing your client has a label is a bit like a tailor knowing that their customer is a size "large". We still need to "measure up", and would never guess exact measurements.

'When you consider the patchy and unequal routes to assessment, it can be misleading if we pay too much attention to diagnostic labels. At the same time we absolutely need to validate the ›

experience of "feeling different" that any diagnosis implies, and which can cause so much psychological distress in a world that struggles to accept this.'

Karen Rawden is a psychotherapist with extensive experience working with neurodivergence, especially ADHD, who says that a diagnosis can only ever be a starting point, and that there can be a great deal of work to do both before and after any diagnosis.

'What we know about how to understand and work with ADHD is evolving,' says Rawden. 'No longer is it sufficient to meet clients solely psychodynamically. Instead, we must ensure that additionally we are creating space for neurobiological potentialities and how these might affect the client somatically.

'There can be a lot of misunderstanding. For example, ADHD has three main presentations: predominantly inattentive, predominantly hyperactive and predominantly combined (hyperactivity and inattentive). Yet research shows that a vast combination of symptoms can present in a myriad of ways, and that these alter on any given day.

'Supporting someone therapeutically requires surrender, not only to the process but of the therapist's own preconceptions. Being open to the possibility of ADHD being present is challenging as it may call for the therapist to be willing to abandon some aspects of traditional psychotherapy training and the usual approaches in the early days of the therapy. Nurturing the needs of the therapeutic relationship must come first, and be revisited regularly.'

Emotional dysregulation (ED) is not currently included in the diagnostic criteria for ADHD but Rawden says it 'can be the most debilitating symptom of all'. Psychotherapist and author Marc Andre Bosset agrees, saying 'there are both challenges and opportunities facing psychotherapists when managing our approach to affect regulation with clients who may display traits of neurodivergence.'

Bosset gives the example of a client called Mike* who came to him seeking help to manage his anger. 'I used a mixture of relational, humanistic and somatic psychotherapy, and borrowed from ADHD self-help literature. After several months I introduced the idea that Mike's main focus of concern – his ED – could be an associated characteristic of ADHD. He was keen to continue our therapeutic work, so I suggested I could accompany Mike on his diagnostic journey.

'We filled out the DIVA, a semi-structured diagnostic interview[3] which

IMAGE: SHUTTERSTOCK

I included in a mental health report Mike could use for further diagnostics. I also explained that we would need to actively hold in mind the potential neurodevelopmental dimension alongside the psychoanalytical exploration in order to minimise psychopathologising what could be neurodevelopmental, and vice versa. In time, our therapeutic work, alongside the practical ADHD self-help tools, enhanced Mike's self esteem and helped him regain agency over his dysregulation.'

Psychotherapy can play a unique and invaluable role in accompanying a client through a complex diagnostic journey. But while there can be transformative power in attuned, informed, flexible practice, there is the potential for damage to be done by ill-informed therapists. 'If a therapist is not knowledgeable enough or is insensitive to working with ADHD, the potential for missing an amygdala hijack, common with ADHD, may result in the client ending therapy altogether,' Rawden adds.

Ayhan Alman is an autistic psychotherapist specialising in trauma, primarily supporting clients who are autistic or have ADHD. He says these are 'communities where trauma is notably prevalent' and that extreme care must be taken to avoid compounding problems.

'Trauma in neurodivergent communities often stems from misattunement between different neurotypes, illustrated by the double empathy problem,[4] which highlights that empathy is expressed and perceived differently between divergent neurotypes. For example, a neurotypical therapist working with a neurodivergent client may face challenges where neurodivergent traits could be misinterpreted resulting in treatment choices that could be ineffective, or worse, harmful.'

The bidirectional relationship of trauma and neurodivergence can add to the complexity. Rawden says 'for example, one might be forgiven for assuming that with a client presenting with what they call ADHD, it is in fact the presentation of trauma. But this assumption risks the therapist being caught in their own unconscious bias and reductionism.

'Although trauma might once have been considered a cause of ADHD, research consistently points to a very strong genetic link; children with a parent or sibling who has the disorder are more likely to have it. ADHD can be exacerbated by trauma, even if trauma itself is not the cause. However, to hold trauma as the only hypothesis can undermine the therapy.

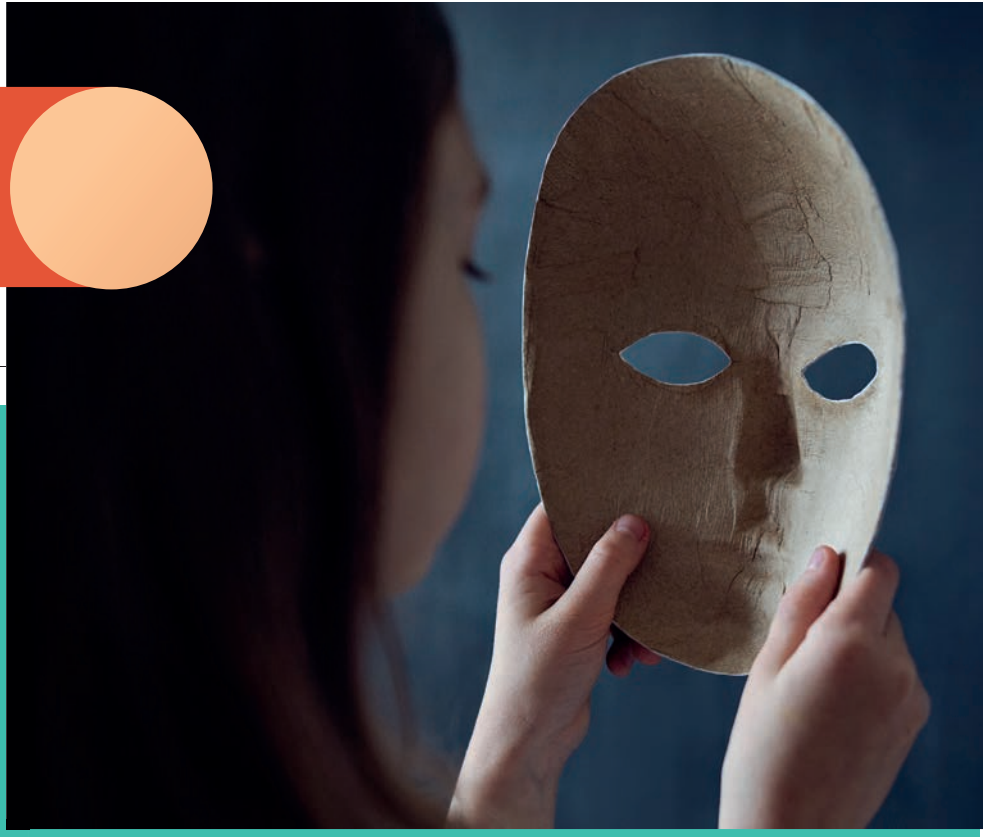
'The intersection of trauma and ADHD is an area of active debate in the context of providing effective therapy. There is clear evidence that neurodivergent conditions risk an individual's proclivity to be more vulnerable to exposure to traumatic experiences. This intersection cannot be disregarded, and clinicians agree it is important that therapy is not only trauma-informed but also ADHD-informed.'[5]

It is a matter of debate as to whether only a therapist with a diagnosis, for example of autism, can really understand an autistic client. Many therapists now use the label neuroaffirmative, meaning they aim to provide a safe and welcoming environment for neurodivergent people 'I choose to work in a team with a combination of lived and learned experience,' says Ward of Special Networks. 'I think it offers a broader view of both the personal perspective and that of the wider community.

'DIAGNOSIS IS NOT THE MOST IMPORTANT PIECE OF INFORMATION'

Talking point

How could we help make our profession more inclusive for neurodivergent trainees, therapists and clients? Let us know
editor@ukcp.org.uk



‘Late diagnosis of autism grew my self-acceptance’

Trainee therapist Carolyn Kempster on her late diagnosis of autism

As an undiagnosed autistic child and adult, I could never shake off the sense that there was something different about me. A sense of shame that I was ‘wrong’ ensured I spent my life working hard to camouflage my difference in an attempt to fit in better.

Two life-changing years of person-centred psychotherapy in my mid-twenties started my process of undoing this shame and accepting myself, although the possibility of my neurodivergence was never raised. Over a decade later, I am studying for my MSc in person-centred and experiential psychotherapy at Sherwood Psychotherapy Training Institute. The course requires 160 hours of personal therapy, and through the relationship with my therapist I began to consider that I was autistic.

Though the threat to my self-concept was great, I found the courage to begin to explore the idea with her. In doing so, the reality of my neurodivergence became clear. Getting diagnosed as autistic aged 38 was a relief, and caused a shift in my understanding of myself. When I look back now I can finally make sense of my earlier experiences and accept myself.

Autism for me is value-neutral; neither a disorder nor a superpower. It describes how I experience the world, and in some way, how others experience me. This gives me a framework to make sense of that feeling of ‘difference’ I always had, granting me greater self-compassion, allowing me to let go of feelings of shame and deficit.

Sharing my diagnosis was a significant moment in my process of unmasking,[1] and moving towards greater congruence between my process of experiencing and what is available to my awareness. I have found the person-centred training I am undertaking to be very neurodiversity affirming, but my Level 4 counselling training didn’t cover neurodivergence at all. In general, in the psychotherapy world, I still think it’s not always safe to share your autism diagnosis.

Today my unmasking continues, shaped in large part by the misunderstandings that autistic people don’t have theory of mind or the ability to empathise.[2] I worry about the stigma of ‘outing myself’ as autistic when others believe these myths. In fact, I know that my empathic attunement and skills are part of what makes me a good therapist.

Awareness around what autism really is – and what it is not – is growing, and writing this piece is a commitment to my further unmasking, as well as helping to raise the voices and visibility of neurodivergent psychotherapists.

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IMAGE: GETTY

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Rawden believes that therapists should pursue CPD opportunities to bridge the gaps left by training and to develop a deeper understanding of the complexities of neurodivergence, and to 'most especially keep informed of the advances in research to meet the client work effectively,' she says.

From finding out about symptoms or potential treatments, the online world is saturated with content about neurodivergence. So where's best to look for CPD? 'It's useful to get a good grounding in the different elements of what is essentially still a medical model of difference,' says Ward. 'It's also important to understand concepts, for example interoception, which are central to the processing of emotions and communication. Informally, talking to people with a diagnosis about their experiences of therapy and other therapists working with a similar client group has been invaluable.'

There are challenges and opportunities facing psychotherapists working with neurodivergence. Perhaps the greatest opportunity is to provide structure and support for those 'who are seeking greater clarity and agency in a landscape overflowing with unregulated clinics taking shortcuts, and a mental health zeitgeist dominated by social media offering "checklist" diagnoses,' says Bosset.

Every client has a unique history, and each client relationship is unique. As Ward concludes 'working with neurodivergence means accepting the natural variety of the human brain, and doing what we would do for any client – understanding the person in the room and adapting the work to suit them.

'This creates a genuine sense of belonging for all people, regardless of how they think, see, feel or interact with the world. Understanding what makes us human means recognising our unity in our diversity.'

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The Checklist

Special Networks' Clare Ward on what to keep in mind when working with people who are (or may be) neurodivergent

- ☑ **Check your perspective. Are you trying to 'fix' this person or enable them to live the life they want?**
- ☑ **Don't make assumptions. Try to forget everything you think you know about diagnoses and see your clients as people first.**
- ☑ **Learn about the Double Empathy gap (when people with very different experiences of the world interact they struggle to empathise with each other) and help people communicate assertively with employers, friends and family.**
- ☑ **Be flexible. Be open to providing other kinds of support on occasion, such as helping a client make a schedule as part of the 'work'.**
- ☑ **Understand 'masking' (the act of concealing one's natural personality or emotions to fit in). There may be times when it is necessary, but no-one should have to mask all the time.**
- ☑ **Be on the look out for uncertainty. Working out what it is that we can't predict in a difficult situation can reduce anxiety and build tolerance.**
- ☑ **Make it visual. Getting thoughts onto paper or a whiteboard can be really helpful.**

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