CHAPTER 2
WHAT IS NEUROAFFIRMING THERAPY?

So much of what we call abnormality in this culture is actually normal responses to an abnormal culture. The abnormality does not reside in the pathology of individuals, but in the very culture that drives people into suffering and dysfunction.[1]

GABOR MATÉ, ADHD PHYSICIAN

Overview

1. **Neuroaffirming Therapy (NAT)**: NAT is an attachment-based and trauma-informed approach tailored to the needs and identities of autistic and ADHD clients.
2. **Key Assumptions**: NAT views neurodivergence as a natural neurological variation, which may coexist with pathologies. It acknowledges the pervasive impact of (often internalized) ableism, contributing to attachment insecurity, trauma, and the development of complex post-traumatic stress disorder (C-PTSD). NAT interprets many symptoms and behaviors associated with neurodivergence as natural responses to

prolonged exposure to relational and environmental stressors.

VIGNETTE: XELIA

Before diving into an explanation of NAT, I want to take a step back and share a common ND experience. Consider the history of Xelia, a 54-year-old Serbian American female and mother of four, who lost her parents in a tragic accident at age seven. Her father was in a motorboat when he struck a submerged obstacle, causing the boat to capsize and throwing both parents from the boat. Both Xelia's mother and father died from their injuries. Throughout Xelia's childhood, she was shuffled to and from the households of various family members. All of them were inattentive to her emotional needs, with some resorting to corporal punishment.

Her intake assessment notes a history of social avoidance, bookish interests, excessive daydreaming, difficulty focusing, a direct, matter-of-fact style of communication, and social anxiety. Xelia describes having struggled with these issues her entire life and of chronic feelings of inferiority. After Xelia's therapist provides her with an ADHD diagnosis, she laments having not known earlier. Like many female ADHDers, Xelia's symptoms were overlooked because she was the "quiet one," well-behaved and introspective.

In seeking treatment, Xelia agrees to consult a psychiatrist to explore medication options aimed at enhancing her focus and concentration. However, she approaches this step with considerable hesitation, influenced by experiences where she felt mental health professionals dismissed or trivialized her symptoms. This history of feeling "gaslit" during previous psychiatric consultations leaves her cautious and unsure about re-engaging with similar services.

When Xelia finally connects with a psychiatrist again, they quickly review her case history and dismiss her concerns about ADHD, citing an absence of hyperactivity and impulsivity. The psychiatrist seems to insinuate that Xelia's sole intention is to get stimulant medications. He declines her request to conduct an assessment and instead refers her to a testing center that does not accept her health insurance.

NAT APPROACH

Xelia's therapist works to dismantle any internalized ableism that she might harbor. Instead of pathologizing her traits, her therapist helps Xelia see them as natural variations. They discuss the pervasive ableism in society and how it has affected Xelia's self-perception. The therapist uses affirming language and encourages Xelia to embrace her ADHD identity proudly.

Xelia's therapist acknowledges the systemic barriers she has faced in accessing care and validates her frustration. Instead of dismissing her concerns, the therapist provides practical support, such as helping Xelia find a psychiatrist who is knowledgeable about ADHD in women and provides neuroaffirming care. The therapist also assists Xelia in navigating insurance issues and finding affordable assessment options.

They also regularly check in with Xelia to ensure that her needs and preferences are being met, while involving her in decision-making processes. This approach leaves Xelia feeling understood, respected, and supported.

GATEKEEPING NEURODIVERGENCE

Many ND clients like Xelia report encountering paternalistic attitudes when seeking support for their identities. This can take the form of healthcare providers making decisions for patients without their input, under the assumption that the provider knows best. Clinicians may also minimize a client's concerns and dismiss their requests for diagnosis and treatment. This is a form of medical gatekeeping that restricts access to care and support by undermining the patient's right to self-determination and ignoring their expressed needs.

Providers may even refer the ND out for services they are perfectly qualified to provide. Some may mandate the completion of complex and expensive tests. Even assuming the client can afford a comprehensive assessment, the waiting lists in some cases are lengthy, leading to months or even years of delays in obtaining a diagnosis. Several clients have lamented to me that if they had presented with anxiety or depres-

sion, the dismissive clinician they encountered would have no qualms about diagnosing them and prescribing medication. This experience can contribute to feelings of disempowerment and frustration among ND patients.

Some NDs also share Xelia's experience of encountering practitioner skepticism. While rarely stated explicitly, some clinicians harbor wariness about prescribing stimulant medications for ADHD for a variety of reasons, not least the potential for abuse or diversion. This wariness may be palpable to ND clients, who are highly attuned to others' reactions, leaving them feeling stigmatized. It also raises questions about practitioner bias, especially given these medications are recommended as a first-line treatment.[2]

While caution in prescribing controlled substances like stimulants is understandable, it's important to note that ADHDers are not more likely than NTs to abuse these medications when properly prescribed.[3] In fact, the use of prescribed stimulants can help ADHDers reduce risky behaviors, including substance abuse. This is perhaps why individuals with unmanaged ADHD are at a higher risk of developing substance abuse issues.

Gatekeeping is a practice frequently observed in structurally ableist societies, where systemic barriers and biases further marginalize NDs. In such cases, clinicians can gatekeep not only services and medications but also ND diagnoses. ND clients can thus find themselves having to navigate a series of burdensome hurdles before their identity is even recognized.

By challenging these practices and advocating for more inclusive healthcare policies, we can work toward dismantling the systemic barriers that hinder the recognition and support of those with ND identities. A therapeutic approach that aligns with these goals is NAT.

NEUROAFFIRMING THERAPY (NAT) EXPLAINED

NAT is a therapeutic approach that embraces the neurodiversity model and rejects the pathologization of ND traits. Where other therapeutic strategies might be rooted in neuronormative logic, standards, and expectations, NAT is anti-oppressive, rejecting the prevailing

belief in a singular "normal" and "correct" mode of neurological functioning.

NAT uses neuroinformed, inclusive, and supportive practices tailored to meet the unique needs of ND clients. It focuses on amplifying the client's voice and working to explore, validate, respect, and celebrate their diverse experiences and identities. NAT emphasizes cultural humility, recognizes the importance of intersectionality in clients' lives, actively opposes structural ableism, and is aligned with the core principles of the critical psychology movement.[4]

NAT is both attachment-based and trauma-informed, and can be used alongside narrative reintegration therapy (NRT), a modality I have developed that addresses shame-related issues in clients with minority identities (detailed further in Chapter 15).

Here are the foundational principles of NAT:

EVERY ND IS UNIQUE

Stephen Shore, an autistic scholar, famously stated, "If you've met one person with autism, you've met one person with autism."[5] This phrase reflects the diversity within the ND community. For example, one autistic might be reclusive, avoiding human interaction; another, a high-masking social butterfly. One ADHDer might struggle with daily routines, while another might be a hyper-productive workaholic, constantly jumping from one task to another. NAT therapists recognize that while there may be common traits within and across neurotypes, each ND's experience is individual. Broad generalizations based on diagnosis alone cannot capture the nuances of each person's experience, which is also shaped by intersectional identities, such as gender, race, and sexuality.

NEURODIVERGENCE IS DYNAMIC

From a medical standpoint, autism and ADHD are recognized as neurodevelopmental conditions. NAT, however, views neurodivergence as a natural variation in neurocognitive functioning, not a disorder. NAT also acknowledges neurodivergence is dynamic and shaped

by genetic, environmental, and evolutionary influences as outlined by life-course health development models.[6]

The following examples demonstrate the dynamic nature of neurodivergence:

- **Gastrointestinal Symptoms and Microbiota**: Links have been established between impaired gut microbiota and autism, ADHD, and mood disorders, with emerging research considering autism as a brain-gut-microbiome axis disorder.[7]
- **Diagnostic Fluidity**: Individuals diagnosed with ASD may not always meet the criteria throughout their lives, indicating variability in traits.[8]
- **Variability of ADHD**: ADHD traits can also fluctuate over a person's life.[9]
- **Trauma and ADHD**: Trauma can increase the likelihood of developing ADHD, and ADHD traits can intensify the effects of trauma.[10] This bidirectional relationship is clear in the overlap between traits of complex post-traumatic stress disorder (C-PTSD) and ADHD, such as reward deficiency syndrome (RDS) and rejection sensitive dysphoria (RSD; see Chapter 6).
- **Impact of Early Experiences**: Exposure to adverse childhood experiences (ACEs) is linked with a higher incidence of ADHD, highlighting the significant influence of early environmental factors on neurodevelopment.[11]
- **Influence of Early Relationships**: Similarly, early social interactions can influence the expression of ADHD genes.[12]

PATHOLOGY OFTEN CO-OCCURS

While NAT does not pathologize neurodivergence, it acknowledges that it can, and often, coexists with pathology. Autism and ADHD often cluster and co-occur with additional conditions and challenges, complicating and confounding the diagnostic process. This phenomenon is what I refer to as the "six diagnosis Cs."

As noted, ACEs not only shape how the ADHD neurotype manifests but also serve as risk factors for various mental disorders, elevating the likelihood of NDs developing psychopathologies later in life.[13] ACEs exemplify how both biological and environmental factors influence gene expression and neurodevelopment through epigenetics.

ABLEISM IS PERVASIVE AND PERNICIOUS

NAT practitioners recognize that structural ableism is both pervasive and pernicious, manifesting as systemic barriers that restrict access to resources, opportunities, and fair treatment. Structural ableism also actively afflicts harm. Take for example the eugenic policies of Nazi Germany, or the modern-day use of electric shock therapy on autistics at a facility in Massachusetts, US.[14]

Structural ableism can take the form of neuronegative attitudes toward different neurotypes, evident in ongoing attempts to "cure" autism using unproven scientific methods. These attitudes are reflected in comments by one spokesperson from The New England Center for Children, likening autism to cancer and applied behavioral analysis (ABA) therapy to chemotherapy.[15]

Structural ableism is also embedded in the environment. Just as wheelchair users require ramps, many NDs need sensory-friendly spaces. Minimal ambient noise, as it turns out, is not just a preference but crucial for their mental well-being.[16] Structural ableism permeates social interactions as well. This is apparent in ableist behaviors by NTs, collectively known as "the five ableist Ss": silencing, shunning, stigmatizing, shaming, and subjugating.

These behaviors can manifest as NTs rolling their eyes at NDs enthusiastically discussing their interests, or interrupting and talking over them. They may mock NDs' stimming behaviors, like echolalia, or express frustration over hyperactivity. NTs might show annoyance at an ND's intense curiosity, ridicule their unconventional statements, or shame them for behaving "abnormally". Additionally, ableist NTs may punish NDs for not being punctual, stigmatize their difference, or subjugate them by assuming they are incapable of achieving certain

tasks. These actions often lead to NDs being socially excluded and treated as inferior in everyday interactions.

While expecting all members of society to follow certain standards of conduct is understandable, the constant scrutiny and negative responses inflicted by NTs upon NDs represents the enforcement of **neuroconformity**. This practice is based on the belief that NT norms should be universally and unilaterally applied to all individuals, regardless of neurotypes. Neuroconformity pressures NDs to adopt NT ways of being, often at the expense of their own personhood.

ABLEIST STANDARDS ARE INTERNALIZED

Some NTs justify structural ableism with the claim that there is a singular "normal" way of neurological functioning, perpetuated through neuronormative standards.[17] NDs frequently face expectations to conform to these standards, such as managing schedules independently, remaining seated in classroom settings, and adhering to social protocols like refraining from commenting on others' appearances.

This one-size-fits-all approach assumes that NDs possess the capacity and desire to follow these standards, fostering feelings of inferiority among autistics and ADHDers when they struggle to do so.

Adding insult to injury, NDs in many cases are given minimal help and are instead pressured to "try harder," implying that their difficulties in conforming are simply a matter of willpower. This experience is incredibly stigmatizing, painting neurodivergence in a negative light that is then internalized by individuals as shame.

ABLEISM CREATES MINORITY STRESS

NAT recognizes that the minority stress model, originally developed to describe the stress experienced by sexual and ethnic minorities, equally applies to ND populations.[18] This model outlines four key processes:

- **Experiencing Stressful Events**: NDs face stigmatization and rejection by NTs for functioning in non-neuronormative ways.
- **Expectation of Stress and Stigma**: NDs may expect to encounter prejudice, which can contribute to ongoing stress.
- **Internalization of Negative Societal Attitudes**: NDs internalize structural ableism, negatively affecting their self-esteem and mental health.
- **Concealment of Minority Status**: To fit in and ensure personal safety, NDs may engage in masking, camouflaging, and compensation (MCC) strategies designed to conceal their neurodivergence. **Masking** involves suppressing visible ND traits, like the urge to stim.[19] **Camouflaging** is adjusting behaviors to conform to NT norms, such as maintaining a socially acceptable level of eye contact.[20] **Compensation** entails adopting strategies to manage perceived deficits, for example, using detailed planners and setting multiple alarms to enhance organization and punctuality.

Continued exposure to minority stress significantly affects the physical and mental health of NDs, a burden described as allostatic load.[21] This stress is especially pronounced in NDs with intersecting identities – people of color, LGBTQ+, or older adults, etc. – because of the compounded effects of multiple sources of discrimination.[22]

Minority stress is a social determinant of health and manifests for NDs at multiple levels. Here are some examples:

- **Intrapsychic**: NDs absorb and assimilate negative societal attitudes toward their own neurodivergence as internalized ableism.
- **Interpersonal**: NDs frequently experience **microaggressions**, which are everyday slights that convey derogatory or negative messages based on their minority identity.[23] This includes experiences of bullying, harassment, exclusion, and victimization.[24]

- **Systemic**: NDs are exposed to higher rates of ACEs, which significantly contribute to the development of trauma. It's important to also recognize that oppression itself is inherently traumatizing.[25]

The impact of minority stress is reflected in ND life trajectories. Research shows that ND children often experience higher rates of absenteeism, exclusion from school activities, reduced academic achievement, and face greater challenges in securing employment after completing their education.[26]

Child ADHDers, for instance, are at greater risk of developing ODD and CD.[27] They may also engage in bullying, particularly if they have been victims of bullying themselves. A 33-year longitudinal study found that ADHDers had poorer outcomes in several areas, including education, employment, finances, social relationships, and overall life satisfaction compared to their NT counterparts.[28]

Autistic children also face a range of increased challenges such as aggression, oppositional behavior, anxiety, depression, attention difficulties, hyperactivity, social isolation, and loneliness.[29] A comprehensive meta-analysis revealed that about 50% of autistic adults may not achieve independent living, secure competitive employment, or form friendships and romantic relationships.[30]

C-PTSD IS COMMON

The DSM categorizes traumatic experiences as involving "actual or threatened death, serious injury, or sexual violence."[31] Researchers John Briere and Catherine Scott, however, define trauma more broadly as an event that "extremely upsets and temporarily overwhelms an individual's internal resources, leading to lasting psychological symptoms."[32] Due to the subjective nature of trauma, this book adopts the latter definition.[33] Supporting this perspective, a study found that autistic participants identified many events not recognized by the DSM, such as bullying, as traumatic.[34]

Why might some experience bullying as traumatic? Psychologist Dan Olweus observes that bullies target children who are anxious,

insecure, cautious, sensitive, and quiet – traits frequently found in autistics and ADHDers, especially those with an inattentive presentation.[35] The likelihood of these individuals developing trauma hinges on their access to protective social responses, support, and resources. Because of their outsider status, these can be limited.[36] This lack of protection can lead to repeated victimization, further increasing the likelihood of trauma developing.

Bullying is just one example of the chronic and episodic environmental stressors NDs are exposed to. Although these stressors individually may not meet traditional trauma criteria, cumulatively they are experienced as traumatic, a phenomenon I refer to as "**ambient trauma**."[37] As these stressors are usually relational in nature, the ND is more likely to develop complex post-traumatic stress disorder (C-PTSD) than PTSD (see Chapter 7).

Susceptibility to C-PTSD is shaped by insecure attachment, which is prevalent among ND populations, with minority stress hypothesized as a significant contributing factor.[38] Research shows that around 90% of ADHDer children show signs of insecure attachment, a stark contrast to the 38% prevalence found in NT children.[39] 77% of ADHDers have been found to have an avoidant attachment style. For autistics, studies report rates of insecure attachment of between 14 and 60%.[40]

Insecure attachment styles develop in response to caregivers misattuning to a child's needs. This is more likely when misattunement is compounded by insults like neglect and abuse. Insecure attachment may then be eventually passed by the child onto their own children, resulting in intergenerational transmission.[41] Insecure attachment is more likely to develop when secondary attachment figures such as relatives, teachers, and peers consistently do not meet the needs of NDs – a common occurrence in ableist societies, as indicated by behaviors such as bullying. The result is what I term "**ambient misattunement**." NAT recognizes that ambient misattunement further decreases resilience while increasing the chances of an ND developing C-PTSD.[42]

RIGIDITY IS A NATURAL RESPONSE

NAT practitioners understand that while cognitive rigidity – which manifests as difficulty adapting to change or considering alternative perspectives – may be characteristic of ND neurocognitive profiles, it is also a response to oppression.[43] This rigidity emerges in reaction to minority stress and allostatic load, reflecting the ND psyche's attempt to cope and survive. Adhering to plans and routines and avoiding uncertain situations is one way for NDs to maintain stability and protect their mental well-being.

Another cause of rigidity is chronic exposure to neurostress – the unique neurological stress experienced by NDs. Neurostress results when an ND's limited capacity to process sensory, executive, and social (SES) information is exceeded (Chapter 13). This triggers what I term a "neurostress response" (NR). An NR manifests in four progressive stages: overload, shutdown, meltdown, and burnout. Neurostress is a major reason anxiety is a daily experience for so many NDs.

The challenge with cognitive rigidity is that it can lead to adherence to certain behaviors, which may begin as adaptive, but over time become maladaptive, as with the "five survival strategies" I describe in Chapter 12. Such strategies are driven by shame scripts – internal, shame-based narratives that influence NDs' perceptions of safety, worthiness, adequacy, and belonging. Shame scripts play a crucial role in many ND challenges, including RSD (Chapter 15).

CHALLENGES ARE BIOPSYCHOSOCIAL

NAT recognizes that some challenges NDs face are developmental. Autistics and ADHDers may struggle with noticing and interpreting social signals, such as body language, facial expressions, and tone of voice; understanding the implications of these cues; clarifying their objectives within an interaction; deciding on verbal or behavioral responses; and effectively executing the chosen responses.[44] This can pose a challenge for communication regardless of whether the ND is interacting with an NT or a fellow ND.

Historically, such challenges were attributed solely to neurocogni-

tive differences – the "bio" component of the biopsychosocial model. However, there is growing recognition of the significant roles played by psychological and environmental factors.[45] For example, attachment insecurity and trauma can exacerbate behavioral problems, social anxiety, and overall social functioning (the "psycho" component).[46] NDs also frequently experience a negative social feedback loop, which isolates them from interactions with NTs and limits opportunities to hone their social skills (i.e., the "social" component; see Chapter 12).

With this understanding, interventions to support NDs should comprehensively address all biopsychosocial considerations. For instance, a NAT practitioner might consider providing social skills coaching. They could also offer interventions that target attachment and healing, while educating both the client and those around them about the social feedback loop and concepts like the Double Empathy Problem (DEP; Chapter 12).

UP NEXT

In this chapter, we explored the fundamentals of NAT and the underlying assumptions that guide its approach to treatment. In the next chapter, we will delve deeper into attachment theory and discuss how insecure attachment might manifest in the therapy room.

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