



Neurodivergence, Trauma, and Somatic Experiencing®

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August 1, 2023

Hosted by:
Somatic Experiencing® International

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Welcome!

- ▶ Sarah as multiple neurodivergent human
- ▶ Pronouns and land acknowledgment
- ▶ Goals for today
 - ▶ Intended focus
 - ▶ Questions
 - ▶ Recording availability
 - ▶ Accessibility of material
 - ▶ Donations: <https://traumahealing.org/give>

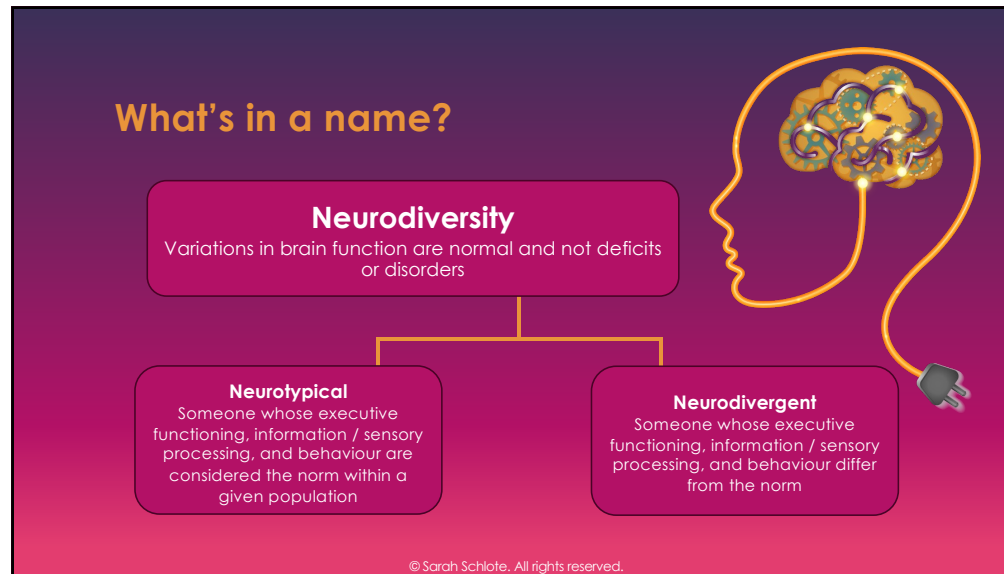
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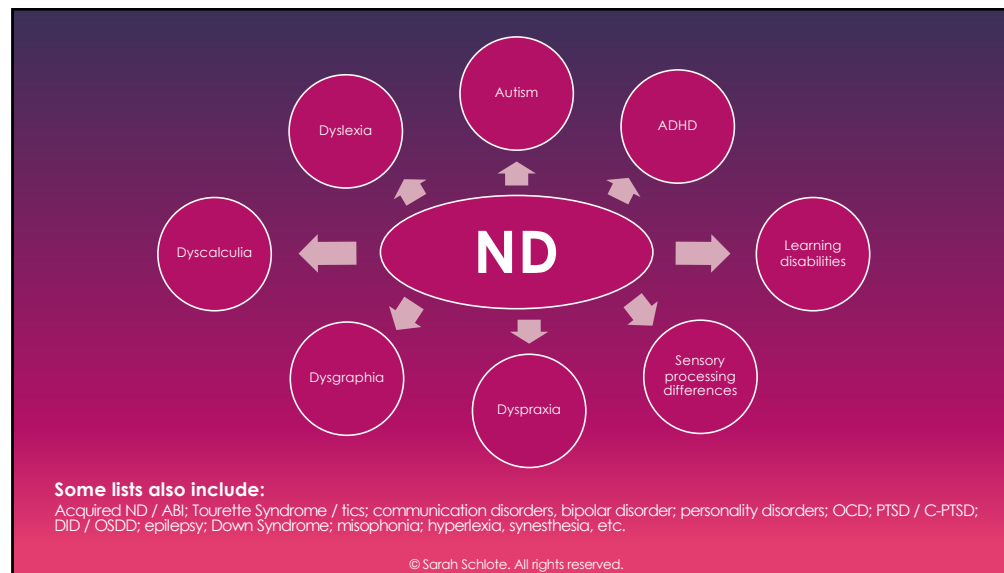
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Autism as Disorder (DSM-5)

► **A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:**

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

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Autism as Disorder (DSM-5)

► **B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):**

1. Stereotyped or repetitive motor movements, use of objects, or speech
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior
3. Highly restricted, fixated interests that are abnormal in intensity or focus
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment

For A or B: Specify current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

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Autism as Disorder (DSM-5)

- ▶ **C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).**
- ▶ **D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.**
- ▶ **E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.**

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Autism as Disorder (DSM-5)

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

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ADHD as Disorder (DSM-5)

- ▶ **A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterised by (1.) and/or (2.):**
- ▶ **(1.) Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:**
 - Often fails to give close attention to details or makes careless mistakes
 - Often has difficulty sustaining attention in tasks or play activities
 - Often does not seem to listen when spoken to directly
 - Often does not follow through on instructions and fails to finish schoolwork, chores, or work duties
 - Often has difficulty organising tasks and activities
 - Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
 - Often loses things necessary for tasks or activities
 - Is often easily distracted by extraneous stimuli
 - Is often forgetful in daily activities

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ADHD as Disorder (DSM-5)

- ▶ **(2.) Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:**
 - Often fidgets with or taps hands or feet or squirms in seat
 - Often leaves seat in situations when remaining seated is expected
 - Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
 - Often unable to play or engage in leisure activities quietly
 - Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time; may be experienced by others as being restless or difficult to keep up with)
 - Often talks excessively
 - Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation)
 - Often has difficulty waiting their turn
 - Often interrupts or intrudes on others

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ADHD as Disorder (DSM-5)

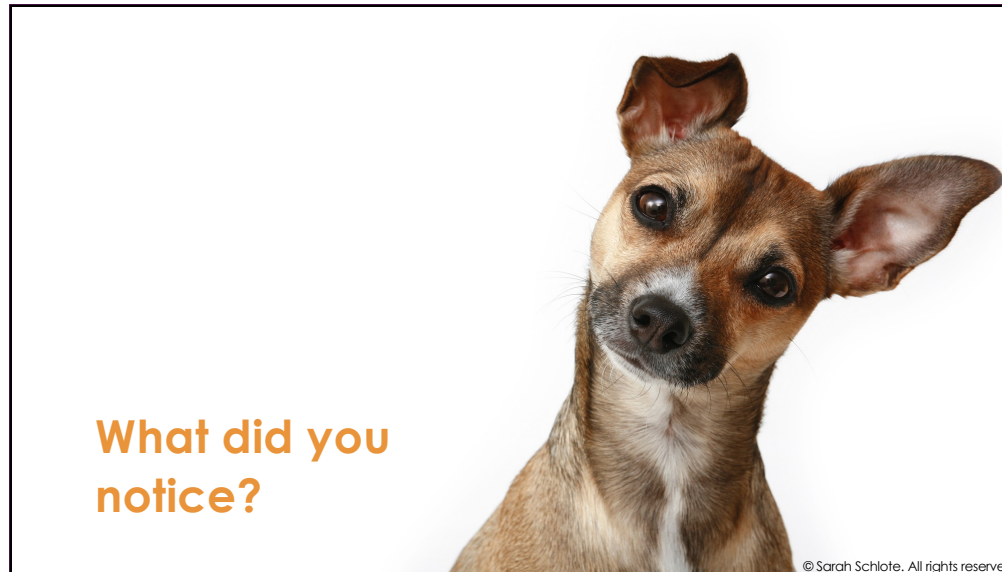
- ▶ B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12.
- ▶ C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- ▶ D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- ▶ E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

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ADHD as Disorder (DSM-5)

- ▶ **Specify whether/if:**
 - ▶ Combined presentation, predominantly inattentive presentation, or predominantly hyperactive / impulsive presentation
 - ▶ In partial remission
- ▶ **Specify current severity:**
 - ▶ **Mild:** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in only minor functional impairments.
 - ▶ **Moderate:** Symptoms or functional impairment between "mild" and "severe" are present.
 - ▶ **Severe:** Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

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What did you notice?

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Challenges

- ▶ Limiting and confusing diagnostic criteria (Singer, 2012; Koutsoklenis & Honkasilta, 2023)
- ▶ Autism diagnosed in cis-boys 4 times more than in cis-girls in childhood (Deweerd, 2014; Halladay et al., 2015):
 - ▶ Early studies and criteria established based on cis-boys
 - ▶ Underrepresentation of Autistic females with higher IQ
 - ▶ Autistic females with average IQ have increased social behaviour compared to males (socialization, higher language ability and cognitive flexibility)
 - ▶ Autistic females have fewer repetitive behaviours
 - ▶ Trans and gender-diverse individuals have higher rates of autism and autistic traits but are underrepresented (Warrier et al., 2020)
 - ▶ Racialized / Black autistic voices also missing (Jones et al., 2020; Malone et al., 2022)

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Challenges

- ▶ ADHD more commonly diagnosed in males vs. females as well for similar reasons (Skogli et al., 2013)
- ▶ Neurotypical as the yardstick for "normal" → communication between ND people indicates that many of these issues are not an issue (Zamzow, 2021)
 - ▶ E.g. Cultural competency → ND culture and trauma (eye contact)
- ▶ Severity scaling discrepancies between ADHD and autism
 - ▶ New criteria exclude people whose traits / behaviours are mild-moderate
 - ▶ Criteria focused on autistic people in distress
 - ▶ Limits access to supports / resources
 - ▶ Treatment primarily focused on behaviour shaping to reduce / eliminate / attempt to "cure" autism

Result:
"no more autism"

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ABLEISM

a·ble·ism \ ˈäbəl-i-zəm \
noun

A system that places value on people's bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity. These constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism.

This form of systemic oppression leads to people and society determining who is valuable and worthy based on a person's language, appearance, religion and/or their ability to satisfactorily [re]produce, excel and "behave."

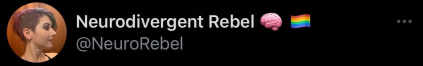
You do not have to be disabled to experience ableism.

a working definition by Tailla "TL" Lewis; updated January 2021
*developed in community with Disabled Black & other negatively racialized people, especially Dustin Gibson

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Challenges

- ▶ Diagnostic overshadowing
- ▶ E.g., "autistics lack empathy" issue (Hume & Burgess, 2021)
 - ▶ A sign of overwhelm or trauma?
 - ▶ Evidence of a different developmental delay or intellectual disability?
 - ▶ Evidence of different kinds of empathy?
- ▶ Double empathy problem (Milton, 2012; Milton et al., 2022)
- ▶ Lack of attention to conditions



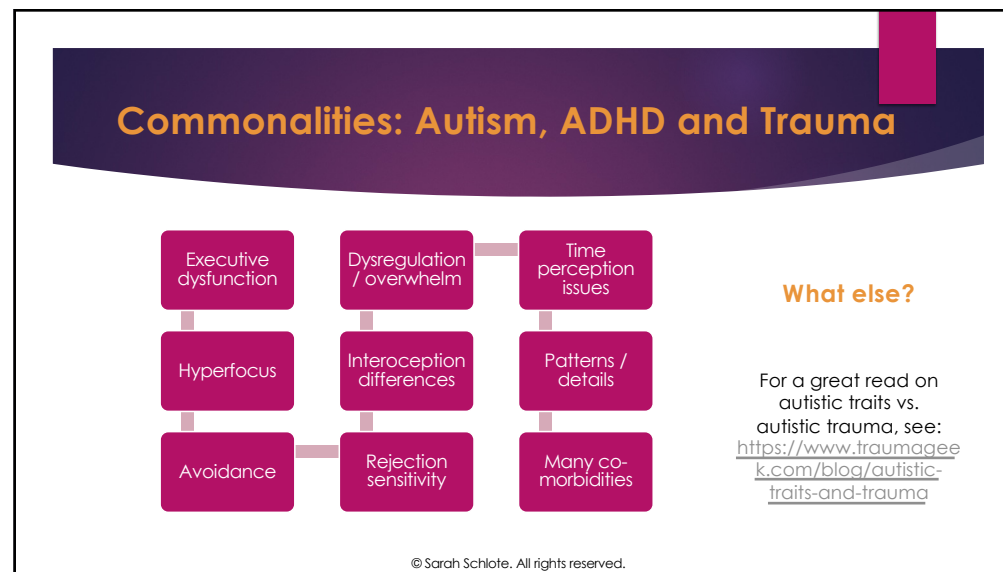
Recently I had the request to "cover the idea that trauma and autism are so hard to distinguish because society doesn't make untraumatized autistics."

#ActuallyAutistic #AskingAutistics - what do YOU think about this?

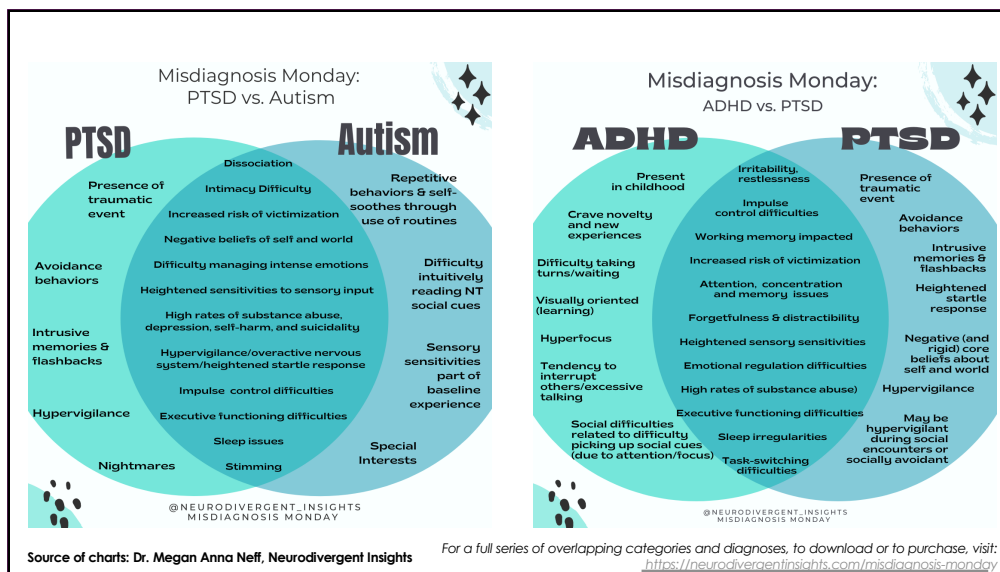
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What would neurodivergent wellness look / feel like?

- Diagnosis vs phenomenology
- Pathology vs strengths
- Seeing the whole person
- Avoiding black and white
- Setting the conditions
- Addressing ableism

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Phenomenology & Lived Experience

- ▶ **Listening to and amplifying neurodivergent voices**
 - ▶ What is it like from their perspective?
 - ▶ Differences from diagnostic criteria and NT norm
 - ▶ E.g., Differences in felt sense / interoception / impacts of sensory input on ANS
 - ▶ Recognize relational / medical trauma (power dynamics)
 - ▶ Freeze and appease
 - ▶ At risk of abuse, exploitation, discrimination, marginalization, gaslighting, crazy-making, and blame shifting
- ▶ **Presume competence and support agency**
 - ▶ Repeated infantilization and told by authorities what they want, need, or should focus on
 - ▶ E.g., ABA, forced guardianships and conservatorships, losing parental and reproductive rights, and other forms of discrimination (Price, 2022)

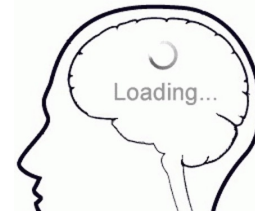
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Phenomenology & Lived Experience

► Acknowledge double binds:

- E.g. Being too much or not enough
 - **Too many strengths / too much masking / too few support needs:** "you don't meet the criteria"
 - **Too many difficulties:** loss of agency / infantilizing, or "excuses, not trying hard enough, we're all a little autistic/ADHD, etc."



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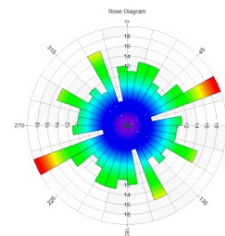
Phenomenology & Lived Experience

► Recognize both strengths and challenges of ND

- Exclusive focus on "superpowers" may mask difficulties
- Disabilities associated with ND may be external or internal
- Avoid "inspiration porn"

► Spiky profile phenomenon:

- Spectrum of traits and behaviours
- Presentation can vary
- Masking may conceal challenges (Miller et al., 2021)
- Impacted by degree of stimulus stacking and other phenomena (see next slides)



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Monotropism (Adkin, 2023; Edgar, 2023; Murray et al., 2005; Murray, 2018)

- ▶ **Monotropism** "is the tendency for our interests to pull us more strongly than most people. It rests on a model of the mind as an 'interest system': We are interested in many things and our interests help direct our attention. Different interests are salient at different times." (Murray, 2018)
 - ▶ "In a monotropic mind, fewer interests tend to be aroused at any time, and they attract more of our processing resources, making it harder to deal with things outside of our current attention channel." (Murray, 2018)
 - ▶ Hyperfocus, info-dumping, and flow states =
 - ▶ Passionate, joyful, regulating, predictable, competent, deeply motivating
 - ▶ Connected with hyper-literal thinking

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Autistic Inertia (Murray, 2018)

- ▶ "Resistance to a change in state: difficulty starting, stopping, or changing direction"
- ▶ "The discomfort of being interrupted or plans changing"
- ▶ "It's as if we've loaded a cart to the brim with thoughts and feelings, and then suddenly we have to steer it round a sharp corner."



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Monotropic Split (Adkin, 2022, 2023; Autisticality)

- ▶ When a monotropic person has to function in a polytropic way / world
- ▶ "A monotropic individual focuses more detailed attention over fewer attention streams than a polytropic (non-Autistic) individual"
- ▶ Having to attend to additional streams requires splitting attention, using more attention than is available, and overriding → not sustainable
 - ▶ Irritability, impatience, anxiety, and frustration → signs of overwhelm
 - ▶ Can result in meltdowns, shutting down, burnout, or mental health crises
 - ▶ A common cause of demand avoidance

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Autistic Burnout (Adkin, 2023; Autisticality)

- ▶ Autistic / AuDHD people experience and process things differently (emotionally, perceptively, cognitively, and on a sensory level)
- ▶ Often perceive layers of nuance, patterns, and details that others miss
- ▶ Regularly misunderstood, misjudged, or scapegoated
- ▶ Having to allocate dwindling resources of attention / emotional labour towards:
 - ▶ Navigating misunderstandings and dynamics with allistic / NT people
 - ▶ Polytropic expectations / low dopamine tasks
- ▶ Not having enough time and space to recover before switching tasks


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Meerkat Mode (Adkin, 2023; Adkin & Gray-Hammond, 2023)



- ▶ "An overwhelmed monotropic person desperately looking for a hook into a monotropic flow state [...] to aid recovery from burnout and/or monotropic split"
 - ▶ Seeking system activated → hypervigilance
 - ▶ A sign of dysregulation or requiring adaptations
 - ▶ May be irritable, frustrated, avoiding demands, looping
 - ▶ Low on spoons

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Considerations for SETTM Practice

▶ Holding space as practitioner

- ▶ Implicit biases and ableism
- ▶ Addressing ND/NT mismatches and misattunements by priming the pump
- ▶ Differences in capacity between practitioner and client?
- ▶ Recognize masking & appeasement (Miller et al., 2021), and that capacity will vary
- ▶ Re-enactments and binds
- ▶ Relational and boundary rupture and repair
- ▶ Supporting ND client self-determination and agency → who determines if something is an issue, trauma or counter-vortex, or a goal?
- ▶ Is the SETTM / SSP to support the client's goals? Or to make them less ND?
 - ▶ Watch for implicit messaging

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Considerations for SETTM Practice

▶ SIBAM and Coupling Dynamics

- ▶ Is it ND trauma (or other traumas), ND traits, personality, or a combination?
- ▶ Hyperfocus / flow state / info-dumping → Meaning channel
 - ▶ Not always evidence of a management strategy or lack of capacity (i.e., to avoid something under-coupled in a different SIBAM channel, such as sensation), but could be!
 - ▶ Sharing relatable stories (image, meaning) → a way ND people express empathy
 - ▶ Info-dumping: "ND love language" (as opposed to "seeking attention", wanting to impress, or sense of self-importance)
 - ▶ May reflect awareness of multiple SIBAM layers and urgency to report on all of them (detail and pattern recognition)
 - ▶ May reflect management strategy related to feeling misunderstood and misjudged
 - ▶ Chasing flow → seeking coherence? Or dissociation to avoid something under-coupled?

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Considerations for SETM Practice

▶ SIBAM and Coupling Dynamics

- ▶ Challenges with shifting SIBAM channels may reflect monotropism, executive dysfunction, differences in interoception, or a trauma response
- ▶ Sliding in by SEP:
 - ▶ Implicit message of "you're too much" (silencing) → shame
 - ▶ Power dynamics (medical ableism, disempowerment)
 - ▶ "Thwarted flow" → irritability and frustration (boundary rupture)
 - ▶ May reinforce neuroception of unsafety in relationship
 - ▶ Does it reflect the SEP's capacity / differences in "containers"?
 - ▶ Is it hyper-arousal or a different capacity for aliveness? (ND vs NT capacity?)

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Considerations for SETM Practice

▶ GHIA and Syndromal Presentations

- ▶ GHIA may be related to trauma or sensory overwhelm / stimulus stacking
 - ▶ Is a meltdown or shutdown a lack of capacity? Or a sign of having coped for too long?
- ▶ Hyper-awareness of all SIBAM elements → ND detail and pattern awareness
 - ▶ Can be overwhelming to sift through → may need help titrating
 - ▶ Not always related to hyper-vigilance, but can be!

Prodromal and coherence work can be useful

- ▶ Many co-morbidities with ND (complex health syndromes)
- ▶ Sequences leading to management strategies, overwhelm, impulses
- ▶ ND traits as gateway into felt sense of coherence

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Considerations for SET™ Practice

▶ Additional considerations:

- ▶ Late discovery of neurodivergence
 - ▶ Importance of psychoeducation
- ▶ Late discovered autism/ADHD → different challenges than when discovered or diagnosed early
 - ▶ Early diagnosis: If client experienced ABA, may need to be aware of themes related to loss of agency, internalized ableism, self-worth, identity, and annihilation (titrating expansion out of contraction)
- ▶ Working with parents, caregivers and partners of ND people
- ▶ "Supremacy of the ventral vagus" / social engagement system
 - ▶ Recognizing social survival and functional freeze (Bridges, 2020)

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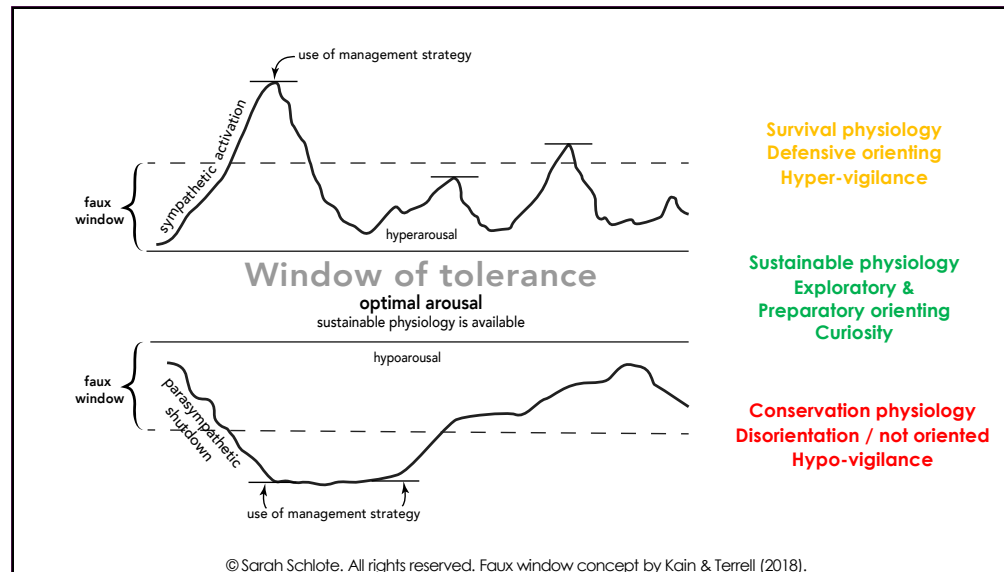
Considerations for SET™ Practice

▶ Additional considerations:

- ▶ Double binds with fight response mobilization
 - ▶ E.g., not wanting to take medication due to intolerable side effects (voicing no / fight response) → deemed noncompliant, or "oppositional defiant", and more likely to be institutionalized
 - ▶ ND clients may not have the same experience of safety in the world as NTs
 - ▶ Working with what's behind "fight" (Low arousal? Powerlessness?)
- Holding the conditions → what systemic conditions need to be addressed?
 - ▶ Trauma recovery is not only an "inside job"
 - ▶ SET™ and ethology → social justice is essential ("outside job")
- ▶ Needing to titrate how much titration is tolerable (next slide)

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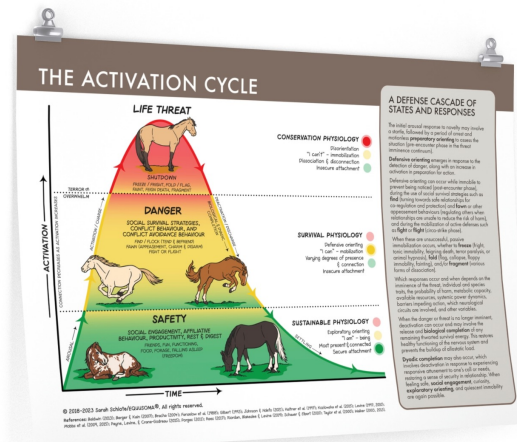
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Online store

- ▶ Apparel, accessories, and educational posters for neuroscience nerds, trauma professionals, and animal lovers
- ▶ For 15% off your order, enter **PROMO15**
- ▶ <https://equusoma.com/shop/>



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Other Theories

- ▶ **Intense World Theory of Autism** (Markram & Markram, 2010)
 - ▶ Concerns: Remington & Frith (2014)
- ▶ **Low Arousal Theory of ADHD** (multiple sources)
- ▶ **Vigilance Regulation Model of ADHD** (Geissler et al., 2014)
- ▶ **Hunter-Gatherer Theory of ADHD** (Hartmann, 2019)
- ▶ Among others...

- ▶ Reviewing models of ADHD (Ziegler et al., 2016)

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