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Introduction to Approaching Autism within the Contexts of the Neurodiversity Paradigm and the Person-Centred Approach

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Summary

This rapid review describes the role of neurodiversity in understanding autism and assesses its implications for clinical practice. The diagnostic criteria and conceptualisation of autism have undergone a number of changes over the last century. Initially, autism was part of the concept of schizophrenia, followed by Kanner's syndrome, which was later expanded to include Asperger's syndrome. Both the 5th edition of the DSM and the 11th revision of the ICD show significant changes in the classification of autism. Traditional models for describing autism within the medical model, such as the triad of impairments and theory of mind, are inadequate in describing the totality of the autistic experience due to the splitting nature of medical language. Splitting can affect approaches to intervention, as well as parental and professional attitudes towards the client and their own identity. The contribution of diagnosis to clinical practice is limited; diagnostic tools for autism are generally not designed to differentiate between co-occurring diagnoses, particularly trauma. A focus on diagnosis runs the risk of ascribing parts of the client's experience to the diagnosis, rather than considering that they make sense in the context of individual development. The neurodiversity paradigm provides a language through which we can relate to the totality of the client's experience.

Keywords

Autism, ADHD, trauma, neurodiversity

Introduction

Autism, ADHD, developmental dysphasia, and other related phenomena are currently classified as neurodevelopmental disorders. In the 10th revision of the International Classification of Diseases (ICD-10) (World Health Organization, 2004), we find, for example, Childhood autism (F84.0) and Atypical autism (F84.1) in the category F84 Pervasive developmental disorders. Asperger syndrome (F84.5) is listed as a separate pervasive developmental disorder. Overactive disorder associated with mental retardation and stereotyped movements (F84.4) is associated with intellectual disability and is distinguished from Hyperkinetic disorders (F90) and Hyperkinetic conduct disorder (F90.1). The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) introduces the overarching category of Autism Spectrum Disorder (ASD). The former

stand-alone classifications 'Asperger's disorder' and 'pervasive developmental disorder' are merged under the ASD classification in the 5th edition. In ICD-11 (World Health Organization, 2019), Childhood autism and Asperger's syndrome are also merged under the single category of "Autism spectrum disorder" (6A02), while "Hyperkinetic conduct disorder" is replaced by "Attention deficit hyperactivity disorder" (6A05), which falls under the category of Neurodevelopmental disorders.

There are three significant changes in ICD-11:

1. The classification refers to typicality or atypicality in actions, experiences, reactions, etc., using, for example, the wording "that are clearly atypical or excessive" (6A02) (World Health Organization, 2019/2021) or "outside the expected range of typical functioning" (6A02) (World Health Organization, 2019/2021);
2. symptoms may now become apparent not only in childhood but at any time during life, or may be externally unobservable, given "an exceptional effort to compensate for their symptoms during childhood, adolescence or adulthood" (6A02) (World Health Organization, 2019/2021);
3. essential (required) features now include sensory difficulties.

A detailed overview of the changes in the ICD-11 classification of autism and integrative commentary is offered by Greaves-Lords (2022). The evolution of classification across the DSM and ICD versions and their epidemiological impact is described by Tsai (2014). Until 1971, autism was part of the classification concept of schizophrenia (Bleuler, 1950), from which it was separated by Kolvin (1971). Initially, autism was associated with an excess of fantasies, later paradoxically being associated with aphantasia (Evans, 2013). Kanner's definition of autism (Kanner, 1943) proved inadequate, lacking the reflection on the characteristics of autism described by Asperger (1944) and Sukhareva (2022). The resulting classification distinction between Kannerian autism and Asperger's syndrome (Wing, 1981) was abolished with the introduction of the DSM-5 and ICD-11. The wording used to describe autism in ICD-11 acknowledges the possibility of aspects of the autistic experience that are not pathological in nature, but given the nature of its purpose, the ICD does not address them any further. The aim of this review is to explore the role of the neurodiversity paradigm in approaching autism in clinical practice. As Russell (2020) notes, the neurodiversity movement seeks a non-pathologising form of identity. It is an activist effort to bring about change in the area of human rights, as has happened in the past with homosexuality, which was also once classified as a disorder (Dyck and Russell, 2020). From this point of view, it is not only a question of human rights, but also a question of the consequences for clinical practice. Hence the hypothesis of this paper: that the theoretical underpinnings of the neurodiversity paradigm have implications for how we work with autistic clients in a clinical setting.

Methodology

Rapid review. The primary source for the database search was the academic search engine Google Scholar, supplemented by a literature and internet search focusing on key authors and topics. Given the interdisciplinary nature of the work, and in particular the rapid review format, Google Scholar was considered to be a sufficient basis for the search. A more extensive paper, such as a systematic review, would require a specialised database search.

Keywords: ABA, ADHD, Asperger's, Autism, Clinical Practice, Diagnostic Criteria, Disability, Dissociation, DSM, Empathy, ICD, Identity, Intervention, Language, Medical Model, Neurodivergence, Neurodiversity, Psychotherapy, PTSD, Schizophrenia, Social Communication, Speech Therapy, Splitting, Theory of Mind, Therapy, Trauma, Triad of Impairments.

Sources in English and Czech were considered. The time criteria were texts from 1910 to the present. The year 1910 is an appropriate lower limit, as it is the year in which Bleuler (1950) first defined autism as part of the concept of schizophrenia. This allows the full historical context, including the pre-Kanner period, to be reflected. The well-known and frequently cited models of autism were chosen to represent the medical models of autism: the triad of impairments and the theory of mind. The concept of splitting, which is at the heart of the argument regarding the need for a language of neurodiversity, belongs to psychoanalytic theory, so the criteria include literature from the field of psychology and psychoanalytic theory, which in turn requires a wider range of temporal criteria, including from the field of 'disability studies' and neurodiversity. To assess the impact on clinical work, the literature had to be cross-disciplinary and the criterion was the relationship to clinical practice in psychotherapy, medicine or speech and language therapy.

Arguments that addressed the issue from a broader sociological human rights perspective and from an identity perspective based on gender identification or ethnicity were excluded. It should be noted that the latter two areas in particular may have significant relevance to identity and clinical practice.

For the review of classification instruments, the criteria are limited to the 4th and 5th editions of the DSM and the 10th and 11th revisions of the ICD, and to articles and review studies that address shifts and changes within the versions. At the time of submission of the review, the final official Czech localisation of the 11th revision was not available. The Czech version of the review refers to the Czech version of the 11th revision of the ICD where a Czech localisation exists, and to the English version where a localisation is not yet available. This English version of the review refers solely to the English version of the ICD-11.

The relevance of the screening was assessed from the abstracts, and the relevance of the cited sources from the full text. One hundred and sixteen sources were selected based on the established criteria. Given the required scope of the thesis, some less relevant or similar sources were not used in the submitted version.

Conflicts of interest

The author of this paper works within the modality of the person-centred approach, the premises of which are in many ways consistent with the neurodiversity paradigm.

A note on terminology

When referring to autism, the terms autism and autistic are used in line with the identity-first language approach (see, e.g., Taboas et al., 2003).

Results

The narrative synthesis identified three moments that help to clarify the implications of the theoretical framework of the neurodiversity paradigm for clinical practice. The first is the absence of a convincing

universal model of autism that adequately explains the clinically, objectively and subjectively observable autistic experience while providing clearly defined criteria for distinguishing pathology from normal experience. Second, it is the implicitly splitting nature of medical language, which forces us towards partial descriptions and perceptions of the client's experience, with implications for the field of diagnosis and for methods of intervention. Third, it is the way in which non-splitting language leads to a shift from working with the diagnosis to working with the client themself in the context of their particular neurodivergent experience, understood as a combination of innate aspects and developmental consequences.

The frontiers of familiar models and the limits of language

Frequently cited frameworks for understanding autism include (a) the triad of impairments and (b) the theory of mind. The triad of impairments (Wing and Gould, 1979) refers to 1) impairments in social interaction, 2) abnormalities in language development as evidenced by speech and gestures, and 3) a behavioural repertoire of repetitive stereotyped movements. The triad was an important factor in the classification of autism in the DSM-4 and ICD-10 (Happé and Ronald, 2008). Cashin and Barker (2009) argue that the behavioural triad is the result of a triad in cognitive functioning: 1) visual information processing, 2) impairments in abstraction, and 3) impairments in theory of mind (ToM). The concept of ToM (Baron-Cohen et al., 1985) contributed to the popular and still oft held notion that autistic people are incapable of empathy, although Baron-Cohen (1988) himself distinguished two components of empathy – affective and cognitive. Baron-Cohen locates problems in social interaction in the cognitive domain, namely the ability to imagine what the other person is experiencing. ToM has been criticised by several research teams, e.g. Zelazo et al. (2002). Gernsbacher and Yergeau (2019) have extensively documented the shortcomings of ToM, including failures in basic criteria of scientific work such as the principle of universality, specificity and reproducibility. In the triad of impairments, there is no single factor that explains all three parts of the triad (Happé and Ronald, 2006), nor are there any consistent neurochemical, neurophysiological or neuroanatomical abnormalities that would indicate autism (Bolis et al., 2018). There is no distinction between pathology and normal human traits (London, 2007). The concept of double empathy (Milton, 2012) contradicts the one-sided attribution of difficulties in social communication. Instead, it focuses on the issue of reciprocity and mutuality arising from the different experiences and neurological functioning of autistic and non-autistic people. It is difficult for non-autistic people to read the social responses of autistic people (Sheppard et al., 2016), resulting in negative perceptions of autistic people (Sasson et al., 2017; Alkhadi et al., 2019; Scheerer et al., 2022). When comparing the communication dynamics of the two groups, there are no significant differences in initiating and responding to social contact (Chen et al., 2021; Chen et al., 2021). Communication works well in homogeneous groups, but there are distortions in heterogeneous groups (Crompton et al., 2020).

The binary condition in which an individual's divergent developmental trajectories and ways of thinking, expressing, and behaving are either completely ungraspable to us linguistically or are labelled as disabilities is noted by Singer (1999), who writes about the need for a new language that allows us to better understand and reflect the reality we encounter. There is a lack of appropriate language for describing autism that distinguishes between interpretations of behaviour that can be observed and internal experiences that cannot be observed (Hacking, 2009). This is illustrated in the video "In My

Language" (Baggs, 2007). The consequence is that we behave as if what we cannot see does not exist (Lovett, 1996). The language of the 11th revision of the ICD is more cautious – differences can be considered deficits if they are "sufficiently severe to cause impairment in personal, family, social, educational, occupational or other important areas of functioning" (6A02) (World Health Organization, 2019/2021). Nevertheless, disability is currently defined by the abnormalities and not by the seriousness of the impact of the phenomenon on the person (Kunc and Van der Klift, 2019). Without this, very severe cases of migraines, for instance, which make it impossible to function normally, would have to be considered as a disability. We can also witness a terminological shift towards the label 'autism spectrum condition' (e.g. Lai et al., 2013). The scientific community is fragmented in its approach to autism, both in the language used, assumptions, hypotheses and areas of satisfaction with research, and in the handling of data (Botha and Cage, 2022).

Splitting

One consequence of language limitations in relation to autism is the splitting of the client's intrapsychic representation. Psychoanalytic theory works with the concept of splitting (Fairbairn, 1940), whereby we divide the experience of reality into two separate parts: good and bad. The good part is consciously accepted, while the bad part tends to be repressed and becomes part of our unconscious phantasies (Klein, 1975). According to Melanie Klein (1975), it is developmentally important to achieve the capacity for ambivalence, whereby the same object can be seen as both good and bad at the same time. The language of the medical model is implicitly a splitting language (Carveth, 2023). Splitting prevents us from considering the totality of the client's life and mode of experiencing in the context of their development and life experiences (Yergeau, 2018). When we do not understand the client's utterances, we regress to splitting by stating that autism is to blame (Mack, 2019). At such times, we ascribe autism traits that are not there. There is symptomatic overlap with post-traumatic stress disorder (PTSD) (Baudino et al., 2010; Pöthe, 2023; Pöthe and Očková, 2023), aversive childhood experiences (Dodds, 2020), borderline personality disorder (Dell'Osso et al., 2023), and other conditions (Takara et al., 2015). Alvarez (1992) describes overt dissociative states in a case study of an autistic boy. Moskowitz et al. (2019) extensively document the role of dissociative states in relation to trauma and PTSD and illustrate common cases of misdiagnosis. The high likelihood of co-occurring PTSD is also reported by Kildahl et al. (2019). Diagnostic instruments for autism are severely limited in this regard (Friveaux et al., 2019). As co-occurring diagnoses are the norm rather than the exception, it can be dangerous to base an intervention on only one diagnosis (Thapar et al., 2017).

Parents engage in splitting when they have fantasies about the healthy child they had at home before the diagnosis and the child who now 'has autism'. Part of this fantasy is the idea that there was once a 'non-autistic' child hiding under the veneer of autism (Sinclair, 2009). Such a fantasy manifests itself in a stubborn refusal to refer to the autistic person as anything other than 'the person with autism'. This is a psychological defence (Walker, 2021). The abandonment of this idea is a transition towards ambivalence. Simply intervening with parents to help them see their child's actions as meaningful and as connected to their intentions can improve communication (Aldred et al, 2004; Mahoney and Perales, 2003).

Some interventions work with split fantasy as reality; for example, Applied Behavioural Analysis (ABA) tends to be described as an evidence-based approach (e.g. Smith, 2013). However, in a meta-analysis, Sandbank et al. (2020) note the lack of well-conducted research. The effectiveness reported by Lovaas (1987) has not been replicated in a randomised clinical trial (Smith et al., 2000, 2001). Based on extensive research over many years, Donovan (2020) concludes that ABA therapy is ineffective regardless of the duration of intervention. Some authors suggest that ABA therapy may lead to traumatisation and the development of PTSD (Kupferstein 2018; Sandoval-Norton et al., 2019).

Approaches that motivate the child to repress part of their experience can lead to a splitting, i.e. a fragmented, intrapsychic reality in the mind of the child (Pöthe, 2022), as we know from divorce proceedings, for example from Woodall (2022). The child may identify with the environment's wish or idea of how they should be. Donald Winnicott described such a reactive form of identity as false (Winnicott, 1960) and Carl Rogers (1961) spoke of false roles. So-called autistic camouflaging or masking is also referred to in ICD-11 as "an exceptional effort to compensate" (6A02) (World Health Organization, 2019/2021). Research suggests that it is a risk factor for anxiety, depression and suicidality (Cassidy et al., 2018; Hull et al., 2021). To avoid splitting in clinical work, we need a language that allows us to consider the client's experience in its entirety.

The neurodiversity paradigm

Neurodiversity is a biological fact that reflects an infinite number of variations in human neurocognitive functioning (Walker, 2014). Chapman sees neurodiversity as a scientific concept that provides a new perspective on function and dysfunction (Chapman, 2020). The neurodiversity paradigm provides a language through which we can describe neurodevelopmental differences without seeing them as a source of stigmatising diagnosis (Constantino, 2018). Asasumasu introduced the term neurodivergence in 2000 to refer to any significant deviation from the dominant social norms (Walker, 2021). Walker (2021) has suggested that neurodivergence can be genetic and innate (autism, dyslexia), acquired through brain-altering experiences (trauma), or a combination of both. Walker refers to the process of becoming aware of one's own neuronormative attitudes and experiences and seeking to understand the inherent neurodivergent ways of experiencing and thinking in oneself and others as neuroqueering (Walker, 2021). Greaves-Lord (2020) situates the perspectives of the neurodiversity paradigm within the so-called biopsychosocial model (Engel, 1977). It represents a natural evolution of the tension between the medical and social models and allows for reflection on psychological aspects of experience, such as individual uniqueness (Whelpley et al., 2003). In the clinical practice of speech and language therapists, psychiatrists, psychologists and other professionals, neurodivergence can be understood in the context of individual development. It implies a shift from working with a specific diagnosis to working with a specific client (De Thorne et al., 2021). The broad nature of autism, combined with co-occurring phenomena (known as comorbidities), is so heterogeneous (Lai et al., 2019) and life histories so varied (Kanner, 1971) that diagnosis has limited informative value for clinical practice.

Clients with a diagnosis of autism are at risk for having their experiences and difficulties seen as a consequence of autism, even in cases where we would look for other causes of the same problem in clients without a diagnosis (Mack, 2019). In the neurodiversity paradigm, we abandon pathologising

ideas and the terminology of 'disorders' and focus on the client's experience (Walker and Raymaker, 2021). For the client, the validation and acceptance of their experience, including its otherness, is crucial. Autism does not need to be at the centre of the conversation unless the clients themselves demonstrate a need to address it (Brook, 2023). If we allow ourselves not to split the client's behaviour and experience according to our own or external normative ideas, we will allow the client to integrate all aspects of their experience, as described by Rogers (1961, p. 80): 'The end point of this process is that the client discovers that he can be his experience, with all of its variety and surface contradiction; that he can formulate himself out of his experience, instead of trying to impose a formulation of self upon his experience, denying to awareness those elements which do not fit.'

Applying the perspectives of the neurodiversity paradigm does not preclude concurrent work within the traditional medical model (Sonuga-Barke and Thapar, 2021). Such a dynamic is consistent with the model of paradigm shifts in science described by Kuhn (1962).

Conclusion

The theoretical underpinnings of the neurodiversity paradigm have implications for working with clients in clinical practice, allowing us to use non-pathologising language and thus relate to the totality of the client's experience. We see the client's experience as meaningful in the context of their development, which prevents us from regressive essentialism that would lead to the application of normative interventions. The lack of a universal model of autism, the shortcomings of existing models, and the highly heterogeneous nature of the autism spectrum lead us to a dynamic approach to the client and their experience. The autistic experience, like other neurodevelopmental phenomena, does not need to be explicitly labelled in order for us to work with the client. Trauma or co-occurring conditions may play a significant role and may constitute a contraindication to autism-specific interventions.

Discussion

The foundations of the neurodiversity paradigm may shape our clinical practice, but the historical context of autism and the perspectives of traditional medical and biopsychosocial models must inevitably inform scientific discussion. Therefore, the present paper is also structured as a review of the traditional conceptualisation, problematisation and consequent delineation of the role of the neurodiversity paradigm. Given the format of the rapid review, the nature of the sources is quite diverse, ranging from randomised controlled clinical trials (e.g. Smith et al., 2000, 2001) to autoethnographic accounts in the field of speech and language, such as those offered by Baggs (2007). Given its limitations, the review could not explore some models of autism that might be considered important, such as the Intensive World Theory model (Markram and Markram, 2010), which offers neuroscientific perspectives describing sensory aspects of the autistic experience, also reflected in the ICD-11. Although the neurodiversity paradigm seeks a non-pathologising approach, it does not shy away from the notion of disability, contextualised from the perspective of the social model of disability (Oliver, 1990). Walker (2021) refers to 'social trauma' in this regard. Thus, in addition to disability, sexual orientation, gender, socio-economic realities, ethnicity and experiences of marginalisation, anger and powerlessness can play an important role. Exploring the dynamics of divergence and normativity is key, with individual characteristics of both changing over time. Perhaps this is also a barrier to the

formulation of static models of autism. Dynamic models of reciprocity may be more appropriate, as Bolis et al. (2023) argue for in the field of social communication. Awareness of the static nature of current models leads to the need for the regular critical review and reinterpretation of existing knowledge, as demonstrated, for example, in the field of schizophrenia by Moskowitz et al. (2019). Although the neurodiversity model seems incompatible with behavioural approaches according to the present work, some (i.e. Schuck et al., 2021) suggest theoretical possibilities for reconceptualisation through naturalistic behavioural developmental interventions in their work. The perspectives of the neurodiversity paradigm coexist with traditional models and have an unmistakable role in clinical practice and research.

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