WORKING FROM A NEURODIVERSITY-AFFIRMING PERSPECTIVE

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Eating Disorder Registered Dietitians & Professionals
ELEVATE YOUR SKILLS

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ABOUT ME

- Registered dietitian & activist with 17 years of clinical experience
- Private practice in Montreal, Qc
- Late identified multiply neurodivergent (autistic, ADHDer, dyslexic, APD)
- Founder of RDs for Neurodiversity

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TODAY'S TOPICS

- Terms, definitions and the neurodivergent umbrella
- Neurodivergent traits and their impact on eating and feeding
- Exploring barriers that can make accessing support difficult
- Neuro-affirming support and the Neurodiversity Affirming Model ®
- Accommodations

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TODAY'S PRESENTATION

An invitation to:

- Question how you currently offer care to neurodivergent clients
- Lean into your discomfort
- Stay curious
- Reflect on your experiences as a provider
- Explore future possibilities

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Please take care of yourselves!

Content warning

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USE OF AFFIRMING LANGUAGE

- Challenging the use of deficit language
- Identity first vs person first
- Functioning labels are harmful

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NEURODIVERSITY

- The term neurodiversity refers to variation in the human brain (mind) regarding sociability, learning, attention, mood and other mental functions.
- Coined in 1998 by Australian sociologist Judy Singer, who helped popularize the term along with American journalist Harvey Blume.
- The Neurodiversity Movement is a social justice movement that seeks civil rights, equality, respect, and full societal inclusion for the neurodivergent.
- Neurodivergent, sometimes abbreviated as ND, means having a mind that functions in ways which diverge significantly from the dominant societal standards of "normal." (coined by Kassiane Asasumasu)

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NEURODIVERGENT UMBRELLA NON-EXHAUSTIVE LIST

- Autism spectrum "disorder" (Autistic spectrum)
- "Pathological" demand avoidance, Persistent drive for autonomy (PDA)
- Attention "deficit" hyperactivity "disorder" (ADHD)
- Rejection sensitive dysphoria (RSD)
- Sensory processing differences (SPD)
- Obsessive compulsive "disorder" (OCD)
- Dyslexia
- Traumatic brain injury (TBI)
- Anxiety & depression
- Borderline personality "disorder" (BPD)
- ARFID (?!)

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TRAUMA AND NEURODIVERGENCE

- Sensory trauma (unmet sensory needs, sensory overload, lack of acceptance and accommodations)
- Social trauma (bullying, isolation, masking)
- Compliance trauma
- Neurological trauma (dealing with uncertainty, communication, language, interoception challenges, processing differences)
- Medical trauma (being misunderstood by medical and health providers)
- Masking, invalidation trauma and ableism

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WHAT IS MASKING?

"There is a misconception that Autistic Masking is about 'fitting in' or wanting to appear to be more non-Autistic (Neurotypical). That implies that conscious choices are being made to Mask, which further implies that it is a deceit. Even the names that are used: masking, camouflaging, assimilating all imply that notion. There is also a misconception that Autistic Masking is a series of social strategies, used by Autistic people to navigate social situations. Things that are picked up, used and then discarded. It is so much more complicated than that though. Our understanding of Autistic Masking needs to be reframed, because Autistic Masking is a trauma response to stigma, invalidation and marginalization."

-Kieren Rose (www.autisticadvocate.com)

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- Neurodivergence is dramatically underdiagnosed in marginalized populations
- The diagnostic criteria themselves are flawed
- Assessments aren't accessible and are costly
- There can be negative consequences to seeking a professional diagnosis
- "Treatment" can be abusive and parents of children with less dominate identities might choose not to get a professional diagnosis.
- **Self-diagnosis is valid!**

DIAGNOSIS AND GATEKEEPING

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- Clients might feel hesitant to disclose their diagnoses, especially when safety is compromised (stereotypes, stigma & judgment)
- Sometimes, diagnoses are weaponized againist ND people, disclosure can compromise safety and agency
- There can be fear of judgment and invalidation
- Clients might appear uninterested, "resistant", "avoidant", "unmotivated", and "non-compliant" when coaching is not trauma informed, affirming, inclusive & safety is compromised
- Pathologizing protective behaviours are harmful, be curious about your client's behaviour
- Focus on connection, building trust and safety with all your clients **regardless of their neurotype**.

DIAGNOSIS, DISCLOSURE AND SAFETY

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NEURODIVERGENT TRAITS THAT IMPACT EATING

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SENSORY PROCESSING DIFFERENCES INCLUDING INTEROCEPTION

- Brand specificity, texture aversions, "food selectivity", temperature preferences, sensory overload during meals, low or high threshold to sensory input (Dunn)
- Sensitivity to mixed textures (foods can't touch)
- Eating is sensory!

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Executive functioning

- Executive function and self-regulation skills are the mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully (working memory, mental flexibility, and self-control)
- Challenges can show up in the following area:
- Meal planning
- Cooking
- Grocery shopping
- Eating schedule
- Food wastage
- Distractibility

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OTHER TRAITS THAT IMPACT FOOD AND EATING
• Oral motor differences
• Demand anxiety
• Social selectivity
• Decision making
• Sense of time
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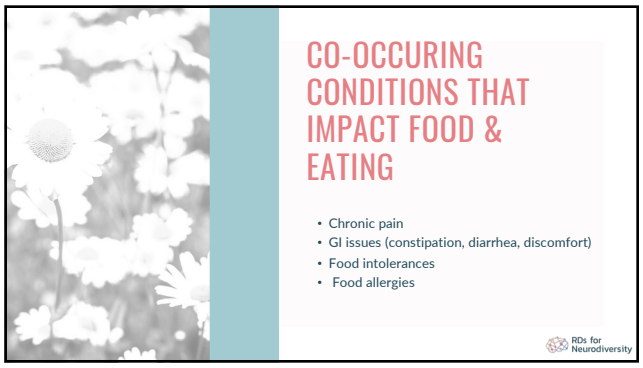
CO-OCCURING CONDITIONS THAT IMPACT FOOD & EATING
• Chronic pain
• GI issues (constipation, diarrhea, discomfort)
• Food intolerances
• Food allergies
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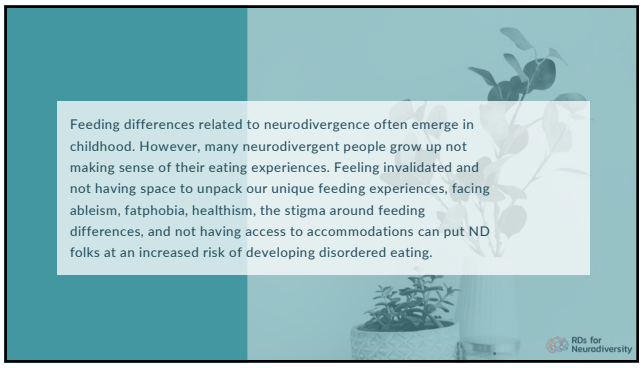
Feeding differences related to neurodivergence often emerge in childhood. However, many neurodivergent people grow up not making sense of their eating experiences. Feeling invalidated and not having space to unpack our unique feeding experiences, facing ableism, fatphobia, healthism, the stigma around feeding differences, and not having access to accommodations can put ND folks at an increased risk of developing disordered eating.
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Neurodivergent people have unique experiences with food and eating. These differences are not inherently bad, nor do they need correction. Invalidation, lack of acceptance, decreased access, and lack of accommodations can exacerbate eating and feeding. Neuordivergence impacts food choices and how people interact with food. Because many neurodivergent people are highly sensitive to their environment, the eating environment can either facilitate eating or create barriers. When working with neurodivergent people with feeding differences, we must prioritize accommodations, decrease barriers to eating and focus on making eating more accessible.

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Barriers to Accessing Support

Systems of oppression that negatively impact eating

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Deconstructing Normalcy

- Normalcy: The condition of being normal; the state of being usual, typical, or expected.
- Normality: Built on an idea of "natural" and denotes average, usual or ordinary.
- Used to justify the exclusion of those who are not ordinary or typical (Normal vs defective)

Constructing normalcy (Based on Lennard J. Davis' work)

- A "normal" body creates "deviant" bodies.
- "The idea of a norm pushes the normal variation of the body through a stricter template guiding the way the body 'should' be".
- The ranked order creates a new 'ideal' of the human body.

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Neurodivergent embodiment, food culture and ways of eating are often labelled "not normal"

- Neurodivergent embodiment and way of being are not accepted by society.
- Texture preferences are seen as rigid and something to be fixed through cognitive behavioural therapy and "brain altering" methods.
- Brand specificity is seen as something to be "cured".
- Dichotomy (Dieter vs intuitive eater) makes ND folks feel damaged
- IE is not always accessible (shame, guilt, feeds the "I am broken" cycle)
- Same foods are pathologized
- Grazing is demonized
- Relying on exteroceptive senses to nourish our bodies is considered the "second best" option.

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Challenging sanism and ableism

- Sanism is a form of systemic and systematic discrimination and oppression of people who have been diagnosed with psychiatric disorders, or who have or are perceived to have mental differences or emotional distress.
  (Vermont psychiatric survivors)
- Ableism is a system that places value on people's bodies and minds based on societally constructed ideas of normalcy, intelligence and excellence. (Talia L Lewis)

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Challenging sanism and ableism

- "Proper" use of utensils & table manners
- Infantilizing food choices is a form of ableism.
- Hyperfocus on hunger/fullness & "fixing" interoceptive awareness (fatphobic & ableist)
- Social interaction is expected which increases demands and anxiety in children and adults who are socially selective.
- Neurodivergent feeding behaviors often labelled "unusual", "strange", "weird", "rigid"
- "Picky eating" or ARFID therapy often focused on making feeding easier for the caregiver (it's often about "fitting in" and appearing "normal")

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Challenging healthism

- Healthism perpetuates the misconception that illness or disability can be avoided or cured solely through healthy lifestyle choices like eating the "right" foods & exercising regularly.
- Many factors can contribute to chronic illness, disability, and neurodivergencies, including but not limited to genetics, viral infections, history of trauma or mental illness, lack of access to preventative healthcare, and social determinants.

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BARRIERS (CLIENT'S PERSPECTIVE)

Forced hospitalization

Feeling unseen

Experts know best

Lack of affirming support

Invalidation

Denied accommodations

Coercive treatment

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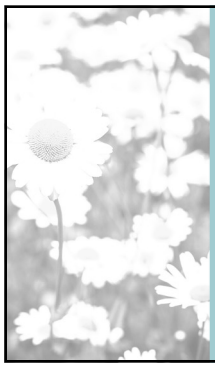

WHAT CAN AFFIRMING SUPPORT LOOK LIKE?

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REMOVING SHAME AND STIGMA

- Spectrum of ability is part of human experience
- **Normalizing** feeding **differences is crucial to reducing shame and internalized ableism which negatively impact** clients' **health and overall well-being**.
- Challenge therapy goals focused on making ND people appear more neurotypical encourages masking.
- Masking is a trauma response. Providers must create spaces where unmasking is possible, where people can process and understand their eating differences and feel validated and understood.
- Many ND people will never eat like neurotypical people!

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THE NEURODIVERSITY AFFIRMING MODEL®

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THE NEURODIVERSITY AFFIRMING MODEL®

- NAM is a framework based on inclusion and acceptance. It is an anti-oppressive methodology that is informed by social justice education, such as disability justice, disability studies, neurodiversity studies, mad studies, critical autism studies and fat studies. It was developed to intervene against the current oppressive models that center individualism and are inherently fatphobic, ableist and sanist. It challenges the medical model of disability, neuronormativity and pathological paradigm that currently pervades and anchors education and practice in dietetics and the mental health field.

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FIVE PILLARS

1. Anti-oppressive + anti-ableist
2. Leadership of those most impacted
3. Acceptance-based
4. Trauma-informed
5. Body liberation

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AFFIRMING SUPPORT ACCEPTANCE-BASED (3RD PILLAR)

- Strength-based and client-centered
- Validate client's eating experiences
- Reduce barriers to eating
- Improve access to preferred foods
- Always honour the client's sensory experiences
- Work with the client's current bodymind
- Accommodate and offer tools so clients can advocate for themselves
- Explore structure and routine
- Challenge healthism, diet culture & other forms of oppression that prevent clients from developing a positive relationship with food and their bodies.

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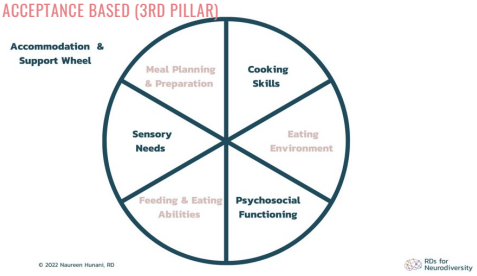
ACCOMMODATION AND SUPPORT WHEEL

ACCEPTANCE BASED (3RD PILLAR)



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SPOON THEORY
LEADERSHIP OF THOSE MOST IMPACTED 2ND PILLAR

Spoon theory:
Coined by Christine Miserandino, an individual with lupus, is popular among many disabled folks and people dealing with chronic illness. It describes perfectly this idea of limited energy, using "spoons" as a unit of energy.

Questions to explore:
How many spoons are clients left with at the end of the day? How many spoons are required to cook certain meals?

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SPOON THEORY

Consider the following:

- Executive functioning skills/differences
- Chronic pain
- Sensory overload
- Window of tolerance

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OTHER CONSIDERATIONS

- Communication style and needs (in person vs virtual, eye contact)
- Office set up (seating, lighting, noise)
- Does the person require any other assistance?
- Allowing fidgets or any other tools for regulation
- Note taking, consider memory
- Always ask how you can accommodate and make care more accessible!

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Questions

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