
Neurodiversity- Affirming Care

Understanding and Navigation of Care for Neurodiverse Populations

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Learning Objectives

1. Describe autism spectrum disorder and other developmental disabilities while dispelling common myths.
1. Reframe behavioral presentations using a neurodivergent and trauma-informed lens. Implement evidence-informed communication and co-regulation strategies to support participation.

Opening Reflection

A patient is distressed, refusing care, and difficult to redirect.

What is your **FIRST** thought?

- A) Noncompliance
- B) Anxiety
- C) Sensory overload
- D) I'm not sure
- E) Other...

Why This Matters

The Impact of Misunderstanding

Misunderstood behaviors can lead to increased distress and provider frustration.

Core Healthcare Barriers

Neurodivergent patients experience healthcare barriers involving:

- **Communication**
- **Environment**
- **Provider Knowledge**

KEY: The healthcare interaction itself can become part of the patient's stress load.

What is Neurodiversity? What is Trauma-Informed Care?

Neurodiversity:

- Natural variation in how brains develop and function (ND Alliance, 2025)
- Not a diagnosis itself
- Examples of neurodiversity:
 - Autism, ADHD, Dyslexia, Dyspraxia, Sensory Processing Disorder

Trauma-Informed Care:

- Recognizes how trauma can impact regulation, behavior, and a person's experience of healthcare (SAMHSA, 2026)
- Respond by creating **safety, trust, collaboration, and choice** while actively working to avoid retraumatization (SAMHSA, 2026)
- A shift from “What’s wrong with this patient?” to “What does this patient need to feel safe, heard, and empowered to participate in care?”

“Diagnosis” from a neuro-affirming lens-

- Describes patterns of the brain
- Identifies strengths and challenges
- Helps providers/others understand what may best support and not support the patient

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Autism: What Providers May See

**Social Communication
Differences**

**Sensory Processing
Differences**

Repetitive Behaviors

**Executive Functioning
Differences**

A TAKEAWAY: Foley & Baz (2021) describe behaviors that may appear aggressive as potentially secondary to sensory, neuroceptive, and emotion dysregulation rather than intent to harm.

Autism: Key Findings (2022)

Prevalence & Demographics

1 in 31

(32.2 per 1,000 overall)

- **Range:** Significant site-specific variation, from 9.7 in Texas to 53.1 in California.
- **Gender Gap:** 3.4x more prevalent in boys (49.2) than girls (14.3).
- **Racial/Ethnic:** Prevalence higher among minority groups (Asian/PI 38.2, AI/AN 37.5, Black 36.6, Hispanic 33.0) compared to White children (27.7).

Co-occurring Disability

39.6%

Classified with intellectual disability

- Higher among Black (52.8%) and American Indian/Alaska Native (50.0%) children compared to White children (32.7%).

Early Identification

1.7x Higher

Diagnosis/eligibility by 48 months

- Observed in children born in 2018 compared to those born in 2014, despite temporary COVID-19 evaluation disruptions in 2020.

Public Health Interpretation

- **Improved Access:** The shift toward higher prevalence in historically underserved groups and improved early identification reflect successful efforts to increase diagnostic and support access.
- **Equitable Strategies:** Marked geographic variability highlights the ongoing need for equitable, consistent implementation of screening and support systems.

Source: CDC Autism and Developmental Disabilities Monitoring (ADDM) Network, 2022. Based on data from 16 active surveillance sites.

Autism Support Levels

LEVEL 1

Requires support

LEVEL 2

Requires substantial support

LEVEL 3

Requires very substantial support

Support needs can change with age, stress, illness, and environment.

KEY: A support level is not a measure of intelligence, worth, or “how autistic” someone is.

(Martinelli, 2026)

Attention- Deficit/Hyperactivity Disorder (ADHD)

Understanding ADHD

Challenges with attention regulation, inhibition, working memory, executive functioning, and emotion regulation.

Three Ways ADHD Presents: Inattentive presentation, hyperactive-impulsive presentation, and combined presentation.

Areas of Impact

ADHD affects multiple areas of daily functioning and behavior under stress:

- **Attention Regulation & Impulse Control**
- **Working Memory & Organization**
- **Processing Instructions & Transitions**
- **Waiting & Emotion Regulation Under Stress**

Current U.S. Prevalence

11.7%

7.0 Million Children
Ages 3–17 with
active ADHD (2024)

13% vs 7%

Boys vs. Girls
Boys more likely
diagnosed (2022-23)

15.5M

Adults with ADHD
Currently diagnosed
in US (CDC 2023)

Co-Occurring Diagnoses

Sensory Processing Disorder (SPD), Autism, Depression, Tic Disorders, and Anxiety are co-occurring diagnoses.

Clinical implication: Heightened sensory or emotional demands in acute or outpatient settings may further reduce access to executive skills.

Sensory Processing Disorder (SPD)

- “Developmental immaturity or impairment in the ability of the nervous system to take in and process sensory signals leads to some degree of disorganization in many aspects of daily life..” (Stallings-Sahler et al., 2022)
- SPD is not a DSM-5 diagnosis. May occur with or without autism.
 - 87% of children with autism had atypical sensory processing challenges (Lord, 1995, as cited in Stallings-Sahler et al., 2022)
- SPD broken into 3 main subtypes- sensory modulation disorders (SOR, SUR), sensory discrimination disorder (perception of vestibular, tactile, etc.) and sensory based motor disorders (dyspraxia and posture) (Stallings-Sahler et al., 2022)
- Stallings-Sahler et al. (2022) found the prevalence of SPD has been estimated to be from 5% to 16% of children nationally
- Potential causes of SPD- appears to be a genetic predisposition, perinatal risks and delivery complications, prematurity, and invasive medical caregiving in NICU environment where sensory experiences can be painful, postnatal occurrence such as jaundice or frequent ear infections have been associated with SPD. (Stallings-Sahler et al., 2022)

Clinical implication: sensory load can change participation, communication, and apparent behavior.

Behavior is Communication: A Reframe

Instead of: “How do I stop this behavior?” or “How do I change this behavior?”

Consider: “What is the nervous system communicating?” or “Why could it make sense they are behaving this way?”

- Always assess medical causes first
- Secondly consider: fear/other emotions, sensory load, communication barriers, task demands, fatigue and arousal state

Myth → Reframe

Myth

"They're being noncompliant."

Myth

"Eye contact means attention."

Myth

"They are having a meltdown...a tantrum...a freakout."

Myth

"Quiet means comfortable, they are okay."

Reframe

"What barrier is preventing participation?"

Reframe

"What communication style may work for this patient?"

Reframe

"Could this be sensory overload or loss of regulation?"

Reframe

"Am I missing any signs of distress?"

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Why Healthcare Environments Can Amplify Stress

ACUTE CARE: pain, alarms, bright lights, unfamiliar staff, procedures, sleep disruption, loss of control

OUTPATIENT: waiting, transitions, crowded spaces, time pressure, unfamiliar routines, repeated instructions

KEY: The same patient may function very differently across contexts.

What Are Patients with Autism Telling Us?

Mazurek et al., 2023 — Perspectives of Autistic Adults

20 adults with autism shared their healthcare experiences through surveys and individual interviews.

1. SYSTEM + CLINIC FACTORS

- Scheduling
- Cost / Insurance
- Transportation

2. HEALTHCARE ENVIRONMENT

- Sensory input
- Anxiety-provoking procedures
- Waiting

3. PROVIDER PRACTICES

- Autism knowledge
- Communication & rapport
- Individualized care
- Patient-provider partnership

Key: Healthcare experiences are shaped not only by the patient's characteristics—but by the **interaction between the patient, provider, environment, and healthcare system.**

The Provider Matters

Mazurek et al. (2023) — Perspectives of Autistic Adults

Five key provider-level factors were identified as central to positive healthcare experiences:

1. KNOWLEDGE

Understanding autism is different for every person

2. COMMUNICATION

Communicate in a way that works for the patient

3. RAPPORT

“I feel understood and respected.”

4. INDIVIDUALIZATION

Don't assume what the patient needs based on their diagnosis

5. PARTNERSHIP

“Work with me—not simply on me.”

Key: Neuroaffirming care is relational.

The goal isn't to learn a list of “autism behaviors” — the goal is to learn how to understand the individual in front of you.

Neuroception

What Is Neuroception? (Before Conscious Thought...)

Neuroception describes the nervous system's rapid, largely unconscious detection of cues associated with **safety, danger, or threat**. **Neuroception** is perceived through **auditory and visual cues**.

What is being detected?

ENVIRONMENT

Noise, lighting, movement, and unfamiliar surroundings.

OTHER PEOPLE

Facial expression, voice, prosody, posture, proximity, and touch.

OUR BODY

Pain, breathing, heart rate, and internal sensations.

The Clinical Connection

- **Autonomic Influence:** Cues can alter autonomic state, emotion, behavior, and communication before conscious awareness.
- **Automatic Threat Response:** Patients do not need to consciously think "I am unsafe" for the nervous system to react defensively.

Why Does Neuroception Matter in Healthcare?

WE ARE PART OF THE ENVIRONMENT: A patient may be receiving information from us **before we ever begin explaining the procedure, information, test results etc.**

OUR FACE

What is my facial expression communicating?

OUR VOICE

Is my tone calm, rushed, frustrated, or demanding?

OUR BODY

What are my posture, proximity, movement, and pace communicating?

EXPECTATIONS

Am I communicating:
"You need to cooperate"
or *"I am here to help you feel safe enough to participate"*?

Clinical Implication: Connection + predictability + attunement can help reduce unnecessary stress and create greater access to participation.

ASD & Neuroception: According to Stephen Porges, a core deficit in autism is **faulty neuroception**. Those with ASD often perceive their experience in relation to the world as dangerous and have difficulty perceiving auditory and visual cues.

Perception of Stress: It Can Change Our Sense of Safety

- REGULATED Nervous System → more flexible thinking and communication
- STRESSED Nervous System → less flexible; greater reliance on familiar pattern, routine, or familiar behavioral responses

In a healthcare setting...

- Patient may be experiencing or interpreting that there is a threat → important for providers to think about what that threat may be:
 - Overwhelm, uncertainty, loss of control, etc.
- A stressed nervous system experiencing fear responds in 1 of 4 ways:
 - Fight, Flight, Freeze, Fawn Linehan et al.(2025)

KEY: A patient may need more support than their baseline suggests.

Arousal State and Transitions

CALM → ALERT → STRESS → FIGHT / FLIGHT → FREEZE / SHUTDOWN

SCAFFOLDING TRANSITIONS

Tal Baz's teaching emphasizes scaffolding transitions through attunement, reciprocity, pacing, and co-regulation.

SHIFTS TOWARD STRESS

Hospitalization, pain, sensory load, and unfamiliarity may shift a patient toward stress states (fight/flight, freeze/shutdown).

ABRUPT TRANSITIONS

"[An] Abrupt transition... demonstrates a costly use of energy (maladaptive) and poor communication through behavior."
— Lillas & Turnbull, 2009, as cited in T. Baz, personal communication, November 25, 2020

KEY: Support the transition; do not demand regulation, give time for transition between states, be mindful of the state the patient is upon your arrival.

Regulation and Patient Interaction

A Capacity-Based View

Dan Siegel Hand Model

Zier Institute's Framework: A 3 Step Approach

1. Safety/ Regulation
2. Connection
3. Problem solving, vulnerability, asking for help, explanations, providing answers

Far too often we jump to Step 3 trying to change the situation or problem solve when the brain is not ready for this!

KEY: When regulation is compromised, higher-level capacities of the brain may be harder to access.

Zier Institute Framework

Informed by DIR/Floortime, DBT, trauma-informed care, and neurodiversity-affirming practice.

Step 1: Safety and Regulation

SAFETY

What is it?

Is this a threat to my life, health, or well-being?

Linehan et al.(2025)

REGULATION

What is it?

One's ability to attune to self and others, alert to the environment, and feel content and connected to self

Zier Institute Framework

Informed by DIR/Floortime, DBT, trauma-informed care, and neurodiversity-affirming practice.

Step 1: In- the- Moment Regulation

Consider:

Am I regulated? Is the patient regulated?



Zier Institute Framework

Informed by DIR/Floortime, DBT, trauma-informed care, and neurodiversity-affirming practice.

If the answer is no...

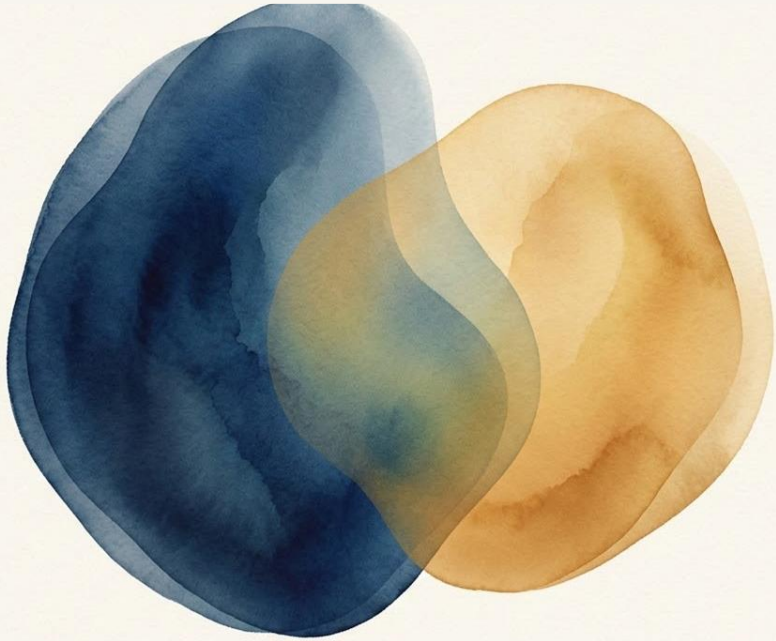
1. Check the Threat: Is this truly a threat to my life, health, or well-being? If not...

2. PAUSE: Take a deep breath.

3. Co-Regulate: If the patient is dysregulated, consider:

- Your body position: sit down, get on eye level
- Use fewer words, more affect and gestures

Step 2: Connection with Self and Others



KEY: Build connection by setting aside judgments, actively listening to the patient's underlying needs, and validating their emotional experience.

Step 2 Guidelines

- 1. Let Go of Background Noise:** Be mindful of past experiences, judgements, expectations. Use mindfulness to stay in the moment.
- 2. Chase the Why:** Look for what's behind the actions instead of focusing only on behavior. Identify the underlying unmet need.
- 3. Stop Talking & Listen:** Don't explain, lecture, or try to talk them out of feelings. Listen for meaning and emotions.
- 4. Validate:** Acknowledge the underlying feeling even if you don't like the behavior. Validate that their emotions are legitimate.
- 5. Reflect What You Hear:** Once you have listened, repeat and reflect back what you have heard to establish real connection.

Zier Institute Framework

Informed by DIR/Floortime, DBT, trauma-informed care, and neurodiversity-affirming practice.

Concepts adapted from the work of Daniel J. Siegel, M.D., and Tina Payne Bryson, Ph.D.

Step 3: Problem Solving, Sharing, Vulnerability, Explanations



KEY: Move into your objective while maintaining regulation and connection.

Step 3 Guidelines

1. Ask & Explain:

Now is the time to ask questions, explain, and share perspectives.

2. Monitor the Process:

This is not always linear. Actively watch for cues from the patient indicating they are becoming uncomfortable or upset.

3. Interactive Self-Awareness:

Be mindful of your own interactions and pace:

- Am I talking too fast?
- Am I asking too many questions?
- Am I giving too many steps at once?

From “Refusal” to Participation Across Settings

A patient is distressed, refusing care, and difficult to redirect.

TRADITIONAL FRAME • “The patient won’t cooperate.”

MINDSET SHIFT • “What could be making this patient feel unsafe or invalidated?”

NEW PLAN • Reduce sensory load • explain one step • offer choice • pause • use caregiver knowledge
• re-check readiness

*Safety and medical necessity remain central.

Before You Enter the Room

Am I calm?

What is my face communicating?

How many demands am I about to place?

Am I creating safety—or unintentionally adding threat?

KEY: Shift away from starting with your own agenda/expectations/judgements → shift towards attunement of the patient. It starts with YOU.

Co-Regulation Toolkit

01 Slow voice

02 Pause

03 Choices

04 Processing time

05 Visuals

06 One speaker

07 Reduce or Increase sensory load

08 Affect Gestures and Body Position

KEY: Co-regulation is not forcing calm; it is modifying the interaction to support access to regulation and participation.

What does neurodiversity-affirming care look like?

Traditional frame	Neurodiversity-affirming frame
He's being noncompliant.	He's communicating distress. Something may not be working.
Repeat instructions louder or repeatedly.	Slow down and allow processing time.
Give multiple commands.	One clear step at a time.
Eye contact = attention.	Respect different communication styles.

Neurodiversity- Affirming Care

Neurodiversity-affirming care does not mean avoiding necessary medical care or eliminating boundaries.

It means reducing barriers to participation while preserving the dignity, autonomy, and safety of the patient.

Five Things to Remember Tomorrow

Behavior is communication- what is going on underneath the behavior?

Regulation can change access to skills- start here.

Connection before compliance or explanation.

Provider regulation is part of the interaction.

Small environmental and communication changes can improve access to care for neurodiverse populations and all patients.

Questions & Discussion

What is one interaction you will approach differently?

What is one environmental barrier your team could change?

What would you want your patients to say about receiving care from your team?

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Foundational Frameworks

Daniel Siegel: Hand Model of the Brain — teaching metaphor for stress and reflective access; *No Drama Discipline* co author- handling behavior through connection, not discipline

Tina Payne-Bryson: *No Drama Discipline*- handling behavior through connection, not discipline

Marsha Linehan: DBT — Understanding of threat and safety, Mindfulness, Judgements vs. Facts

Stephen Porges: Polyvagal Theory — influential framework; specific mechanisms remain debated

Tal Baz + DIR/Floortime: attunement, reciprocity, co-regulation, and scaffolding of arousal transitions; co-regulation concepts

Susan A Stallings Sahler and Gilbert Foley- *Linking Sensory Integration and Mental Health* co-authors- connects emotion regulation and sensory integration principles