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Two meetings⁶: Neurodivergence and the Conversational Model of Therapy

MJ Basilio

Abstract

Growth and learning is boundless and endless. I have dipped and dived into so many different types of therapeutic model, but the one that feels like home to me is the Conversational Model (CMT) of therapy. I'm drawn to the model because it humanises the treatment of mental health conditions (Benjamin, et al., 2019) and because it is a process of "learning, and learning how to learn, within a personal conversation...the mutual creation or discovery of a feeling-language – language of the heart" (Hobson, 1985 p.15).

This paper will explore my clinical experience as a trainee CMT psychotherapist and how I evolved and transformed as a therapist and as a person. It will explore a two-person experience: the client, the therapist, and the relationship. In this space both participants in a conversation grow and find themselves exploring a co-created world, a mutual exploration into the unknown "alone and yet together" (Meares, 2005). I will discuss clinical applications of the CMT and how it may also benefit neurodivergent individuals, mainly those diagnosed with Autism and Attention Deficit Hyperactivity Disorder (ADHD).

This paper will first begin with a summary of the CMT and neurodivergence, before discussing how CMT may be a useful model in helping neurodivergent individuals find and discover a stable

sense of self. The paper will then explore case examples and how my learning in the CMT has expanded my therapeutic skills and enhanced the experience of co-creating a world between therapist and client⁷.

It is also an aim of this paper to promote acceptance of differences in order to contribute to the co-creation of an inclusive and equitable society. When people feel accepted, supported and understood they can "emerge from loneliness" (Hobson, 1985) and feel more empowered in their healing and growth journey.

The Conversational Model and Neurodiversity

To discover truth about the patient is always discovering it with him
and for him as well as for ourselves and about ourselves. And it is
discovering truth between each other, as the truth of human beings is
revealed in their interrelatedness
Hans Loewald, 1980

Neurodiversity

Neurodiversity is a term used in the context of people who have been diagnosed with neurodevelopmental conditions such as Autism, ADHD, Dyslexia, Tourette's Syndrome, and Dyscalculia. This paper will mainly explore neurodiversity in

⁷ Please note that in order to maintain confidentiality, client personal details including client names have been de-identified and other identifying information has been altered. Consent was kindly given by 'Seth,' 'Angela' and 'Charlotte' in order to promote a neurodiversity affirming approach to therapy.

relation to ADHD and Autism as the symptoms tend to co-occur (Lau-Zhu, Fritz, & McLoughlin, 2019).

Neurodiversity is a term that proposes that people experience and interact with the world in a multitude of ways and there is no “right” or “normal” way of thinking, feeling, learning, or behaving (Baumer & Frueh, 2021). It is a strength-based approach that emerged during the 1990’s and was first coined by Australian sociologist Judy Singer. It embraces neurological differences with the aim of increasing awareness, acceptance, and inclusion for those who are neurodivergent (Silberman, 2015). Attitudes regarding autism are changing, and there are ongoing discussions within society as to whether it should be considered a disorder. A survey on autism in March 2022 conducted by Chris Bonello (an autistic teacher, author, and advocate) revealed that most of the autistic respondents in the survey see Autism as a “neurotype” rather than as a disorder, with 60% of autistic respondents indicating that they like being autistic. Additionally, identity-first language (autistic person, autistic, autists) is preferred over person-first language (person with autism).

Dr Edward Hallowell, a Psychiatrist with ADHD and Dyslexia, has been a strong proponent of strength-based approaches to treatment. He argues that for centuries most psychiatric conditions “were relegated to the dungeon of ‘moral’ diagnosis and treatment, where weak character was assumed to be the cause of the problem, and

shame, pain and humiliation were the standard ‘treatments.’” (Hallowell, 1998, p.344). Ratey et al. (1997) suggest that discovery of one’s own sense of self can occur when neurodivergent individuals feel understood, accepted, and are helped to recognise that their functional and interpersonal limitations are due to their underlying biology rather than defects in their character, morality, or abilities.

Currently the most supported treatment for Autism and ADHD are cognitive and/or behavioural approaches for children and young people (Hume et al., 2021) however there is limited research into autistic adults. Price (2022) has found that finding a therapist who understands neurodiversity and is able to work with autistic adults is very difficult. Additionally, Associate Professor Dr Vanessa Bal, a researcher in understanding adult autism, indicates that “there is a shortage of mental health clinicians adequately trained to provide supports for autistic adults” (Choi, 2022).

Applied Behaviour Analysis (ABA) is the most commonly used early intervention treatment for autistic children. Research has shown that ABA can have positive effects on an autistic child’s intellectual functioning, language skills, daily living skills and behaviour (Makrygianni et al., 2018; Medavarapu et al., 2019). This however has been contentious, and some autistic advocates do not recommend ABA as a treatment for children (Bonello, 2022). What is advocated for instead is the concept of ‘neurodiversity’ whereby people

should be accepted as naturally different rather than trying to 'fix' or make them 'normal' (Devita-Raeburn, 2016).

Milton (2012) highlights the 'double empathy' problem which means that autistic people and non-autistic people have a difficult time understanding each other. It is a "double problem" because the disconnection in interrelatedness is experienced by both autistic and non-autistic people due to the lack of insight into each other's minds and culture. The idea that autistic people have a 'social deficit' or 'lack a theory of mind' does not consider that perspective taking, theory of mind and empathy are two-way processes (Milton, 2019). This is very closely related to Jessica Benjamin's concept of intersubjectivity whereby relationships involve mutual recognition of each other, in which a person experiences the other as a "like subject" yet "has distinct, separate centre of feeling and perception" (Benjamin, 2004, p.5). The 'double empathy problem' might, then, be analogous to 'the doer/done to' dynamics where one person feels 'done to' and "not like an agent helping to shape a co-created reality" (Ibid, p.9). It then follows that society and relationships are co-created and neurodivergent people should be understood rather than pathologised for their unique way of thinking and feeling (Milton, 2019; Grace, 2021).

The Conversational Model

The CMT is a contemporary form of psychody-

namic psychotherapy that was developed by Robert Hobson and Russell Meares. It is an approach that was initially developed to treat 'unanalysable' patients; mainly those with 'disorders of the self' also known as Borderline Personality Disorder (BPD) (Korner & McLean, 2017).

The CMT has been found to be effective for the treatment of Depression, Personality Disorders, Irritable Bowel Syndrome and Self-Harm. Moreover, "CMT, and indeed other psychodynamic psychotherapies, are not 'stand-alone' treatments. CMT aims to develop a

creative therapeutic relationship. The use of adjunctive interventions (writing; painting; music) may have an important role in some cases. More broadly, many interventions

(e.g. eye movement desensitization and reprocessing; yoga; meditation; judicious use of medication) may play a critical role for some patients and can be used in conjunction with psychodynamic treatments" (Korner & McLean, 2017, pp. 220-221).

The CMT approach focuses on empathic attunement, empathic responsiveness, interpersonal 'connectedness' and a feeling of cohesion. The therapeutic conversation highlights 'moments of aliveness' and gives emphasis to 'fellow feeling' which is generated in the therapeutic relationship. The therapist gives value to the patient by responding to 'what is given' focusing on the 'minute particulars' and attuning to what is most 'alive' in the patient. (Hobson, 1985; Meares, 2005).

The Principles of the CMT and clinical indications for neurodiverse clients

Neurodivergents often have difficulties in relationships and with constructing their own sense of self (Brezis et al., 2016; Mate, 2019). The research on autism indicates that women and gender minorities tend to ‘mask’ or compensate for their autistic behaviours in an attempt to ‘blend in’ and fit in with society (Price, 2022). Autists who ‘mask’ tend to develop an unstable and insecure sense of self, suffer from low self-esteem, and have poorer mental health outcomes (Cage, Troxell & Whitman, 2019; Hull & Mandy, 2020).

Autists are more susceptible to bullying, interpersonal conflicts and sexual and physical violence (Grace, 2021). Moreover, children and adults with ADHD “crave highly charged and highly stimulating activities and situations” which predisposes them to conflict and trauma (Ratey et al., 1997). These situations cause those with ADHD to feel overwhelmed and also serves as a “pivotal force to quell feelings of boredom” where individuals are drawn to live from one crisis to another (Ratey et al., 1997).

There is a high comorbidity rate between ADHD and Personality Disorders, with ADHD being a developmental risk factor for Borderline Personality Disorder (Weiner et al., 2019). A recent study conducted by Jadav & Bal (2022) showed that adults diagnosed with autism after the age of 21

years old were more likely to report co-occurring psychiatric conditions such as anxiety, eating, and personality disorders. Moreover, some studies have found that autistic adults are likely to be misdiagnosed with personality disorders (Au-Yeung, Bradley, & Shaw et al., 2019; Kentrou & Oostervink et al. 2020; Iversen & Kildhal, 2022).

Whilst diagnoses are important in the medical model, the central focus of the CMT is the development of the self through empathic resonance in the therapeutic conversation. The theoretical framework is based on the development of self in relationships, the processing of unconscious traumatic memories and the integration of self (Meares, 2005). The development of self during the therapeutic process is seen in language where there is a shift from literal, linear, and concrete to something more poetic, metaphorical, spontaneous, and imaginative demonstrated in the play space and inner speech (Meares, 1992; Meares, 2005). The attuned therapist makes space for play, creativity, and love which supports the development of the client’s own capacity for play, love, creativity, and intimacy in other relationships.

The therapeutic encounter can help shift inner affective and somatic states from deadness to aliveness, from alienation to integration, from rigidity to fluidity, and from struggle to play. It is in this sense that the CMT can greatly assist neurodivergents to develop a stable sense of self, find joy and fulfilment in their life, and heal from trauma.

The road of discovery with Seth

Seth is 15 years old and has a diagnosis of Autism, ADHD, Oppositional Defiant Disorder, and Anxiety. I first met Seth when he was about 5 years old when I was his Applied Behaviour Analysis (ABA) therapist. I was his therapist for about 12 months and we worked together with his parents and a team of ABA therapists to help improve his communication, play, and social emotional skills. Like most neurodivergent children he had a 'spikey' cognitive profile and, whilst he struggled in some areas, he was very good in other things such as Maths, Computers and Music. He loved his cat, playing outside, playing on his iPad and jumping on the trampoline. Seth's parents were evidently loving and nurturing. They were dedicated to his growth and happiness.

Nine years later his parents contacted me to ask whether I could work with Seth again as his therapist. Having very fond memories of working with Seth and his family I immediately agreed.

Working with Seth as a teenager has been very different to working with him when he was 5 years old. Seth remembered me as his former therapist, but he did not talk much at the start and there was limited reciprocity in our interaction. He was very quiet and withdrawn, often responding with "I don't know." His parents reported aggressive behaviours at home including physical fights with his dad. He seemed to have lost the aliveness and

exuberance that had been so prominent when he was a child. Recalling his five-year-old smile and his excitement when it was time to play outside on the trampoline, I wondered what had caused Seth to move away from his vibrant self.

Due to COVID restrictions our sessions were online, which made it very difficult to engage.

Despite this, we both persisted in our work together. Similar to other autistic teenagers, Seth opposed cognitive behaviour therapy strategies, and refused to engage in certain activities. Rather than resisting and attempting to teach Seth skills that he didn't want to learn, I decided to listen, observe, find moments of 'aliveness' and 'windows' of engagement.

One day Seth spontaneously created an 'infinity of windows' on his computer which was comprised of our images multiplied on the screen (see image 1).

I said, "Wow there is an infinity of us."

He giggled and laughed. He continued doing this on his computer.

He asked, "How many is there of us now?"

I said, "Still infinity."

He giggled again, then combining both our images he created a different image which looked like a road in a tunnel.

I said, "Oh I can see you are making a road." He smiled and he kept going.

I said, "I wonder where this road is going?" No

response from Seth.

I said, "I'm curious about who is driving? Is it you and me?"

He said nothing then he said "Meow meow".

I said, "Oh I can hear a cat. Maybe the cat is driving."

Again, with a cheeky smile, he said "Meow meow".

I said: Oh, maybe its Ari⁸ (Seth's cat)."

He laughed, I laughed, and Seth continued to create the road which was a combination of our images. This spontaneous interaction created a positive shift in our relationship.



Image 1: The road of discovery which Seth created on his computer using infinity windows which includes a combination of our images together.

Seth's astonishing ability with computers and his creation of 'the road' is mesmerising. At the start of our therapy, I was anxious about not teaching Seth social skills and cognitive behaviour strategies. I sensed, however, that he didn't want to learn 'skills' - he wanted me to be a participant in his world. In supervision, my supervisor helped me notice that what was happening in the virtual

room is similar to Winnicott's (1989) 'squiggle game'⁹ – albeit a more modern version on the computer.

Analogous to Hobson's (1985) story with 'Sam,' Seth helped me to learn about psychotherapy and deepen my understanding of the 'two meetings' that Hobson beautifully described in his book *Forms of Feelings*. I came to realise that I was also making 'metaphorical statements,' conveying to Seth that I wished to understand him and sought a togetherness and a "feeling with".

Over time, the depth of our conversation and reciprocity in our interactions developed even more. Seth no longer says "I don't know", but plays pranks and jokes on me. He is now able to talk about his fears of hurting others (particularly his dad), his frustration with things that are 'incorrect,' his difficulties with school, and his feelings of worthlessness in subjects he doesn't understand, like English. He also shares things that he enjoys such as mathematical equations, video games, and YouTube videos. He shares YouTube videos that he has created, his hopes to get more followers, and songs that he is learning on his guitar. Seth also reminisces about our time together when he was 5, recalling when we would play on the trampoline, kick a soccer ball in his backyard, or play on the slide.

In a session which was immediately prior to the Christmas break he said, "I'm going to miss you"

⁹ The squiggle game is a pencil-and-paper technique for eliciting children's thoughts and feelings in an unstructured format.

and wrote in the chat box “Never gonna say good-bye.”

I smiled and I wrote back “Never gonna give you up.”

Seth then played the Rick Astley song ‘Never Gonna Give You Up’ and we laughed as we listened to the song together.

Seth seems to be emerging from isolated loneliness (Hobson, 1985) through the sharing of positive affect and experiences. We are mutually seeking and discovering his uniqueness, co-creating a new world we can both take part in. I continue to grow from these experiences with Seth. Seth has helped me fully understand what it means to be “alone together” (image 2). A new and different kind of experience is co-created within the “many universes of discourse” and many forms of relating (Hobson, 1985). ‘The road’ continues to evolve, and what was once an image of a black and white road, has transformed to a road with blue water and an orange ledge (image 3).

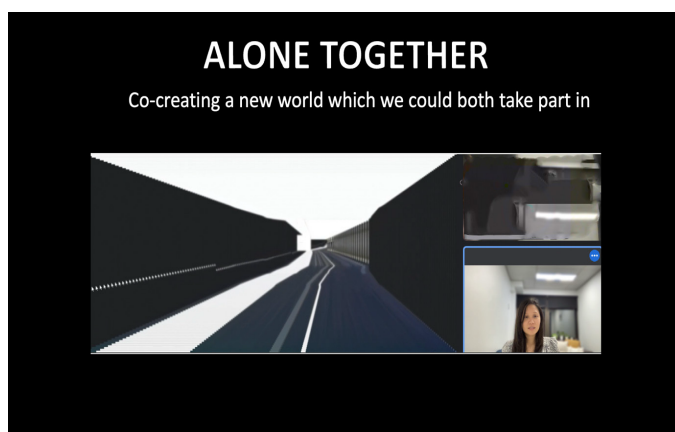


Image 2: “Alone together”

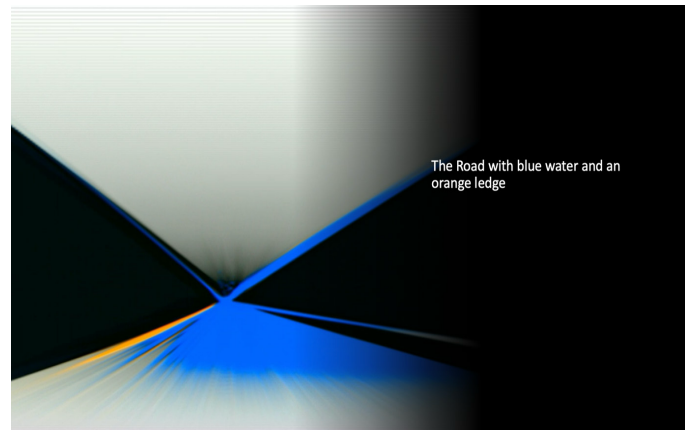


Image 3: A different kind of road has evolved

A plea to just “sit with it” - a story about Angela

A plea

Tired, angry sad

Pain, fear, loss.

Can you sit with it?

Not fix it,

Not react to it,

Not control it.

Tiredness, anger, sadness

Grief-stricken, heart-broken,

Loss, loss, loss...

Can you sit with it?

Not schedule it,

Not medicate it,

Not make plans, or change thoughts,

Not brainstorm, examine, or question,

Not prescribe “breathe and relax.”

Not judge.

Just sit.

Just feel.

Just flow.

Just be.

Can you listen?

Can you hear me?

With me in

This moment

Now.

Anonymous (as cited in Benjamin et al., 2021)

I met Angela¹⁰ in 2019 when I was just a year into my training as a CMT psychotherapist. Angela works part-time, is in her fifties, and was referred by a social worker for the treatment of her depression and anxiety. As I got to know Angela, I discovered that she had multiple diagnoses which included Schizophrenia, Bipolar Affective Disorder, Borderline Personality Disorder (BPD), Schizoaffective Disorder, Anxiety, Major Depressive Disorder, and Post Traumatic Stress Disorder (PTSD). She was taking various medications, however she continued to suffer from chronic insomnia, depression, and anxiety. She heard voices telling her “you’re hopeless, you’re worthless, go kill yourself.” Angela also suffered from diabetes, sciatica, and hypertension, and was on medication for treatment of these conditions. Angela had very

vague recollections of her childhood but remembered that her father died when she was 7 years old and that she was left in the care of her grandmother. When Angela was in her mid 20s her grandmother became chronically ill. At this time Angela’s mental health deteriorated and she was detained in a mental health hospital. There had been many admissions since that time, with Angela having had annual voluntary admissions in the last 10 years.

As we were working together I noticed that Angela also presented with autistic traits, and I wondered whether Autism might be a diagnosis that could help explain Angela’s particular constellation of difficulties.

Angela prefers to be on her own, gets overwhelmed by social interactions, has restricted and repetitive patterns of behaviour, is hypersensitive to noise and finds it difficult to tolerate change. Angela requires a lot of notice in order to cope with any type of change. She prefers to be in the comfort of her own home, has a strict routine (getting visibly upset when this routine is disturbed), and has an unusual preoccupation with horror movies and crime fiction. Angela also has a keen interest in Medical Forensics and had completed a course in this.

Angela frequently rubs her thumb on her index finger which appears to be a ‘stim’¹¹ and this

¹¹ A stim is short for stimulating. These are repetitive behaviours, e.g. movements or noise, commonly displayed by autistic people to help them manage and regulate their emotions.

behaviour increases in frequency when she is highly stressed or anxious. She has never been in a romantic relationship but has one good friend, Sam¹², who has ADHD. She reports that she often finds Sam annoying because “they talk too much”. She limits her interactions with Sam and will see them on special occasions or when they need each other’s help. Angela will also help Sam with things related to technology and lets them come over when they need company. Whilst their friendship seems to involve limited social interactions, it is a friendship that works for them and enhances their lives.

Angela doesn’t like inconsistencies and is upset when rules are not followed. This became evident during the COVID-19 restrictions. Despite her social anxiety she ensured that her neighbours followed COVID-19 social distancing rules. When I discussed the possibility that she may be autistic Angela agreed to do the Autism Quotient (AQ) and her high score was indicative of autism. Angela has indicated that she would like to identify as someone who is autistic and high functioning.

As a novice CMT psychotherapist, I initially did not feel adequate to be Angela’s therapist. I wondered if she would be better cared for by someone with more experience.

Our CMT journey began in March 2020 and we

moved from once a week to twice-weekly therapy. The shift was initially challenging and Angela conversed with a sense of ‘deadness’ talking about the same ‘chronicle’ of stressful things happening to her at work. I also became concerned about her suicidality, especially when she talked about her intent to overdose, which was coupled with voices telling her to “kill yourself”. In supervision my supervisor listened and provided space and containment for my anxiety and negative feelings. My training as a psychologist had been about finding effective solutions and working towards a goal. Additionally, when a client discloses self-harm or suicidal thoughts, it has been embedded in my training to complete a formal suicide risk assessment. The CMT, however, is a different way of relating and being. Whilst it is important to keep safety in mind, and to liaise with the crisis team who can support Angela when this becomes necessary, it was more important to understand and connect with her feelings (Bendit, 2011). I learned through this experience that what is most useful is to provide a consistent, secure, predictable environment and a containing space for Angela’s feelings, just like my supervisor provided for me.

As time progressed, we were able to play within the ‘conversational play space’ and what was ‘dead’ became ‘alive’ (Meares, 2005). Angela has a very good sense of humour and we laugh a lot during our sessions. I get the sense that Angela enjoys our sessions as much as I do, and I look

12 Sam’s name has been de-identified and uses a non-gendered pronoun they/them

forward to our continued time together.

By 2021 a change had occurred. For the first time in 10 years Angela had not had an annual hospital admission. We reflected on this as a significant achievement. Her contact with the crisis mental health team had also become infrequent. Although Angela experiences ongoing work stress, she remains a conscientious worker. There continues to be a sharing of positive moments and our interpersonal dynamic is ever changing. Our therapy is ongoing and our experience together has been humbling. I have become comfortable with being present and can now “sit with it, just be, just flow”.

A re-evaluation of devaluation – A story about Charlotte

Charlotte¹³ has been my client for 12 months and we have been working together in CMT therapy twice a week in the last 6 months. Charlotte is in her 30s and is a design student who initially contacted me for the treatment of Anxiety, ADHD, and Complex Post-Traumatic Stress Disorder (cPTSD).

Charlotte reported difficulties with interpersonal relationships, reading social cues, severe anxiety, fear of abandonment and maintaining a job. She described herself as clumsy and very disorganised. She was often late to appointments and had low self-esteem. She also questioned her gender and wondered whether she was heterosexual, bisexual,

or non-binary. Due to a fear of abandonment, she had a pattern of being very compliant with others and easily became distressed with any personal slights or perceived rejection.

Charlotte’s developmental history had been characterised by neglect, instability, and devaluation from her father. She had witnessed domestic violence incidents between her parents and felt isolated in her childhood and teenager years. She described her mother as controlling and reported that her father was cold, uncaring, and manipulative. She felt like a burden to her parents but craved their love and affection. Due to Charlotte’s learning difficulties, which included Dyslexia, she experienced a lot of bullying at school and felt disliked by her teachers. In order to conform and make friends, she would mimic other people’s behaviours and overly comply, but she also felt resentful that she was unable to be herself. Charlotte is also a survivor of sexual abuse. Charlotte reported that, as an adult, she often talked about her trauma and difficulties with “everyone” she met, and I got the sense that her trauma had become interlinked with her identity.

Charlotte told me that she had wondered whether she had Borderline Personality Disorder (BPD) and/or Autism. After further exploration she told me that she resonates with being autistic telling me that she struggles with following ‘social norms’, relates better with neurodivergent friends, and that her own research on autism had helped her understand herself better. We are continuing to

discover different aspects of herself and are working towards a more coherent and integrated sense of self.

When I first met Charlotte, she told me that she had previously worked with other therapists but felt that I was a better fit for her. I noticed that there was some idealisation which made me feel cautious. Her speech was initially choppy, fast, and high pitched. It was sometimes difficult for me to get a word in, and her speech was ‘curly’, often bouncing between one topic to another and then, midway through, she would say “what was I talking about again?” She would often apologise for being “all over the place”. Prior to agreeing to work together in CMT Charlotte would request to do a certain type of therapy like CBT or DBT¹⁴. When I agreed to do so, and we would begin working in that other therapy modality, she would ask if we could “just go back to talking again”.

Despite setting the frame and the expectations of attending the scheduled sessions on time, Charlotte was often late and sometimes did not turn up to sessions. Just like her speech our relationship felt ‘choppy’, and I reflected on Charlotte’s struggle to connect with me.

When Charlotte missed her appointments she often apologised, stating that she got her days “mixed up”. She was distressed for being late and

missing her appointments but continued to repeat the same pattern. I was pulled into the ‘expectational field’¹⁵ and there was a part of me that also did not want to turn up to appointments on time, or even not show up at all. I did not want to “commit a crime” and “submit” to her devaluation (Frederickson, 2017) but I also knew that in the CMT I needed to try and understand her experience. I pondered on how to approach this and brought it to supervision.

In supervision I was able to take notice of what was going on for her and came to understand that her behaviour was not just the ADHD, it was also because of her early life experiences. She had not had the experience of a caring other, and her experiences of rejection and neglect has resulted in an impairment to respond to other minds (Benjamin, 2018). I realised that the ‘yoyo’ and the mixed-up feelings inside of me may also be happening for her. I sensed she was strongly reliant on me, but that there was also a fear of dependence because those she had previously relied on had let her down. I was also conscious about the possibility of unconsciously repeating similar traumatic experiences. I was encouraged to let her know that when she missed her appointment she misses out on her own therapy and the opportunity to get better. For psychological healing to occur, it was important

14 Dialectical Behaviour Therapy is a type of psychotherapy which was initially developed by Marsha Linehan for the treatment of Borderline Personality Disorder and interpersonal conflicts. It is mainly a skills-based approach designed to teach emotional regulation, mindfulness, distress tolerance, interpersonal effectiveness, acceptance and tolerating change.

15 The expectational field is the notion of bi-directional experiences, and a mutual involvement of the client and therapist in past and present experiences. It is a relatedness that is constantly shifting and involves a “particular mood or feeling, body feelings, postures, and facial expression.” (Meares, 2012 pg.9). An unconscious traumatic memory can pull the therapist into the client’s trauma system where the therapist unconsciously (and without awareness) find themselves drawn and behave like the original traumatiser (Meares, 2000a, 2000b).

for me to facilitate a new relational experience of 'being with', one that involves empathic resonance, sharing of positive affect and a mutual recognition that her actions affect me and that she matters to me (Benjamin, 2018).

As I have understood Charlotte better, our ways of relating have changed. Charlotte is able to recognise that she had a hard time forming a relationship with me and was fearful of being manipulated, which was analogous to her early childhood experiences with her parents. As Charlotte gained more awareness of the childhood patterns she was repeating in our relationship, the voices of mistrust and the chaos in her mind softened. There is now more of an ease to our relating. She turns up to her appointments on time, is less accommodating, and is working on setting her own boundaries. She has identified that the most appropriate place to talk about her trauma is in therapy, and she is now able to enjoy different kinds of conversations with her friends. Charlotte has come to realise that gender is a spectrum and that she does not have to fit into definitive and 'neurotypical' stereotypes. She identifies as non-binary and uses the pronouns she/her or they/them. Charlotte stills struggles with emotional regulation, and there is still anticipatory anxiety in expressing her own needs and opinions, however she has come to notice that she can be herself and still be accepted.

Conclusion

I hope I have been able to convey how the CMT can assist those who are neurodivergent find connection and explore their own sense of self without having to 'mask' and conform to societal norms.

The CMT approach acknowledges difficulties as well as strengths and works with the relationship to increase self-reflective capacity, self-compassion, and acceptance of self. This sense of acceptance will help neurodivergent individuals understand their difficulties and apply adaptive coping strategies that are positive. Most importantly, the mutuality and the relational approach creates a widening of one's 'window of tolerance'¹⁶ (Siegel, 1999), an integrated sense of self, and an ability to connect with others.

It is also important to keep in mind that everyone has a role in co-creating an inclusive culture, and that this is an ongoing process of negotiation and accommodation of differences rooted in mutuality and compassion.

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¹⁶ The window of tolerance is the optimum zone of arousal (or comfort zone of tolerating stress and emotions). This is where a person is able to self soothe and self-regulate when dealing with daily events and stressors. When a person has had traumatic life circumstances, or has a dysregulated nervous system, their window of tolerance narrows and they are more prone to quickly move into a state of hyperarousal (anxious, angry, out of control, fight/flight) or hypoarousal (zone out, frozen, shut down, numb, depressed). A widening of one's window of tolerance allows an individual to be able to cope better with stress and daily challenges.

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