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Accessibility and affirmation in counselling: An exploration into neurodivergent clients' experiences

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Abstract

Neurodivergence is having 'a mind that functions in ways which diverge significantly from the dominant societal standards of "normal"' (Walker, 2021, p. 33; Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic Empowerment, and Postnormal Possibilities). The neurodiversity paradigm reframes the medical model of neurodivergence within the social context of disability (den Houting, 2018 [Autism, 23, 171]; Dwyer, 2022 [Human Development, 66, 73]). Research converges counselling and neurodiversity in a disorder-specific context, for example, the wide range of barriers of access to counselling that autistic individuals face (Hallett & Kerr, 2020 [You need support, validation, good coping skills. You need and deserve acceptance]). More recent literature points towards the need for a flexible, clear approach to neurodivergence-informed counselling (Bolton, 2023b [Three ideas in person-centered, neurodivergent-affirming therapy]; Chapman & Botha, 2022 [Developmental Medicine & Child Neurology, 65, 310]; Pantazakos, 2023 [Counselling and Psychotherapy Research]). This research aimed to explore whether lived experiences of neurodivergent individuals within counselling were accessible, validating and affirming, in particular, regarding reasonable adjustments, communication and environment. An inductive, qualitative approach was adopted. Five individuals participated in semi-structured interviews, which were analysed following a six-phase approach to thematic analysis. Six main themes were found: (1) Feelings of frustration and confusion at language used in counselling; (2) Feelings of clarity and validation in language; (3) Feelings of overwhelm due to uncertainty and masking; (4) Feeling understood, heard and able to self-advocate; (5) The need for a safe, secure sensory environment and accommodations made; and (6) General accessibility and practicalities. Recommendations for practice include amending the counselling contracting process and sensitivity to the communication and sensory needs of each individual client. Further research may wish to explore specific details of the present, and other emergent, neurodiversity research in more detail.

KEYWORDS
attention-deficit/hyperactivity disorder, autism accessibility, counselling, neurodivergence, reading disorders, thematic analysis

1 | INTRODUCTION

1.1 | Definitions and scope

Neurotypicality is 'having a style of neurocognitive functioning that falls within the dominant societal standards of "normal"', and neurodivergence is having 'a mind that functions in ways which diverge significantly from the dominant societal standards of "normal"' (Walker, 2021, p. 33). The medical model of disability conceptualises neurodiversity in a deficit framework, representing a traditional pathologising 'suffering' view, which ignores the historical oppression of neurodivergent individuals (Bolton, 2023a; Botha & Frost, 2020).

The neurodiversity paradigm rejects this model and initially reframed neurodivergence within the social disability model: disability being the product of incompatibility between individuals' characteristics and their social contexts (den Houting, 2018; Dwyer, 2022). The neurodiversity movement seeks 'civil rights, equality, respect, and full societal inclusion for the neurodivergent' (Walker, 2021, p. 33). Neurodivergent individuals may require societal support, acceptance of difference and reasonable adjustments (Baron-Cohen, 2017; Nicolaidis, 2012).

Interpretations of the neurodiversity movement differ across the literature, but awareness of its core concepts may foster more solid cross-disability alliances (Gillespie-Lynch et al., 2020). This is encapsulated within the affirmative, or identity, model of disability, wherein the social construct of disability is recognised and accepted from the social model, but disability is claimed as a source of pride and positive identity (Retief & Letšosa, 2018; Swain & French, 2010).

Essentialist beliefs (the idea that social and cultural categories are united by innate underlying essence) may empower and validate frequently stereotyped and marginalised groups. Neurodivergent individuals endorsing self-essentialist beliefs had higher self-efficacy (Lebrón-Cruz & Orvell, 2023). Within support groups, the usage of the neurodiversity concept helped build self-esteem, social skills and peer relationships (Barnhart, 2016). Reclamation of neurodivergent identity was seen as value-neutral, akin to hair colour or race, and reframed negative connotations (Botha et al., 2020). While critics profess that identity politics may 'other' potential allies within a neurodivergent/neurotypical (us/them) dichotomy, the neurodiversity paradigm advocates against groupthink (Russell, 2020). Identity-first language (e.g., 'autistic person') is generally preferred over person-first language (e.g., 'person with autism') by the majority of autistic adults in the UK (Kenny et al., 2016), the United States (Taboas et al., 2023) and France (Geelhand et al., 2023), and will therefore be used henceforth.

Autism is a heterogeneous, life-long neurodevelopmental condition that influences how people interact and communicate with others, learn and behave (National Institute of Mental Health, 2023a, 2023b). Attention-deficit/hyperactivity disorder (ADHD) is 'an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development' (National Institute of Mental Health, 2023a, 2023b). Dyslexia is 'a learning difficulty that primarily affects the skills involved in accurate and fluent word reading and spelling' (British Dyslexia Association, 2010). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) categorises dyslexia under SpLDs, which are neurodevelopmental disorders 'characterized by a persistent impairment in at least one of three major areas: reading, written expression, and/or math'.

It is estimated that approximately 70% of autistic individuals may experience comorbid mental health conditions, with 41% of them presenting two or more concurrent conditions, such as ADHD, anxiety and mood disorders, oppositional defiant disorder and conduct disorder (Lai et al., 2019; Leyfer et al., 2006; Simonoff et al., 2008). Reading disorders co-occur with ADHD at a rate of 20%–40% and autism at 6%–57%, the variation of which may be ascribed to the differentiation between 'true' comorbidity and symptom overlap. Individuals with reading disorders experience more severe generalised and social anxiety than those with typical development (TD), and experience worse depressive symptoms than those with TD and non-verbal learning disorders (Hendren et al., 2018; Mammarella et al., 2014). Attention-deficit/hyperactivity disorder co-occurs with mood disorders at a rate of 38.3%, anxiety disorders at 47.1% and substance abuse disorders at 15.2% (CHADD, 2023; Elia et al., 2008).

Implications for practice

- Interventions should be formed in collaboration with neurodivergent individuals to provide a more flexible and direct approach.
- It is recommended that practitioners undergo neurodivergent-informed training and that this is included in core counsellor training.
- It is recommended that counselling services provide information about the process in advance and include questions around physical, environmental and communication accessibility needs within their assessment.

Implications for policy

- Policy should consider the need to adapt services to address the significant mental health needs of neurodivergent individuals.

The disproportionate ratio of diagnoses in those assigned male at birth (AMAB) compared to those assigned female at birth (AFAB; 4:1 in autism, 3:1 in ADHD) may be attributed to differences in likelihood of diagnosis (Pachowicz, 2020). Assigned female at birth individuals are generally more able to mask their autistic traits in interpersonal contexts (Lai et al., 2014). Manifestations of ADHD and autism may differ according to assigned sex at birth (ASAB) and phenotype—for example, the inattentive subtype of ADHD is more prevalent in those AFAB, while AMAB autistic individuals may show more repetitive behaviours and interests (Lai et al., 2014; Pachowicz, 2020).

Previous research suggests that sensory sensitivities in autism contribute to chronic stress, hypervigilance and context conditioning (e.g., generalising environments as unfriendly or dangerous; Morgan, 2019). In counselling, neurodivergent individuals often experience both hyper and hyposensitivity to lighting, colours and patterns, leading to difficulties in engagement, understanding and a sense of overwhelm (Ward, 2018). Clinical assessment of trauma, and understanding of what constitutes a traumatic event, may not be universal to neurodivergent populations (Morgan, 2019). Autistic individuals attempted suicide at a rate fivefold that of non-autistic populations, yet nearly half of them did not have a diagnosis of depression, suggesting it is underdiagnosed in the autistic community (Croen et al., 2015).

A broad acceptance of different communication styles (freely stimming, varied eye contact, reciprocal stimming, and monologic, dialogic or rambling conversations) was observed within an autistic self-advocacy community group (Bagatell, 2010). Non-speaking autistic people may conceptualise language via imagery, thought processes and sensorial experiences, so sensitivity to all communicative needs is imperative (Reading, 2018).

1.2 | Neurodivergence in other practices

Students with Asperger's syndrome (AS) may need administrative and environmental support alongside furthered staff/student awareness to combat difficulties with visualisation, imagination, setting expectations and problem-solving (Beardon et al., 2009). Healthcare interventions for autistic patients should align with self-advocacy values, such as heeding natural autistic processes, coping strategies, autonomy and well-being (Leadbitter et al., 2021).

A multimodal approach to guidance counselling (prioritising environmental needs, psychoeducation, medication and mindfulness) is recommended to support university students with ADHD (Sedgwick-Müller et al., 2022). Dyslexic students struggled with open-ended examination questions and lecture-style teachings, while teachers and academics lacked training and awareness of concessions, were overburdened and believed in a need for assistive holistic services for dyslexic students (Bajaj & Bhatia, 2019; Mortimore, 2013; Tops et al., 2022).

Neurodivergent students in higher education struggled with communication, inflexible teaching and assessment methods, and ignorance to sensory and social needs (Clouder et al., 2020; Gillespie-Lynch et al., 2017). Occupational therapy may become a neurodivergent-affirming practice by rejecting past practices (such as microaggressions and behaviourism), identifying and accepting co-regulation of environmental triggers, supporting non-harmful stims and valuing clients' consent, autonomy and social agency (Dallman et al., 2022).

The overarching theme throughout the literature is the existence of a rift in the needs of the service users or students and in awareness of staff and support services. Effective training is a repeated recommendation across studies, alongside a call for the understanding of the individualised needs of each neurodivergent individual.

1.3 | Neurodivergent-informed counselling

Counselling 'provides a safe and confidential space for you to talk to a trained professional about your issues and concerns' (British Association for Counselling and Psychotherapy, 2023). In 2020–2021, 1.46 million referrals were made for talking therapies (NHS, 2021). As neurodivergent individuals experience mental health problems at a disproportionate rate, it is pertinent to explore neurodivergent-informed therapies (Laderer, 2022).

Counsellors were unable to effectively adjust their standard approach for clients with AS who had negative prior counselling experiences and needed a validating, understanding approach (Wilson, 2016). In dance movement therapy, however, adjustments were made to lighting, tactile materials and communication style for autistic participants (Edwards, 2013). Counsellors working with autistic clients generally integrated autistic traits within the whole human experience, but, at times, felt autistic traits and mental health problems should be separately discussed within sessions (Brook, 2022).

Autistic adults in counselling reported barriers to access (e.g., lack of clear guidance); communication barriers (e.g., misunderstanding); barriers related to autism awareness and understanding (e.g., outdated knowledge); and a lack of broader knowledge in areas related to autism (e.g., gender). Up-to-date knowledge on autism and a clear, flexible, open approach to counselling were recommended (Hallett & Kerr, 2020).

In the UK, cognitive behavioural therapy (CBT) is the most widely available therapy through the National Health Service (NHS). Pantazakos (2023) noted that there is some evidence that CBT is effective for autistic anxiety and depression (Lang et al., 2010; Pezzimenti et al., 2019), but there is a need to tailor CBT to autism (Sze & Wood, 2008). Pantazakos (2023) suggested a move towards developing neurodivergent-affirming phenomenological therapy that explores and values neurodivergent clients' lived experiences. Chapman and Botha (2022) proposed neurodivergence-informed therapy. This encompassed a rejection of normalisation; consideration of neurodivergent perspectives; relational and political understanding of disability; sensitivity to disability as a source

of community and pride; and engaging in relational humility when exploring validation and knowledge of neurodivergent and disabled identities. Providing a person-centred approach for neurodivergent clients should include non-directivity, empathy and congruence—for example, providing an authentic space for clients who may have long histories of masking or experiencing conditions of worth (Bolton, 2023b).

1.4 | Aims of the present research

Current neurodiversity research is potentially compounded by the proliferation of autism researchers who undermine the neurodiversity paradigm's core concepts, such as autonomy and dignity (den Houting, 2018; Neumeier, 2018). It is within emergent neurodiversity research that this study aimed to form part of a foundational premise upon which more definitive, possibly deductive, research into neurodivergent-informed counselling can occur.

Research in other practices highlighted the referral of neurodivergent students or service users to counselling—but how accessible, validating and affirming is counselling for those individuals? This study aimed to provide an inductive approach to explore lived experiences of neurodivergent individuals who have accessed counselling, in particular, pertaining to reasonable adjustments, communication and environment.

2 | MATERIALS AND METHODS

2.1 | Recruitment and participants

Participants were UK-based adults. In alignment with previous studies (e.g., Botha & Frost, 2020; Kapp et al., 2013; Nocon et al., 2022), participants who self-identify as neurodivergent were included to capture the experience of individuals who self-identified with neurodivergent traits but were unable or unwilling to access formal diagnosis. Self-diagnosis is a 'working hypothesis' and may counteract discrimination towards and within the autistic community (Charlton, 2005; Clouder et al., 2020). Participants were not excluded based on specific support needs, besides the ability to independently access counselling, and the interview.

Opportunity sampling was utilised as follows: participants volunteered in response to a recruitment advertisement across social media platforms. Five participants completed interviews. While a larger sample size would have been more desirable, awareness of the wider data adequacy is equally important within qualitative research (Vasileiou et al., 2018). Each participant chose or was given a pseudonym (Table 1).

2.2 | Design, procedure and analysis

The interview questions (Figure 1) were constructed based on the literature regarding neurodivergent traits and experiences in other practices. Within higher education and workplaces, neurodivergent individuals had issues with indirect and generalised communication, open-ended questions, sensory environment, imagination and visualisation (Beardon et al., 2009; Seitz & Smith, 2016; Tops et al., 2022). Figurative expressions, particularly metaphors due to their reliance on semantics, placed heavy processing demands on autistic individuals (Morsanyi et al., 2020; Vulchanova & Vulchanov, 2022). Autistic adults in counselling repeated the need for a more inclusive sensory environment alongside clearer communication and administration (Hallett & Kerr, 2020).

The interview questions' comprehension was validated by a group of autistic individuals. The questions were broad, with the intention of asking more direct follow-up questions. The interviews were held, recorded and transcribed via Microsoft Teams.

Analysis followed Braun and Clarke's (2006, 2012) six-phase thematic analysis approach. Transcript excerpts were coded within a Word document before forming a thematic map via LucidChart (Dilts & Sun, 2010; Figure 2). This visualised how codes fit together in themes to explore the separate and intertwined narratives of participants' experiences in counselling.

TABLE 1 Participant demographics.

Participant	Gender	Age	How they identify as neurodivergent	History of counselling
Fern	'I'm a girl'	20	Clinical ADHD diagnosis, in the process of receiving autism diagnosis	At 9 years old, during high school, at 17, and presently in CBT
Francisco	Non-binary	23	A 'catch-all'—diagnosed with ADHD and anxiety, suspected autism	Relationship counsellor at 17 and currently in private counselling
Anna	Female	24	Dyslexia, struggles with her mental health which she believes is rooted in her dyslexia	Counselling at 15, currently in CBT
Liv	Female	23	ADHD—inattentive subtype	Accessed counselling many times from mid-teens until now
Beth	Female	22	Dyslexia and depression	Accessed counselling twice, at 21 and 22

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; CBT, cognitive behavioural therapy.

1. What is your age?
2. What is your gender?
3. How do you identify as neurodivergent?
4. How many times and when did you seek counselling?
5. Why did you seek therapy? What were your expectations, and did they get met?
6. How accessible overall did you find your counselling experience?
    a. How was the counselling environment (e.g. the journey to counselling, the lighting, the room)
7. Did you find the contracting clear? What would have helped make it more digestible?
8. Were you asked if you needed any reasonable adjustments to improve your counselling experience?
    a. Did you feel able to ask the therapist for further adjustments if needed and was this implemented successfully?
9. How was the language used by your counsellor? Were you able to understand what the counsellor was saying (e.g. when using metaphors)
    a. If not, were you able to voice this, and did the counsellor amend what they said in a way you could understand?
    b. Did you feel appropriately understood by your counsellor?
10. What would have helped to make counselling more accessible for you overall?
11. Do you have any other thoughts you'd like to tell me?

FIGURE 1 Semi-structured interview questions.

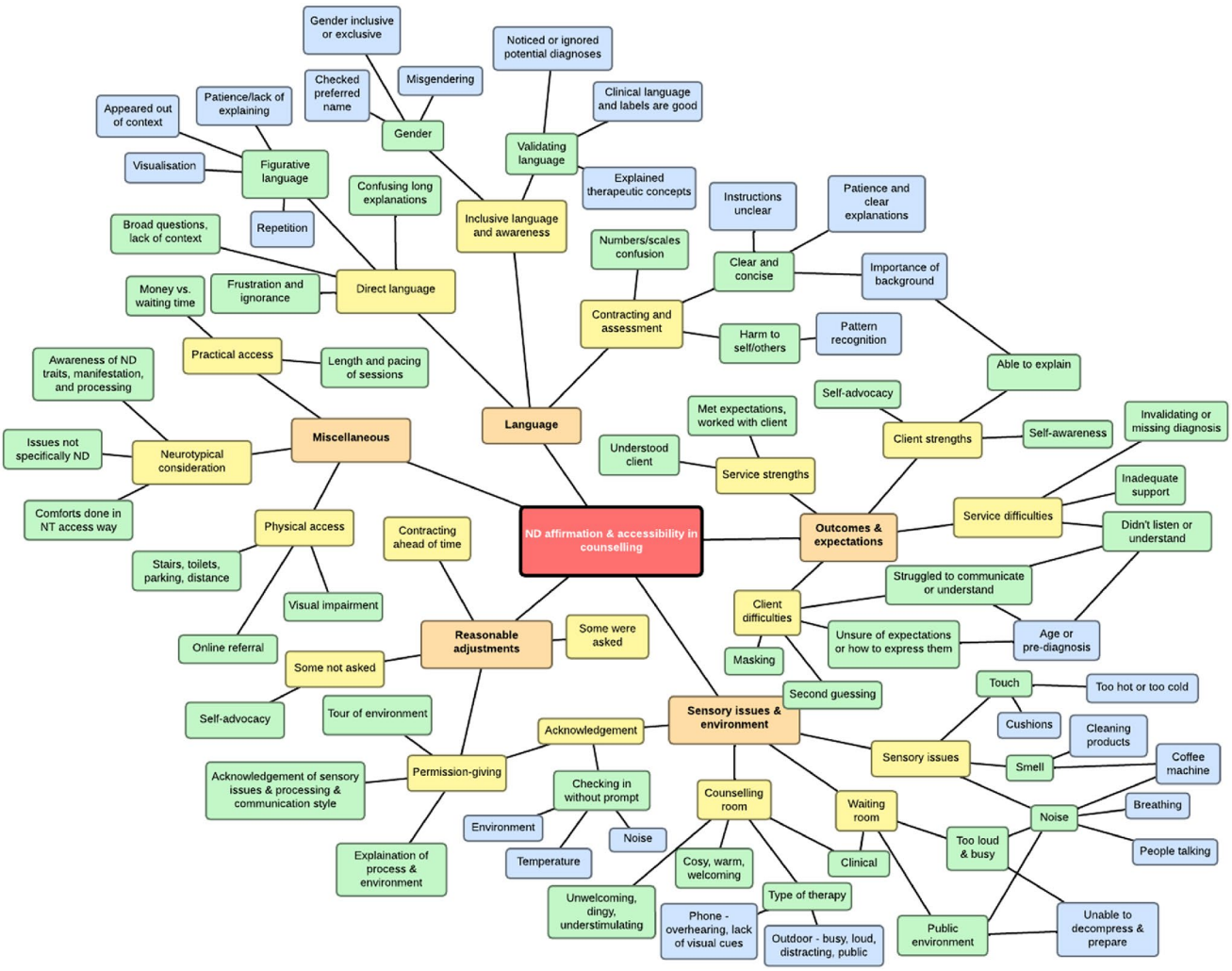

FIGURE 2 Thematic map produced on LucidChart.

2.3 | Ethical considerations

This research received ethics approval from the University of Lincoln Ethics Committee. Participants gave fully informed consent. Prior to recording, they were reminded of the limits of confidentiality, the process of anonymisation and the BACP (2018) policy for named practitioners or at-risk individuals. Participants were asked about reasonable accommodations, and verbal consent to record was obtained. Participants were provided with verbal and written debriefs.

Participant details and, separately, the original and pseudonymised recordings and transcripts were held on a OneDrive account accessible only to the research team. Transcription was undertaken by the principal researcher and not outsourced. Participants were offered the opportunity to 'black out' any exceptionally sensitive information prior to analysis; however, they all approved the raw transcripts.

Risk of emotional distress was mitigated by providing signposting and policy information. Interviewer–interviewee boundaries were maintained by responding warmly and professionally. The interviewer made appropriate use of research and clinical supervision. The benefits of this research as outlined to participants were contributing to neurodiversity research and counselling practice. Some participants felt the interview space provided closure for them.

2.4 | Research philosophy

This research had a qualitative, cross-sectional, non-experimental design. For candour and integrity, it is important to ensure that the researcher's assumptions, background and personal justification are transparent, especially within the qualitative context (Braun & Clarke, 2006; Holloway & Todres, 2003). It is important to recognise the active role a researcher plays in identifying and reporting themes (Braun & Clarke, 2006).

As counsellors, we understand the roles of supervision and reflection in practising ethically and responsibly. Practitioners struggle to act primarily as researchers over counsellors, so we were mindful of this during the research process (Knox & Burkard, 2009). The research team are neurodivergent and have considered that our experiences may cause unconscious bias. However, the wider literature recognises sameness between counsellors and clients as advantageous (La Roche & Maxie, 2003; Lehmann, 2014).

An inductive ('bottom-up'), phenomenological approach was used, meaning the thematic analysis was data-driven—although it is impossible for data to be 'coded in an epistemological vacuum' (Braun & Clarke, 2006, p. 84). The epistemology was pragmatic and postmodernist. Themes were moulded by participants' realities, experiences and worldviews (Pantazakos, 2023). While essentialism and constructionism are at the core of neurodivergent advocacy, data were also examined through the critical lens of operations of power and accessibility (Carling-Jenkins, 2009).

3 | RESULTS

3.1 | Feelings of frustration and confusion at language used in counselling

3.1.1 | Unclear assessment information and contracting

Participants were asked whether they found contracting in counselling clear. It was clarified to them that this meant the process regarding obtaining consent, discussing confidentiality and setting expectations. Fern and Francisco felt the statement 'we will not tell anyone unless we feel you are a harm to yourself or someone else' was unclear, and as a result, they felt unable to speak freely. Fern felt unable to use pattern recognition. Anna's assessment forms were sent without clear instructions, and she found scale numbers confusing (Table 2).

3.1.2 | A lack of and a need for inclusive language and awareness

Francisco had one counsellor who used gender-specific language, and another who misgendered them. Liv's counsellors lacked awareness of neurodivergent traits and experiences. Beth's counsellor simplified her feelings as grief.

3.1.3 | Indirect and confusing language

Fern, Francisco and Liv had counsellors who used complicated or unexplained visualisation and metaphors. When they asked for clarification, they were met with the same explanation, frustration or another analogy. Indirect, confusing language was stressful for most participants. Fern found being asked broad questions challenging.

3.2 | Feelings of clarity and validation in language

3.2.1 | Clear assessment information and contracting

Francisco's current counsellor explained contracting well and clarified the 'harm to self or others' statement. Beth and Liv felt able to understand contracting due to their academic background. Anna felt able to ask for further clarification (Table 3).

3.2.2 | Informed, inclusive and aware language

Francisco and Anna had counsellors who used gender-inclusive terminology. All participants named instances in which their therapist

TABLE 2 Feelings of frustration and confusion at language used in counselling: transcript excerpts.

Initial theme	Sample quotes
Unclear assessment	What do I have to say, for that alarm to be triggered? I have no idea. But it's kinda … it's taken as an obvious. (Fern, 20) It was just a bunch of forms with the questionnaire on that came before the screening … I didn't know what it meant. (Anna, 24) I think the pressure of trying to read it right there and sign it on the spot got to me. So I just skimmed it really quick and signed it. (Liv, 23)
A lack of and a need for inclusive language and awareness	… he'd talk about 'men' and 'women', like 'this is how men behave, and this is how women behave'. (Francisco, 23) … a better understanding of neurodiversity, and what that looks like in an adult. Because people's assumption is usually that of a male child. (Liv, 23) I think it would have been nice to have that actual buzzword language used. (Liv, 23)
Indirect and confusing language	… she was like, you've gotta think of things like a ladder. And I was like, 'what the fuck does that mean?' … Looking back, I understand the point … but it didn't go in like that. (Fern, 20) … she made me eat a bar of chocolate, and think about how the bar of chocolate felt in my mouth … and I was like, 'what on earth? What are you getting me to do?' (Liv, 23) There's always been a lot of like, every single time, 'how've you been this past week?' What day? What hour? Like, under what circumstances? (Fern, 20) I said, 'could you expand on that?' and he quite often just used another analogy. (Francisco, 23)

TABLE 3 Feelings of clarity and validation in language: transcript excerpts.

Initial theme	Sample quotes
Clear assessment information and contracting	And the first session was very much about going through it, like, 'how do you feel about this?', 'this is consent', that kind of thing. (Beth, 22) They gave examples of when I might be in danger or when someone else might be in danger. And I was like, 'great! Thank you! Now I understand and now I can tell you things'. (Francisco, 23)
Informed, inclusive, and aware language	You know, my current therapist and I will sometimes talk about certain hormones … But it's very, based on what the hormones do … it's very much about the chemical. (Francisco, 23) … the first session was just her saying … 'are you fine with me calling you by this name?' (Anna, 24) … you sometimes feel like you're being sorry for yourself, she never made me feel like that. She always said there's a reason you're feeling like that. (Anna, 24) I didn't even explicitly ask, I just told her I didn't understand something in a session and she was able to go, 'OK, let's take that right back and figure this out'. (Liv, 23)

validated their symptoms, experiences or diagnoses. Fern, Anna and Liv each spoke of counsellors who explained therapeutic concepts or reflected on their feelings clearly.

3.3 | Feelings of overwhelm due to uncertainty and masking

3.3.1 | Clients' difficulties

Every participant expressed that they sometimes struggled to communicate. For Fern, this was due to her age. For Fern, Liv and Francisco, this was because it was before they were aware of their neurodivergence. Liv struggled with connecting her physical and emotional health. Fern and Anna mentioned the complexities of masking within sessions. Fern and Liv were unsure of their expectations and did not know how to conceptualise that they just needed help. Fern, Anna and Liv alluded to second-guessing themselves within sessions (Table 4).

3.3.2 | Services' difficulties

All participants, at times, felt misunderstood, invalidated, provided with inadequate support or as though they were not making progress. Fern, Francisco and Liv stated that their counsellors did not listen to them, each having been patronised or sent to another service. Fern explained that she had a 'visceral' feeling of being different since she was young, but that this was not understood by her counsellor.

3.4 | Feeling understood, heard and able to self-advocate

3.4.1 | Clients' strengths and skills

Francisco, Anna, Liv and Beth felt that despite not being asked about reasonable adjustments, they would have been able to advocate for themselves if they needed any. Each participant had

TABLE 4 Feelings of overwhelm due to uncertainty and masking: transcript excerpts.

Initial theme	Sample quotes
Clients' difficulties	But it was at an age where I didn't have the tools to explain *why* I didn't understand. (Fern, 20) … they want you to figure it out for yourself, and I don't think that's bad for me … but like, I almost want it to be easier. (Beth, 22) … I deal with things every day. I deal with noises and smells and lights. But, it's the pretending that I'm not dealing with that that gets difficult. (Fern, 20) I'm like here just twinging my hairband on my wrist. So it's like, there's just certain things. I think it's easy to be less truthful online. (Anna, 24) I struggle with that every single time. They say, 'what do you want from this? Like, what are your aims?' and I just, I don't know. (Fern, 20) I didn't use the time like I meant to because even though they wouldn't judge me, I'd felt like they would. (Anna, 24)
Services' difficulties	I couldn't explain my problem, they didn't listen to me when I tried, the way that I was trying to communicate wasn't the way that they expected from me, so they brushed it off completely. (Fern, 20) So I was like, 'well this is everything that's ever happened to me' … and she was like, 'how can you tell me all of that with a straight face?' (Fern, 20) … a lot of the time she will reference my feelings as being grief, and I do believe they are grief, but I also think that there's more to it than just grief. (Beth, 22) … they're almost too personal about it. To the point where they'll say, 'this is how [Francisco's] brain works', and they don't say, 'maybe you have autism, maybe you have ADHD'. (Francisco, 23) … it felt as though they weren't tackling the root of the problem. Like, the anxiety and the depression were the 'affect' of the condition … it actually comes from executive dysfunction issues. (Liv, 23)

TABLE 5 Feeling understood, heard and able to self-advocate: transcript excerpts.

Initial theme	Sample quotes
Clients' strengths and skills	I think I found it easy to understand after the first session I had, but I would have been able to email my counsellor and she would have been able to help me out. (Anna, 24) I do feel confident that if I struggled … I could have raised it and received extra support for sure. (Beth, 22) It's been something I've gotten better at with study. With essay writing, and practising articulating things in a way that people want to hear them. So I've kind of got a cheat sheet now. (Fern, 20) So, I think I can verbalise it. And I think now that I have the diagnosis, it means I can understand where these difficulties are coming from, and she has adapted. (Francisco, 23)
Services' strengths and skills	I think I explained things well, and when she did wanna know more, she would just ask questions around the subject. (Anna, 24) I'm gonna mainly focus on my current counsellor, because they are very good at spotting things in me, or getting me to expand to a point where they go, 'oh! I know how to help with this!' (Francisco, 23) So, my first counsellor, I feel like without question she understood everything that I said. I didn't feel the need to explain myself further. (Beth, 22) I didn't really know what to expect, because I haven't had counselling since I was 15 … but I was way more open to it this time. I think my expectations got met. (Anna, 24) I think my expectation was to become more content with myself, and manage my relationships with my parents. I do believe I got that. (Beth, 22)

at least one experience in which they explained themselves well, understood the therapeutic process or had high self-awareness (Table 5).

3.4.2 | Services' strengths and skills

Anna said her counsellor would ask for more detail, which helped her feel understood. Beth and Francisco had counsellors who understood them without further explanation. Fern, Anna and Beth each had a counselling experience which met their expectations. Anna felt accommodated for, and Beth developed a sense of understanding and coping strategies.

3.5 | The need for a safe, secure sensory environment and accommodations made

3.5.1 | Atmosphere: Waiting and counselling rooms

Fern and Francisco felt waiting rooms were too busy and public, too loud or too clinical. Liv had a challenging experience with counselling

TABLE 6 Need for a safe, secure sensory environment and accommodations made: transcript excerpts.

Initial theme	Sample quotes
Atmosphere: waiting and counselling rooms	… there is always, just, music playing in the waiting room … that's often been an overwhelming element for me. (Fern, 20) … the waiting room was very clinical, and I just got very anxious going in. *(Francisco, 23)* Like the coffee machine in there … but the noise, it made me wanna cry … it made me alter my mood for the rest of the session, because I had to then, in the waiting room, where I suppose you're supposed to decompress and get yourself ready, I was too busy not crying. (Fern, 20) I was hesitant and uncomfortable, and didn't want to talk while people were near, or I was cold and focussing on the fact that I was cold, and I didn't know what time it was because there was no clock. (Liv, 23) … his first room was really under-stimulating, like, I couldn't concentrate on what he was saying. (Francisco, 23) … it wasn't cosy, it wasn't homely. It didn't make you want to open up. *(Liv, 23)* … she's got a lamp, and rugs, and she's made it look nice. It's a more welcoming environment. (Liv, 23) I sit on this comfy settee, I really enjoy that, and I sit there and I know that I'm in a safe space. (Beth, 22)
Specific sensory concerns	If it's a low-lit room, and there's a naked flame, it fucks my eyes. (Fern, 20) I'm like, 'put the lights on! I can't. I can hear your breathing, I can't say anything to you'. (Fern, 20) … he had such a stark, white room. It was a little bit too toasty. It was a little bit smelly, like nice smelly, but too smelly. It just wasn't a great room, it was very clinical. (Francisco, 23) I don't wanna move it, because I don't wanna cause a fuss, but I *hate* this fucking cushion. (Fern, 20)
Acknowledgement and accountability	… she always says 'oh, let me know if you're feeling warm' … or like, she'll turn the computer on, and say, 'I'm sorry, it whirs really loud'. Just like, the acknowledgement of it. (Fern, 20) I think everything is sort of accounted for. Being online, and the nature of our appointments means I can focus on them. I do a lot less … So, I think only having to worry about bringing things to a session. (Francisco, 23) … she did ask about lighting and generally I think she is good at being aware of things I might need. (Liv, 23) I remember my first session being pretty much all around, like, the paperwork, and if I needed any adjustments, and asking about, like, if I felt comfortable in the space. (Beth, 22)
Suggested improvements	They could keep (the coffee machine) in the hallway, or, they could just, even if they said, 'do you want anything to drink?' (Fern, 20) Like, maybe, on first entrance to a building, 'this is where the waiting room is, this is where some of the rooms are'. (Fern, 20) I think making it more obvious what they wanted from you before the first call. (Anna, 24) … so just the acknowledgement of, 'I don't know you, I don't know how you process your environment, let me know if this is distracting or uncomfortable'. From that point onwards, that's on me to communicate that. (Fern, 20) So, being sent (the contract) ahead of time, and then being given a physical copy, because, it's like, the cross-section between the autism and the ADHD. I need to know ahead of time what you're gonna say to me, but I also have ADHD and I'm gonna forget to read it. (Fern, 20) I think they could have been a bit more organised and explained what they expected me to do before the telephone interview. Because I had no idea. (Anna, 24) Yeah, I think if I'd been given it before, and then gone in and agreed to it, rather than the opposite: agreeing to it in the session and then being given it to take home. (Liv, 23)
Asked about reasonable accommodations?	I don't think so … I don't think I've ever been asked that. (Fern, 20) No. Not any at all. (Francisco, 23) No, but I also didn't ask for it either. Maye if I did, they would have asked. (Anna, 24) I didn't for any at school or at uni … but for the therapy now she did ask about the lighting. (Liv, 23) And it's also the difficulty of pre-empting it. Like, if I've never been in that situation how am I gonna know what I'll need in that situation? (Liv, 23) I was actually, yeah. They asked me in the first session and via email first as well, yeah. (Beth, 22) I feel as though the service was able to deal with whatever I brought to them, but in the case of my dyslexia, I'm quite high functioning. (Beth, 22)

outdoors during the COVID-19 pandemic, and with online counselling in which she worried her family would overhear. Francisco and Liv had uninviting, under-stimulating counselling rooms. Liv and Beth experienced comfortable and welcoming counselling rooms (Table 6).

3.5.2 | Specific sensory concerns

Fern, Francisco and Liv mentioned visual, tactile and temperature issues within their counselling rooms. Fern discussed auditory sensory issues. Fern and Francisco raised olfactory sensitivity.

3.5.3 | Acknowledgement and accountability

Francisco, Beth and Liv said at least one of their counsellors accounted for their concerns without prompt. All participants said that either acknowledgement of the environment or clearer explanation of the therapeutic process would have improved their experiences. Fern's, Anna's and Liv's experiences could have been improved by being sent the contracting information ahead of time. Fern, Francisco and Anna were not asked about reasonable adjustments, but Beth and Liv were. Fern raised the difficulty of asking for accommodations later without having been given 'permission'.

Liv did not know what accommodations to ask for as the question was too broad.

3.6 | General accessibility and practicalities

3.6.1 | Physical accessibility

Liv sometimes found lighting and font size difficult due to her visual impairment. Francisco and Beth mentioned physical access issues, such as stairs, parking, distance and online referral (Table 7).

3.6.2 | Neurotypical accommodations

Fern and Liv said the issues that they found inaccessible came from a place of awareness of the needs of a neurotypical client. Fern was not sure which of her experiences were directly related to her neurodivergence.

3.6.3 | Practical considerations

Anna, Francisco and Liv highlighted contrasts between private and free services, and respectively, affordability versus waiting lists. Francisco liked their session pacing and length, while Anna felt her sessions were sometimes too short.

4 | DISCUSSION

4.1 | Language in counselling

Participants found unclear and unspecific language confusing and stressful, while inclusive, direct and compassionate language was appreciated. This is supported by research in other practices, such as higher education and workplaces—where direct, individualised language was key for neurodivergent individuals, alongside clarity of administrative and pre-entry information and closed questioning (Beardon et al., 2009; Gillespie-Lynch et al., 2017; Seitz & Smith, 2016; Tops et al., 2022). Participants highlighted the importance of concise contracting and assessment. Healthcare practitioners are similarly reminded to be sensitive to general language needs of autistic patients, while adopting a flexible approach to individual communication needs (Mason et al., 2019).

The use of clinical language in counselling is clouded by fears of labelling theory. Fern, for example, did not receive an autism diagnosis until adulthood despite feeling different from her peers during childhood. It is suggested, however, that counsellors may wish to discuss diagnosis with clients who state they feel 'different' (Pachowicz, 2020). The concept of neurodiversity has been acclaimed in support groups to improve self-esteem, social skills and relationships—this may therefore support its benefit within counselling (Barnhart, 2016). Reframing a client's internalised discourse about themselves or their label, and instead nurturing neurodiversity pride and acceptance, may reverse ableist and negative social perceptions of neurodivergent labels

TABLE 7 General accessibility and practicalities: transcript excerpts.

Initial theme	Sample quotes
Physical accessibility	… she has a lamp behind her and I find it hard to see her, because the light almost blinds me. (Liv, 23) … the text was not the size that I would have preferred it to be. And it was fine, I can read small print if I hold it close enough to my face. (Liv, 23) My first counsellor, again, had a lot of steep stairs, and low ceilings on the staircase. (Francisco, 23) It takes me half an hour to drive there … I think also, having parking at the place would have made it more accessible. (Beth, 22)
Neurotypical accommodations	I never wanted (the coffee machine) to be an issue because it was so clearly put there as comforts. (Fern, 20) It was always assumed that people process things, are comforting by things, are discomforted by things, in the same way. (Fern, 20) … awareness of the sorts of things that somebody who has ADHD, autism, whatever it might be, might say. You know, the ways it might present itself in a therapy situation. (Liv, 23)
Practical considerations	I think, In terms of all of the more CBT, NHS, or school side of things, it's accessible to actually start the process. To go on a waiting list. But then there's the waiting time … But then you've got the other side of it where with private therapy, there's no waiting time but you have to pay for it. (Liv, 23) And then my sixth form, there were two counsellors, but they only worked one day each … And obviously when you reach that crisis point, you are referred to those people, but then you are stuck for a year. (Liv, 23) … they said if I wanted face-to-face, I might have to wait … And I was like, I need it now, so I will just do the virtual one. And they seemed a lot happier with that. (Anna, 24) … their timing is very good. Their pacing of the session. (Francisco, 23) I really like having sessions that are 50–55 minutes long. And I don't need much flexibility in that because it's really useful to me to constrain it. (Francisco, 23) I think sometimes I do wish the sessions were longer than half an hour, because some days are worse than others … I do wish that I did have a little longer just to validate how I was feeling and how to overcome those feelings. (Anna, 24)

(Chapman & Botha, 2022; Elftorp & Hearne, 2020). Bolton (2023a, p. 13) recommended a 'process-based language' to decentre neuronormativity—wherein neurodivergent clients are recognised as being the process and being in the process (i.e., being autistic is intertwined in their very being and in how they will experience the world). The novelty of this theory, and therefore its lack of presence in counselling training, may explain participants feeling misunderstood or ignored by their counsellors.

As established, neurodevelopmental conditions co-occur with each other and with mental health problems at a high rate. Individuals who do not identify with their ASAB are 3–6 times more likely to be autistic than cisgender people (Warrier et al., 2020). This, alongside transgender and non-binary (TNB) youth being disproportionately affected by poor mental health (e.g., depression, anxiety and suicidal ideation), prompts concern into the apparent lack of gender issue-specific trainings in counselling (Kuper et al., 2019; Shannon, 2019; Tordoff et al., 2022). Trans-affirmative models in counselling centre around overlapping person-centredness and cultural competence to embrace clients' individuality (Argyriou, 2021). Neurodivergent-informed therapy may mirror this by shifting the pathologising of neurodiversity to an affirming approach—for example, Francisco's story of experiencing gendered language, to not being situated with a gender-inclusive counsellor. Mindful, validating language is paramount, and sameness between the client and the counsellor can be rewarding (Brook, 2022; Chapman & Botha, 2022; La Roche & Maxie, 2003; Rosati et al., 2022).

Participants reiterated therapists' confusing, indirect language, and overuse or under-explanation of figurative language. Figurative language, such as visualisation, is frequently adopted in therapy, with CBT therapists using metaphors as a psychoeducational technique (e.g., 'building bridges'; Malkomsen et al., 2022). Some autistic individuals find non-literal language challenging, which may explain Liv's, Anna's and Fern's struggles with counsellors using imagery or analogies in sessions (Morsanyi et al., 2020; Vulchanova & Vulchanov, 2022).

4.2 | Understanding, advocacy and masking in counselling

Alexithymia (difficulty in identifying and self-regulating emotions) and interoceptive mismatch (discrepancy between bodily signals and anticipated physiological state) are both associated with neurodivergence, mental health problems and poor outcomes in counselling (Grimes et al., 2023; Larsen et al., 2003). They may explain participants' difficulties in conceptualising their emotions, such as Liv, who struggled to connect emotions to physical feelings. Participants also struggled to recognise or express their therapeutic expectations, which was mirrored in neurodivergent students who overthought expectations and could not set goals (Beardon et al., 2009; Rolak et al., 2023).

Neurodivergent students who were able to self-advocate had improved experiences in higher education and were more able to access support (Gillespie-Lynch et al., 2017; Leadbitter et al., 2021). Acceptance of external support and strength-based perception of neurodivergent identity promoted positive therapeutic outcomes and predicted lower depressive symptoms and higher self-esteem (Cage et al., 2018; Cooper et al., 2017). This reflects present participants' positive experiences in counselling in which they felt able to self-advocate and self-refer.

The literature relating to participants' own struggles and strengths in counselling is prominently based on practitioner recommendations. This, in addition to the unique life experiences and therapeutic relationship between participants and each of their counsellors, contributes to a difficulty in grounding the themes within existing theory.

Interventions based upon autistic views have more regard for autonomy, well-being and narrowing the gap between autistic people and their environment (Leadbitter et al., 2021). This was seen in present participants' reports of potential benefits of 'permission' or acknowledgement. Similarly, reconceptualising counselling within the neurodiversity paradigm means resisting the neuronormative and non-affirming approaches historically entrenched in counselling, such as therapies that 'treated' autistic traits or involved microaggressions, behaviourism and 'normalisation' (Chapman & Botha, 2022; Dallman et al., 2022).

All participants felt misunderstood, ignored or not listened to at times. Irvine (2019) proposed that neglectful therapy misunderstands how trauma and bereavement can be prolonged and expressed differently in neurodivergent individuals. This may explain Fern's lack of distress when explaining her trauma to her counsellor. Mindful therapy should modify and adapt to the client, for example, by enhancing/decreasing sensory exposure and utilising receptive language and directive approaches. Further validating therapeutic approaches recommend valuing the client's autonomy and social agency (e.g., accepting all forms of communication and framing stimming and other behaviours as natural and valid responses), and furthering the person-centred approach to encapsulate neurodivergent traits (e.g., an empathetic understanding that ADHD fidgeting is not pathologised; Dallman et al., 2022; Bolton, 2023b). This suggests that participants' urges to mask in counselling may be due to a non-affirming or non-accepting environment.

These theories are further supported by opposing participant excerpts—in which they felt their needs were validated, listened to and accommodated for. Here, therapists acted without prompt, took the time to explain or checked in and re-evaluated indirect language. Reflecting this are the experiences of counsellors for autistic clients, in which validating approaches included zooming in and out of clinical language and being conscious of autistic information and sensory processing (Brook, 2022).

4.3 | Environment and sensory sensitivity

Most codes within the analysis were made up of environmental and sensory concerns. This is consistent with health care, where sensory

issues, such as lighting and crowded waiting rooms, were the main barriers to access for autistic individuals (Mason et al., 2019). Fern and Francisco felt their waiting rooms were overwhelming and busy. Sensory sensitivities contribute to harmful schemas and context conditioning. This means that prolonged hypersensitivity causes hypervigilance, chronic stress and the generalised belief that any overstimulating environment may be unfriendly or dangerous (Morgan, 2019).

Dysregulation in counselling clients can lead to sensory seeking, anxiety, mistrust and misdirected perception (Van Nest, 2019). This implies, for example, that when Fern sat away from the cushion to avoid meltdown, while her counsellor may have been a comforting presence, the sensory evidence made her nervous system feel unsafe. Sensory sensitivities can make engaging in counselling difficult when hypersensitivity causes burnout, chronic exhaustion and reduced tolerance to stimuli (Kiep et al., 2023; Ward, 2018). This validates participants' feelings of overwhelm and lack of focus when overstimulated in counselling.

When creating a therapeutic atmosphere, continuity, wayfinding, spaciousness and soft lighting is recommended (Pearson, 2012). This differs from participants' views in the way of lighting, suggesting that counselling environments may not be informed by neurodivergent needs. Wayfinding and continuity were not established in many of their services—for example, lack of explanation of building layout. Interestingly, where environmental accommodations, such as lighting and noise, were made in dance movement therapy for autistic adults, this was well-received (Edwards, 2013).

Participants overwhelmingly stated a need for acknowledgement and accountability for reasonable adjustments and sensory concerns. This could be by being given contracting information ahead of time and given 'permission' to ask for accommodations. A framework that counselling services may be able to replicate is the Academic Autism Spectrum Partnership in Research and Education (AASPIRE, 2023) toolkit, co-created with autistic individuals. It contains information and worksheets designed for autistic adults, supporters and healthcare providers to assist them in identifying and reframing challenges as disability-related needs (Nicolaidis et al., 2016; Raymaker et al., 2019). Practitioners should be sensitive to the social and identity disability models, and counsellors may adopt congruence, especially for neurodivergent clients who have a history of masking and enduring conditions of worth (Baron-Cohen, 2017; Bolton, 2023b). This may help participants such as Fern and Francisco, who struggled to unmask in counselling.

4.4 | Physical accessibility and practicalities

Lack of specialist mental health services for people with visual impairments, alongside other issues participants raised regarding physical/practical accessibility and session pacing, highlighted the need for an intersectional, individualised approach to counselling and support services. A consistent approach across services regarding reasonable adjustments, contracting, acknowledgement and information dispersal prior to the first session is pertinent.

4.5 | Implications and further recommendations

Healthcare and higher education services refer neurodivergent individuals to counselling for additional support; therefore, inclusive and affirming therapeutic networks are paramount. 'Needs frustration' due to therapeutic neglect can lead to therapeutic harm, general distress and mental ill-health (Bolton, 2023a). For instance, Fern, Francisco and Liv each had experiences in which their expectations in therapy were not met, or they felt misunderstood.

Interventions should be formed in collaboration with neurodivergent individuals (Leadbitter et al., 2021). Adaptations for neurodivergent clientele should be included in core counselling training, and service protocols may need to change to address access barriers (Cooper et al., 2018). Practitioners are recommended to undergo neurodivergent-informed training and adapt to communication, sensory and social needs of their neurodivergent clientele.

The practicality of accommodating for individual client needs may seem challenging; however, an individualised and tailored approach is a core tenet of person-centred counselling. However, the overarching narrative was that acknowledgement and opportunity would have provided a more accessible experience. It is recommended for counselling services to include questions around accessibility needs within their assessment or first session.

Further research may wish to investigate present themes on a wider scale. It would be worthwhile to consider the intersectionality of mental health issues, physical disabilities and access needs. Further research could explore the impact of skills such as self-advocacy on neurodivergent counselling experiences. It may be beneficial to facilitate discussions between practitioners and service users in a research or focus group capacity.

4.6 | Limitations

The broad nature of the interview questions was intentional due to the scarcity of relevant literature, with a semi-structured design to allow for further clarification. However, this caused some difficulties for participants, such as differing interpretations of 'accessibility'. Self-identification as neurodivergent in research may exclude some people who are not aware of the concept or do not want to be labelled as such (Russell, 2020). This causes potential limitations for the present research, which called for any individuals self-identifying as neurodivergent, meaning it may not have been adequately defined. However, the final participants did settle into at least one of three groups (ADHD, dyslexic and autistic), thus allowing for more specific exploration of findings.

Participants in this research were all White and AFAB, with unknown socio-economic background, limiting its universality. The small sample size also contributed to this. However, qualitative research is typically not generalisable to the wider population, and self-reported data are limited in its ability to be verified (Huberman & Miles, 1994). While most suicides in the general population occur in men at a ratio of 4 to 1 (NIMH, 2020), research has revealed that

autistic women without comorbid learning disabilities face a higher risk of dying by suicide (Hirvikoski et al., 2016; Kirby et al., 2019). This suggests a different pathway to suicidality compared with the general population. Consequently, this could offer another potential explanation for the overrepresentation of AFAB individuals in our sample.

Attempts to contextualise each participant's strengths and struggles along their therapeutic journeys within a theoretical framework were complex, as there are many areas of their backgrounds, histories and lived experiences that were not discussed in interviews. Future research and methods may therefore wish to recruit a wider demographic and probe further into participants' backgrounds to find a richer depth and context to the narrative.

5 | CONCLUSION

This research aimed to explore the extent to which lived experiences of neurodivergent individuals within counselling were accessible, validating and affirming, in particular, regarding reasonable adjustments, communication and environment. It was found that participants experienced a range of communication styles, but common themes were highlighted regarding direct language, validating language and confusing explanations or figurative language. In some instances, participants felt that their counsellor misunderstood them or ignored their needs, but conversely, it was also found that some counselling experiences were sufficiently supportive and understanding.

A variety of sensory concerns were noted, for example, environments that were noisy, clinical or unwelcoming; or environments that were cosy, and where sensory needs were checked. Most participants had never been offered reasonable adjustments, but there were mixed feelings as to whether they felt able to ask independently. Participants also referred to a range of physical and practical considerations. Overall, a flexible approach to language, environment and sensory sensitivities was recommended, with consideration to individual client needs.

Due to the inductive approach, findings were discussed in relation to the previous literature on neurodivergent traits, and within the framework of the neurodiversity movement. Participants' reports of affirming and non-affirming practices generally complemented each other within the narrative. Recommendations for practice include amending the counselling contracting process and sensitivity to the communication and sensory needs of each individual client. Further research may wish to explore specific details of the present, and other emergent, neurodiversity research in more detail.

CONFLICT OF INTEREST STATEMENT

The authors declare no competing interests.

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