

NEUROAFFIRMING PRACTICES IN A CLINICAL SETTING

FOR ANY PROVIDER WORKING WITH AUTISTIC OR ADHD INDIVIDUALS

ESSENTIAL PRACTICES NON-NEGOTIABLE

- Care goals are defined by the individual.
- Using a strengths-based approach that presumes competence.
- Prioritizing connection over compliance.
- Recognizing the functionality of ND traits (e.g., stimming, routines, monotropism) and working *with* them.
- Using strategies that account for differences in executive functioning and cognitive processes (e.g., attention, decision-making, learning).
- Recognizing the individual's sensory, interoceptive, and communication needs.
- Setting up an environment that accommodates different individuals' needs (e.g., adjustable lighting, quiet space, variety of regulation tools).
- Individualizing strategies for meeting nutrition needs (e.g., alarms, body-doubling, pre-portioned meals, small frequent meals).
- Respecting social preferences (e.g., eating alone, reduced interaction).
- Taking the individual's reports of pain and distress seriously, regardless of how they are expressed.
- Aiming to be person-centred, trauma-informed, gender-affirming, and intersectional.



* You may refer to the document *Supporting ADHDers and Autistic Individuals with Eating Disorders: Start-Up Kit for Clinicians* for the meaning of abbreviations.

PREFERRED PRACTICES IDEALLY IN DEVELOPMENT

- Understanding ND-related ED pathways; these include sensory and executive functioning differences, alexithymia, RSD, and PDA.
- Using adapted screening tools (e.g., ASRS-5, RAADS-R, SWEAA, AEQ).
- Adapting traditional approaches (e.g., intuitive eating) or using ND-specific frameworks.
- Recognizing medication effects and co-occurring chronic conditions (e.g., GI issues, POTS, hEDS, PCOS).
- Understanding demand avoidance; using declarative language and autonomy-supportive strategies.
- Using *Spoon Theory* to adapt expectations.

NON-AFFIRMING PRACTICES SHOULD BE AVOIDED

- Attempting to “normalize” the person or reduce ND traits.
- Enforcing eye contact, stillness, or suppression of stimming.
- Ignoring sensory, interoceptive, or communication needs.
- Pressuring the person to engage in sensory or food exposures to “increase tolerance.”
- Using coercion or punishment to promote compliance (e.g., removing access to items, withholding privileges).
- Labelling behaviours as manipulation, laziness, or attention-seeking.
- Blaming the person for difficulties they are experiencing with their care.
- Documenting based on neuronormative expectations (eye contact, tone, posture).

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National Eating Disorder Information Centre