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# Facing Neurotypical Normativity: An Ethical Call for Therapeutic Sensitivity to Neurodiversity

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Facing Neurotypical Normativity: An Ethical Call for Therapeutic  
Sensitivity to Neurodiversity  
Capstone Thesis  
Lesley University

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Expressive Arts Therapy

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### Abstract

This paper explores the relationship between counseling education, clinicians-in-training, and neurodivergent client populations. Arguing that there is an absence of adequate training to address the specific needs of clients with developmental disabilities, this paper introduces the term *neurotypical normativity* in order to delimit deeply embedded biases operating within the mental health profession. These biases generate modes of treatment that overlook emotional and relational needs in favor of symptom-based diagnosis and behavioral management. Through the critical examination of the connection between fundamental presuppositions, education, and treatment, this paper initiates an ethical call for therapeutic sensitivity to neurodiversity.

*Keywords:* neurodiversity, counseling, education, trauma

## Facing Neurotypical Normativity: An Ethical Call for Therapeutic Sensitivity to Neurodiversity

This work has grown from three assumptions drawn from my graduate school experience. First, mental health counseling students, such as myself, are not adequately trained to work with neurodivergent populations in a person-centered way. Second, this lack of adequate training reveals a neurotypical bias and represents an ethical failure within the discipline. Third, expressive arts therapy is uniquely positioned to bridge this gap. This argument proceeds by first defining and operationalizing terms used throughout the paper. Subsequently, I will relate my own story to the development of these emerging ideas. These narratives will clarify why confronting these biases is worthy of the attention of counseling students and professionals. Finally, the paper concludes by speculating how expressive arts therapy is uniquely equipped to face this ethical dilemma and provide an important service to the community.

### **Definitions**

Operationalizing and defining terms is an important task for the sake of linguistic and conceptual clarity; however, caution must be taken to avoid imposing normative discourses on the lives of individuals with disabilities. Definitions, when dogmatically adhered to, can quickly become rigid boxes that stifle communities in their own attempts at self-definition. Far too much literature and discourse about developmental disabilities is written at the expense and exclusion of those same voices that they wish to address. Learmonth and Gibson (2010) aptly point out that “therapy literature is mostly written by an ‘us’ (therapists), writing about ‘them’ (clients)” (p. 54). Similarly, disability advocacy organizations such as the Autistic Self-Advocacy Network (2019) stress that inclusion must necessarily incorporate the voices of those with disabilities, exclaiming the motto: “nothing about us, without us” (“About,” 2019). It has been

important for me to keep this paradox in mind as I write this paper and begin a career. My desire is to contribute something helpful rather than harmful, while simultaneously navigating the complex world of language with generosity and grace.

According to the website Disabled World, neurodiversity is a social justice movement which seeks “civil rights, equality, respect, and full societal inclusion for the neurodivergent” (“Neurodiversity: Definition and Information,” 2019). A neurodivergent person refers to an individual with neurological development that is atypical in respect to the average range of human neurological development; whereas a neurotypical person refers to someone whose neurological development falls within a typical or average range of human development. However, it is important to note at the outset of this paper that these categories do not define discrete characteristics or particular individuals. Rather, they simply distinguish statistically defined ranges that are capable of describing common and uncommon patterns of neurological development. Neurodiversity is a worldview that considers difference among all people as the normative state of human existence. For example, this movement embraces the autism spectrum (which is currently classified as a neurodevelopmental disorder) as divergent rather than disordered. Intrinsic to this understanding is the view that individuals on the autism spectrum follow an alternative developmental trajectory rather than a *delayed* typical trajectory.

The World Health Organization (2013) defines developmental disorders as a group of conditions with onset in infancy or childhood that are characterized by impairment or delays in functioning. In alignment with this definition, the Diagnostic and Statistical Manual Fifth Edition (2013), also known as the DSM-5, defines neurodevelopmental disorders as “a group of conditions with onset in the developmental period” (p. 31). Further, “the disorders typically manifest early in development, often before the child enters grade school, and are characterized

by developmental deficits that produce impairments of personal, social, academic, or occupational functioning” (p. 31). This approach and its conceptual underpinnings constructs the diagnostic basis for mainstream mental health counseling services and is also how I was taught to understand developmental disabilities.

*Neurotypical normativity*, a term used within this paper, describes an approach to counseling education that assumes neurotypicality as the basis for psychological treatment and discourse. One of the important reasons to acknowledge neurotypical normativity is that treatment should ideally be tailored to the unique and specific needs of individuals, while remaining capable of adapting to those with developmental disabilities. Insofar as neurodivergent clients are generalized and categorically restricted by existing DSM-5 classifications, they find themselves reduced to a fringe specialty of therapy. This is reflected in pathology, which has a normalization goal that seeks to make someone *normal* rather than *abnormal*. In contrast to this active *othering* process, neurodiversity seeks to normalize difference. Clinically, this demands that clinicians take the time to learn and understand an individual on their own terms.

### **The Beginning**

Lesley University requires mental health counseling graduate students to complete two internships during their program of study. I completed my first internship at a community-based day program for adults with autism and other developmental disabilities. One of the challenges of the day program was to provide services and support for members with co-morbid mental health challenges in addition to an existing developmental disability. An example: a client would have access to our program for services relating to their disability. However, the behavioral challenges they experienced would have been better supported by mental health

services for symptoms relating to anxiety, depression, or trauma. Because this was a day program, mental health services were not explicitly prioritized. What was instead prioritized included life skills, community development, and relationships.

My final internship was at an outpatient counseling center for youth and families. Though the center provides services to the community for children and their families, clinicians nonetheless frequently struggle when encountering clients who have a previous diagnosis or are suspected of having a developmental disability. My fellow interns often displayed uncertainty regarding how to engage with such ambiguity, and there existed an underlying assumption that clinicians were ill-prepared to successfully adapt to a client's particular needs. A more worrisome conclusion derived from inadequate preparation is that people with developmental disabilities do not belong in outpatient mental health treatment—that their mental health difficulties *belong with a specialist exclusively*. The ethos of my internship site was organized around deep compassion and a desire to provide accessible, person-centered care to children and families. However, the dense regulations around billing and the institutional emphasis on productivity cultivated an environment unsuitable for clinicians to learn the language of particular to each individual person. Given immense caseloads and the number of complex nuances in family work, it is no surprise that clinicians often struggle within the context of such environments.

## **Literature Review**

### **What is the Problem?**

There does not currently exist adequate and available training for clinicians to provide mental health treatment for individuals with developmental disabilities. Individual state requirements in the United States requires specialty coursework in substance use, vocational

counseling, human sexuality, and marriage and family therapy for licensure in mental health counseling (“counselor-license,” 2019). Surprisingly, no state currently requires specific training related to disabilities of any kind. Because all absence is a presence of something, this lack of training reveals an ableist bias built into counseling education and practice. This absence further indicates a neurotypical bias in which developmental disabilities are excluded from the discourse around mental health and wellbeing.

### **Why is This a Problem?**

One of the initial hurdles preventing individuals with developmental disabilities from accessing mental health services is finding a confident therapist (Dagnan, Masson, Cavagin, Thwaites, & Hatton, 2015, p. 392). In other words, clinician knowledge, confidence, and experience all function as gatekeepers for neurodivergent clients seeking mental health services. As Whitehouse, Tudway, Look, and Kroese (2005) explained in a review of services, “people did have access to psychotherapy, but it depended on the skills of practitioners, and that a major barrier to receiving psychotherapy was the lack of appropriately trained clinicians” (p. 63). We often think of access as mere availability, but these authors show that access depends on the openness, readiness, and preparation of informed and competent therapists.

Dagnan et al. (2015) further explained that the impetus for clinician confidence is training (p. 395). Speaking from my own experience, my training at the graduate level has lacked alternative educational approaches to developmental disabilities apart from the domain of psychopathology. Although I was fortunate to find an internship at a community-based day program for adults with developmental disabilities, exposure alone does not guarantee clinical confidence and informed care (p. 395). In addition, an attitude of continual education must be adopted by both new and experienced clinicians in order to provide services to this population.



The World Health Organization (2013) reported that the rates of autism spectrum disorder are rising. This claim involves complex interpretive factors that are highly contested, a conversation that lies beyond the scope of this paper. Regardless, neurodevelopmental diagnoses are indeed showing up in mental health clinics with greater frequency and mental health counselors find themselves encountering this population regardless of their educational level. Clinicians, therefore, are gatekeepers of competent therapeutic treatment. Due to this responsibility, clinicians must recognize their role in perpetuating oppressive stereotypes, executing clinical errors, performing incompetent counseling, and ignoring the potential needs of a marginalized population. Each of these clinical mishaps is a potential violation of the ethics and values set forth by the American Counseling Association (2014).

**Clinical errors.** Possible clinical errors that clinicians can make while working with individuals with developmental disabilities include underdiagnosis, misdiagnosis, and diagnostic overshadowing. Several studies (Standen, Clifford, & Jeenkeri, 2017; Holub, Horne-Moyer, & Abar, 2018; Wilkenfeld, 2015; Whitehouse et al., 2005; & Dagnan et al., 2015) have exhibited that clinical errors such as misdiagnosis and underdiagnosis occur at a significantly higher rate in individuals with developmental disabilities when compared to neurotypical populations. Diagnostic overshadowing refers to the process by which symptoms of mental illness are attributed solely to the developmental disability diagnosis (Holub et al., 2018, pg. 12). In other words, “the cognitive content . . . (what a person thinks) has been overlooked in favor of the cognitive process (how a person thinks)” (Whitehouse et al., 2005, p. 57). These misunderstandings overlook the emotional inner life by focusing exclusively on functional aspects of thinking and behavior.

**Prejudiced counseling.** Corollary to my argument that inadequate education amounts to an ethical failure, it is important to differentiate between learning *about* neurodevelopmental disabilities through the lenses of psychopathology or assessment and learning about how to work specifically *with* individuals who have a developmental disability. This differentiation involves a reversal in priorities within the therapeutic encounter, and demands that the clinician performs therapy not from a theoretical construct but from the lived experience of the client. One of the consequences of beginning therapy from theory is demonstrated by Learmonth and Gibson (2010) who pointed out that “people without disabilities usually identify the impairment as the main problem facing the disabled person” (p. 54). In contrast, they go on to explain that “people with disabilities are far more likely to identify disabling social factors [as the main problem]” (p. 54). This difference in orientation suggests that clinicians may fundamentally misunderstand a client’s motivation for seeking out services.

In a similar vein, “one of the difficulties facing people with disabilities seeking therapy is that they often have to ‘train’ a ‘TAB’ [temporarily able bodied] therapist in the issues [of disabilities]” (Learmonth & Gibson, 2010, p. 55) thereby being forced into explaining their existence while simultaneously advocating for themselves. This degree of self-advocacy requires that an individual possess the confidence and ability to self-report, skills that can be significantly more difficult to cultivate if they have any linguistic or communication limitations. These preconditions (the ability and confidence to communicate) thrive in safe environments as well as the willingness and receptivity of a collaborative and open therapist. Unfortunately, this combination is rarely met with in the world of patient overload, productivity, and billing.

One dangerous consequence of the disparity between research and counseling resources is the perpetuation of a narrative that suggests the absence of an emotional life in individuals

with developmental disabilities. In the past, “early psychodynamic theoreticians denied the presence of mental disorders in this population on the basis of the mistaken premise that these individuals could not develop internalized conflicts” (Butz, Bowling, & Bliss, 2000, p. 44). Perhaps this misassumption is based on the fact that psychopathology is constructed from presenting symptoms, an emphasis that excludes the underlying conditions or experiences that might be of more psychological and personal importance.

**Ignoring a need.** Despite the aforementioned prejudices, there is no research to suggest that individuals with developmental disabilities have an inability to feel. It is now recognized that adults with developmental disabilities experience emotional lives and can experience and suffer from mental health difficulties at the same rate as neurotypical populations (Whitehouse et al., 2005, p. 55). However, in contrast to neurotypical populations, individuals with disabilities experience abuse and victimization at an alarmingly higher rate (McEachern, 2012, p. 386). Many United States statistics do not even include disabilities in their data on sexual abuse and victimization, leaving this population to be an often underreported or not reported population concerning abuse (McEachern, 2012, p. 387). This is a glaring and problematic blind spot in clinical practice—one which has severe moral implications if ignored.

### **An Area of Particular Need**

According to the National Crime Victimization Survey (NCVS: Harrell, 2017), individuals with disabilities are 2.5 times more likely to experience violent victimization. Those with cognitive disabilities have the highest victimization rate at 57.9 per 1000 people (age 12+ with a disability), and individuals with disabilities are exposed to serious violent crime (rape or sexual assault, robbery, or aggravated assault) at a rate of three times the norm (p. 1). This survey extrapolates that 40% of violent crimes perpetrated against individuals with disabilities

are committed by persons who know the individual personally (Harrell, 2017 p. 6). Additional research by Mansell, Sobsey, & Calder (1992), adds that (in a survey of 119 sexual abuse victims with developmental disabilities) 53.8% of abuses happened on repeated occasions (p. 405), in a multitude of locations that include the private home (57.3%), public spaces (7.7%), and in institutions (7.7%). Perpetrators ranged from paid caregivers (26.3%), to family members (17%), neighbors (13.5%), strangers (9.0%), and transportation providers (6.0%) (p. 405). It is important to note that this survey was the largest and most comprehensive of its kind in 1992—capping out at 119 victims interviewed—further demonstrating the neglect of researchers to acknowledge this population as worthy of study. These statistics demonstrate that this vulnerable population is often reliant upon and abused by the very supports which ideally should serve to protect them.

Other well studied abuses include infantilization and dehumanization (McEachern, 2012; Thornberry & Olson, 2005). Infantilization describes the process by which clients are treated as children whereas dehumanization occurs when clients are treated as less than human. One example of infantilization is the disbelief that a person with a developmental disability can experience sexual desire. This misguided ignorance often leads to a neglect of education regarding the discernment between appropriate and inappropriate interactions, sexual knowledge, and sexual abuse prevention (McEachern, 2012, p. 392). Additionally, individuals with developmental disabilities are sometimes taught to be compliant to authority figures (p. 392) which can increase the risk of abuse while discouraging autonomy.

More discrete forms of abuses are found within institutional policies which “deny the right to privacy, to express sexuality, or to have someone available who will actually take the time to listen” (Thornberry & Olson, 2005, p. 7). The need for someone to take the time to listen

should be an active call to counselors everywhere because “victims who do disclose most often do so because they feel protected by and cared for by a significant other individual in their life whom they trust such as a residential counselor, a caregiver, or a family member” (McEachern, p. 392). In this context, it is important to be diligent in remembering the aforementioned statistics describing where and by whom individuals are most likely to experience abuse.

### **Treatment**

Mental health treatment for neurodivergent individuals is a multifaceted and complex process. In order to consider what such mental health treatment entails, it is fruitful to examine the many ways in which individuals with developmental disabilities have been treated over time while also recognizing the traces of past abuses within current conceptions of treatment.

Questions regarding any sort of treatment must include historical context and must examine who the treatment is designed for and the ways in which the treatment is carried out. My inquiry concerns the mental health treatment of individuals with developmental disabilities and aspires to outline a healthy collaboration between mental health and disability.

**Historical treatment.** While the law in the United States now recognizes individuals with developmental disabilities as citizens who possess equal right to education, health care, and employment, this was not always the case (Conrad, 2018). Though many facets of life for neurodivergent individuals have improved, progression has not been linear. Rather, it has been “a product of periods of growth and decline, backsliding, and hard-won battles across political, cultural, and legal domains” (p. 1). When considering historical context, the question of who the treatment serves must be scrutinized. Often, as Whitehouse et al. (2005) explained, treatments and interventions were designed to meet the needs of service providers rather than the individuals experiencing the difficulties (p. 56).

Historically, neurodivergent individuals have been categorized under titles including imbeciles, idiots, backwards-children, mentally-defective, feeble-minded, deviant, and burdens upon society (Conrad, 2018). This kind of attitude encouraged the idea that they were “totally and permanently unable to participate in rational deliberation in a way that was characteristic of being human” (p. 3), resulting in the belief that these individuals needed to be the recipients of charity rather than equality. Support for individuals with developmental disabilities was characterized more by maintenance than by care, often involving asylums that were tasked to provide treatment, but were in reality “merely a method to remove them from public life” (p. 3). Treatment in this context is aimed more at protecting society from these individuals rather than supporting them. Further, mental health does not even enter into the equation, namely because their entire inner world was interpreted to be defective or broken.

In the mid-19<sup>th</sup> century, there was a move away from institutionalization and toward education. However, even the education provided to individuals with developmental disabilities leaned heavily toward vocational training at the expense of academic growth and skill (Conrad, 2018). Although these individuals were supported in aspects of social life, they remained largely unseen in their academic and emotional capacities. This neglect further hampered their ability to participate in society in an equal, valued, and holistic way.

The history of the social treatment of individuals with developmental disabilities is wrought with abuse and neglect. One well documented abuse was involuntary sterilization (Conrad, 2018). Fueled by the attitude that people with developmental disabilities were defective and therefore a burden to society, the shared belief among many was that perceived *feeble-mindedness* was the result of undesirable characteristics that were passed down through the genes of “unfit parents” (p. 5). This belief led to the imposition of eugenics as a theoretical

model with which to *deal* with this population, a movement that was upheld in the Supreme Court in 1927 (p. 6). Though eugenics fizzled out in the years after World War II, forced sterilization continued to be lawful until 2003 (p. 6). It is important to note that forced sterilization disproportionately affected African Americans and women and was especially supported by the field of social work (p. 6). The popularity surrounding eugenics began to change after World War II, especially due to the horror of witnessing of Nazi Germany's intended eradication of certain populations. Additionally, as veterans returned home from the war with emotional distress and physical disabilities, society as a whole started to become more sensitive to disabilities.

This history is relevant to neurotypical normativity because it has helped to lay the groundwork for mental health treatment. The crux of my argument is best illuminated in the following example of the Architectural Barriers Act of 1968 which required buildings to be accessible to individuals with physical impairments. Conrad (2018) explained:

The assumption in [this act] is that it is an obvious case of prejudice to assume that an individual in a wheelchair is less productive or economically viable than a person without a disability. The act implicitly recognizes that public space has been designed for those without physical disabilities and that when people with physical disabilities are given the opportunity to participate in a society that is not slanted against them in advance, they may contribute equally. (p. 11)

Likewise, when counseling education excludes training about neurodiversity and working *with* neurodivergent individuals apart from psychopathology, it encourages a discipline that is “slanted against them in advance” (p.11). This residual prejudice still impacts the way we treat this population—in society, and as it pertains to their mental health and wellbeing. My argument

is that psychotherapy and counseling education, based on the mistaken idea that individuals with developmental disabilities are lacking an emotional world, was designed for those without developmental disabilities. It is therefore the responsibility of counselors to give individuals an opportunity to participate.

### **Therapy**

The discipline of psychotherapy has many theoretical orientations, theories, and practices. However, because of neurotypical normativity, little research has been conducted about the effectiveness of different theoretical orientations being used with individuals who have developmental disabilities. Research into the effectiveness of different theoretical orientations is important for multiple reasons. The discipline must understand specific adaptations required for individual psychotherapy to effectively meet an individual's needs—therapists must understand developmental disabilities beyond the scope of diagnosis to understand the specific challenges an individual might face regarding their expressive language, sensory experience, executive functioning, and other neurological intricacies. This knowledge is impossible without education and published research. Furthermore, research is imperative to the learning process which may interrupt the possible clinical errors and prejudiced counseling practices outlined previously in this paper.

**Research.** Despite the history of neurotypical normativity, research has been conducted with the hope of beginning a dialogue around the need for counseling and therapeutic interventions to be both available and accessible to individuals with developmental disabilities. Traditional therapeutic orientations such as psychodynamic psychotherapy (Beail, Warden, Morsley, & Newman, 2014; Whitehouse et al., 2005), cognitive-behavioral therapy (CBT) (Whitehouse et al., 2005), dialectical behavioral therapy (DBT) (McNair, Woodrow, & Hare,



2016), and art therapy (Schweizer, Spreen, & Knorth, 2017), have endeavored to understand what works, and what needs to be modified and adapted to provide effective therapeutic treatment for neurodivergent individuals. Practices and models such as trauma-informed care (Keesler, 2015), trauma treatment (Harley, Williams, Zamora, & Lakatos, 2014), bereavement counseling (Dowling, Hubert, White, & Hollins, 2006), and sexual abuse treatment (Mansell et al., 1992) have additionally worked to understand how they might be needed for this specific population of individuals.

**Findings and themes.** Though the research is sparse, common themes emerge throughout the literature. The themes describe a neglect of available psychotherapeutic interventions, a lack of adequate research about effectiveness, the need for flexibility and adaptation, research findings, and an active call for more widely accessible options of therapeutic support for neurodivergent individuals.

Neglect is described in a plethora of ways. Whitehouse et al. (2005) assign fault to institutionalization which kept individuals “out of site and out of mind” (p. 55). This neglect is problematic because individuals with developmental disabilities are at greater risk of exposure to adverse events such as trauma and abuse than the neurotypical population (Keesler, 2015; Mansel et al., 1992). Additionally, there is growing evidence to suggest that experiences such as bereavement and trauma can be prolonged and expressed differently in individuals with developmental disabilities, yet often unrecognized or misunderstood by caregivers (Dowling et al., 2006). Neglect within psychotherapy can also be explained by the reallocation of support being located to “specialist learning disability teams, or in day and residential services, rather than in mainstream counselling and psychological therapy services” (p. 277), along with the

limitation of mental health services to “behavioral modification, rehabilitative socialization, and little else” (Butz et al., 2000, p. 42).

There was general agreement about the sheer lack of research conducted about the efficacy of different therapeutic approaches to neurodivergent populations. The problem with this lack of research is that it can mistakenly be interpreted as ineffectiveness which then justifies continual neglect. Butz et al. (2000) described that there is a “paucity of research on the topic” (p.42) of psychotherapy with individuals with developmental disabilities, explaining that this was possible due to professionals believing that these individuals could not benefit from psychotherapy, even though there was no research to support that view (p. 43). Overall, in regard to psychotherapy, “there has been little progress regarding the evaluation of its efficacy and effectiveness” (Beail et al., 2004).

One of the possible reasons for lack of clarity regarding assessing effectiveness could well be the diversity of neurodivergent populations, a diversity that poses special challenges to generalizations and categorization. This diversity is best encapsulated in Dr. Stephen Shore’s famous quote “if you’ve met one person with autism, you’ve met one person with autism” (“105 Favorite Quotes About Autism and Aspergers,” 2019). Therefore, modifications of existing approaches may be adequate in some cases, though success ultimately depends on how well treatment is tailored to a unique individual. That considered, modifications and adaptations to psychotherapy were often suggested. Examples include: learning to use the client’s receptive language, using symbolic communication, utilizing visual imagery and enhancing or decreasing tactile and kinesthetic experiences (Mansell et al., 1992). Dowling et al. (2006) emphasize the awareness of the therapeutic relationship, while Whitehouse et al. (2005) suggested attention to negative countertransference. Further modifications might include simplification, language,

activities, consideration of developmental level, directive and flexible methods therapy, and involving caregivers in the treatment process (p. 59-60).

Despite the dearth of research, positive results often ensued from suggested modifications. Psychodynamic psychotherapy was shown to reduce psychological distress, improve functioning, and increase self-esteem (Beail et al., 2004). Likewise, cognitive-behavioral therapy has exhibited favorable outcomes (McNair, 2016). In a study by Dowling et al. (2006) on bereavement counseling, individuals in the counseling interventions showed “significant improvement in post-intervention scores” (p. 280). Butz et al. (2000) assessed that “both group and individual psychotherapy are undoubtedly therapeutic for clients with developmental disabilities” (p. 43). Therefore, “individual therapeutic interventions should be widely available to the general population” (Whitehouse et al., 2005. p. 55).

### **An Ethical Dilemma**

A person-centered clinical encounter is based upon the belief and trust that an individual has the capacity for self-direction, dignity, and worth (Rogers, 1993, p.3). Within this approach the role a therapist plays is one that is open, empathetic, honest, congruent, and caring as they encourage growth and build a therapeutic alliance (p. 3). When working with individuals with developmental disabilities, this principle should remain the same. However, if collective presuppositions suggest that neurodivergent individuals are incapable of creating meaningful connection, therapists run the risk of perpetuating these same abuses through negligence and unconscious permission.

Outlined below are many ways in which neurodivergent individuals are treated in contradiction to the values set forth by the American Counseling Association (2014). The ACA lays out core values and ethical behaviors which counselors are ideally committed to. If

counseling students only learn about developmental disabilities through psychopathology, then they adopt a perspective that can only approach developmental disabilities from the standpoint of diagnosis and exclusion. This approach is radically at odds with foundational tenets of neurodiversity, which identifies differences in neurological development to be normative.

Values of the ACA Code of Ethics (2014) include:

Enhancing human development through the lifespan; honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts; promoting social justice; safeguarding the integrity of the counsellor-client relationship; and practicing in a competent and ethical manner. (p. 3)

Further, the foundation for ethical behavior is as follows:

Autonomy, or fostering the right to control the direction of one's life; nonmaleficence, or avoiding actions that cause harm; beneficence, or working for the good of the individual and society by promoting mental health and well-being; justice, or treating individuals equitably and fostering fairness and equality; fidelity, or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships; and veracity, or dealing truthfully with individuals with whom counselors come into professional contact. (p. 3)

Autonomy is contradicted by infantilization, and the stereotype in which individuals with developmental disabilities cannot be active participants in their own life choices. Beneficence is challenged through the limited access to mental health services. Justice is denied by the segregation of disabilities into specializations. Honoring diversity and uniqueness are questioned in a neurotypically normative environment where the goal of treatment is normalization.

Clearly, the implementation of the values and behaviors outlined in the Codes are not inclusively applied. It is important to recognize this incongruency; self-critique is an opportunity for transformation through which counselors may more faithfully aspire to the values that are foundational to the discipline. In this context, this involves acknowledging the ways in which neurotypical normativity has functioned in history, and remains embedded in our own practices, institutions, and classrooms.

**A.4.a Avoiding harm.** The issue of avoiding harm rests in the question of whether inaction is an action which can cause an effect. The Code explains that counselors will act to avoid harm, and to remedy unanticipated or unavoidable harm caused (ACA, 2014, p. 4). Inaction is an action in the same way that absence is a presence. To be informed of the statistics regarding abuse while having gatekeeper power as counselors reveals inaction to function as complacency, thus perpetuating harm. Such a revelation initiates an opportunity for responsibility to find graceful and helpful remediations.

**A.7.a. Advocacy.** Within the Code of Ethics (2014) is a declaration of the “roles and relationships at individual, group, institutional, and societal levels” (p. 5). This section promotes the responsibility of counselors to advocate on behalf of clients at an individual, group, institutional, and societal level (p. 5) when barriers appear that might limit “access and/or growth and development of clients” (p. 5). A scarcity of appropriately trained clinicians is a barrier to accessing mental health services which certainly limits growth and development. It is an ethical responsibility to advocate for education and knowledge.

**C.2.f. Continuing education.** It is considered an ethical responsibility for counselors to further their education in order to meet the demands of clinical practice (p.9). Due to the awareness of misdiagnosis, underdiagnosis, and abuses, learning about developmental

disabilities is an area of need for continuing education. This would require continuing education to be more than gathering CEU credits, but rather the continual and active pursuit of knowledge intended for improvement, preparation, and effectiveness. A diversity in education would therefore represent an openness to working with a diversity of people.

**C.5. Non-discrimination.** Counselors, according to this section, agree to not condone, or engage in discrimination against others based on disability or language preference (p. 9). I have isolated these two identities for a purpose. An individual seeking services for their feelings of depression who is turned away or disregarded due to diagnostic overshadowing, for example, is experiencing discrimination. Likewise, misdiagnosis and underdiagnosis due to the ignorance of the counselor is discriminatory. Language preference is to note that some individuals with developmental disabilities might be nonverbal or have alternative ways of communicating. Assuming and privileging verbal expressive language is an unfair expectation for some.

**C.2.a. Boundaries of competence.** The biggest potential counterargument for an ethical based call for therapeutic sensitivity to neurodiversity is within section C.2.a. Boundaries of Competence of the ACA Code of Ethics (2014) that suggests that a counselor may only practice within their scope of professional training, education and experience (p. 8). This is undoubtedly an excellent point, as practicing beyond the scope of competency can be dangerous and irresponsible. However, if this principle is used as an excuse to avoid or ignore the need for education and growth, the question must be asked regarding who this Code protects. If it is used as a safeguard to avoid learning how to work with individuals with developmental disabilities, the Code serves as yet another gatekeeper that individuals must fight through to receive appropriate services. Therefore, this Code can be better utilized and appreciated as a motivator

for students and professionals to extend their competencies, seek out training, and demand better education from their institutions.

### **Bridging the Gap with Expressive Arts Therapy**

The International Expressive Arts Therapy Association (2019) claims that the expressive arts combine the visual arts, movement, drama, music, writing, and other creative processes to foster deep personal growth and community development (“Who We Are,” 2019). As I have come to understand it, expressive arts therapy uses multiple senses, and multiple creative outlets to explore the inner and outer world—understanding that expression does not have to be verbal or logical (in a typical way) in order to be meaningful. Instead, expression can be sensory, kinesthetic, symbolic, and affective, all at the same time (Hinz, 2009, p.7). Additionally, the use of art materials can be therapeutic in and of themselves—feelings, emotions, connection, and communication can be fostered through engagement with art materials even if an external image is not created (p. 7).

While expressive arts therapy can have different meanings to different theorists and practitioners, it is fundamentally a philosophy of psychotherapy as well as a way of practicing psychotherapy (Rogers, 1993; Knill, Levine, & Levine, 2005). It is a philosophy that respects the process, not just the product, as meaningful, and one that respects symbolism and the imagination as powerful tools of meaning making. Within the IEATA Code of Ethics (n.d.) is an affirmation of the power of the emotional and imaginal as well as the literal (para. 24). The nonverbal is an important aspect of human understanding, communication, and meaning making within expressive arts therapy. This is important because “language impairment can increase the vulnerability of sexual abuse as limited language may impede disclosure and detection of the victimization. Language and speech impairment may also affect how the abuse is understood

and processed by the victims” (McEachern, 2012, p. 389). Expressive arts therapy may therefore be able to provide a unique vehicle for communication and a strong therapeutic alliance.

In terms of meeting the needs of individuals with developmental disabilities, “expressive arts therapists are aware that involving the mind, the body, and the emotions brings forth the client’s intuitive, imaginative abilities as well as logical, linear thought” (Rogers, 1993, p. 3). Therefore, the expressive arts therapist relies on multiple ways of knowing and communicating to involve multiple capacities and abilities. Research by Dagnan et al. (2015) suggests that “those [clinicians] who identify themselves as using dynamic or analytic therapy and who identify themselves using an eclectic therapy approach report themselves as significantly more confident” (p. 395) in working therapeutically with populations with intellectual disabilities in contrast to those using approaches such as cognitive behavioral therapy (p. 395). Expressive arts therapy, in its flexibility, accommodates a multiplicity of perspectives and multiple ways of knowing. For example, individuals with challenges in using expressive language might find that other artistic mediums could be a more natural mode of communication (Silberman, 2015, p. 465). Therefore, expressive arts therapy could be adaptable in meeting neurodivergent individuals with specific needs rather than putting the onus on the individual to fit into a specific model of therapy.

### **Conclusion**

As previously stated, this is an exploration. This paper is not intended to promote an upheaval of education or counseling services. I believe that specialties are important and that certain individual therapist personalities will be drawn to work and specialize with specific populations of people. Contributions from in-depth inquiry and research is how we grow as a discipline, and then by proxy, how we grow to be more effective therapists. I do not think we



should all be experts on adaptive therapies or developmental disabilities. However, I believe the lack of education for counselling students is an ethical failure because it leaves clinicians unable to even consider disabilities to be anything but impediments to therapy. Therefore, it is an ethical responsibility for counselors to engage with neurodiversity. Such an engagement would inevitably inspire the transformation and growth of both client and clinician. Neurotypical normativity does not have to be a hindrance; rather, it could be taken up as a challenge that when overcome could aid mental health counseling in fulfilling its highest aims of greater inclusive care.

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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