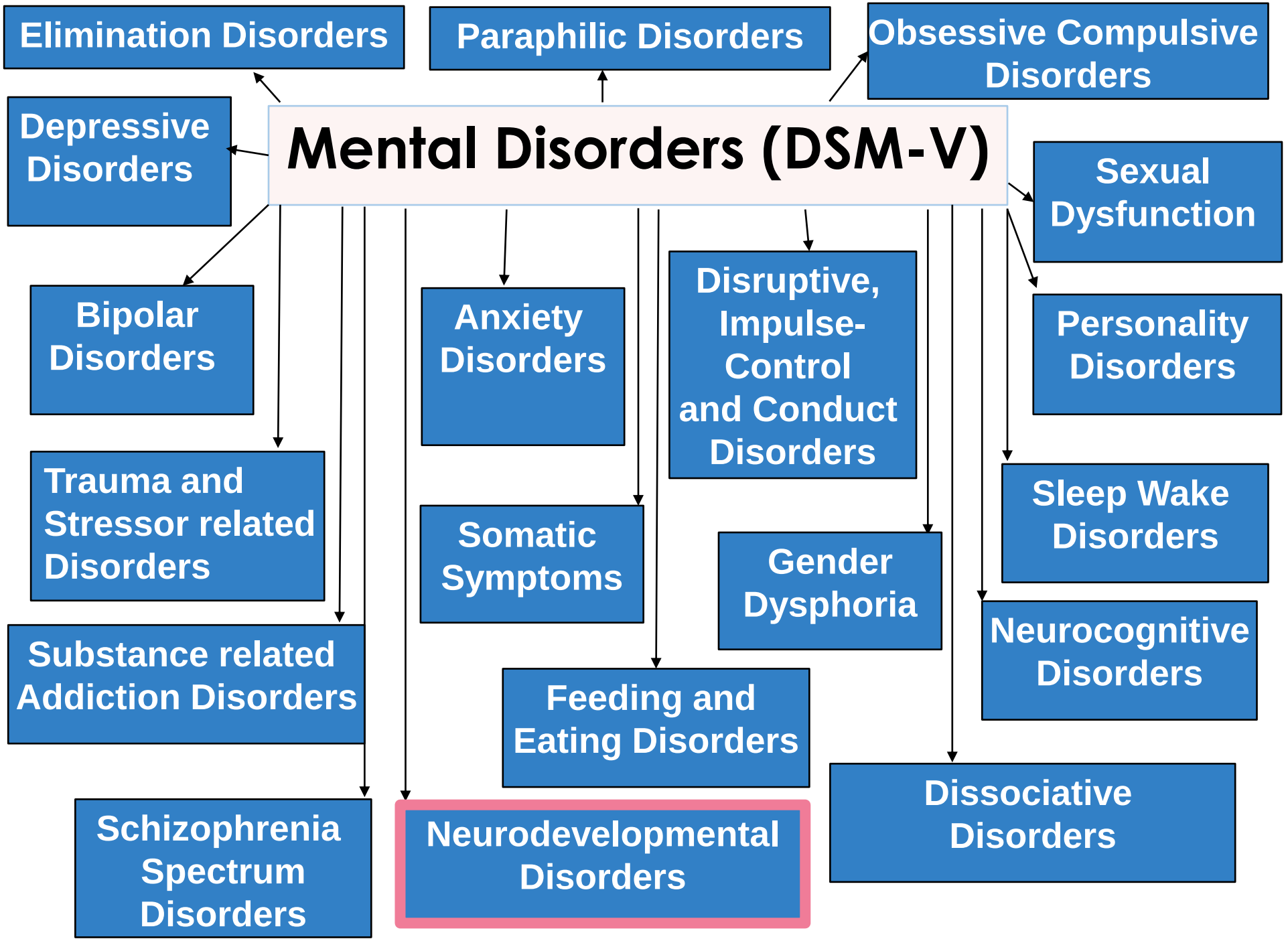
# *Neurodiversity and vulnerability to crime*


## *Dr Liz Gillett*
## *Consultant Clinical Psychologist*


Phoenix Psychology


Mental Disorders (DSM-V)
Elimination Disorders
Paraphilic Disorders
Obsessive Compulsive Disorders
Depressive Disorders
Sexual Dysfunction
Bipolar Disorders
Anxiety Disorders
Disruptive, Impulse-Control and Conduct Disorders
Personality Disorders
Trauma and Stressor related Disorders
Sleep Wake Disorders
Somatic Symptoms
Gender Dysphoria
Substance related Addiction Disorders
Neurocognitive Disorders
Feeding and Eating Disorders
Dissociative Disorders
Schizophrenia Spectrum Disorders
Neurodevelopmental Disorders

# *Notes on Diagnosis*

- Receiving a diagnosis does not infer causality or give an absolute explanation for the difficulty.  It just means that some or all of the difficulties match criteria for that particular disorder at that time
- It is not uncommon for one individual to have diagnoses of multiple ‘mental disorders’, with many overlaps
- Diagnoses can be changed, varied or even removed as the individual  grows older and / or a better ‘explanation’ or understanding emerges – this is especially true for ‘high functioning’ individuals where more sophisticated coping strategies mask difficulties being experienced

# *Notes on Diagnosis*

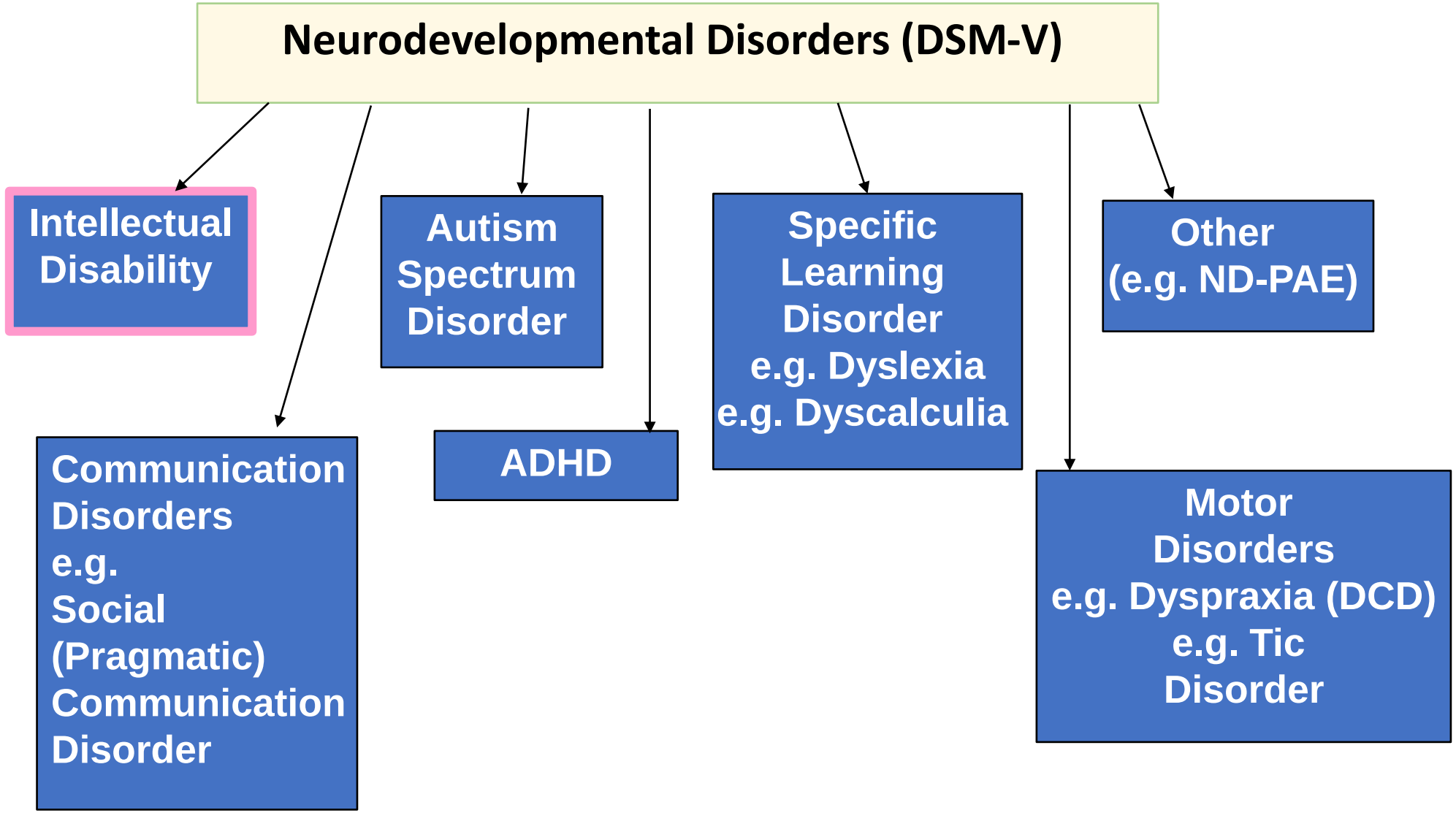
- The extent of innate / biological / genetic contribution varies significantly across and within disorders (e.g. ASD versus ADHD)
  - Role of epigenetics / transgenerational issues
  - Known association between poverty and enhanced risk of psychological distress among mothers and of emotional and behavioural disorders amongst children and / or mild learning disability

# *Searching for a Neurodevelopmental Diagnosis*

- There is often a search for a diagnosis, a label, a condition that can provide an answer / explanation for ‘mental’ problems being experienced
- This is very common with neurodevelopmental conditions which are perceived as ‘located’ within the individual
- A diagnosis can externalise the ‘problem’ and relieve family of guilt / shame / responsibility
- Seeking ‘expert’ input can be perceived as a way of legitimising genuine concerns that are otherwise hard to articulate, explain, change and / or risk assess

# *The Big Picture*

- Classifications of mental disorders struggle to account for the social context and multilayered issues relevant to an individual
- Specialist health services / treatment pathways are typically shaped and funded on the basis of these classifications
- Medical model focuses on pathology (psychopathology) / ‘illness’ and not the broader functional / psychological understanding of wellbeing / resilience
- Significant gap between individual need and service capacity (e.g. waiting lists, minimal post-diagnostic support)
- Barriers to information sharing and integration with other agencies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Other (e.g. ND-PAE)

# *Intellectual / Learning Disability*

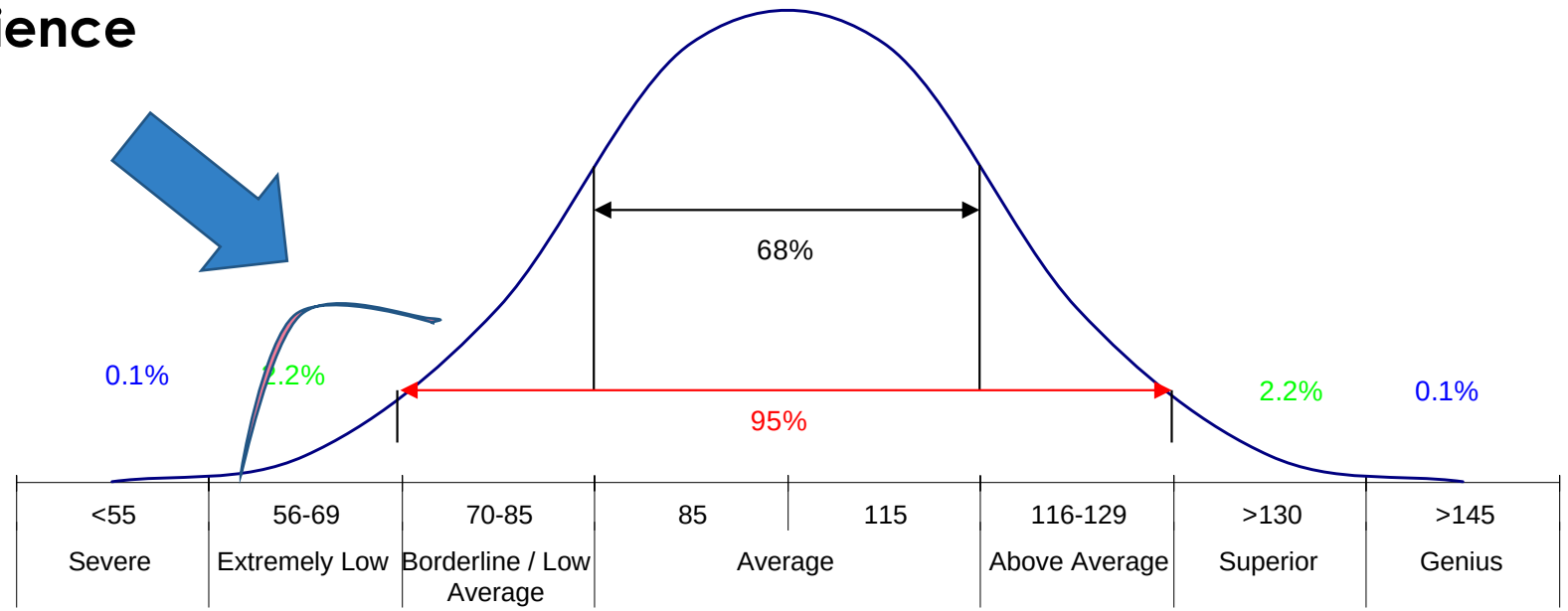
**Global deficits not specific learning disorders such as dyslexia**

**“Learning Difficulties”**

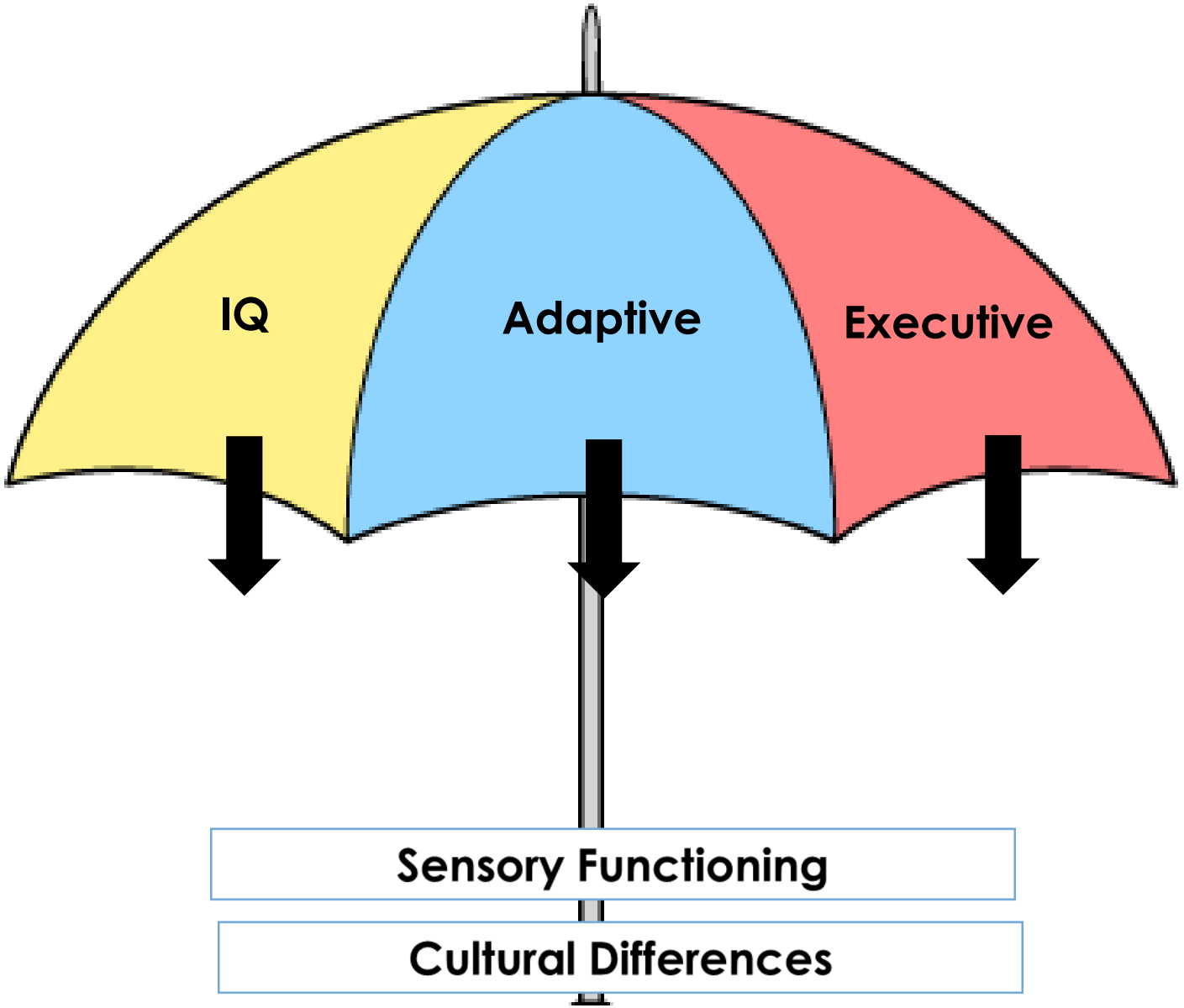
**Three criteria**
**Significant impairment in intellectual functioning; significant impairment in adaptive / social functioning; onset during developmental period**

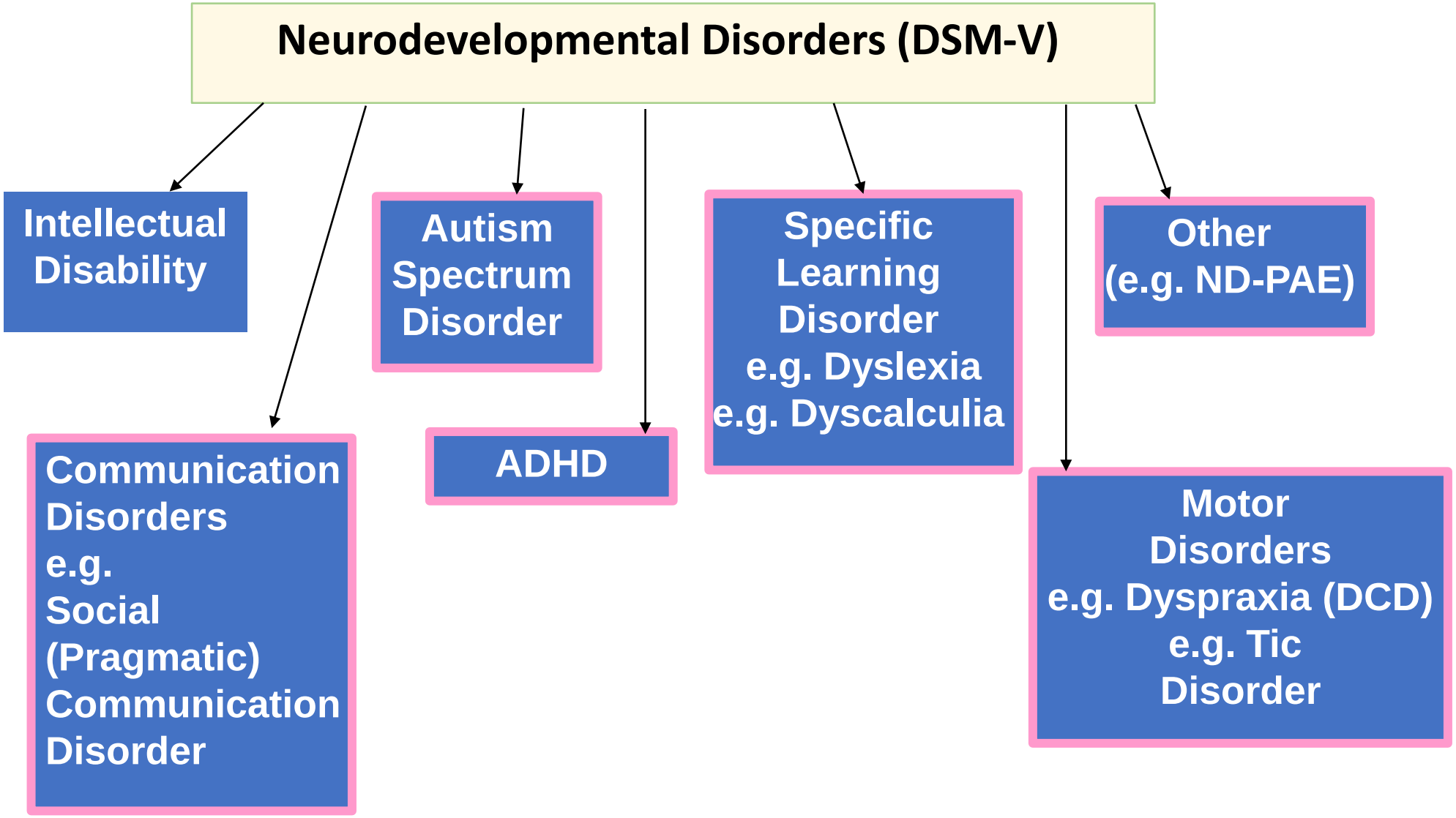
# Intellectual Functioning

**Consequence of life experience**



# *Individual Functioning – Intellectual Disability*

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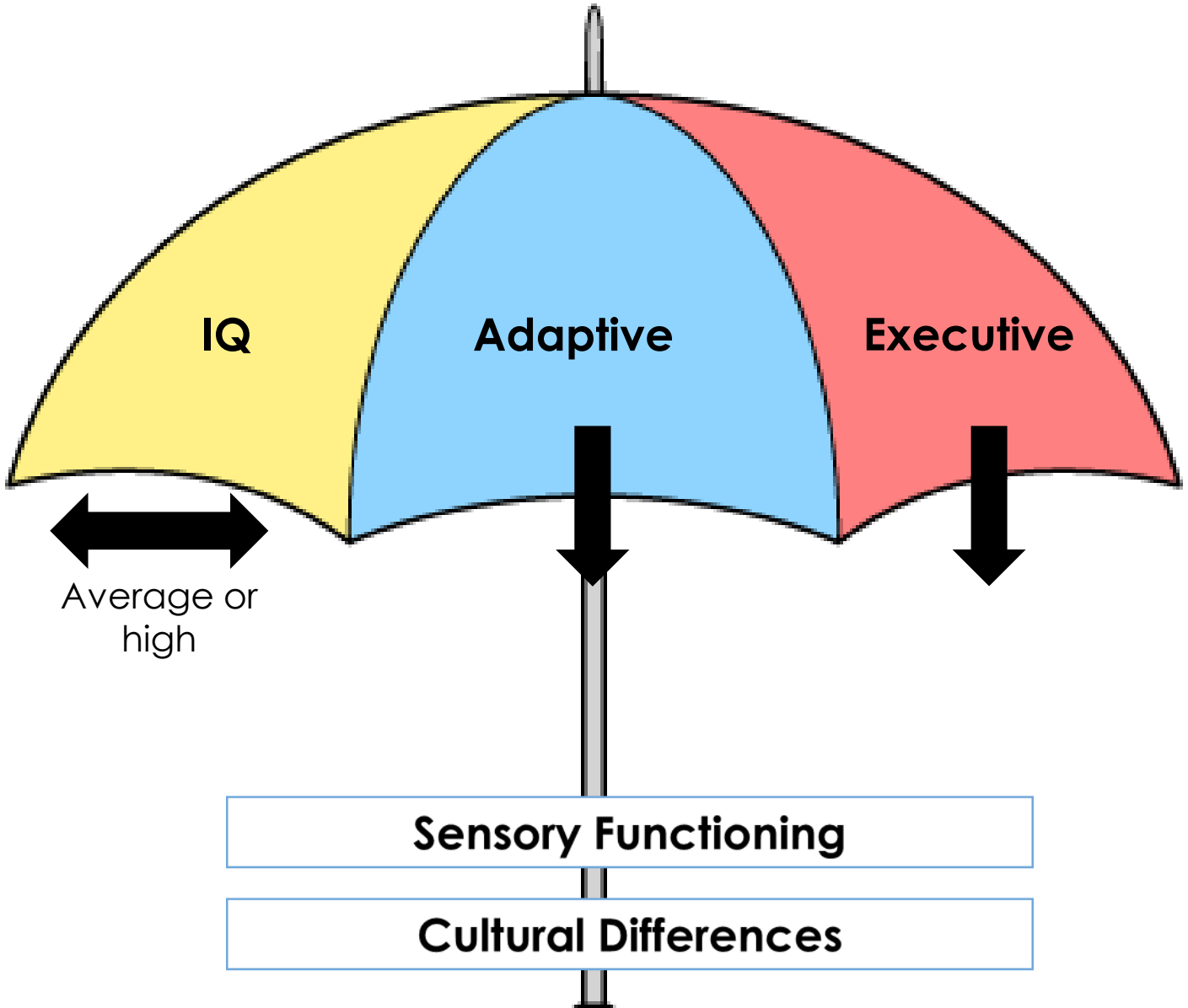
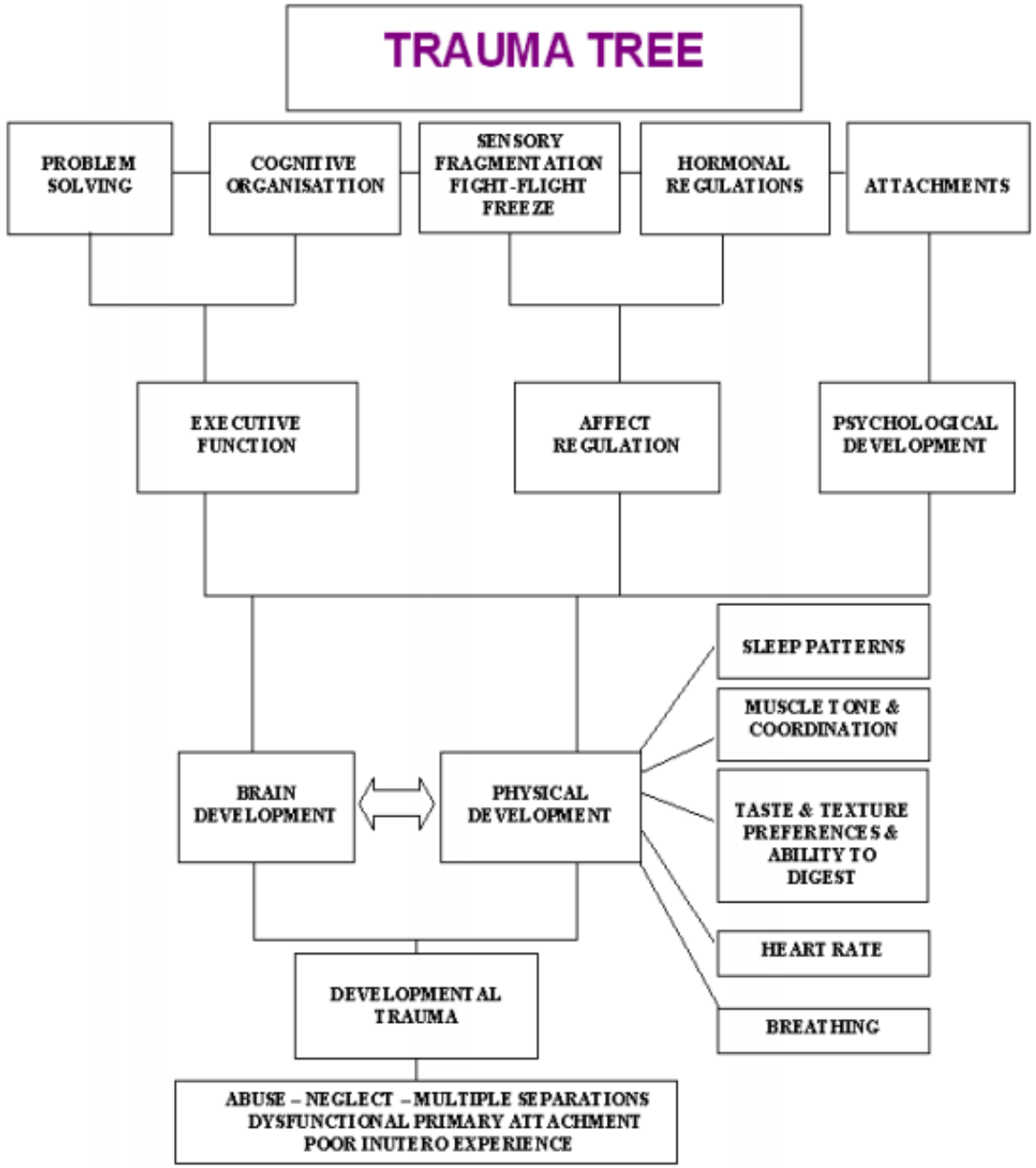
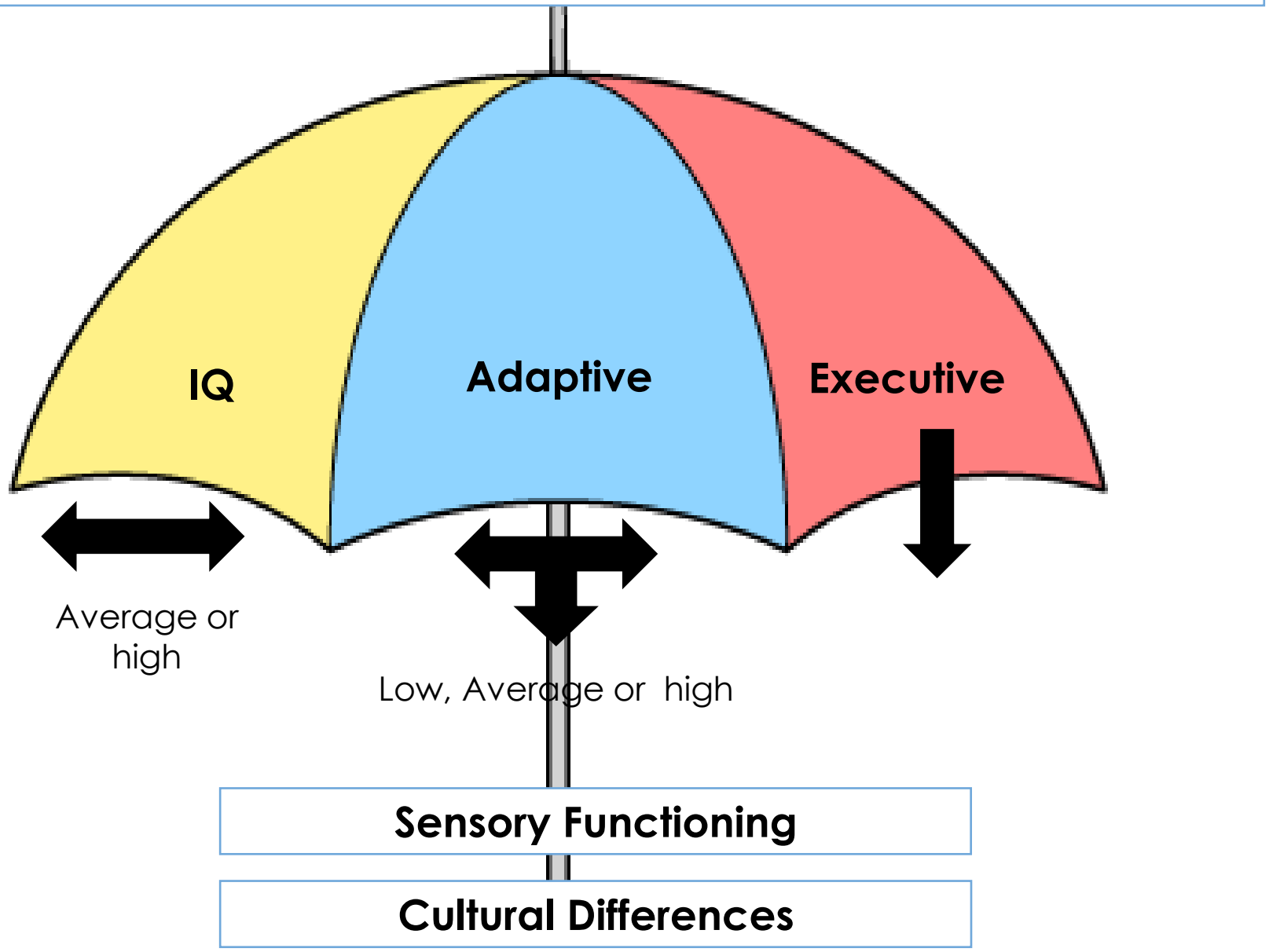
# *Individual Functioning – Neurodevelopmental Disorders*



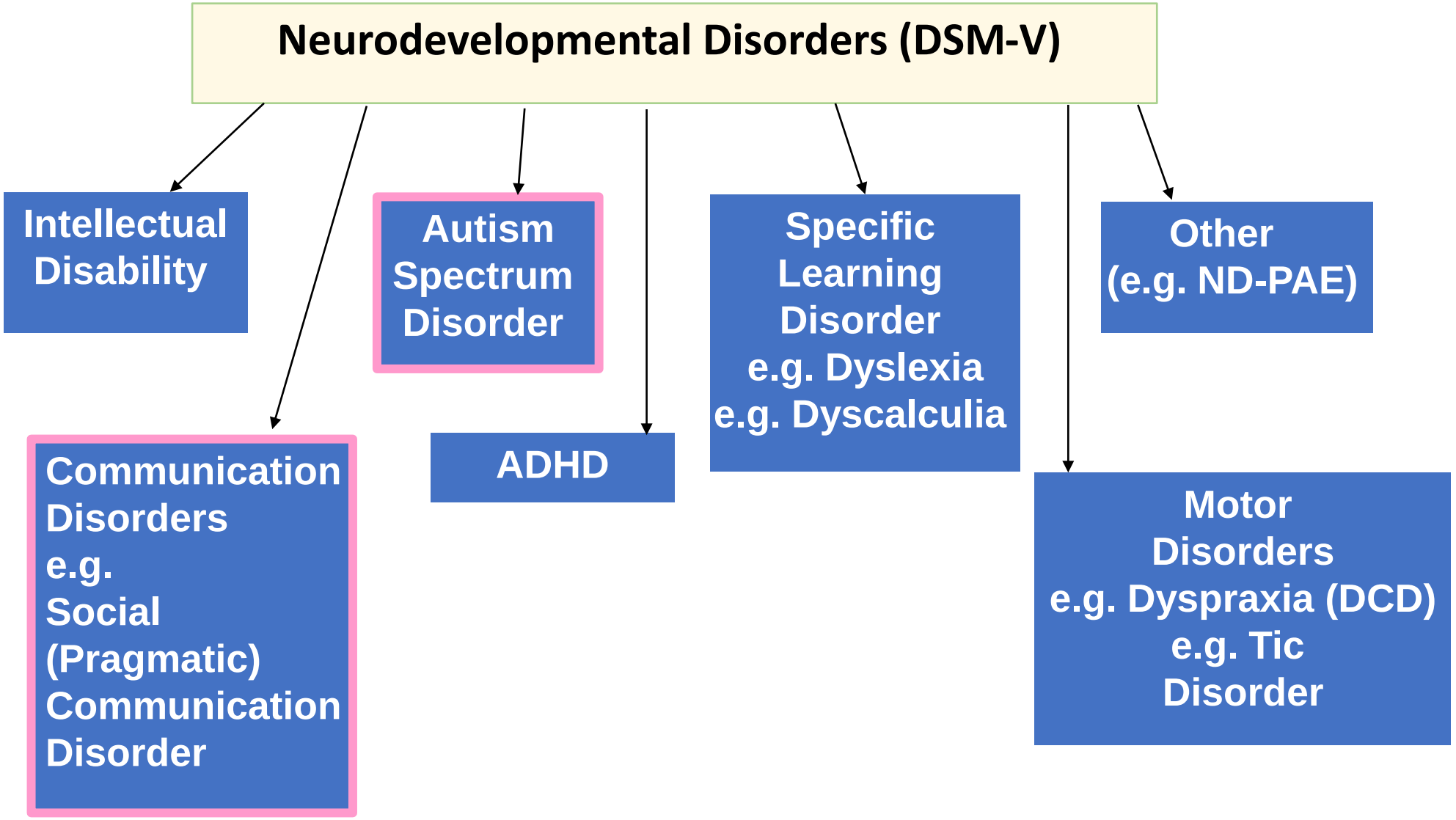

TRAUMA TREE
PROBLEM SOLVING
COGNITIVE ORGANISATTION
SENSORY FRAGMENTATION FIGHT-FLIGHT FREEZE
HORMONAL REGULATIONS
ATTACHMENTS
EXECUTIVE FUNCTION
AFFECT REGULATION
PSYCHOLOGICAL DEVELOPMENT
BRAIN DEVELOPMENT
PHYSICAL DEVELOPMENT
SLEEP PATTERNS
MUSCLE TONE & COORDINATION
TASTE & TEXTURE PREFERENCES & ABILITY TO DIGEST
HEART RATE
BREATHING
DEVELOPMENTAL TRAUMA
ABUSE – NEGLECT – MULTIPLE SEPARATIONS
DYSFUNCTIONAL PRIMARY ATTACHMENT
POOR INUTERO EXPERIENCE

# *Individual Functioning – Developmental Trauma*



# *Common issues with neuro-atypical 'spiky' profiles*

Organisation skills
Sensory processing
Gross motor / fine motor skills
Awareness of body position in space
Left / Right difficulties
Time keeping and time management
Dislike of change / need for routine
Non-linear thought process
Emotional regulation
Monitoring of self / task (checking behaviours)
Working memory
Perception (e.g. clock face)
Balance
Restlessness
Sequencing
Planning
Social Communication
Attentional issues
Impulsivity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# *Autism Spectrum Disorder – Criteria I*

**Persistent deficits in social communication and social interaction across multiple contexts**

*A) Deficits in social-emotional reciprocity*
*B) Deficits in nonverbal communicative behaviours*
*C) Deficits in developing, maintaining, and understanding relationships*

# *Autism Spectrum Disorder – Criteria 2*

**Restricted, repetitive patterns of behaviour, interests, or activities**

A) Stereotyped or repetitive motor movements or use of objects

B) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour

C) Highly restricted, fixated interests that are abnormal in intensity or focus

D) Hyper- or hypo -reactivity to sensory input or unusual interest in sensory aspects of the environment

# *Autism Spectrum Disorder (3)*

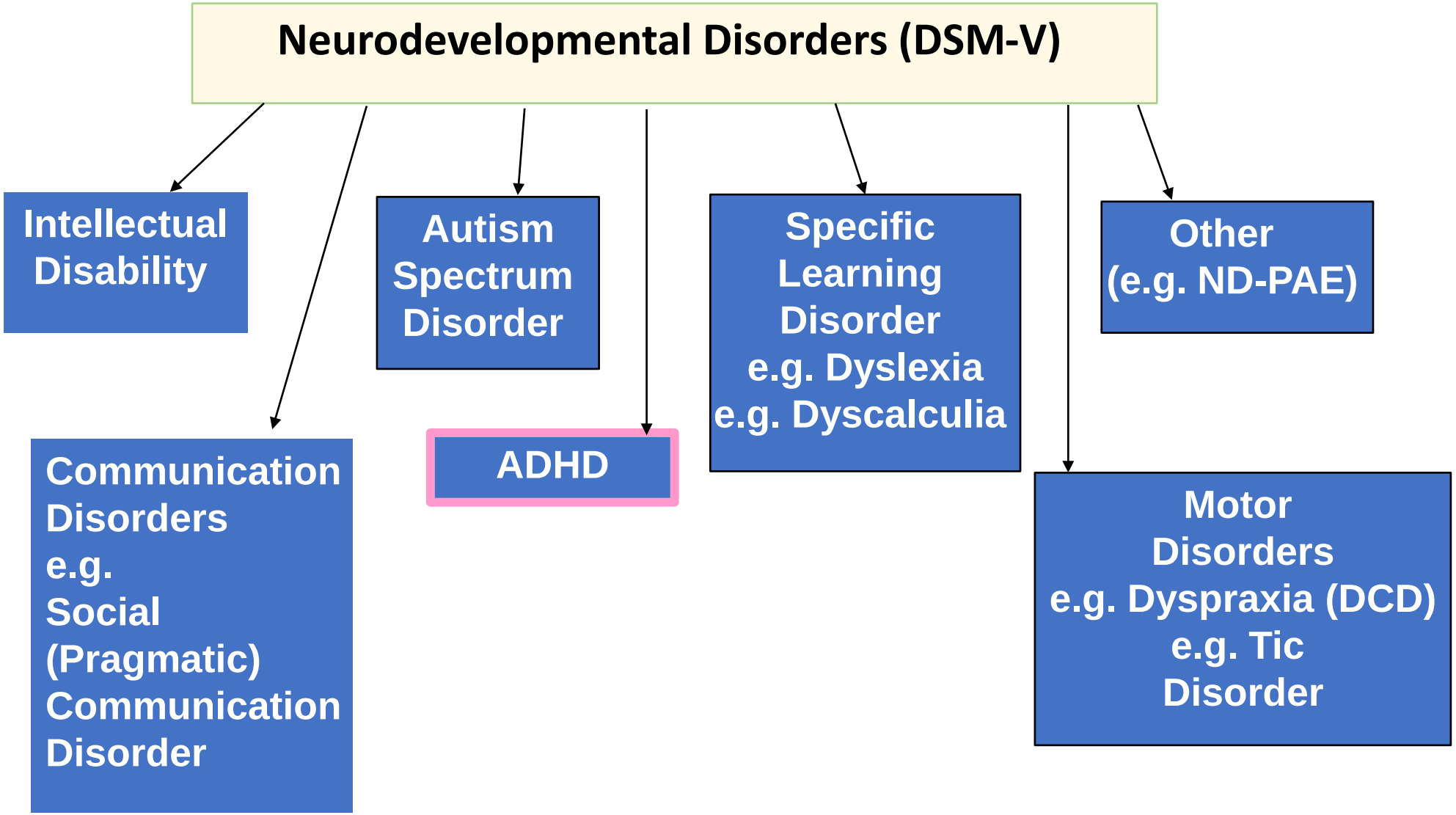
***Symptoms must be present in the early developmental period*** *but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life*

***Symptoms cause clinically significant impairment*** *in social, occupational, or other important areas of current functioning*

***Disturbances are not better explained by intellectual disability or global developmental delay***

# *ASD and Attachment / Trauma*

***"autism and attachment difficulties result in similar symptoms and even very experienced clinicians find identifying which symptoms are attributable to autism extremely challenging"*** (McKenzie & Dallos, 2017)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# *Attention Deficit Hyperactivity Disorder (1)*

**Persistent pattern of inattention and hyperactivity-impulsivity that interferes with functioning across time and environment**

***and***

**development characterised by:**

# *Attention Deficit Hyperactivity Disorder (2)*

***A) Inattention (6 or more of below)***
*fails to give close attention / difficulty sustaining attention / does not seem to listen / often does not follow through / difficulty organising tasks / avoids tasks involving sustained mental effort / loses things / easily distracted / forgetful in everyday activities*

**B) Hyperactive / Impulsive (6 or more below)**
often fidgets / leaves seat / runs about inappropriately / unable to engage in leisure  quietly / often 'on the go' / talks excessively / blurts out / difficulty waiting turn / often interrupts or intrudes on others

# *Attention Deficit Hyperactivity Disorder (3)*

**1. Persistent pattern of inattention and hyperactivity-impulsivity that interferes with functioning across time and environment**

**2. Several symptoms before age of 12**

**3. Several symptoms in two or more settings**

**4. Interfere with functioning**

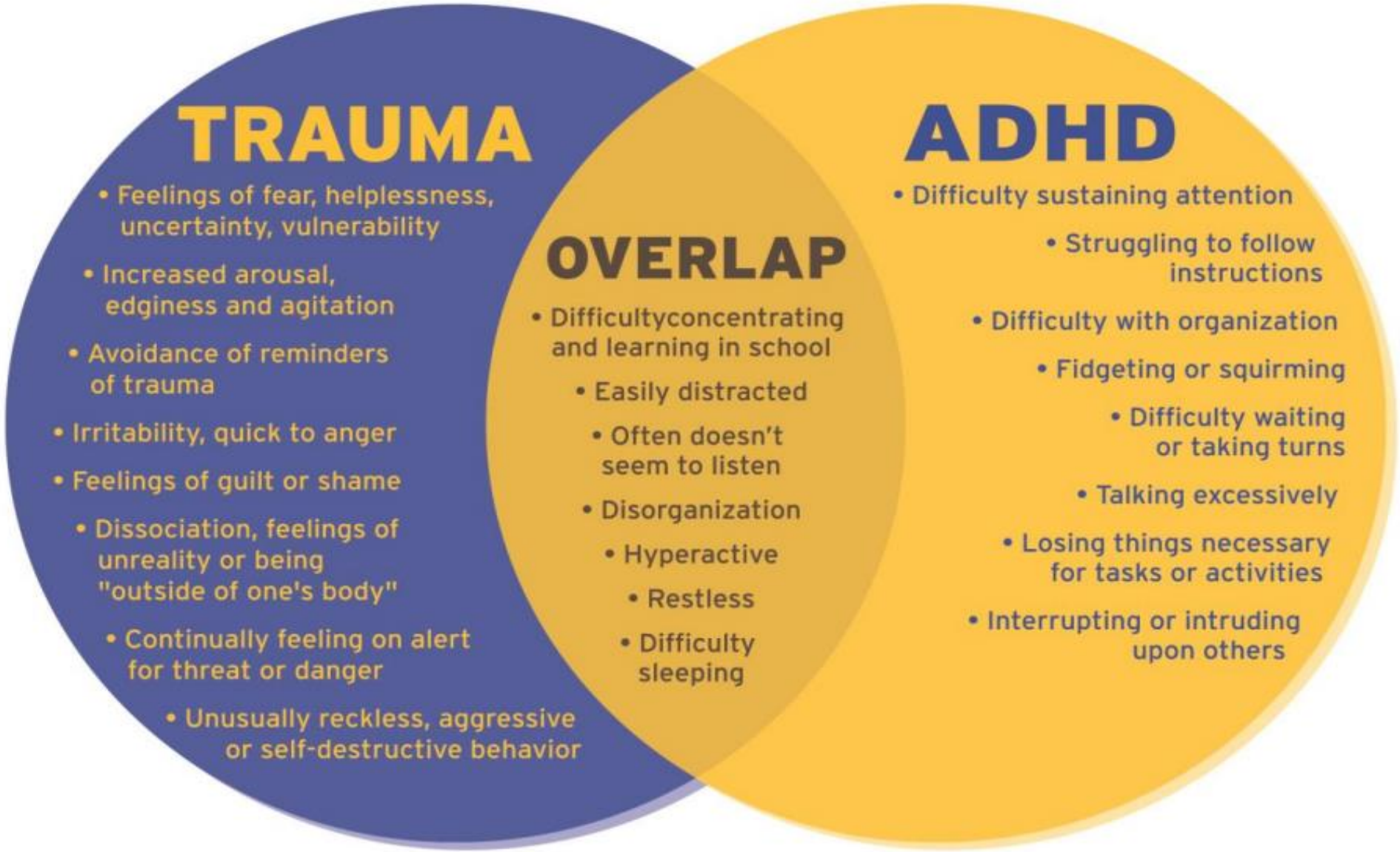
**5. Not better explained by another disorder**

**Combined Inattentive / Hyperactive – Impulsive**

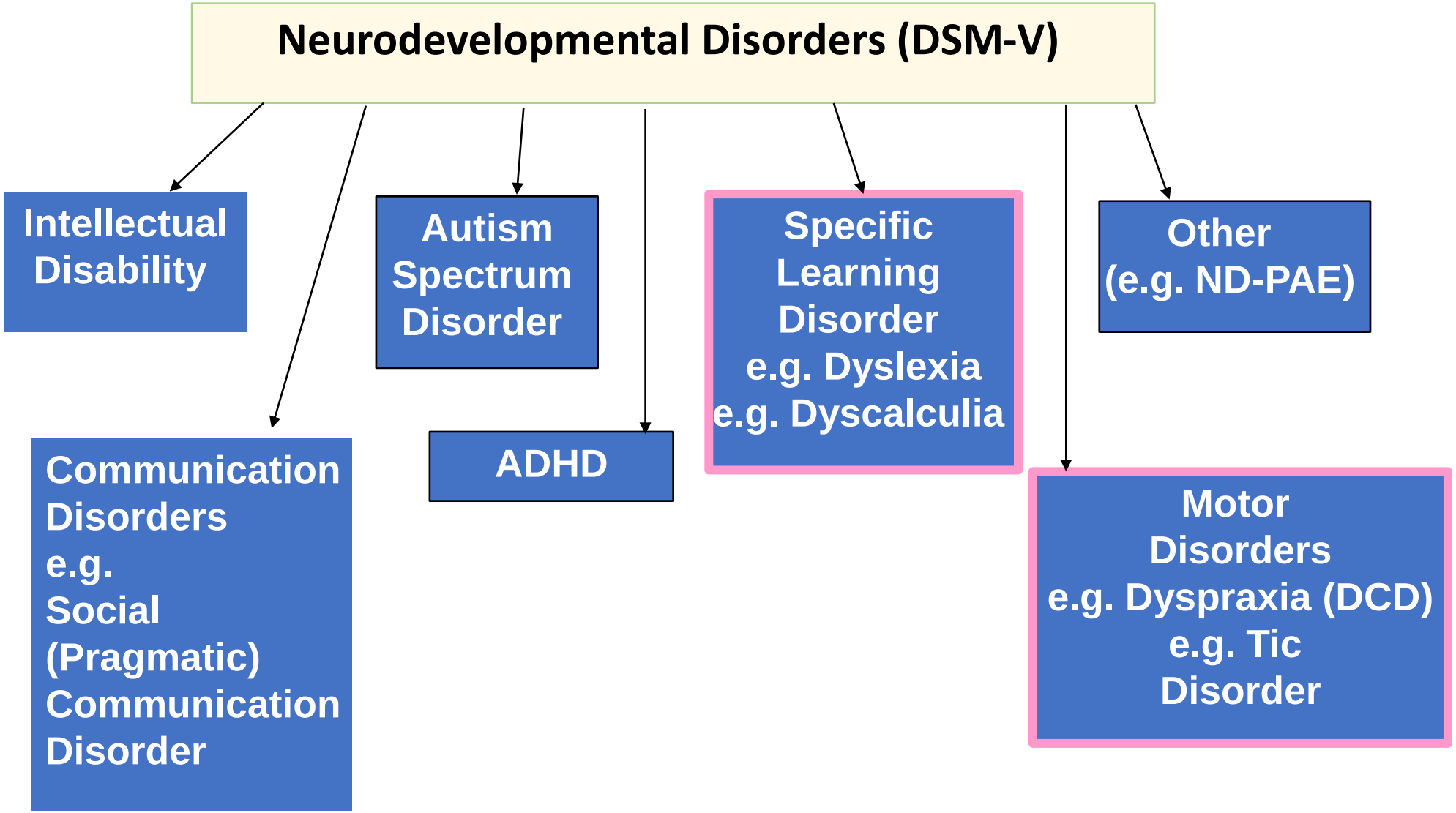
**Predominately Inattentive**

**OR**

**Hyperactive - Impulsive**




The National Child Traumatic Stress Network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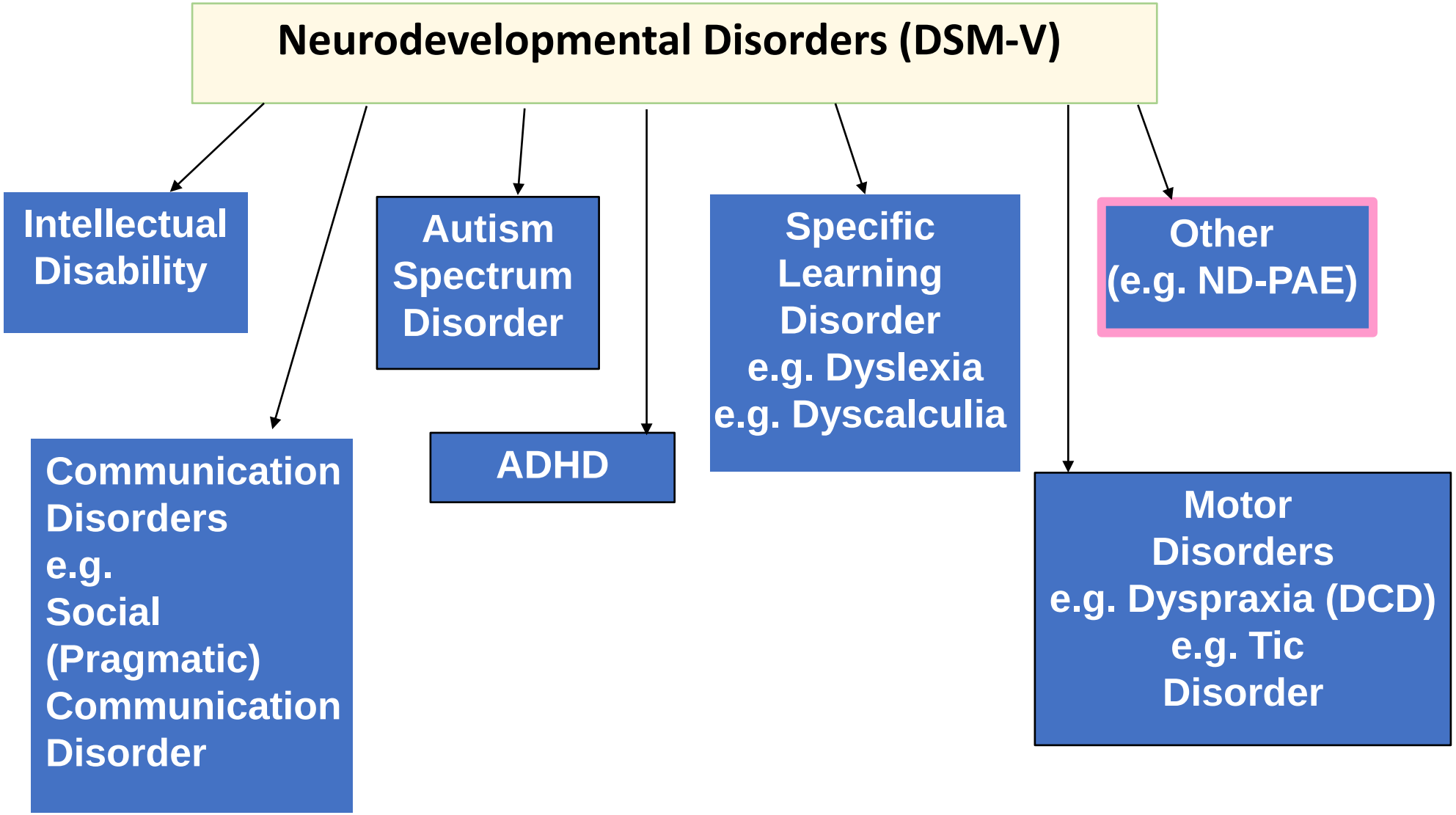
# *Specific Learning Disorder: (Dyslexia/Dyscalculia)*

Difficulty in mastering reading, writing, arithmetic skills, number sense, number facts or calculation and mathematical reasoning

# *Developmental Coordination Disorder (Dyspraxia)*

Motor performance well below expected levels given age – coordination problems, poor balance, clumsiness, dropping or bumping into things, late development of skills, poor awareness of time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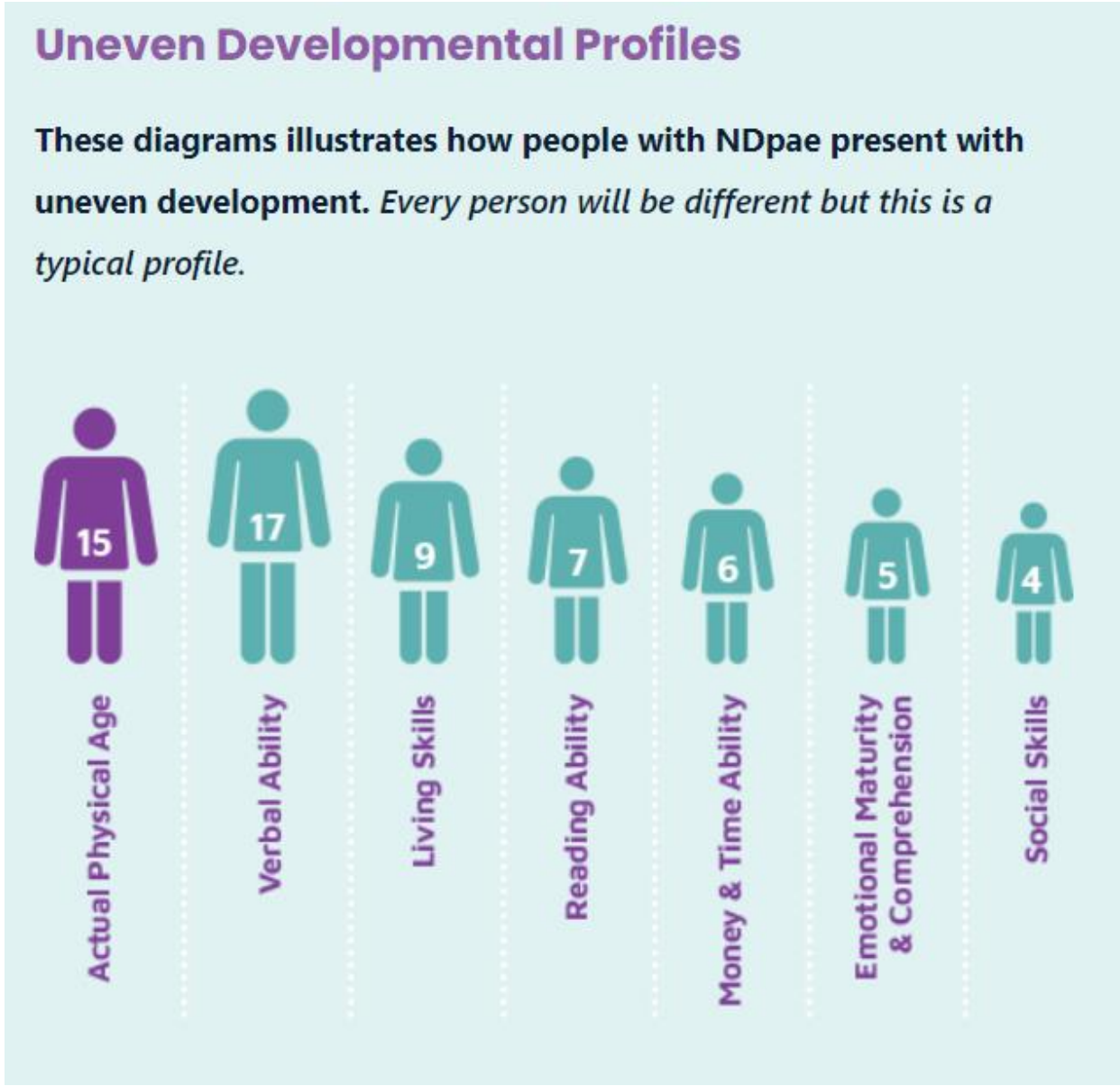
# *Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure*

- Most people with ND-PAE score higher on IQ tests than they can function in the real world
- **Adaptive and Executive Functioning** is affected

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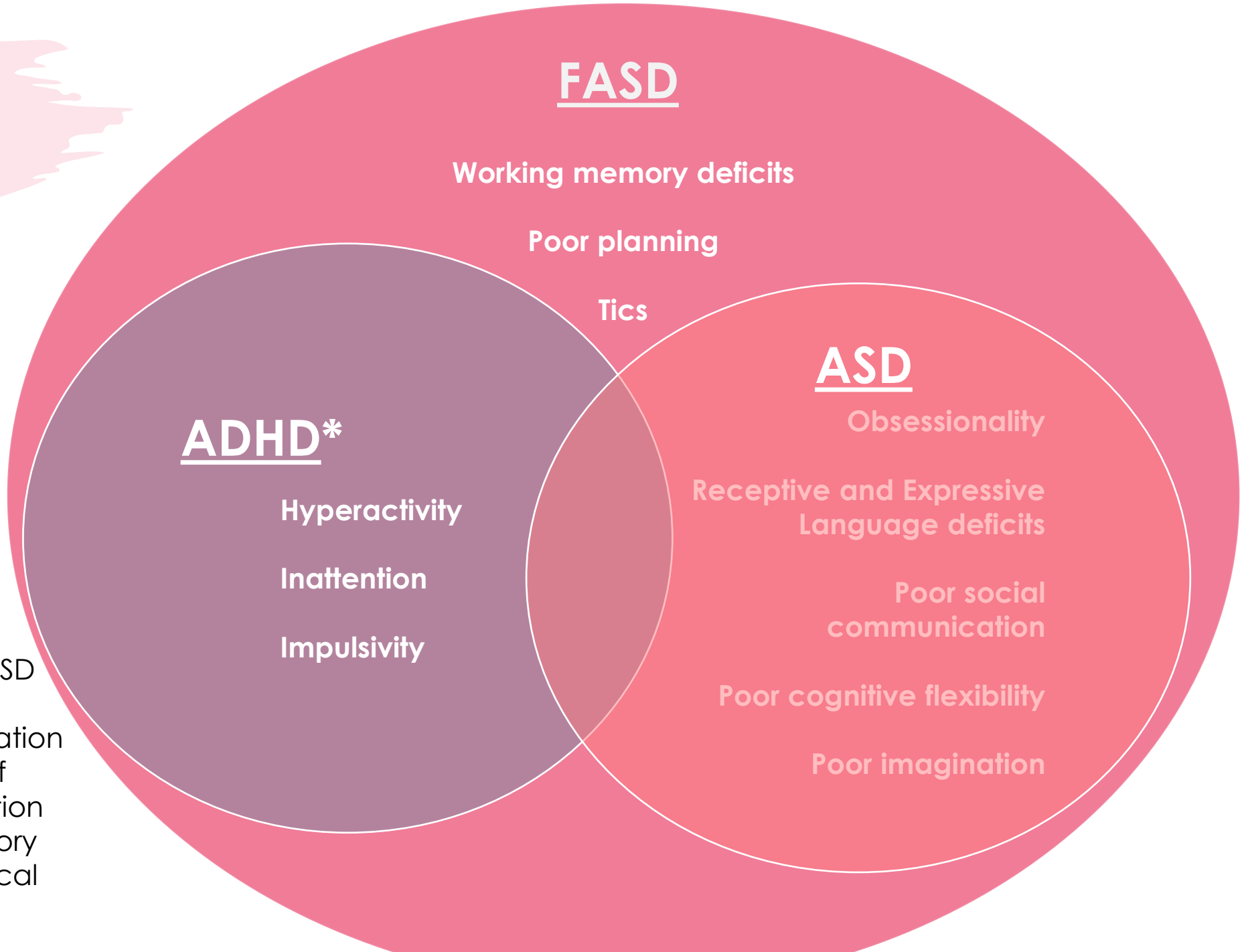
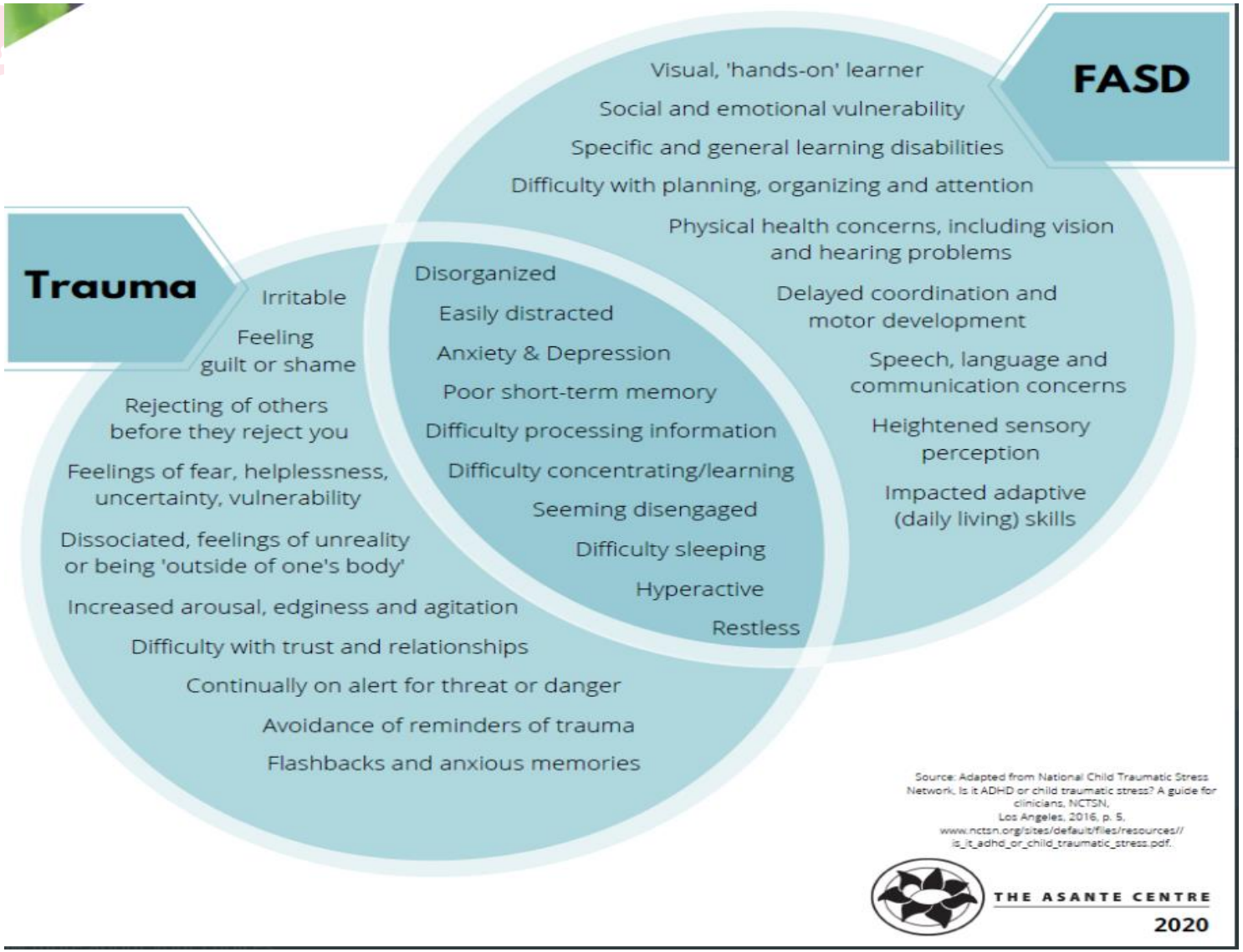
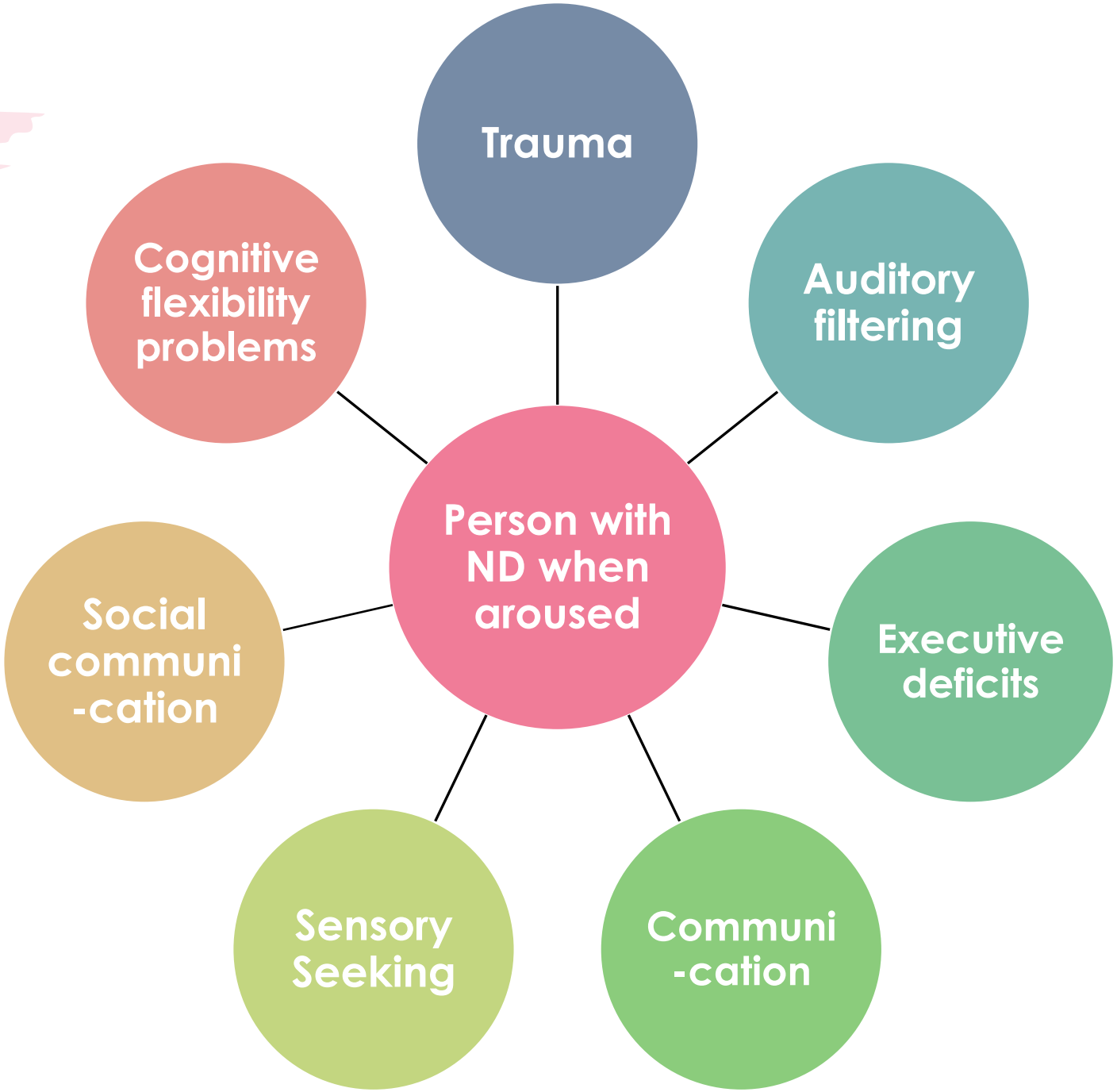



*Individuals with FASD have an atypical response to medication and higher levels of social communication problems and sensory problems than typical ADHD


FASD
Visual, 'hands-on' learner
Social and emotional vulnerability
Specific and general learning disabilities
Difficulty with planning, organizing and attention
Physical health concerns, including vision and hearing problems
Delayed coordination and motor development
Speech, language and communication concerns
Heightened sensory perception
Impacted adaptive (daily living) skills
Trauma
Irritable
Feeling guilt or shame
Rejecting of others before they reject you
Feelings of fear, helplessness, uncertainty, vulnerability
Dissociated, feelings of unreality or being 'outside of one's body'
Increased arousal, edginess and agitation
Difficulty with trust and relationships
Continually on alert for threat or danger
Avoidance of reminders of trauma
Flashbacks and anxious memories
Disorganized
Easily distracted
Anxiety & Depression
Poor short-term memory
Difficulty processing information
Difficulty concentrating/learning
Seeming disengaged
Difficulty sleeping
Hyperactive
Restless
Source: Adapted from National Child Traumatic Stress Network, Is it ADHD or child traumatic stress? A guide for clinicians, NCTSN, Los Angeles, 2016, p. 5. www.nctsn.org/sites/default/files/resources//is_it_adhd_or_child_traumatic_stress.pdf.
THE ASANTE CENTRE
2020

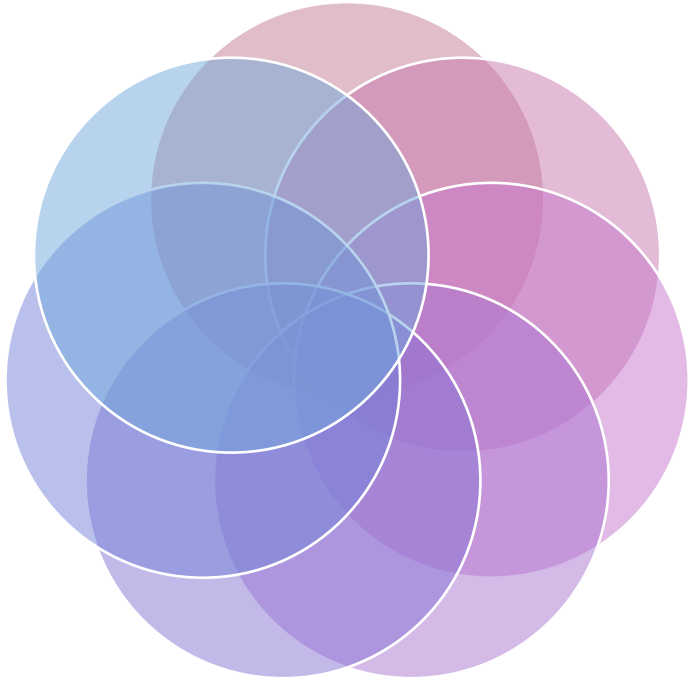

Trauma
Cognitive flexibility problems
Auditory filtering
Person with ND when aroused
Social communi -cation
Executive deficits
Sensory Seeking
Communi -cation

***Overlap across all!!!***

ASD

FASD

ADHD



Learning Disorders/Disabilities

Trauma / ACE's

Communication issues

Sensory Needs

It’s about

**behaviour and the impact on daily functioning for that individual**

# The Three R's: Reaching The Learning Brain

Dr Bruce Perry, a pioneering neuroscientist in the field of trauma, has shown us that to help a person who has experienced trauma to learn, think and reflect, we need to support them in a sequence which prioritises regulation first so that the brainstem can be calmed.

This sequence is not linear, you may need to travel back and forth between the different R's multiple times in one interaction.

**Reason:**

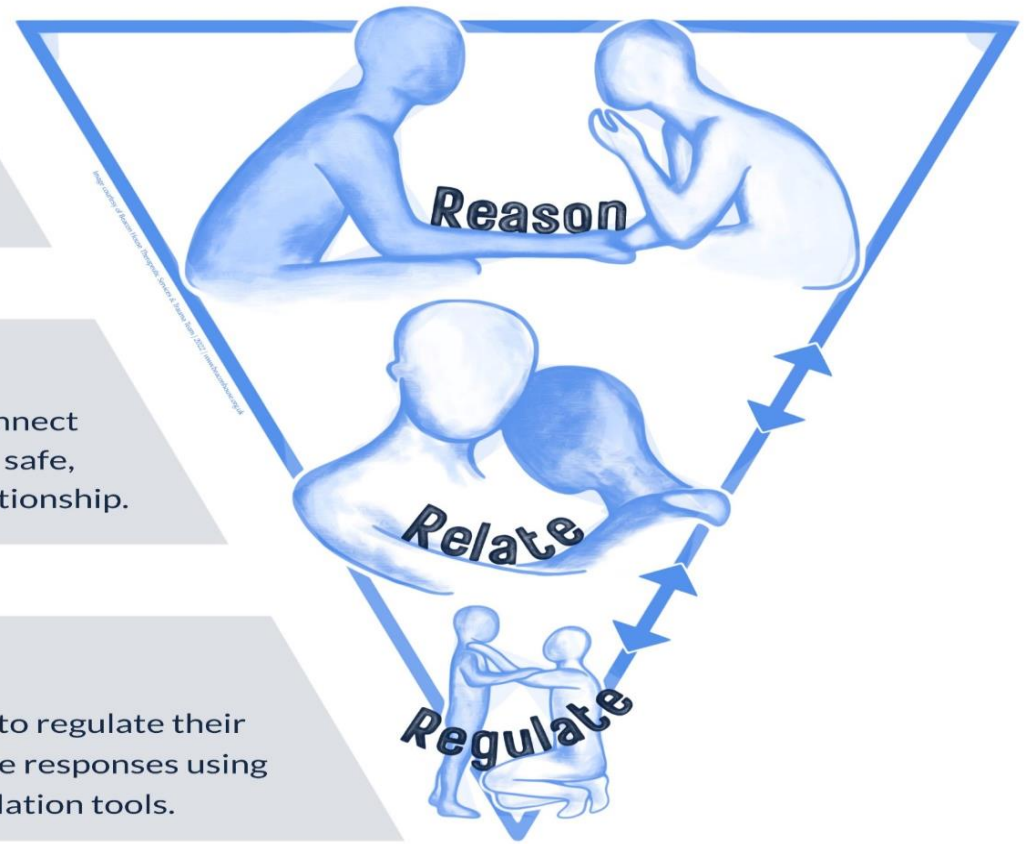
**Third**: We support the person to reflect, learn, remember, articulate and become self-assured.

**Relate:**

**Second**: We relate and connect with the person through a safe, attuned and sensitive relationship.

**Regulate:**

**First**: We help the person to regulate their fight/flight/freeze/collapse responses using safe and appropriate regulation tools.




Talking directly to the reasoning part of the brain without attending to the person's dysregulation will mean that their potential for learning and reflection is reduced or even blocked.

# *Individualised Adaptations*

- **Investigate the basis of diagnosis / previous professional involvement**
- **Hold the 'AND/BOTH' position**
- **Achieve co-regulation and connection by:**
  - Physical Environment
  - Sensory activities ('brain calmers')
  - Communication
  - Relational focus