



Transactional Analysis Psychotherapy with Clients who are Neurodivergent: Experiences and Practice Recommendations

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Abstract

This qualitative research study uses Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009; Smith & Nizza, 2022) to explore how Transactional Analysis Psychotherapy can be used effectively with clients who are neurodivergent. It aimed to explore the lived experiences of participants, all of whom were neurodivergent and received psychotherapy as adults but who were undiagnosed in childhood.

Participants all reported a sense of frustration, sadness, and shame regarding how others have responded to their neurodivergence and neurodivergent behaviours historically. This study aimed to look beyond the outward presenting behaviours to the underlying need and consider what neurodivergent clients may need, both from their psychotherapist and from their psychotherapy.

This study suggests four main psychotherapeutic needs, identifies three main traps that psychotherapists may fall into when working with neurodivergent clients, and describes eight relational affirmations which are important to consider when working with neurodivergent clients.

Keywords

neurodivergence, Attention Deficit Hyperactivity Disorder, ADHD, Autism, transactional analysis, therapeutic relationship, alliance, rupture, Interpretative Phenomenological Analysis

Introduction

This article is focused on the lived experience of neurodivergent clients who have experienced transactional analysis (TA) psychotherapy, and on identifying aspects of good practice in TA psychotherapy for neurodivergent clients. It is

beyond the scope of this paper to discuss the diagnostic criteria for different neurodivergent presentations and therefore we recommend that readers familiarise themselves with these diagnostic categories in either the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) (American Psychiatric Association, 2013), or the International Classification of Diseases - 11th Edition (ICD-11) (World Health Organisation, 2022).

The presentations of participants in this study include Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia, Dyscalculia and Autistic Spectrum Disorder (ASD), all grouped under the term 'neurodivergence'.

It is also beyond the scope of this article to explore therapies which are used as 'treatments' for the different neurodivergent 'disorders'. Instead, our focus is on the experiences of neurodivergent persons of psychotherapy in general, and on potential adaptations the therapist can make to their way of working in order to best meet the needs of their neurodivergent clients.

This research study developed from the first author's experiences of adult-assessed ADHD and dyscalculia, and of having a child with ASD. Receiving a diagnosis of ADHD enabled her to make sense of historical experiences of social anxiety and low-level panic in unfamiliar situations and with unfamiliar people. I (CB) often felt ill-equipped to navigate social norms. I was recurrently hypervigilant, scanning the environment to understand how best to 'behave', and sometimes avoided social situations altogether. This led to ruptures in interpersonal and professional relationships.

Working with neurodivergent clients, I noticed similarities with their behaviours, internal dialogues,

and described felt experiences. They described a sense of shame linked to how others perceived them and their behaviour. This led to 'masking', over-adaptation, withdrawal, and a sense of loneliness rather than connection. Clients' 'behaviour' would be observed first and the underlying need for connection would be missed.

The second author was the research supervisor for this project, assisting with the design, data analysis and writing up of this project, and also has recently been diagnosed with ADHD. I (MW) have experienced not only a sense of huge relief, as lifelong problems have started to make sense, but also a deep sense of sadness and anger. Sadness over missed opportunities and years of being pathologised and misunderstood by myself and others, and anger over the way I have been treated in the past and of the lack of understanding and empathy I have experienced on numerous occasions.

Neurodivergent clients who were diagnosed in adulthood often experience their diagnosis as a mixed experience. On the one hand, it can generate a sense of liberation, and of finally understanding the nature of their problems and being able to let go of deeply-held script beliefs about 'not being good enough', 'being lazy', 'stupid', 'crazy', or 'weird' (Kelly and Ramundo, 2006). On the other hand, this can also facilitate powerful feelings of anger at how they have been mistreated throughout their lives, and a deep process of mourning for what might have been had they been diagnosed earlier (Ramsay and Rostain, 2005), thus matching the experiences of the present authors.

Both authors have had both positive and negative historical experiences of personal therapy, and with hindsight we can clearly see that the negative experiences were probably due to the therapist's lack of knowledge or sensitivity to working with neurodivergence and the lack of models for working with neurodivergence within their respective therapeutic modalities. We are also both acutely aware of the risks of and seductive pull to pathologise around issues associated with neurodivergence, which can lead to over-focusing on 'the label' and missing the underlying need of the neurodivergent individual (Ludici, Faccio, Belloni and Costa, 2014).

We have chosen to use the umbrella term 'neurodivergence' throughout this paper, which "describes people whose brain develops or works differently ... the person has different strengths and struggles from people whose brains develop or work more typically" (Cleveland Clinic, 2022, website). We have both found this term to be a source of healing as it implies that "there is no one "right" way of

thinking, learning, and behaving, and differences are not viewed as deficits" (Baumer and Freuh, 2021, website).

We open this paper with the reflections of a fellow neurodivergent person: "... if you've met one Autistic person, you've met one Autistic person. And yes, I choose to say Autistic person and not person with Autism ... given that I can't leave my Autism at home while I pop to the shop ... this is the way I prefer it. Before you start complaining that I'm nothing like your Autistic brother, child ... or goat, that's OK. I don't have to be." (Gibbs, 2021, p. 4)

Literature Review

Historically, research on neurodivergent conditions has tended to focus on low-functioning individuals with severe intellectual disability. It is only in recent years that awareness has grown regarding the large numbers of high-functioning neurodivergent people. Research on psychotherapy for neurodivergent conditions has largely focused on therapies which seek to address core symptoms of these conditions, with relatively few studies which have explored the lived experiences of and preferred adaptations to psychotherapy amongst neurodivergent people. To date, within the TA literature, there is very little research which has examined neurodivergence, although Baker and Widdowson (2016) explored the experiences of dyslexic trainees of TA psychotherapy training. However, there is growing literature on defining and exploring neurodivergence within the TA community. As far as we know, the present paper is the first research article within the TA literature [in English] to explore the lived experience of neurodivergent people who have undergone psychotherapy.

Specific considerations around neurodivergence and psychotherapy

The difficulties in daily life that neurodivergent people encounter often lead them to seek psychotherapy. For example, about 74% of the patients seeking evaluation for ASD at a German University Hospital expressed the need for psychotherapy (Gawronski, Kuzmanovic, Georgescu, Kockler, Lehnhardt, Schilbach, Volpert, and Vogeley, 2011).

From a psychotherapeutic point of view, most striking in autistic individuals is the high prevalence of comorbid psychiatric disorders, many of which have repeatedly been reported to be found more often in autistic adults than in neurotypical controls (Hofvander, Delorme, Chaste, Nyden, Wentz, Stahlberg ... and Leboyer, 2009; Lugnegard, Hallerback and Gillberg, 2011; Struntz, Dziobek, and Reopke, 2013, Anderberg, Cox, Neeley-Tass, Erikson, Gabrielsen, Warren ... and South, 2017). Amongst several mental health conditions, depression is the most frequent comorbid disorder in

autistic adults with studies indicating it is present in 34–55% of autistic individuals (Gawronski et al. 2011; Struntz et al. 2014; Lever and Geurts, 2015). About 40-50% of adults with ASD experience at least one anxiety disorder (commonly social anxiety, obsessive compulsive disorder, and specific phobias (Buck, Viskochil, Farley, Coon, McMahon, Morgan and Bilder, 2014); Lugnegard et al, 2011) and around 70% experience a major depressive episode (Lugnegard et al, 2011). A recent study of 262 adults with ASD presenting for psychotherapy at an outpatient psychotherapy clinic at a hospital in Germany found the five main reasons for seeking psychotherapy were depression (76%), interaction and social problems (48%), social anxiety (44%), problems coping with everyday life (44%), and anxiety (38%) (Lipinski, Blanke, Suenkel and Dziobek, 2019). Similarly, studies have estimated between 70-75% of adults with ADHD have at least one additional comorbid disorder (Wilens, Biederman and Spencer, 2002; Ramsay and Rostain, 2005).

It seems likely that a failure on the part of psychotherapists to recognise either undiagnosed neurodivergence, or a lack of understanding of neurodivergent 'conditions' and appropriate adaptations, could be a major contributing factor to treatment failure or drop-out. For example, the most frequently cited reason for non-engagement with psychotherapists by people with ASD was the therapist's lack of understanding/experience of working with ASD (Lipinski et al, 2019).

With regards to preferred adjustments to psychotherapy, a recent study conducted in Germany found that clients with ASD expressed a clear preference for a low-stimulus environment, with consistency in day, time and location of sessions. The study recommended that sessions should have a clear and consistent structure to allow for predictability and reduce unnecessary anxiety about unexpected change. Participants also expressed a preference for having the option of communicating with their therapist in written form in addition to verbally. This extended from a preference for email as the primary means of initial contact through to the occasional use of written communication during sessions (Lipinski et al, 2019).

Useful adaptations to psychotherapy for ADHD involve an interactive, semi-structured style of therapy, gently helping clients refocus on their contract goals or current session focus. (Ramsay and Rostain, 2005). Psychoeducation is seen as being an essential aspect of therapy for adult ADHD. Although the therapist does not need to be an expert on ADHD, it is reasonable to expect therapists to have some basic understanding of the specific

difficulties adults with ADHD experience. Encouraging clients to self-educate promotes client empowerment, such as through signposting the client towards recommended books, or reputable online information (such as <https://chadd.org/> or <https://www.additudemag.com/>).

It is not unusual for therapists to offer well-meaning but misguided suggestions to clients. For example, a therapist may suggest that a client with ADHD who is persistently late for meetings simply leaves earlier for their meeting. Such comments fail to understand the specific executive functioning difficulties their client has and may well reinforce feelings of failure in their client who simply cannot follow this suggestion (Ramsay and Rostain, 2005).

Avoidance is a common strategy used by many people with ADHD. Because the individual with ADHD may expect failure, and/or may be acutely aware that they do not have the necessary skills for completion of the task, this can fuel a sense of incompetence and script beliefs of 'not being good enough'. Avoidance thus has a quick effect on reducing their anxiety and discomfort, whilst simultaneously negatively reinforcing the avoidance behaviour and ultimately generally creating more distress in the long run (Ramsay and Rostain, 2005; Widdowson, 2014).

Many people with ASD or ADHD have difficulties around processing social cues regarding their impact on others (Baron-Cohen, 1989). This can have a negative impact on social interactions, and can lead neurodivergent people to expect criticism and/or rejection from others. These negative expectations can have a strong impact on the transference; therefore explicitly enquiring about the client's fantasies about the therapist's reactions can be useful, such as asking 'I'm wondering if you have any thoughts about what I might be thinking or feeling right now? Where the client does have transference fantasies that the therapist is having a negative or critical response to the client, asking the client what cues they are using on which to base these fantasies can promote reality testing and greater understanding of social cues. We recommend that, after enquiring about the client's transference fantasies, and remaining accepting towards the client, that the therapist makes use of self-disclosure to communicate this acceptance to their client.

Increasing numbers of therapists are now using cloud-based diary management systems. These systems tend to automatically send email or text notifications of agreed appointments and some also send reminders, which clients (and therapists) with ADHD may find especially helpful.

Working With Neurodivergence and Risks of Over Adaptation

Therapies offered by the United Kingdom's National Health Service (NHS) for neurodivergent presentations include psychoeducation to help people cope with living with the 'conditions'; behaviour therapy, which 'rewards positive behaviour'; social skills training; and Cognitive Behavioural Therapy (CBT), which the NHS (2021) state "can help you manage problems by changing the way you think and behave" (website). The (UK) National Institute for Health and Care Excellence (NICE) (2021) guidelines also recommend CBT as a nonpharmacological treatment for ADHD and Social Learning Programmes for those with ASD. Solanto (2013) observes that CBT programmes used in treating ADHD can "address critical deficits in everyday executive self-management, including time management, organisation and planning" (p.22). Whilst not denying the evidence-based effectiveness of CBT in the treatment of ADHD (Wiess, Murray, Wasdell, Greenfield, Giles and Hetchman, 2012) and neurodivergence, we have concerns that addressing the deficits mentioned by Solanto may lead to the management of neurodivergence being based on observable change, rather than on relationship and shame reduction, and may risk inviting over-adaptation and collapse.

Conversely, Watkins (2020) puts emphasis on the importance of the therapeutic relationship, arguing that the building of trust within the therapeutic relationship may be the first time the client has felt safe enough to show their real selves without fearing judgement or a sense of expectation. She also argues that practitioners working with neurodivergent clients should be trained and experienced in working therapeutically with neurodivergence.

Oates (2021) argues that "in our desire for measurable and observable change ... we may well invite further masking ... as well as reinforce external behaviours that mask a troubled interior". (p.73). For the first author's daughter, the 'change focused' modelling, support with decision making, work to improve social interaction, and strategies for dealing with socially difficult situations (NICE, 2021) have been important and will continue to be so into adulthood. However, we query whether sole use of such approaches invites 'masking' – defined by Pearson and Rose (2021) as "conscious or unconscious suppression of natural autistic responses" (p.52) to fit into a neurotypical world, rather than experiencing acceptance, attunement, and meeting in relationship (involvement) (Erskine & Trautmann, 1996).

Gibbs (2021) states that long term masking can lead to "a total collapse of our ability to function." (p.318) Research shows a link between ADHD and Chronic Fatigue Syndrome (CFS/ME) (Sáez-Francàs, Alegre, Calvo, Ramos-Quiroga, Ruiz, Hernandez-Vara and Casas, 2012; Young, 2013), with patterns of overwhelm followed by severe fatigue (Young, 2013). The experience of both authors of living as undiagnosed people with ADHD was often experiencing feelings of exhaustion, shame, and decades of masking to attempt to fit into a neurotypical world. Indeed, the first author strongly believes this is what led to a diagnosis of CFS/ME in her early twenties.

The Feeling of Neurodivergence

Kessler (2013) observes that "when I was five or six, bedtime was a torture. I would lie in bed for hours rolling my legs from side to side to shake off excess energy ... being quiet and still was painful" (ch.2, para.1). Maté (1999) also describes the experience of keeping still when hyperactive as deeply uncomfortable, likening the internal sensations to being stuck in a 'mental whirlwind'. He states that "hyperactivity and ... lethargy ... are both exaggerations of body states ... they represent the activity of the autonomic nervous system, which in ADD, is poorly controlled" (p. 130). Maté observes that "hyperactivity ... continues to be a human response during times of high anxiety ... hyperactivity in ADD is fed by a current of permanent, subterranean anxiety." (p.132).

Gibbs (2021) describes her own hyperactivity and talkativeness, stating that she clung to her words as her most valuable tool when she was unsure how to act socially. She observes that this can create relationship ruptures, but notes "... if it's frustrating for the people around me, I CAN NEVER SWITCH IT OFF. No one is more exhausted by me than I am." (p.31).

For a client experiencing this, creating a contract for behavioural change (e.g. to slow down) can be tempting – and may even be what they request. However, we question whether this would be inviting them into adapted behaviours – into what is expected of them in a neurotypical world. Oates (2021) states that to avoid clients masking and adapting to our 'norm' as therapists, "... we need to pay as much attention to our clients' lived experience as we do to their outward presentation or even to their narrative" (p.66).

Oates states that neurodivergent people "... have difficulty processing sensory information and reach sensory overload more easily than others do. This is experienced bodily and can be intense ... many people with autism feel overwhelmed by too much

interpersonal contact.” (p. 69). She observes that neurodivergent people may need to leave situations to regulate their emotions. She considers the likelihood of assumptions being made about such behaviour, and is careful to argue “... this is not a passive behaviour of escalation ...” (p. 69), neither is it withdrawal or an inability to ‘stay in Adult’ but is, instead, the effects of sensory overload. She notes that encouraging people to stay in situations and ‘ground themselves’ may lead to further exposure, fear, and dysregulation.

The Therapeutic Relationship

Maté (1999) states that adults with ADHD need “more than organisational tools and behavioural modification techniques” (p.272) – i.e. more than putting a “shiny new show on the road” (Kemp, 1972 in Oates, 2021, p.66) and risking the “client’s vulnerable interior world” (Oates, 2021, p.66) lacking attention.

If one holds this important awareness in mind, the question becomes less ‘Why are you behaving that way?’ and more ‘What do you need right now?’. Erskine and Trautmann (1999) observe, in their introduction, that: “as people weather the inevitable traumas of life ... they develop ways of protecting themselves from pain. These self-protective patterns, helpful ... at their inception, may become destructive as one moves into new life phases ... what has been learned as a response to a specific traumatic situation tends to generalise ... one’s ability to make full contact is impaired”. (p.x).

They go on to state that the task of the therapist is to support the client to “break out of such script patterns” (p.x) to relate contact-fully to others through inquiry, attunement and involvement – thus responding to the vulnerable interior world (Oates, 2021) and not to the behaviour itself. This raises a further question regarding the ways neurodivergent adults may have been responded to historically - with physical and verbal punishment/shaming for what may seem like ‘bad behaviour’: hyperactivity, inattention, lack of understanding, difficulties organising self, seeming not to listen, poor eye contact, excessive talking, etc, but which are manifestations of their neurodivergence which they have little control over - when what may be needed is understanding and attunement.

Brown, Crawford, Rucklidge and Japlan, (2006) researched a link between adult ADHD and childhood trauma, hypothesising that what is mistaken as hyperactivity may be hyperarousal – a survival response. Whilst not the focus of this paper, it is worth noting Brown et al’s research found men and women with adult-diagnosed ADHD had higher prevalence of childhood trauma. However, it is not clear whether children with ADHD symptoms are

more likely to be abused, or whether experiencing child abuse increases the likelihood of the development of ADHD symptoms. Maté (1999) also explores the possibility of ADHD being a developmental disorder resulting from misattunement in infancy. This has also been discussed by Vrijssen, Tendolkar, Onnink, Hoogman, Schene, Fernández ... and Franke (2018) who questioned whether adults with ADHD were more likely to have experienced childhood trauma, or whether children with ADHD are more likely to be abused due to their ‘behaviours’. Regardless of whether childhood trauma contributes to ADHD or ADHD to childhood trauma, Brown et al (2006) argue clinicians working with neurodivergence should be trauma informed and aware of this potential link. We believe this is important to avoid inviting clients who are experiencing survival-based hyperarousal into over-adaptation or, potentially worse, dissociation, re-traumatisation, or flooding.

Novak (2021) states that: “In childhood, traumatic impingements [mis-attunement] ... can significantly damage the experience of the isolate. This can be repeated in psychotherapy. When the core self of the client is available and the therapist does not offer adequate attunement and relatedness ... the client may experience a traumatic re-enactment ...” (p.244).

Irrespective of the ‘root cause’ of neurodivergence, we are clear; being neurodivergent in a neurotypical world is traumatic. Chastisement for hyperactivity/inattention/misunderstanding, and stroking for conforming to a societal norm is traumatic mis-attunement and will result in the formation of a False Self (Winnicott, 1960,1963) (defensive behaviours) to keep the core self ‘safe’.

Neurodivergence in the Transactional Analysis literature

At present, TA literature and guidance for working with neurodivergence is relatively limited, but thankfully growing.

Peter Flowerdew’s *Asperger’s in the Therapy Room* series, that ran from 2016 to 2022, supports therapists in gaining an understanding of Asperger’s Syndrome (Note: Asperger’s Syndrome has been included in DSM-5 in the category of ASD). Flowerdew explores using time structuring to understand and support the development of relationships (Flowerdew, 2019a), emphasises the need to avoid false intimacy when defences are raised (2019b), and suggests ways of building trust with clients with Asperger’s (Flowerdew, 2018). Flowerdew (2017a) also places importance on the therapeutic relationship, stating that “the prime function of the therapeutic relationship is to create the visceral experience of welcome and safety, and

to ... demonstrate that, in this space, 'You are OK, teach me how to be with you.' (p.37).

Flowerdew draws a link between Asperger's Syndrome and lack of attunement in childhood, agreeing with Erskine and Trautmann (1999) that "failure to meet the relational needs of a child causes trauma that results in a loss of awareness of thoughts, feelings, needs, memories, even a sense of self. (Flowerdew, 2018, p.28)" He states that this presentation requires a different kind of therapy (Flowerdew, 2016), highlighting the need for explicit contracting, slower pace, conscious avoidance of re-traumatisation, or rejection, and the exploration of the clients' inner world. He also observes how useful TA diagrams are in aiding clients with Asperger's Syndrome in their understanding (Flowerdew, 2017b).

In her recent work exploring ableism, Oates (2021) questions, regarding behavioural outcome, "for whom is the change a necessary outcome?" (p.73) She discusses the risks around inviting over-adaptation in clients and trainees, arguing that invitations to cathect the Adult ego state could sadly be Parent invitations to over-adapt (p.66), and are therefore inviting masking.

Both Oates and Flowerdew (2021) discuss the importance of phenomenological diagnosis (Berne, 1961) in assessment to avoid inviting over-adaptation. Flowerdew questions "how can I possibly attempt to make a change in someone's subjective world until I have explored that subjective world?" (Flowerdew, 2017c, p.42). He observes that "for (a person with Asperger's)... , the experience of being with someone who understands their way of being in the world ... is transformational" (Flowerdew, 2017c p.42).

This is contradictory to information on the use of CBT in working with neurodivergence, which includes such statements by Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) (2021) as "positive thoughts and positive behaviours reinforce each other; as the person becomes more effective in managing time, s/he comes to have more positive beliefs and cognitions about the self, and these in turn help to generate and maintain more adaptive behaviours" (website). Whilst we do recognise the value of change-focused therapy and of therapy which increases the client's functioning, we also remain conscious of the potential that change-focused therapy can have in generating shame in clients who are exhausted by masking and are therefore unable to sustain adaptive behaviours. We are also conscious that such an approach may invite an unhelpful over-adaptation (Schiff, 1975).

Oates (2021) discusses supporting a client with ADHD to teach her TA training group what she needed when she experienced overwhelm, rather than adapting to the neurotypical environment in which she found herself. She explores the importance of therapist and client just being together as opposed to being change focused, with the permission being 'you don't have to over-adapt here'.

In a recent workshop, Oates and Moores (2021) argue the importance of practitioners working with neurodivergence being trained and knowledgeable on the subject. They also reflect on the potential shaming nature of behavioural interventions in therapy with neurodivergent individuals, questioning instead whether 'neurodivergent behaviours' are themselves survival strategies that have kept the individual 'safe' and therefore need to be accepted and honoured, rather than 'spotted' as drivers (Kahler, 1975) that need to be 'reduced' or changed.

Baker and Widdowson (2019) researched the experiences of psychotherapists with dyslexia. Themes identified included: difference and shame; strategies created for developing resilience; ambivalence around the label 'dyslexia'; and impact on the therapeutic relationship. Interestingly, like Oates and Moores (2021), Baker and Widdowson draw a link between the adaptation processes and development of drivers, or defensive behaviours, in order to make self 'acceptable' to others.

Aims and Objectives of this Research

The aim of this research was to investigate what neurodivergent clients might need within psychotherapy and whether TA might meet those needs.

The Objectives included:

- Increase psychotherapists' understanding of neurodivergence;
- Explore whether the needs of neurodivergent clients can be better met through an outcome focused therapeutic approach (NICE 2018) or a relationship focused approach;
- Identify challenges and helpful and unhelpful psychotherapeutic approaches when working with neurodivergent clients;
- Identify recommendations for therapists in how best to adapt TA therapy to meet the needs of neurodivergent clients.

Practical and Ethical Considerations

As with all phenomenological research, there was potential to evoke uncomfortable feelings, leaving

participants with a sense of unease, anxiety, and distress (Finlay and Evans, 2009; Richards, 2002). Protection (Crossman, 1966) and holding were provided for participants to have the opportunity to discuss any arising discomfort safely through the offer of a debrief session with a trusted colleague.

Interviews were contracted for, to ensure no confusion with a therapeutic encounter (Richards, 2002). Research terms were clearly defined with no expectation, obligation, or requirement to take part. Participants were prepared, knew what details would be explored, and that they could refuse to answer questions that evoked discomfort (Finlay and Evans, 2009). Participants were in full control of the information that they disclosed to avoid exposure, vulnerability, and exploitation of the relationship (Finlay and Evans, 2009). Participants received an Information Sheet, completed an Informed Consent Form (Appendix 2), and were aware of how much time they needed to commit to the project. This research was approved by The Berne Institute Research Ethics Procedures (2021), and was supervised from inception by the second author, an experienced psychotherapy researcher.

There was a risk of participants feeling their material had been taken out of context, resulting in loss of self-identity, creation of racial/gender/sexual stereotypes, and creation of assumptions (Richards, 2002). Research direction, progress and terms of agreement were contracted for throughout (Richards, 2002). Supervision was undertaken to ensure that misrepresentation did not take place. Themes and data were shared and checked with participants prior to writing up this article in a member-checking procedure.

Participants were aware of limits to confidentiality arising from research that shares personal stories and experiences (Richards, 2002). The Consent Form (Appendix 2) detailed such risks and arranged

for the use of pseudonyms and changing of all identifying details. Records of an identifying nature were kept in a password protected digital folder. Transcripts and protocols were fully anonymised and contact details were held electronically, password protected and disposed of in line with UK Information Commissioner's Office (2018) General Data Protections Regulations (GDPR).

There were no financial incentives offered for participating in this research, although participants who were required to travel for interviews had their travel costs reimbursed.

Participants

Participant demographics can be found in Table 1. Six adult participants were recruited from responding to an open invitation to participate in this study, which was posted on a TA neurodivergence social media page. All participants were neurodivergent, some with dual diagnoses, although none of the participants were diagnosed in childhood. Inclusion and exclusion criteria were minimal, and the inclusion criteria were that participants must be neurodivergent and have had experience of receiving psychotherapy as an adult. These similarities in presentations ensured that the research specifically looked at the experience of living with undiagnosed neurodivergence (Smith & Nizza, 2022) and receiving adult psychotherapy.

Methodology, data collection and data analysis

This research made use of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2009; Smith & Nizza, 2022). IPA is a methodology that is designed to understand the lived experience of participants and how they make sense of their "personal and social worlds" (Smith & Nizza, 2022, p.3). IPA is useful to gain an in-depth understanding of the lived experience of individuals, including their thoughts and feelings and, in the case of this study, behaviours, beliefs, and physical sensations.

Pseudonym	Pronouns	Age Range	Neurodivergence
Donna	She/her	50+	ADHD, Potential ASD
Maria	She/her	30 – 39	ADHD
Fran	They/them	40 – 49	ADHD
Cath	She/her	40 – 49	ADHD/ASD
Sandra	She/her	50+	ADHD, Dyscalculia
Mischa	She/her	50+	ADHD, Dyslexia

Table 1: Participant Demographics

Data was gathered in the form of semi-structured interviews of approximately 40-60 minutes. Interviews were conversational, allowing participants to share their own stories, allowing the first author who conducted the interviews to listen carefully to what was said, whilst guiding the interview towards answering the question itself (Smith & Nizza, 2022).

Interview questions can be found in Appendix 1 and consisted of a mixture of:

- Descriptive questions exploring the facts around the participants' experiences;
- Narrative and reflective questions to gain more in-depth understanding of the lived experience;
- Probing questions to gain further information about ideas/concepts that felt important in the interview itself (Smith & Nizza, 2022).

Questions explored how participants' neurodivergence affects them (historically and now) including how other people relate(d) to them; their perception of self; education, home, and professional life; reasons for starting psychotherapy; positive and negative experiences of psychotherapy; and any psychotherapy goals specifically relating to neurodivergence.

Results

The research relationship was a "constantly evolving, negotiated, dynamic, cocreated relational process to which both researcher and co-researcher contribute" (Finlay and Evans, 2009, p. 9). The first author retained a level of flexibility and creativity within the interview, keeping the participants' felt experience central to the process to avoid any bias which may have arisen from becoming too rigid with questioning.

Interviews were recorded and transcribed before being individually analysed using guidance from Smith and Nizza (2022). Following the initial note-taking, each participant's transcript was re-read to transform the detailed notes into emerging themes supported by data evidence (Pietkiewicz and Smith, 2012). Each major theme was given an individual label and any themes with insufficient accompanying transcript material were discarded at this point. Cross-case analysis took place to identify common themes or patterns. Group Experiential Themes (GETS) were identified (Smith & Nizza, 2022) regarding the lived experience of people who are neurodivergent (Table 2) and what they need in a psychotherapeutic relationship.

	Main Theme	Sub-Themes
Theme 1	The need to be understood and accepted	1.1. Historical experience of others seeing them as 'too much', difficult and wrong
		1.2. The fear of being judged and/or rejected
Theme 2	The experience of over adaptation, performing and masking	2.1. A terror of getting things wrong
		2.2. The use of Permission and Protection
		2.3. Avoiding overwhelm and crash
Theme 3	The need for a balance of tolerable nurture and tolerable structure	3.1. The exploration of bodily (somatic) experience to remain within Window of Tolerance
		3.2. The importance of curiosity, creativity and novel experience
Theme 4	The experience of repeated relationship ruptures (felt to be) due to neurodivergence	4.1. The need for the therapist to be flexible and knowledgeable
		4.2. The importance of trust, clarity and consistency in the therapeutic relationship

Table 2: Themes and Sub-Themes

Theme 1: The Need to be Understood and Accepted

All participants talked about feeling misunderstood and experiencing frustration with people making assumptions about behaviours. This led to the emergence of two sub-themes, specifically relating to how participants are seen by others.

1.1 Historical experience of others seeing them as 'too much', 'difficult' and 'wrong'

All six participants reported being seen as 'too much' in childhood and reported feelings of sadness, shame, loneliness and frustration. Results indicated that this adds to the experience of 'not being understood' as behaviour would be seen first, and needs would be missed.

"I'm always thinking 'don't say too much; you're talking too much, don't talk over people. I have all these ideas that come into my mind, but I don't want to appear narcissistic or over talkative.'" (Donna)

"With my mum, I've always been a nuisance. I always felt different. I was different and I looked from the outside in and couldn't understand how they [other people] could understand things. And I always felt that way. Um, and it didn't matter how many times people would repeat - teachers would repeat things. I couldn't get it all. I really struggled." (Sandra)

"I was making life difficult for my dad and the doctors said I was doing it for attention ... they kept saying I was a hypochondriac." (Cath)

"The term oversensitive was used quite a lot in, in those kind of scenarios." (Maria)

1.2 The fear of being judged and/or rejected

As a result of being seen as 'too much' or different, participants reported experiencing rejection and judgement. Fran and Mischa talked about defensive behaviours – or coping mechanisms - they had adopted to avoid this. In conducting the interview, the first author was particularly impacted by the power of Mischa's therapist not accepting the invitation to reject her and end the therapy.

"We can't control her – bad parenting; this, that and the other ... they just said 'we'll just take her out [of high school]' and they expelled me." (Cath)

"I'm very emotions based, and I can feel totally abandoned by [my husband] when I'm emotional." (Donna)

"I broke up with my first therapist because she was too person centred. I bawled my eyes out because I didn't want to hurt her feelings because I know how it feels to be excluded." (Cath)

"He [the teacher] said 'can you stop putting your hand up all the time? Because we need to make room for other people in the class as well. And it stopped me completely – it's stayed with me forever and I did everything I could to not present in-front of people.'" (Fran)

"...then I got scared ... and I wanted to finish with him. And then we arranged [a session] for the day I was due to finish, and I remember going into his room and I was in tears and he said "Well we don't need to finish today if you don't want to." and I said "No, I don't think I do want to." and then we worked together for another year." (Mischa)

Theme 2: The Experience of Over Adaptation, Performing and Masking

As discussed in the literature review, 'masking' is common in people who are neurodivergent so the authors were not surprised by this theme. Cath, however, spoke about how unconscious a process 'masking' is. Mischa reflected that her performing had become so much a part of her that she was unsure who her real self was. All Participants discussed over-adaptation, and the reasons behind this, in depth.

2.1 A terror of getting things wrong

Participants had developed creative ways to avoid getting things wrong (and then being rejected or judged as in Theme 1), including 'over-learning', but reflected that this was exhausting. Five of the six participants apologised for forgetting the question that had been asked (usually due to deviation from the topic) and expressed frustration for this.

"I remember there was one times table that I struggled with ... And I cheated by writing the times table on my hand. I'd never cheated in my life before ... so went off to school. And after the teachers saw that I was copying from my hand they called my Mum in and I got so upset and I went home because I was so upset. And the teacher was like, well, I don't understand – you're so good at everything, why do you need to cheat? I think it's that fear of not getting it right. That and overworking are very linked. I was really, really precise about what I was doing and if I made a mistake, I had a full-on meltdown. They said I was oversensitive." (Maria)

"He used to make me read aloud which I found really difficult. When I knew I was next I wouldn't be listening, and I would read my bit ahead. So, instead of just reading it, I'd kind of over-prepare, knowing that I would have to do something, and I didn't want to get it wrong." (Mischa)

"I've forgotten the question which is really not very clever. Oh, sorry – it's not ... that's not very clever." (Mischa)

2.2 The use of Permission, and Protection to Facilitate Unmasking

This subtheme indicates the importance of participants feeling safe enough to show their 'unmasked' selves. Cath, Fran and Maria found this permission in other people who are neurodivergent, but all participants reflected on the importance of therapists giving sufficient permission (Crossman, 1966) for the emergence of unmasked selves, and of not inviting them to conform to their idea of normal (Oates, 2021).

"I learned to take off my mask. I didn't even know I was wearing a mask until I had counselling and I could explore how I felt." (Cath)

"I wasn't supposed to fit in with those guys because they are a different shape to me. Like if you say a jigsaw puzzle, they are the size a thousand and I am a size 50, whatever. I'm a different size jigsaw. I'm not gonna [going to] fit in their box. I ... I'm gonna fit in my jigsaw box with other 'neurodivergents'." (Cath)

"I remember my therapist said to me, 'you don't ever have to cry for your therapy to work' and I just felt that permission to be me. Permission. But then I did cry after that, not that session, but there were no rules for the therapy to work. I didn't have to adhere to a set of rules." (Donna)

"The protection, permission to just be myself and, stroking my creativity instead of putting it down were all really important." (Fran)

"What happened is I was given so many permissions. It was about learning to accept – acceptance rather than behavioural change." (Donna)

"Actually there was no shaming at all because she didn't try and make me fit in. She didn't fit me in a neurotypical box – she didn't give me skills to fit in somewhere where I was very different or try to make me 'normal'. There was acceptance." (Maria)

"This is your space. This is where you can just be yourself. There is no judgement here." (Cath)

2.3 Avoiding overwhelm and crash

Participants talked about the pattern of overwhelm and crash, both from experiences of sensory overload and resulting from performing/masking for too long. This was linked to the terror of getting things wrong and not wanting to be rejected (2.1 and 1.2).

"I remember seeing a therapist and saying, 'I just want to feel whole'. I said 'there's this part that everyone sees, and there's this other part which no one sees. And I said, 'I want them to come together. It was just a performance all the time.'" (Mischa)

"I can't plan ahead – I just can't. If it's overwhelming – too many steps, I just can't do it." (Cath)

"When things get really stressful, I can lose all memory of the conversation. I can't remember something I would have said a few minutes ago ... I can just go into a freeze scenario ... and I think that's, again, a bit of a fear of kind of getting it wrong and not being, not getting it right." (Maria)

"I was depressed from a very young age, but I would never show it because I was the performer and the entertainer who everyone was happy to see but then at college, I was dissociating all the time. I was super tired and dozing all the time." (Fran)

"But then the symptom management is important too because I was killing myself at some points. I was overcompensating and really hurting my body. And instead of being like 'stop' and shaming me, she was kind of like 'you're important and your health is important.'" (Maria)

"People always put me in this category like I'll always have a laugh but what really happens for me is that my energy just gets drained really quickly and I literally have to stay in bed the entire weekend because I was just drained." (Mischa)

Theme 3: The Need for a Balance of Tolerable Nurture and Tolerable Structure

This theme related to both historical and therapeutic relationships. Participants used words such as 'fluffy' and 'soft' inviting them into hypo-arousal, but also spoke about the experience of feeling shamed inviting them into hyperarousal/stress response, both common in people who are neurodivergent (Silver, 2022).

This theme largely explores the importance of clients learning to widen their Window of Tolerance (Siegel, 1999).

3.1 The need for careful attunement and exploration of bodily (somatic) experience to widen the window of tolerance

This subtheme indicates how important participants found the use of careful attunement. Participants reflected on experiences of relationships feeling 'too much' and 'overpowering'. Three participants also spoke about the safety that their driver behaviour brings them in terms of 'self-regulation' (Oates & Moores, 2021). This subtheme also shows how important participants felt it is that therapists have a good understanding of neurodivergence and how it affects the nervous system and the body.

"Sometimes they [friends] want too much from me, or I want too much from them – or I want to be completely left alone." (Maria)

“My ‘be perfect’ driver – I can’t start something and it not be perfect and if it’s not going to be perfect, it’s going in the bin and my anxiety gets really high – and they were really critical about that.” (Cath)

“She talks about my Child and how much my Child needs to be nurtured. It’s all about Nurturing Parent for me, but sometimes it can be overpowering. I can get quite tearful because I find the presence too much sometimes ...”. (Mischa)

“I was being pushed too much. You know, this, this, lots of reflection, lots of summarising and just nodding the head and like ... It’s not for me.” (Sandra)

“She, uh, regularly repeated the, the invitation [to stand up and move around] but didn’t rescue me. So that was very important for me. Um, and she always inquired about my body experience, how I was feeling, what was going on. So, uh, that was very useful for me to understand my process actually, because, you know, unless you think about it, you just do whatever.” (Fran)

“I needed to explore the developmental trauma, but I just found her too soft.” (Mischa)

“It, it was just, they were, there were too ... what’s the word I would use ... fluffy. Too fluffy. I don’t do fluffy.” (Sandra)

3.2 The importance of curiosity, creativity, and novel experience

Participants spoke about the importance of the psychotherapist remaining curious to avoid the client feeling misunderstood (Theme 1) or assumptions being made about behaviours - and underlying needs - being missed. Mischa, Cath, and Fran also spoke about the importance of creative methods, including writing, drawing, the use of art work and music for providing ‘tolerable’ ways of attuning to clients who are neurodivergent.

“He helped me see I experience things differently. He was like “let’s talk about difference” rather than saying “you need to do things this way”. That really helped me.” (Mischa)

“Always love new things. Love it. I’ll always be the one that’s out there trying things ... “ (Sandra)

“I just wanted to talk to someone. I just wanted to talk. They were like ‘let’s talk about solutions to your problems and all I wanted to do was talk about what my experience was. I just needed space to talk – without being guided and without being told ‘Right – this is what you need to do.’ (Cath)

“He had this amazing consulting room with lots of different pieces of art and books and ornaments and things. And I’d be just sitting there and then I would

say ‘oh my God, that wasn’t there last week’ and he would say ‘it was’. And I’d think ‘Why have I only just seen it now?’ and then we’d work around that.” (Mischa)

“Like the curiosity has really helped ... so she isn’t like ‘oh don’t be stupid’, she was more like ‘oh, that’s interesting – tell me more about that.” (Maria)

Theme 4: The Experience of Repeated Relationship Ruptures

This theme links directly to Theme 1 and indicates that participants have experience of repeated relationship difficulties, personally and professionally, potentially due to neurodivergence. There are potential links here with lack of understanding, rejection, and judgement (Theme 1), and relationships built on over-performing and masking (Theme 2).

4.1 The need for the therapist to be flexible and knowledgeable

This subtheme relates to how well participants feel that their therapists understand neurodivergence. Participants discuss frustrations around assumptions that are made about them, inviting masking (Theme 2) and inviting them to conform to others’ idea of normal (Oates, 2021). Participants also reflected on frustrations around both overly rigid therapy styles and lack of understanding from therapists which can lead to repeated relationship ruptures (personally and in therapy).

“The frustration was like ‘this [outcome focussed] works for other people – why isn’t it working for me? It kind of touched the surface – it touched the behaviour. But underneath it was still there. So it’s not like it was negative – more like ‘maybe there’s something wrong with me, or maybe I’m making it up.’ (Maria)

“I felt that she knew her stuff. I felt confident that she knew her stuff. She would be curious. And she would engage more with me. The others would just sit down and nod their heads and just wait for me to talk.” (Sandra)

“Goals would have made me leave. That’s would have made me say ‘sorry, this isn’t what I’m looking for.’ (Cath)

“I think I would have found that [concrete goals] quite shaming.” (Donna)

“And she also didn’t know necessarily a huge amount about ADHD but was reading about it, which was really positive because then it was always like she was learning something as well ... There’s a lot, lot of instances with doing that kind of thing ... she still feels she can learn from her clients which is really positive for me.” (Maria)

4.2 The importance of trust, clarity, and consistency and in the therapeutic relationship

Participants reflected on how their trust in supportive relationships had been challenged over the years due to repeated relationship ruptures. Cath reflected on her literal thinking and how this has hindered relationships historically. The authors believe this links to fear of getting things wrong (Theme 2) and indicates the importance of therapists being consistent and clear with neurodivergent clients.

"I would never deviate. I would, I'll need exact instructions. And I would stick to those almost to the point where people thought I was being sarcastic." (Cath)

"Unfortunately, she left suddenly that wasn't helpful. I just adored her and then, suddenly, she just didn't come back." (Sandra)

"Trust is a problem. Being led is a problem. I can't be told what to do. You need to learn to trust the therapist and test them out a bit with 'is this ok, am I being too weird?'" (Cath)

"I was still doing, you know, some, some good work and she [the therapist] decided that was a good, uh, we needed to end therapy all of a sudden after eight months of working together. Um, and, uh, for, for me that day, for example, um, I really felt really angry." (Fran)

Discussion and implications for transactional analysis psychotherapy practice

Analysis of these research themes indicates three main traps in working with neurodivergent clients.

- The lack of understanding (and pathologising) of coping behaviours – or defence mechanisms;
- Over-reliance on change or outcome focused care, resulting in the invitation to over-adapt and mask;
- Making assumptions about the needs, abilities, interests, etc. of people who are neurodivergent, based on behaviour.

We believe that these traps risk the invitation of shame; the repetition of mis-attunement; missed relationship opportunities; relational rupture; and social, emotional, and physical exhaustion.

A 'vicious cycle of conforming and reacting' takes place in relationships (Figures 1 and 2) (see Widdowson, 2014, for discussion on vicious cycles). This vicious cycle of conforming and reacting is, in our experience, often what brings neurodivergent clients into therapy. However, focusing solely on

change or 'improving behaviours' may re-enact these experiences for clients who lacked attuned relationships in childhood, whether due to the emergence of neurodivergent behaviours or contributing to such behaviours.

Based on the findings of this study, we have formulated the following guidance for working with neurodivergent clients: details of what neurodivergent clients need; a model of building blocks for psychotherapy with clients who are neurodivergent; and a set of relational affirmations and explanations of how TA psychotherapy can be used with neurodivergent clients.

Neurodivergent clients need:

1. Understanding and acceptance:
 - a. Learning that they are not 'too much' for their therapist.
 - b. Knowing that they are not at risk of rejection or judgement.
 - c. Knowing that their neurodivergence is celebrated and that they are not seen as difficult or inconvenient.
 - d. A trauma-informed therapist who is willing to understand the lived experience of their neurodivergent clients
 - e. A therapist who is willing to make reasonable adjustments to the amount of stimuli in the therapy setting in line with the client's specific needs
2. A therapeutic relationship where they feel safe enough to show their 'unmasked' selves:
 - a. Reassurance that there is no 'right or wrong' way to behave (or be).
 - b. Permission to test 'unmasked' relating patterns out in the therapeutic relationship.
 - c. Permission to 'not understand', to get things 'wrong' and to be 'uncertain'.
 - d. A therapist who is intuitive, aware, and skilled enough to not invite adaptation.
 - e. Protection for their scared Child ego states that fear rejection
3. A Balance of Tolerable Structure and Tolerable Nurture
 - a. Therapists paying close attention to their own responses, being mindful of when they feel pulled to invite adaptation.
 - b. Therapists paying close attention to the client's levels of arousal to avoid hyper- or hypo-arousal (Davies, 2021).

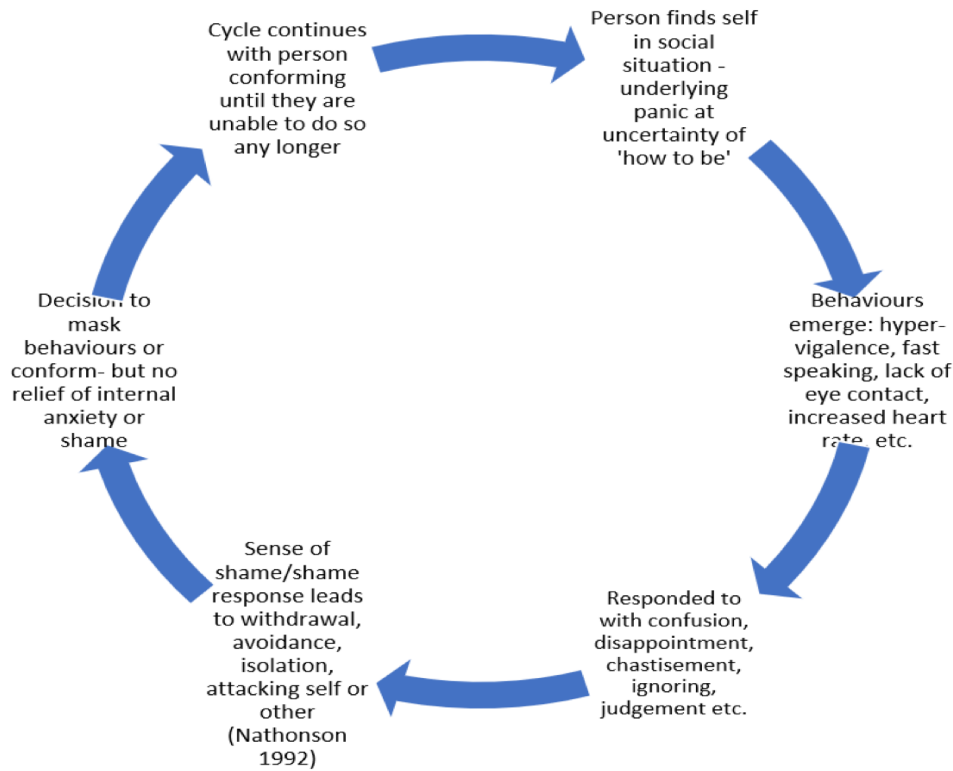


Figure 1: 'Vicious cycle of conforming and reacting'

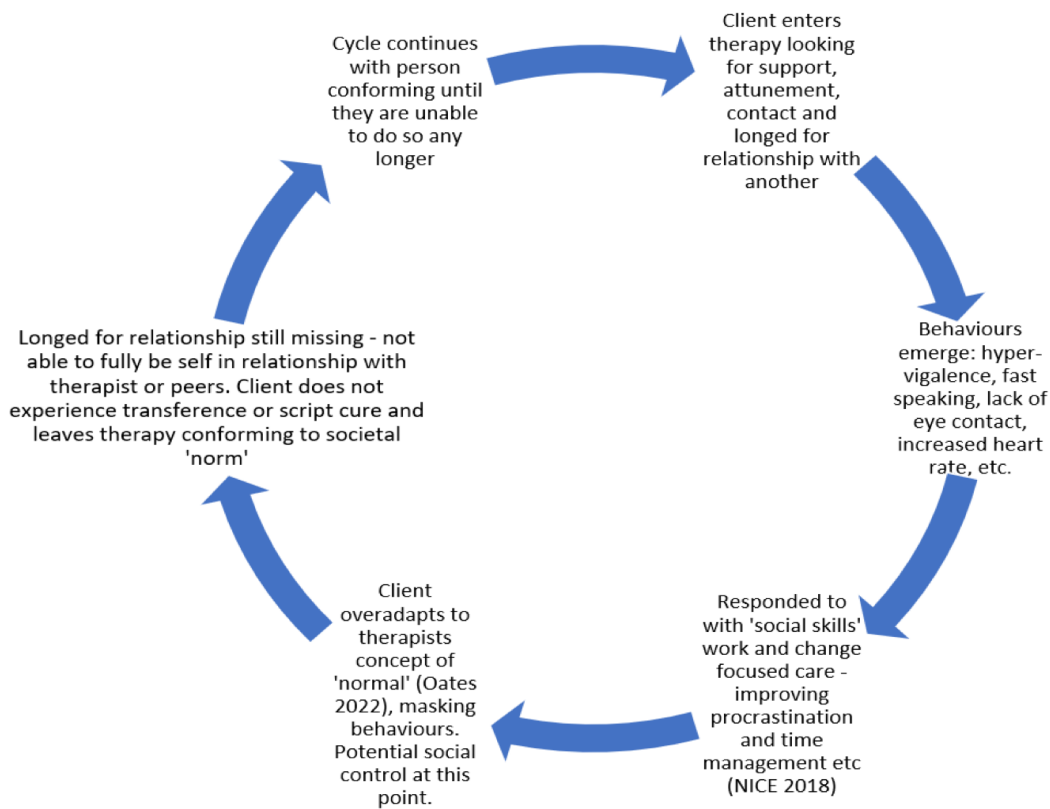


Figure 2: Vicious cycle of conforming and reacting re-enacted in therapeutic relationship

- c. Not shaming clients for self-regulating (defensive/driver) behaviours but honouring these coping mechanisms.
 - d. Curiosity around (as opposed to pathologizing or discounting) clients lived experience
 - e. A therapy that is creative and novel
 - f. Careful pacing to avoid an invitation to over-adapt which can result in overwhelm and crash.
 - g. Therapists willing to have an ongoing and open conversation with their clients about their client's preferred amount of structure to the therapy
4. A therapy that is different to historical relationships that have felt shaming, unsafe or conditional
 - a. Feeling there are no assumptions made about them, based on their neurodivergence.
 - b. A therapist who is willing to be flexible, depending on client's levels of arousal on that day
 - c. Moment by moment relating and contracting
 - d. Clarity in relationship
 - e. A therapist who understands neurodivergence and is willing to learn how neurodivergence feels for each client
 - f. Trust that their therapist will not disappear or reject them

Figure 3 demonstrates simply and visually what is needed in a psychotherapeutic relationship with neurodivergent clients.



Figure 3: The Building Blocks of Psychotherapy with Neurodivergent Clients

This diagram was created following discussion with colleagues to be a reminder of the importance of

building the therapeutic relationship for neurodivergent clients on a foundation of acceptance. This allows clients to feel safe enough for their 'true selves' to emerge and be received by the therapist. Once this acceptance has been established, the other building blocks can be put into place. However, without acceptance I (CB) would argue that clients may over-adapt to avoid rejection or judgement.

Relational Affirmations for Neurodivergent Clients

The following are suggestions of implicit affirmations and practical ideas for using transactional analysis with neurodivergent clients, which are based on the findings in this research. They are not intended to be used as verbal affirmations (although some practitioners may choose to use them in that way), but instead are offered to help practitioners think about the implicit psychological level of contracting with their clients, and what they might communicate at an ulterior level which promotes their client's sense of safety and acceptance and which supports the development of the therapeutic relationship.

You are Not Too Much for Me

This research indicates that neurodivergent clients have repeated experience of feeling and believing that they are too much for others. Unfortunately, this is generally grounded in historical reinforcing memories that provide evidence and justification for these feelings and beliefs (Erskine & Zalzman, 1979).

Neurodivergent clients need a therapist who can respond to them with acceptance and empathy, and need to be given space for their authentic, neurodivergent selves to emerge. Here, we consider Ray Little's (2006) work on ego state relational units, assuming that the historical experience of being rejected or judged by peers, parents, teachers, medical staff, etc, has been internalised, with the 'expectation' that all other people will also respond to them in this way – and the splitting off of these parts of self. Providing an accepting relationship can allow the authenticity, vibrancy and excitement of the neurodivergent client to emerge as they realise that they are welcomed and accepted for who they are. Oates and Moores (2021), in their workshop on Neurodivergence and TA in the Therapy Room, observed that this leads to the client realising that they are not failed neurotypical people, but instead are perfectly good neurodivergent people!

I Will Not Pathologize You or Make Assumptions About You – I am Interested in You.

Neurodivergent people have made decisions to hide parts of themselves that have been seen by others as, e.g. 'over sensitive, difficult, too much, nuisance,

hypochondriac, different, too emotional, obsessive, and overly talkative'. Oates and Moores (2021) talk about 'gifts' in neurodivergence – 'hyper-empathy', 'hyper-porousness', and 'hyperfocus'. Neurodivergent clients need a therapist who will welcome these 'gifts' without making assumptions based on societal beliefs and opinions. To reframe 'obsessiveness' as 'hyperfocus', for example, celebrates the enthusiasm, creativity and expertise seen in people who are neurodivergent.

Through listening to client's 'special interests' (Flowerdew, 2017b) with our own sense of curiosity, engaging in two-way conversation, exploring the excitement and emotions arising and being open to being impacted by the client (Erskine and Trautmann, 1999), we can provide an authentic and accepting relationship.

You Have Learnt Amazing ways to keep Yourself Safe (and when you feel ready, you don't need to do that here).

Oates and Moores (2021) observe that driver (defensive) behaviours (Kahler, 1975) are what people may 'move into' when affect becomes too much to manage. However, Oates (2021) reflects that she believes 'driver spotting' can be shame-inducing and can increase a sense of feeling self-conscious. This raises the question of how such self-regulatory behaviour can be honoured without inviting shame.

Speaking at the North East Transactional Analysis Conference, Gerry Pyves (2020) spoke about life script as being the most creative way to make the most of our situation, regarding script as neither needy or pathological (Pyves, 2014). However, it was the honouring of defence mechanisms that had kept the client safe, modelled by Pyves in his workshop, and that most impacted the first author as he exclaimed: "*How clever! What a wonderful defence mechanism*". Both of the present authors have found that when they use such language with clients to honour their self-regulatory behaviours, the clients shoulders would drop, their body would relax, and we would experience a different phenomenology in the therapeutic relationship – one that involved the neurodivergent clients feeling safe to show their full selves rather than using past methods to stay safe.

We will Find a Way of Working Together that Works for You

Winnicott (1971) argued that it was only in playing that people are "able be creative and to use the whole personality, and it is only in being creative that an individual discovers the self." (p.54). Play and creativity provide the ability for connection without eye-contact or fear of being 'watched'. It also provides something to 'focus on' when affect becomes intolerable or silence unbearable. The first

author has found play and creativity invaluable for working with neurodivergent clients. She shares some of her own ideas and those contributed by clients below:

- Sand tray work (Day & Day, 2012; Salters, 2013)
- Working with clay and other modelling materials (Model Magic by Crayola is fantastic for clients who may struggle with the sensory experience/mess of clay)
- Dance and movement
- Small world play
- Mindfulness colouring book
- Collage and artwork
- Visual art displayed in therapy room
- Creating sculpture together (most recently created was a 'Fairy Garden' with a neurodivergent client who struggled to access their Child ego state).
- Board Games – personal favourites being: Dixit (Roubira, 2008; Bowers, 2019), and Star Dew Valley (wonderful for pastiming) (Barone & Medeiros, 2021).

I Will Support You to Feel Safe

Oates and Moores (2021) discuss excitability and anxiety being features of neurodivergence that cannot be suppressed, highlighting the way in which neurodivergent people may (subconsciously) use anxiety to increase the availability of executive functions. They argue that this leads to more focus, thus normalising and honouring this sense of excitement, but observe that it can also lead to overwhelm and possible shame. The results of this study, particularly Maria's observations, support this theory. The first author has adapted a visual created by Oates and Moores for their workshop, using language agreed with a client, to use with clients enabling them to move the 'pointer' themselves to indicate how aroused they are when words cannot be found (Figure 4). Of course, phenomenological enquiry and observation are vitally important in monitoring client levels of arousal but making use of such tools enables clients to be a part in this and becomes part of the contracting process for what they do and do not want to experience at that moment. The first author has found that the action of moving the arrow can also become a grounding and regulating activity in itself.

I am Willing to Learn

We believe that it is important not only that therapists working with neurodivergent clients do not 'assume' that they understand their client's experience but that they do not embark on therapy with neurodivergent clients without prior experience/CPD in this area.



Figure 4: 'Regulation Gauge' created with a client (and shared with permission). (Based on Oates and Moores, (2021)

The British Association of Counselling and Psychotherapy (BACP) Code of Ethics (2018) states that we need to “recognise when our knowledge of key aspects of our client’s background ... is inadequate and take steps to inform ourselves from other sources where available and appropriate, rather than expecting the client to teach us.” (p.22). We would expand on this, stating that this needs to be a two-way process whereby the therapist has sufficient training and experience to work with neurodivergence but is also willing to be curious and explore the client’s lived experience with them.

I Will Check What You Need from Moment to Moment

Lee (1997) explains that process contracts are “characterised by the counsellor’s close tracking with her client’s thinking, feeling and behaviour”. (p.94). They involve paying close attention to the client’s levels of affect (Davies, 2021), ensuring that the client does not experience overwhelm, flooding, underwhelm, or dissociation. Process contracting is an interpersonal, cocreated process which involves ‘checking in’ with the client moment by moment, asking what do they want (or need) in this moment (Lee, 1997). It is important that neurodivergent clients are given permission, to ask questions and seek clarification in order to fully understand what is expected of them and of the therapist, and to test out their authentic, unmasked selves in the therapy. Figure 5 demonstrates a development of Sills’ (2006) Contracting Matrix with the inclusion of moment-by-moment considerations for neurodivergent clients.

I Will be Consistent and Will Not Reject You

Experiences of rejection and the trauma associated with this can be re-enacted in the therapeutic

relationship. Erskine and Trautmann (1999) argue that if these needs are acknowledged in the therapeutic relationship, internal contact can be re-established. They argue that clients need to experience the therapist as stable, dependable, and protective.

For clients who are neurodivergent, to be rejected is not a fantasy – it is grounded in personal, repeated experience – and, as can be seen in the results, neurodivergent clients will often protect themselves by either expecting the relationship to break down or by ‘getting there first’.

Neurodivergent clients need a therapist who is stable and consistent and who will not respond to any invitation to reject them. They need to know that, regardless of people seeing them as ‘too much’ historically, this will not be re-enacted in the therapeutic relationship. Therefore, we choose to end this discussion with a quote by Erskine and Trautmann, (1999), who state that: “... we are available, we are consistently focused on the client ... We keep appointments and respond to phone calls. We are able to listen to the client without being upset or overwhelmed. We can be trusted and we can be counted on. If we are forced to do something upsetting to the client, we warn him or her ahead of time. If we make a mistake, we admit it and apologize. We are here, and we are the same person today as we were yesterday and will be tomorrow.” (p.132).

Limitations and Implications for Future Research

The lack of male clients in this research is a limitation. Responses to the advertisement came from female and non-binary participants. This bias may be due to the current climate of neurodivergent females seeking diagnoses (Ciccone, 2022; Lockwood Estrin, Milner, Spain, Happe, & Colvert, 2021)) and the high male to female ratio for childhood diagnosis historically (Milner, McIntosh, Colvert and Happe, 2019). This is seen to be due to females being better at ‘masking’ their neurodivergence, leading to a historical lack of understanding of the presentations in females and lack of childhood diagnoses. This study called for participants who were not diagnosed in childhood. Extending this research, we would explore the experiences of males who are neurodivergent, in addition to the potential differences for participants who were and those who were not diagnosed in childhood.

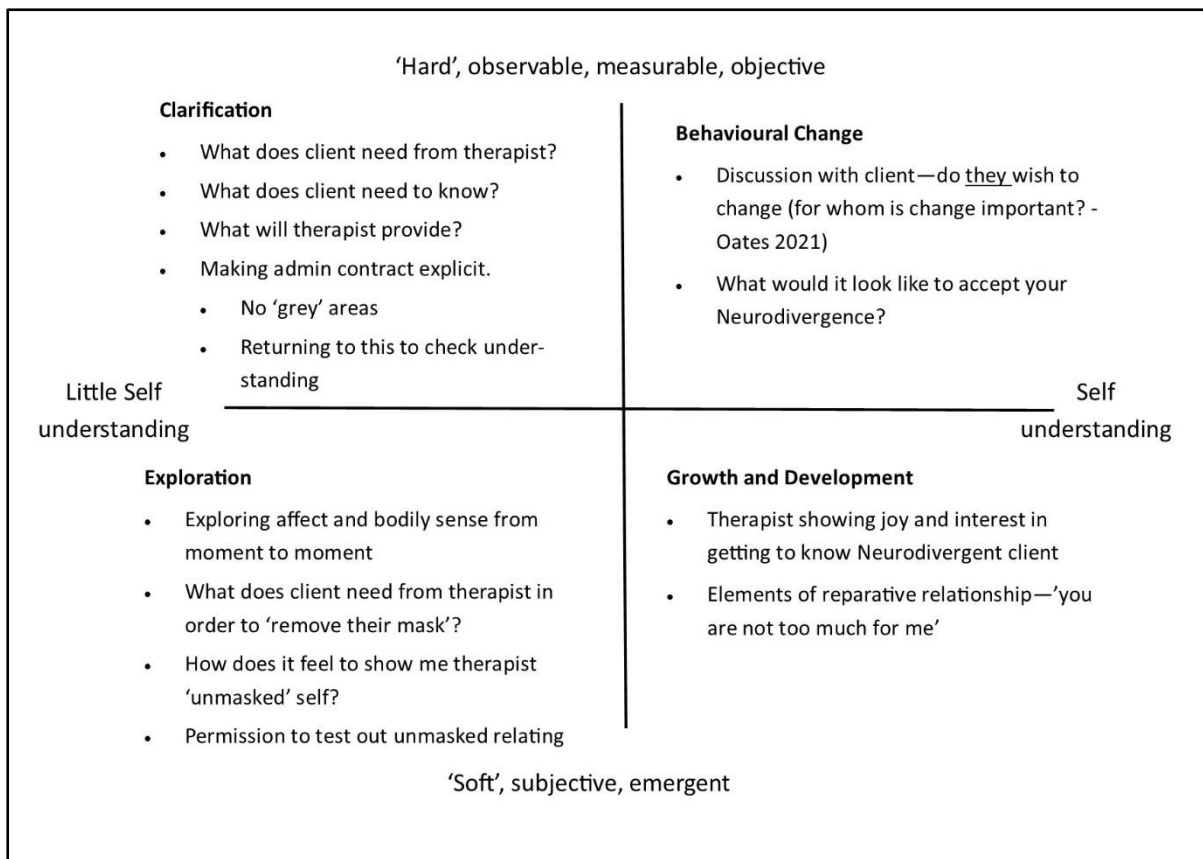


Figure 5: Contracting Matrix for Neurodivergence (Adapted From Sills, 2006 p.17)

To avoid bias due to her own experience as a neurodivergent adult, the first author kept the interview questions as open as possible – holding the overall question in mind but not making assumptions or asking about specific feelings or experiences that may have been familiar to her. When analysing the data, she aimed to think ‘Martian’, remained curious and watched “what happens without preconceived eyes ... [and looked at things with]... the eye of innocence” (Hostie, 1982, p.169). Although the data collection and data analysis process was supervised by the second author and reflexively checked for potential bias, it is important to acknowledge that the second author is also a neurodivergent adult, and therefore may share biased ‘blind spots’ with the first author.

We also note that due to the small sample size, there are limitations regarding the generalisability of the findings, and that the recommendations presented in this article may change in light of future research and of research which draws on wider experiences of neurodivergent clients. It is important also to note that all of the participants were British, and it is possible that the findings may be culturally situated and therefore may not necessarily transfer to other cultural groups.

Although this was a small study with six participants, the only psychotherapy modality considered was TA. It would be interesting in future studies to explore how other modalities may be used when working with clients who are neurodivergent, potentially making use of the same interview questions.

Conclusion

In relation to the aims and objectives of this research, this study has examined a rich amount of data regarding the lived experience of neurodivergent clients and what they need from psychotherapy. It identified four themes and sub-themes regarding these psychotherapeutic needs which were summarised in Table 2. Following the identification of these themes and sub-themes, we have suggested ways in which TA can be used when working with neurodivergent clients.

The data analysis indicated a lack of understanding from the wider psychotherapeutic community regarding what clients who are neurodivergent need. It raised the issue of relational ruptures due to assumptions made about neurodivergence being repeated in the psychotherapeutic relationship. We hope that by reading about the lived experience of neurodivergent people who have undergone TA therapy that we have also addressed the objective of

increasing psychotherapist's understanding of neurodivergence. In line with this, we have also discussed some of the specific challenges neurodivergent clients experience in therapy. We hope that the identification repetition of relational ruptures (as highlighted in this paper) will also support practitioners in further understanding neurodivergence and the importance of adapting therapy to meet the needs of the client. We have presented a range of recommendations for practice which were derived from our data analysis.

In line with our objectives, the findings also raised questions about the appropriateness of solely focusing on change and outcome-based care in working with neurodivergence, and placed more importance on the psychotherapeutic relationship, identifying the need for acceptance, consistency and clarity, flexibility, ongoing open conversations about the therapy, careful pacing and attunement, curiosity, celebration of neurodivergence, trust, and creativity. It also emphasised the importance of not shaming clients for behaviours that have supported them historically to feel psychologically safe and regulated.

Claire Bowers MSc TA (P) is a CTA (Psychotherapy) who is in private practice She has interests in developmental trauma, neurodivergence, and working creatively with clients using skills developed in her previous role as a primary school teacher. She can be contacted on clairebowerstherapy@aol.com or via <https://www.clairebowerspsychotherapy.com/>

Mark Widdowson PhD, Teaching and Supervising Transactional Analyst (Psychotherapy), UKCP Registered Psychotherapist, EMDR Europe Accredited Practitioner, is a senior lecturer in counselling and psychotherapy at the University of Salford and is associate director of The Berne Institute, an associate of several other TA training centres, author of TA books, and maintains a private practice for individuals and couples in central Manchester. He is an active psychotherapy researcher and was awarded the European Association for Transactional Analysis Silver Medal in 2014 and the International Transactional Analysis Association Research Award in 2017 for his contributions to the evidence base for transactional analysis. He can be contacted on therapyexcellence1@gmail.com

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Appendix 1: Interview Questions

1. Can you tell me about your neurodivergence?
 - a. How did it present as a child?
 - b. What does it feel like for you?
 - c. How does it affect your life now?
 - d. How did/do other people relate to you?
2. What did you think/believe about yourself as a child (with ND behaviours in mind)?
 - a. What do you believe about yourself now?
3. What was like for you in school and at home?
 - a. Did you feel different?
 - b. If so, in what way?
 - c. What support (if any) did you get?
 - d. Did you have friends/meaningful relationships?
4. Why did you start having TA Psychotherapy?
 - a. What did you try (if anything) previously to having Psychotherapy?
 - b. Can you remember what you wanted to get out of Psychotherapy?
 - c. Did you try other modalities or therapies prior to having TA?
5. What was Psychotherapy like for you/how did your therapist work with you?
 - a. Have you had any particularly negative experiences with therapy, which you feel are associated with your ND? If so, please can you say a little about these?
 - b. Have you had any particularly positive experiences with therapy associated with your ND? If so, please can you say a little about these.
 - c. With hindsight, did your ND create any specific challenges for you in therapy? If so, can you please say a little about these.
6. Did you have clear, defined goals/outcomes to work towards in Psychotherapy relating to ND?
 - a. Can you remember what they were?
 - b. Did you find this helpful or unhelpful?
 - c. Please tell me a bit more.

Appendix 2: Co-Researcher Informed Consent Form

This form had the name of the project and the name, email and phone number of the co-researcher.

The data I collect from you includes name, address, phone number, email address, date of birth and GP details.

All paper data will be kept in a lockable filing cabinet and will be shredded 3 months after completing the research project. Any digital data held on my phone or computer (also the above-mentioned data types) will be password protected and will be deleted after 3 months.

Subject Access Requests for research data made by research participants will be responded to within one calendar month, irrespective of any national holidays or holidays. There is also no longer a fee attached to a subject access request.

Name:

Preferred Pronouns:

Phone Number:

Date of Birth:

Address:

.....

.....

.....

Email Address:

GP:

	Yes	No
I confirm that I have read and understood the information sheet for the above study.		
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.		
I understand that data collected during this study will be processed in accordance with GDPR as explained in the Participant Information Sheet		
I understand that consent forms will be retained and kept in a locked folder.		
I understand that GDPR legislation I am entitled to access the information I have provided at any time while it is in storage as specified above.		
I consent for my interview to be audio / video recorded. The recording will be transcribed and analysed for the purposes of the research		

I agree to my written interview and/or reflections being modified with changes to any details that may lead to identification of myself or anyone else involved in the research.		
I consent to verbatim quotes being used in publications; I will not be named (and a Pseudonym will be used) but I understand that there is a risk that I could be identified by those who know me/my history.		
I understand that whatever I say in the interview or reflective writing is confidential unless I tell the researcher that I or someone else is in immediate danger of serious harm, or the researcher sees or is told about something that is likely to cause serious harm. If that happens, the researcher will raise this with me during the interview and tell me about what could happen if I continue to talk about it and explore how I would prefer to deal with the situation. The researcher will encourage me to seek support from elsewhere to help me make the situation safer. If the researcher feels unsure that I will go and get support, they will talk to me about what they need to do and what might happen next. In an extreme case where a child (or any other vulnerable person including the interviewee) is at serious risk, and I choose not to seek help/advice the researcher has a duty to disclose this to the relevant agencies.		
I understand that exploring my phenomenological experiences may lead to emotional discomfort. I understand that I will be offered a de-brief session with a Psychotherapist following the research interview, if I choose.		
I understand that I will not benefit directly from participating in this research.		
I understand that should I disclose possible criminal offences that have not been investigated or prosecuted, in the course of the interview, the researcher may report the matter(s) to relevant agencies.		
I understand that disguised extracts from my interview may be used to inform future psychotherapy practice within the Code of Ethics guidance for BACP, UKCP and UKATA.		
I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.		
I understand that the interview and reflective writings are designed for the purposes of the research and I will not receive any personal results relating to my health or well-being, but in the event of the results indicating any concerns about my health or well-being, I agree to this information being passed on to my GP.		

Name of Participant:

Date:

Signature:

Name of Researcher:

Date:

Signature:

Note: When completed, one copy will be given to the co-researcher, one copy to be retained by researcher