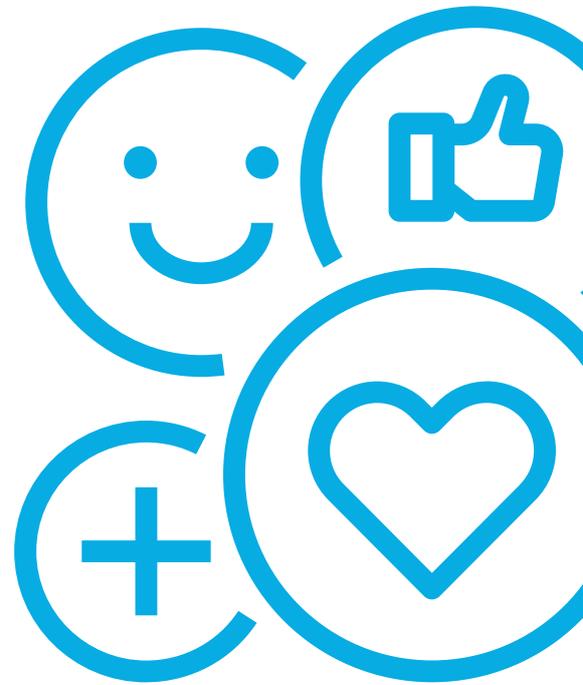


**NEURODIVERSITY-AFFIRMING & TRAUMA-INFORMED THERAPY:****Self-Assessment Checklist for Allied Health Practitioners****1. FOUNDATIONAL KNOWLEDGE AND ATTITUDES****Reflection Questions**

- Do I understand neurodiversity as a natural variation of the human brain, not a deficit?
- Am I familiar with the principles of trauma-informed care (safety, choice, collaboration, trust, empowerment)?
- Do I consistently avoid pathologising language in documentation and sessions (e.g., "deficits," "non-compliant")?
- Do I view stimming, special interests, and communication differences as valid forms of expression?

**Evidence/Lived Experience Insight**

- Neurodiversity is a difference, not a disorder (Singer, 1998; Walker, 2021).
- Trauma can alter nervous system responses; support must be regulation-first (Herman, 2015; SAMHSA, 2014).
- Lived experience reports describe pathologising language as alienating or dehumanising.
- Stimming is often a self-regulatory behaviour, not a behaviour to extinguish.

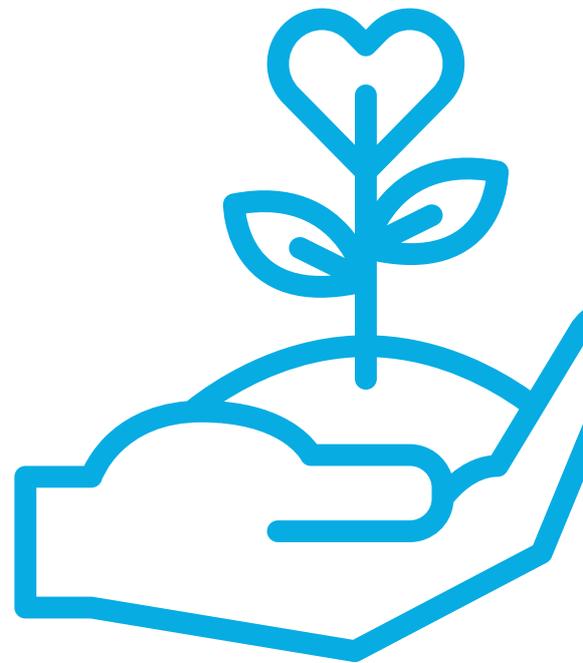


**NEURODIVERSITY-AFFIRMING & TRAUMA-INFORMED THERAPY:****Self-Assessment Checklist for Allied Health Practitioners****2. SELF-AWARENESS AND REFLEXIVITY****Reflection Questions**

- Have I examined how my own neurotype, trauma history, or identity may affect my practice?
- Can I notice when I feel discomfort in the presence of difference, and explore what that says about my biases?
- Do I actively seek supervision or peer consultation to process my emotional responses and countertransference?

**How to Grow with Experience**

- Personal insight can deepen empathy, particularly when we identify shared struggles with clients.
- Biases are normal, but unexamined biases can cause harm. Reflective practice and supervision are essential.
- Regular supervision supports trauma-informed responsiveness and reduces practitioner burnout.



## NEURODIVERSITY-AFFIRMING & TRAUMA-INFORMED THERAPY: Self-Assessment Checklist for Allied Health Practitioners

### 3. PRACTICE BEHAVIOURS AND ENVIRONMENT

#### Practice Component

- I offer clients choice and control throughout sessions (e.g., breaks, modalities, pacing).
- I adapt sensory environments (lighting, sound, seating, etc.) and ask clients about their preferences.
- I co-create goals with the client and/or their family, rather than assuming what is “appropriate.”
- I prioritise regulation and connection over compliance or performance.
- I focus on building trust over time and do not rush rapport.

#### Affirming & Trauma-Informed Application

- Trauma survivors and neurodivergent clients often have a heightened need for agency.
- Environmental safety is a core part of emotional safety (Kapp et al., 2013).
- “Compliance” is not a therapeutic goal; autonomy and self-advocacy are.
- “Regulate first, relate, then reason” (Perry, 2006).
- Many clients have histories of invalidation; safety must precede intervention.



## NEURODIVERSITY-AFFIRMING & TRAUMA-INFORMED THERAPY: Self-Assessment Checklist for Allied Health Practitioners

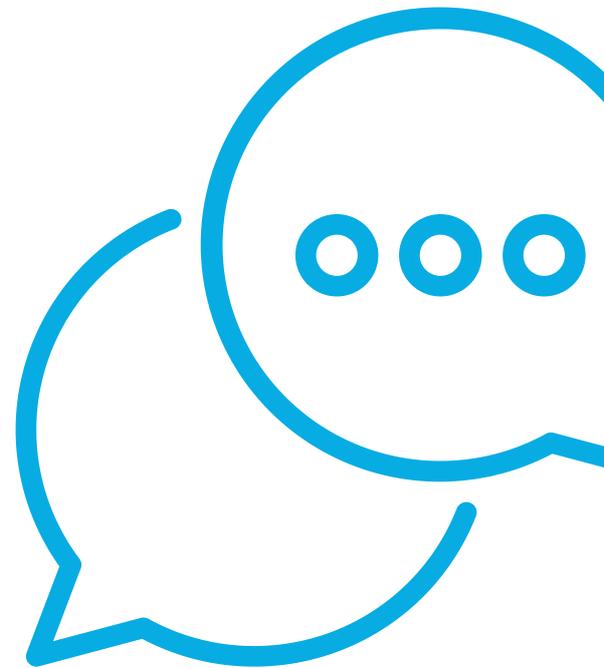
### 4. COMMUNICATION AND INTERACTION STYLES

#### Reflection Questions

- Do I adjust my communication to match the client's preferred style (AAC, visuals, scripting, text)?
- Do I respect a client's right to not make eye contact or engage socially on my terms?
- Am I able to slow down, offer silence, and wait for a response without rushing or filling space?

#### What This Looks Like

- Autonomy in communication style affirms identity and reduces trauma.
- Eye contact is not a reliable indicator of engagement or understanding.
- Processing time varies; pressure can create shutdowns or dysregulation.



## NEURODIVERSITY-AFFIRMING & TRAUMA-INFORMED THERAPY: Self-Assessment Checklist for Allied Health Practitioners

### 5. INTEGRATION OF PERSONAL AND PROFESSIONAL EXPERIENCE

#### Reflection Questions

- Have I reflected on how my own identity (e.g., neurodivergent, disabled, culturally diverse) informs my understanding of safety, inclusion, or belonging?
- Do I intentionally learn from neurodivergent voices (e.g., authors, activists, clients, peers)?
- Am I open to unlearning practices I was taught in training if they conflict with affirming approaches?
- Can I name at least one way I've changed my practice based on something a client or family has shared with me.

#### How to Use Lived & Learned Experience

- Sharing aspects of yourself authentically (with boundaries) can model self-acceptance and trust.
- Lived experience must be at the centre of affirming practice. Start with authors like Dr. Devon Price or Damian Milton.
- Clinical knowledge evolves. Growth comes from flexibility, not rigidity.
- Integrating client feedback is a marker of relational, ethical practice.



## NEURODIVERSITY-AFFIRMING & TRAUMA-INFORMED THERAPY: Self-Assessment Checklist for Allied Health Practitioners

### 6. ONGOING LEARNING AND COMMITMENT

#### Commitment Area

- I engage in regular CPD on trauma, neurodivergence, disability justice, and affirming practice.
- I seek feedback from clients and families on whether they feel seen, safe, and respected.
- I reflect regularly (journaling, peer discussion, supervision) on ethical dilemmas and moments of disconnection.

#### Suggested Action

- Include training from neurodivergent-led organisations and communities.
- Feedback can be anonymous, informal, or structured.
- Practice is relational, not perfect. Reflection = repair.



#### Final Reflection: Bringing Your Whole Self

- Have I considered how my values, vulnerabilities, and growth edges can be tools in the therapeutic space—not liabilities?
- Do I recognise that holding space for others requires me to know how to hold space for myself?
- “I am the tool in the room. My knowledge, my identity, and my story shape the safety I offer others.”