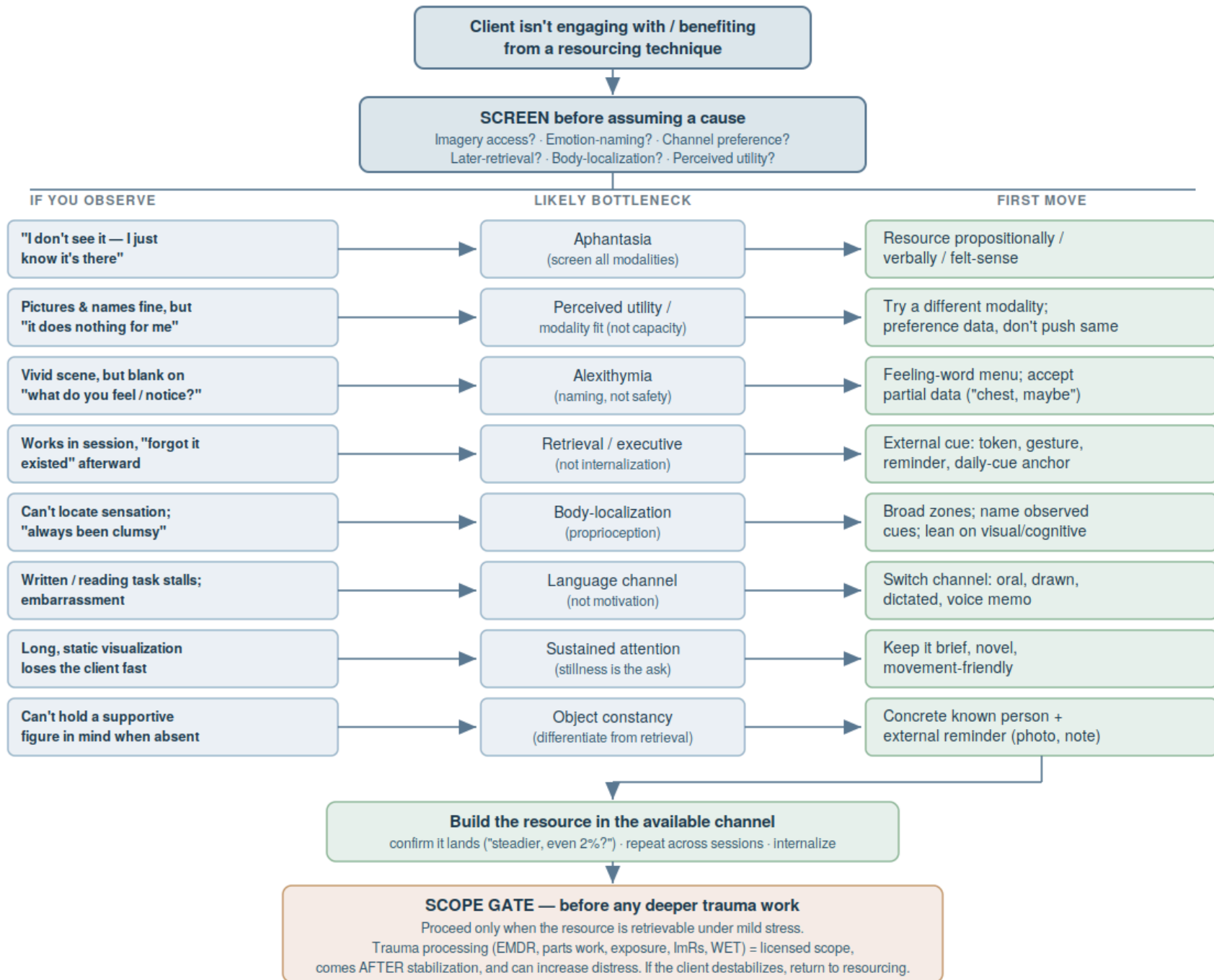


Resourcing Across Neurodivergent Profiles — Decision-Making Reference

*A companion decision aid to the study guide. **Observation-first: route from what you see to what you do.***

How to use this guide: Start from what you observe, not from the diagnosis. Screen the individual, then follow the branch. A diagnostic label narrows the odds but never settles the case — confirm each branch with the person in front of you. This is a decision aid, not a protocol; clinical judgment governs. Techniques flagged as licensed-scope require appropriate training and come after stabilization.



Screen every client individually — don't infer capacity from a label. Rows aren't exclusive: more than one may apply — address the most fundamental bottleneck first.

Observation-First Decision Matrix

The core reference. Match the presentation, read across. “Avoid” lists the common misread — usually treating a channel/mechanism problem as resistance or as the resource failing.

Rows are not mutually exclusive. A client may present with more than one bottleneck at once (e.g. autism with both alexithymia and aphantasia, or ADHD with co-occurring dyslexia). When several apply, work them in sequence — usually starting with the most fundamental (imagery access and naming before retrieval or utility).

If the client...	Likely bottleneck	Do	Avoid
Describes an imagined scene vividly but goes blank / pauses long on “what do you feel or notice in your body?”	Alexithymia (naming, not safety)	Scaffold the naming step: offer a feeling-word menu or sensation checklist; accept partial data (“chest, maybe”) as real	Pushing for more vivid imagery; reading “it didn't do anything” as resistance
Says “I don't actually see anything — I just know what it would look like”	Aphantasia (any client, not only ND)	Resource propositionally / verbally / by felt sense; screen the other modalities (sound, touch) for a usable channel	Treating imagery as required; implying they're doing it wrong
Can visualize fine and can name feelings, but says the exercise “doesn't do anything for me”	Perceived utility / modality fit (not a capacity gap)	Treat it as preference data; try a different modality or resource type; find what this client does find useful	Pushing harder on the same technique; reading low utility as the resource failing or as resistance
Engages well and it helps in session, but “forgot it existed” afterward and never used it	Retrieval / executive (not internalization)	Build an external retrieval bridge: token, phrase-plus-gesture, phone reminder, tie to an existing daily cue	Making the in-session image more vivid; reading forgetting as failure to internalize
Can't say where a sensation sits; guesses, points vaguely, frustrated; mentions being “always clumsy”	Body-localization / proprioception	Simplify to broad zones (“somewhere in your chest”); name what you observe; lean on visual/cognitive/relational resources	Pressing for precise self-location; reading vagueness as dissociation or avoidance
A written or reading-based task stalls; returns incomplete, embarrassed, quieter	Language channel (not motivation)	Switch channel: oral check-in, drawing, voice memo, dictation or scribe	Framing the incomplete task as avoidance or resistance
Loses focus fast during long, static internal visualization	Sustained-attention limit	Keep resourcing brief, novel, movement-friendly; invest in retrieval over vividness	Long static internal-attention exercises as the default
Can generate a supportive figure but can't hold it in mind once it's “gone”	Object constancy / mentalization (may overlap with retrieval or alexithymia — differentiate)	Use a concrete, specific, known person; anchor with an external reminder (photo, saved voice note) between sessions. First move holds whichever underlies it	Generic “imagine a compassionate figure” prompts with no concrete anchor; assuming one mechanism without checking

Per-Profile Decision Cards

When a diagnosis is known, this is the fast view. “Confidence” signals how hard to lean on the profile's core claim.

Profile	Bottleneck	First move	Avoid	Evidence confidence
Autism	Naming internal experience (alexithymia); imagery & mentalization vary	Scaffold emotion-labeling; build concrete, specific, interest-linked scenes	Assuming poor imagery; pushing visualization if another channel works better	High for alexithymia (~50%, meta-analytic); a DBT RCT reduced emotion dysregulation via alexithymia improvement (small sample). Double-empathy & interoception contested
ADHD	Holding & retrieving the resource under stress and over time	External retrieval bridge; brief, novel, movement-friendly resourcing	Conflating mind-wandering with volitional imagery; more-vivid image as the fix	Solid for retrieval/EF framing; “creativity boost” weak in diagnosed clients
Dyslexia	The reading/writing channel — not the emotional mechanism	Oral, drawn, dictated, therapist-guided verbal forms; counter “not trying hard enough”	Reading a stalled written task as resistance	Language basis solid; primary emotional-reactivity component is limited/less-replicated
Dyspraxia	Body-based work: proprioception & precise self-location unreliable	Broad-zone anchors; name observed cues; lean on visual/cognitive resources	Pressing for motor precision; anchors that expose coordination	Proprioceptive difficulty well-evidenced; broader interoception thinly evidenced
Aphantasia (<i>cross-cutting</i>)	No/low voluntary imagery in one or more modalities	Screen directly; route to propositional/non-visual channels; screen all modalities	Inferring it from a label; treating it as a barrier	Prevalence solid; hypophantasia-worse & neural-substrate claims unreplicated / theoretical

Scope Stop-Points — Proceed, Hold, or Refer

Situation	Decision
Grounding, safe-place, breath, felt-sense resourcing / stabilization	In scope for trained therapists; the simpler grounding/safe-place work is generally coaching-appropriate too
Trauma processing: EMDR, IFS/parts work with trauma content, exposure/extinction, imagery rescripting, written exposure therapy	Licensed clinical scope only. Comes AFTER stabilization. Can temporarily increase distress. Not a resourcing technique — don't deploy as one
Resource is not yet retrievable under mild stress	Do not move to deeper trauma work; keep building and repeating the resource first
Client destabilizes, dissociates, or floods during deeper work	Stop deepening; return to resourcing/grounding; re-establish the window of tolerance before proceeding
Presentation is a sensitive channel-specific bind (e.g. WET for a dyslexic client)	Re-choose the channel (dictation/oral/spoken) so the intervention doesn't reintroduce the client's area of difficulty

Confidence Tiers — How Hard to Lean

Lean on it (well-evidenced)	Hold loosely (single-study, contested, or theoretical)
<ul style="list-style-type: none"> • Alexithymia elevated in autism (~50%, meta-analytic) • Mind-wandering ≠ volitional imagination (ADHD) • Imagery rescripting & WET efficacy (RCT / meta-analytic) • Proprioceptive difficulty in dyspraxia • Aphantasia prevalence & its multimodal forms 	<ul style="list-style-type: none"> • Double-empathy framing — actively contested (2026 studies) • Hypophantasia worse than aphantasia — single cross-sectional study • Insula/ACC shared substrate — theoretical proposal, untested pathway • Dyslexia primary emotional-reactivity — limited, less-replicated • Propositional extinction — one research group, not independently replicated • ADHD interoception differences — emerging and mixed

Rule of thumb:

- 1. build clinical decisions on the left column***
- 2. treat the right column as hypotheses that may inform, but shouldn't anchor, what you do.***