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Theory of *Neuroemergent Mindset*: New Paradigms of Understanding

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Commentary

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Commentary

Recently, extant research has exemplified the value of multiple intelligences and the term neurodivergence has given it credence. Neurodivergence originated from neurodiversity coined by Judy Singer, who is autistic, in 1997. Neurodivergence, a non-medical term, is used to describe ADHD, autism, and dyspraxia. Also, any classified disorder can fall under the umbrella of neurodiversity, including anxiety, depression, PTSD, developmental impairment, physical limitations through injury, illness and or disease. Although not a classified disorder, the increased understanding of a highly sensitive person (HSP) coined by the psychologist Elaine Aron EN [1] will also encompass neurodivergence. For the purposes of this discussion, emphasis on ADHD with resulting symptoms of anxiety, depression and trauma are exemplified. Neurodivergence has been gaining wide acceptance as differing personality types specifically, introverted personalities are revered versus treating it as an abnormality. Perhaps, this shift in thinking can be credited to generation z which, in addition to living through COVID-19, has spent significant periods of their childhoods in isolated environments. If we are looking at a majority of our youth this lends the question:

> *Is neurodivergence in fact a new paradigm that describes the majority with emphasis on "emergent" as we begin to understand and destigmatize multiple intelligences?*

I offer the term *Neuroemergence t*o the scientific community from a strength-based perspective when describing neurodiversity. The latest version of the DSM-5 has sought to expand the classifications of trauma, forming a new category of "trauma and stressor related disorders". Recently, iterations, such as, "Trauma unspecified" have added to the conceptualization of trauma which lends a broader view of the symptomatology of anxiety, depression, and post-traumatic stress, including complex PTSD with trauma originating from childhood although not a distinct disorder in the Diagnostic Statistical Manual of Disorders, DSM-5. Note, distinctiveness should be discerned from psychological distress and impairments that have had great advances utilizing the medical model for alleviation of symptoms due to severe psychological distress or psychosis. The trauma classifications may aid in the alleviation and stigmatization of mental health disorders as clients build awareness to the origin of their traumatic memories. Although, the unspecified aspect of the disorder has provided advancements, much is to be gained and warrants further investigation, including how historical trauma, early childhood development and attachment disorder interplay with the complexities of trauma. Due to the fact that many *neuroemergents* may have spent a majority of their childhoods in a nuerotypical school system, are they in fact reacting to that stigmatization when suffering from the ill effects of ADHD? Aron EN [1] describes in her book HSPs that are a minority of people however, a majority of clients as adults.

According to Gardner H [2], multiple intelligence and traits that cause divergence also result in supportive strengths. For example, the ability to become hyper focused on a project in the case of an ADHD adult may lead to enhanced creativity and insights. Inattentiveness or daydreaming can lead to creative discoveries although, in school settings, it is also being misrepresented as "maladaptive daydreaming" leading to resulting anxiety or depression for daring to dream or escaping from unpleasant

realities. ADHD correlational research has been remiss in identifying one single variable causing the disorder. This misdiagnosis is widely utilized to treat hyperactivity and inattentiveness both medically and behaviorally. ADHD has been ingrained in our collective mindset as a disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Kazda L, et al. [3], in a systematic review of 334 published studies, found that over diagnosis of ADHD, with children and adolescents having milder symptoms are harmful. Viewing ADHD, for example, sensitivity to light, loud noises, and overstimulation would be considered diverging from the norm. If neurodivergence is where a path diverges, how do we classify a neurotypical?

> *Should we describe these atypical individuals as remiss to sensitivity of artificial bright lights or seemingly unbothered by loud thundering noises outside the classroom?*
>
> *Conversely, is their lack of attention something to consider an abnormality?*

As a trauma informed clinical mental health practitioner and professor utilizing an experiential approach with my students, I have come to appreciate the associated trauma and symptoms of anxiety and or depression growing up in a neurotypical environment. Psychologists predict 40-50% of adults will be classified with a mental disorder throughout their lifetime [4]. ADHD is often managed through medication and or behavioral cognitive therapies. Specifically, the public school systems adhere to standardized testing with teaching styles accommodating primarily audio learning through lectures and emphasis on core curriculum, including: mathematics, science, English, history and deemphasizing the arts, music, and physical education. This has been a norm set for a neurotypical environment in the United States. There has also been relief associated with the awareness in adulthood of describing the existence of neurodivergence to normalize conditions such as ADHD.

Before assigning the classification of a diagnosable disorder associated with hyperactivity or inattentiveness let us fully consider a fully capable *neuroemergent* mindset. For most of our human history, it was important to adapt and scan our environments for danger, allowing for sensitivities to emerge and develop throughout our human evolution. Also, our ability to secure food, shelter and safety took a tremendous amount of energy to survive. In our relatively brief human history, shifting towards industrialization and, now the advanced information age, with increased sitting and screen time, has become valued over movement in order to adapt to our world. Furthermore, our schools have added to our perception of a disordered or divergent behavior, such as ADHD, related to behavioral problems in boys and inability to sit for long periods of time. The environmental origins of ADHD also have a relationship to environmental factors and adverse childhood experiences [5]. Their neurodivergence may have been utilized to navigate traumatic childhoods and to eventually end up with a disorder associated with the traumatization of divergence in an atypical environment. Rather, we also ascribe the abnormalities as normal reactions to abnormal circumstances.

With the recent classification of Trauma-unspecified, practitioners should be able to better understand and treat their clients when adjustment disorders did not fully describe the client narrative or warrant a specific disorder yet, distressing to the client. Given correlation to health outcomes and adverse childhood experiences, the importance of addressing other ways of viewing and learning about the world's mental health concerns has become normalized in the prevalent culture. The idea that a disorder originates from our traumas has also been given more traction in extant literature with the validation from scientific studies of a mind-body connection. Therefore, when a client presents with ADHD and resulting anxiety and depression, instead of adding to stigmatization, a trauma explanation as to why the individual is seeking help screening can include how their *neuroemergence* was accommodated. Our challenge then becomes transforming **s**trength-based perspectives into therapeutic modalities and redefining our educational systems to meet the needs of a *neuroemergent* mind. Before we seek to assign disorders, it is crucial to look deeper into the origins of the issue as well as positive childhood experiences such as, having a meaningful relationship with an adult, family friend, coach, teacher, etc. Rather than oversimplifying the resulting symptomology or creating obstacles that further stigmatize the *neuroemergent* mind from capitalizing its strengths.

Somatic understanding that reduces the trauma response such as, diaphragmatic breathing, autogenic training, visualization, mindfulness and experiential therapies including, art, and movement should be prescribed before seeking a diagnosis of ADHD. The umbrella accompanying the *neuroemergent* mind needs to be included in the diagnosis. Schools that are aligned with outdoor education and meaningful kinaesthetic experiences can be prescribed as an antidote versus medicating and stigmatizing children who produce "disordered" thinking in adulthood [6]. The antidote will be capitalizing on their "superpowers." As our seemingly unsolvable problems increase the *neuroemergent* mindset can become hardwired to seek creative solutions and address these challenges with ease.

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