Beyond the Mask:

Working with Late-Diagnosed Neurodivergent Women Therapy

Presented by Melissa Weisel, MSW, LCSW, MSM PH-PP
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Important Info

I have no conflicts of interest to report.

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Agenda

Welcome & Community Agreements

The Landscape: Who Gets Missed & Why

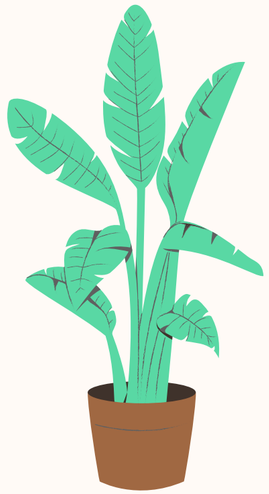
Masking, Identity & The Cost of Late Diagnosis

Break- 10 mins

Affirming Assessment & Ethical Practice

Interventions

Synthesis & Closing Reflection



COMMUNITY AGREEMENTS

This space is yours. Here's how we'll hold it together.

Honor multiple ways of being present

Cameras on or off. Move, stim, doodle, step away. Your nervous system knows what it needs.

Protect each other's stories

What is shared here stays here. This topic may land personally. We hold that with care.

Embrace not knowing

Curiosity and humility are more useful than certainty. There are no wrong answers — only thinking in progress.

Use affirming language

We speak about ND people as whole human beings. We try, stumble, and correct ourselves. That is the practice.

Take up appropriate space

Participate how it works for you — chat, speaking, Mentimeter. Silence is also valid. You won't be cold-called.

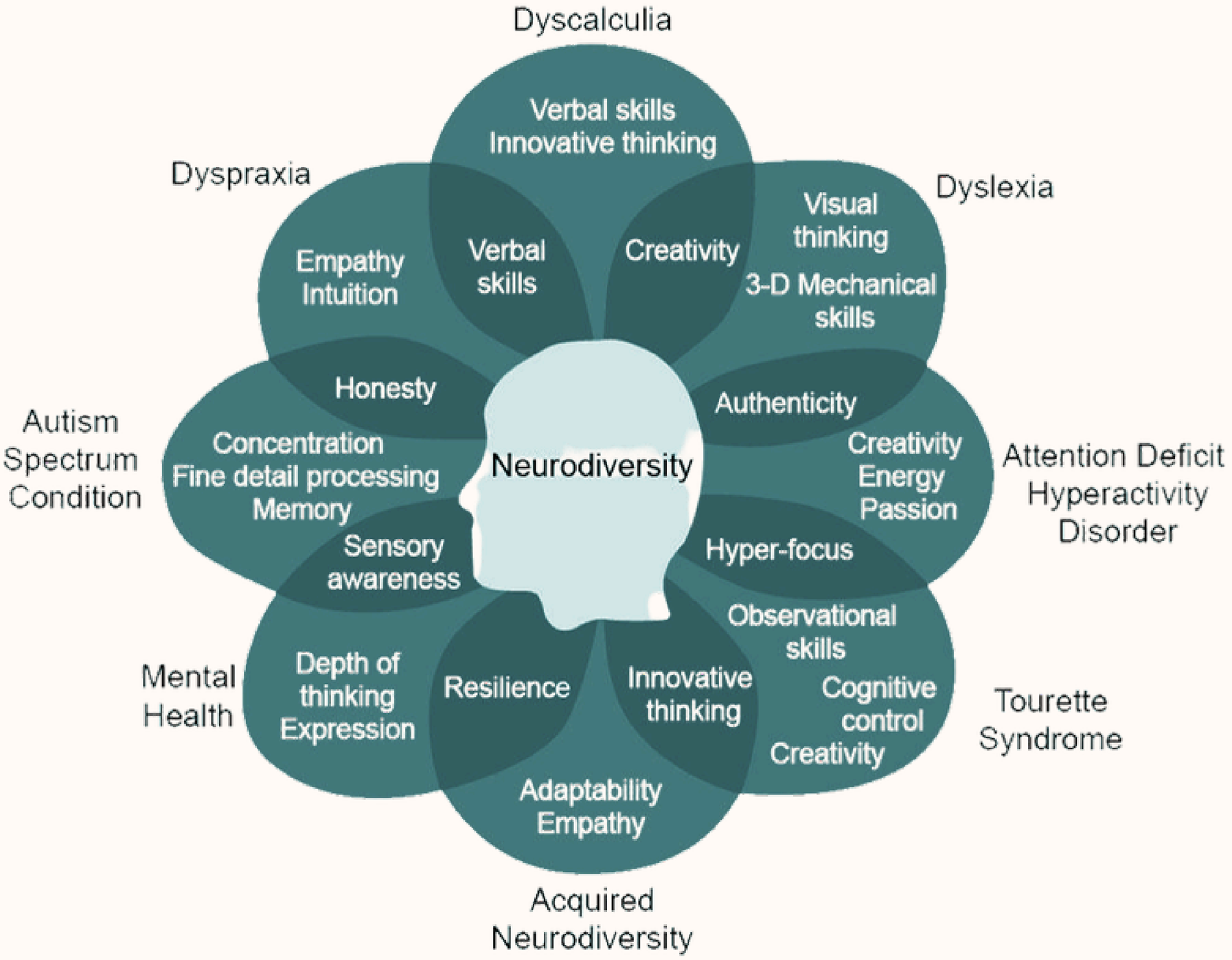
Rest without guilt

A break is built in. Take it fully. Rest is not a reward for productivity — it is a right.

Notice what this stirs

This may connect to your own life or people you love. You're allowed to feel that. You're not required to share it.

By being here, you're already practicing. Thank you for showing up.


Dyscalculia
Verbal skills
Innovative thinking
Dyspraxia
Empathy
Intuition
Verbal
skills
Creativity
Dyslexia
Visual
thinking
3-D Mechanical
skills
Honesty
Authenticity
Autism
Spectrum
Condition
Concentration
Fine detail processing
Memory
Neurodiversity
Creativity
Energy
Passion
Attention Deficit
Hyperactivity
Disorder
Sensory
awareness
Hyper-focus
Observational
skills
Mental
Health
Depth of
thinking
Expression
Resilience
Innovative
thinking
Cognitive
control
Creativity
Tourette
Syndrome
Adaptability
Empathy
Acquired
Neurodiversity

Defining Neurodivergence

The Neurodiversity Paradigm

- Neurodiversity: The natural variation in human brain wiring and functioning
- Neurodivergent: Having a brain that functions differently from the dominant societal norm
- Neurotypical: Having a brain that functions within the dominant norm

The paradigm positions neurological differences (autism, ADHD, dyslexia, etc.) as part of normal human variation rather than deficits to be cured

So What is AuDHD?

Co-occurring Autism and ADHD

50-70% of autistic individuals also meet criteria for ADHD

DSM-5 (2013) first allowed dual diagnosis; previously treated as mutually exclusive

Today's Focus

Autism and ADHD in women and AFAB individuals—the conditions most frequently missed, misdiagnosed, or late-diagnosed in this population due to androcentric diagnostic criteria and gender-based socialization patterns.

Diagnostic Ratios

Historic autism diagnosis ratio:
4:1 male-to-female (current research suggests closer to 3:1 or 2:1)

ADHD diagnosis ratio: 2:1 male-to-female (women more likely to have inattentive presentation)

Average age of autism diagnosis for women:
27+ years (vs. childhood for most males)

Why The Diagnostic Disparity?

Androcentric Diagnostic Criteria

Research conducted primarily on white male children, with criteria developed based on male presentations

Externalized behaviors prioritized over internalized experiences

"Unusual" special interests valued over socially-acceptable ones

Social difficulties measured against male-typical expectations

Gender Socialization Factors

Girls/AFAB receive more intensive social coaching earlier

"Good girl" behavior masks underlying struggles

Internalized distress is less disruptive to others → less noticed

Teachers and clinicians may have gender-biased expectations

The "Female Autism Phenotype"

Social Camouflaging

Socially-Acceptable Interests

One Close Friend Pattern

Internalized Overwhelm

Relational Focus

Sensory Sensitivities

"In comparison with males with ASD, females may have better reciprocal conversation, and be more likely to share interests, to integrate verbal and non-verbal behavior, and to modify their behavior by situation, despite having similar social understanding difficulties as males."
- Grunya Sukhareva

Common Symptoms

Inattentive Presentation
(More common in women)

Difficulty sustaining attention

"Spacey" or daydreamy quality

Easily overwhelmed by demands

Difficulty with task initiation

Forgetfulness, losing things

Time blindness

Common Misattributions

"Just anxious"

"Lazy" or "unmotivated"

Depression

Personality disorder traits

"Not trying hard enough"

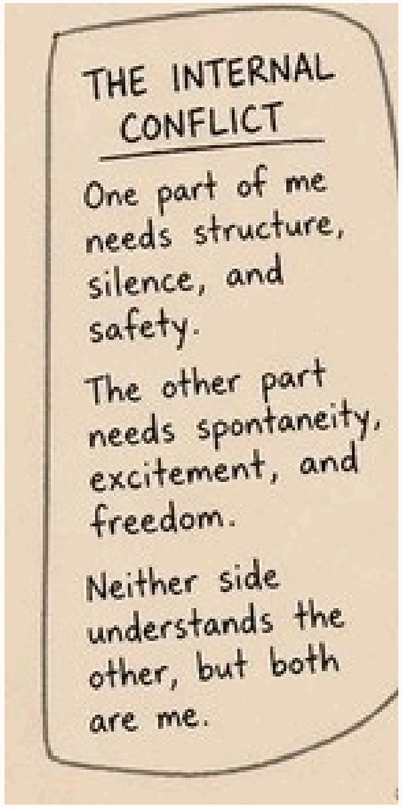
Hormonal issues*

Understanding AuDHD

(Co-occurrence)

Autism Pulls Toward	ADHD Pulls Toward	AuDHD Experience
Need for sameness	Novelty-seeking	Craving routine but bored by it
Deep focus interests	Interest-based attention	Hyperfocus then abandon
Pattern recognition	Time blindness	Traits may mask each other

Understanding AuDHD (Co-occurrence)



AuDHD

reality is too loud and not loud enough

Autism

- crave routine
- need predictability
- overwhelmed by sensory input
- deeply focused interests
- social rules are confusing
- need time alone to recharge
- literal thinker
- analyze everything
- masking to survive

ADHD

- crave novelty
- need stimulation
- easily bored
- overwhelmed by too little input
- passionate about many things
- impulse control struggles
- constant need for movement
- think in abstract
- act before thinking

too much noise
too many thoughts
can't focus
be productive
What's the point anyway
I need silence
I need excitement
don't forget
don't
too bright
not enough time
I want order and peace
I want freedom and fun
I'M NOT LAZY. I'M EXHAUSTED FROM SIMULTANEOUSLY NEEDING OPPOSITE THINGS.
CAFFEINE & COPING
too much in my head not enough outcomes
MAYBE TOMORROW
PLANS
IDEAS EVERYWHERE
It's not one or the other. It's both. All at once. All the time. And it's exhausting.

THE INTERNAL CONFLICT
One part of me needs structure, silence, and safety.
The other part needs spontaneity, excitement, and freedom.
Neither side understands the other, but both are me.

What it looks like

- cancelling plans last minute from overload or burnout
- starting 10 things, finishing none
- overthinking everything... then doing something impulsive
- needing alone time, but hating being lonely
- intense empathy, social confusion
- chronic exhaustion

THE COST OF LATE DIAGNOSIS

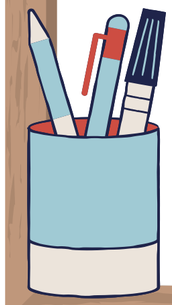
Masking (or Camouflaging) — The conscious or unconscious suppression of natural neurodivergent traits and behaviors in order to appear neurotypical, meet social expectations, or avoid negative consequences.

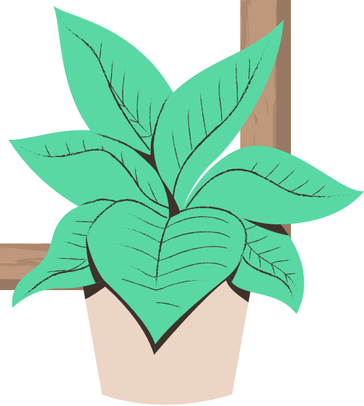
Components of Masking

Compensation: Developing workarounds and strategies to hide difficulties

Assimilation: Copying others' social behaviors, expressions, and mannerisms

Suppression: Hiding natural responses like stimming or emotional reactions

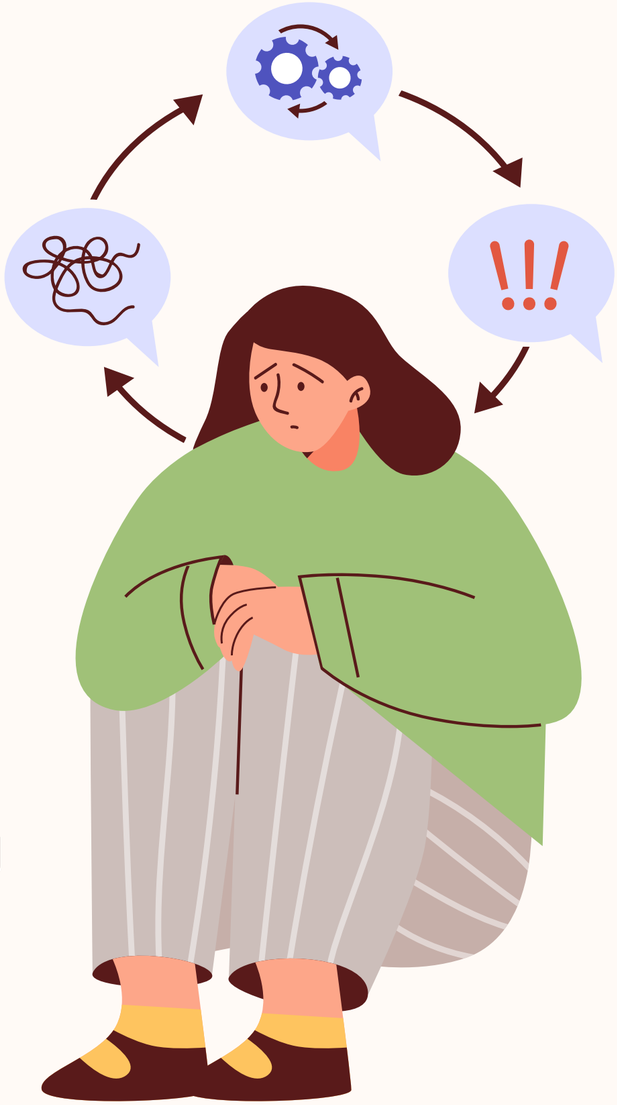




Trauma of Being Missed

Trauma of Missed ND in Women:
Neurodivergent women often train themselves to hide traits to fit in, leading to a loss of identity, extreme fatigue, and severe anxiety.

Internalized Ableism & Shame:
Without knowing they are neurodivergent, many blame themselves for their struggles, viewing their challenges as personal failures rather than structural differences.



Medical/Professional Gaslighting:
Women often experience being dismissed or misdiagnosed by professionals, resulting in traumatic medical interactions and a lack of proper support.

Relational and Social Vulnerability:
Difficulty navigating neurotypical social cues and a need to conform can make women more vulnerable to manipulation, abuse, and coercive relationships.

Trauma of Being Missed

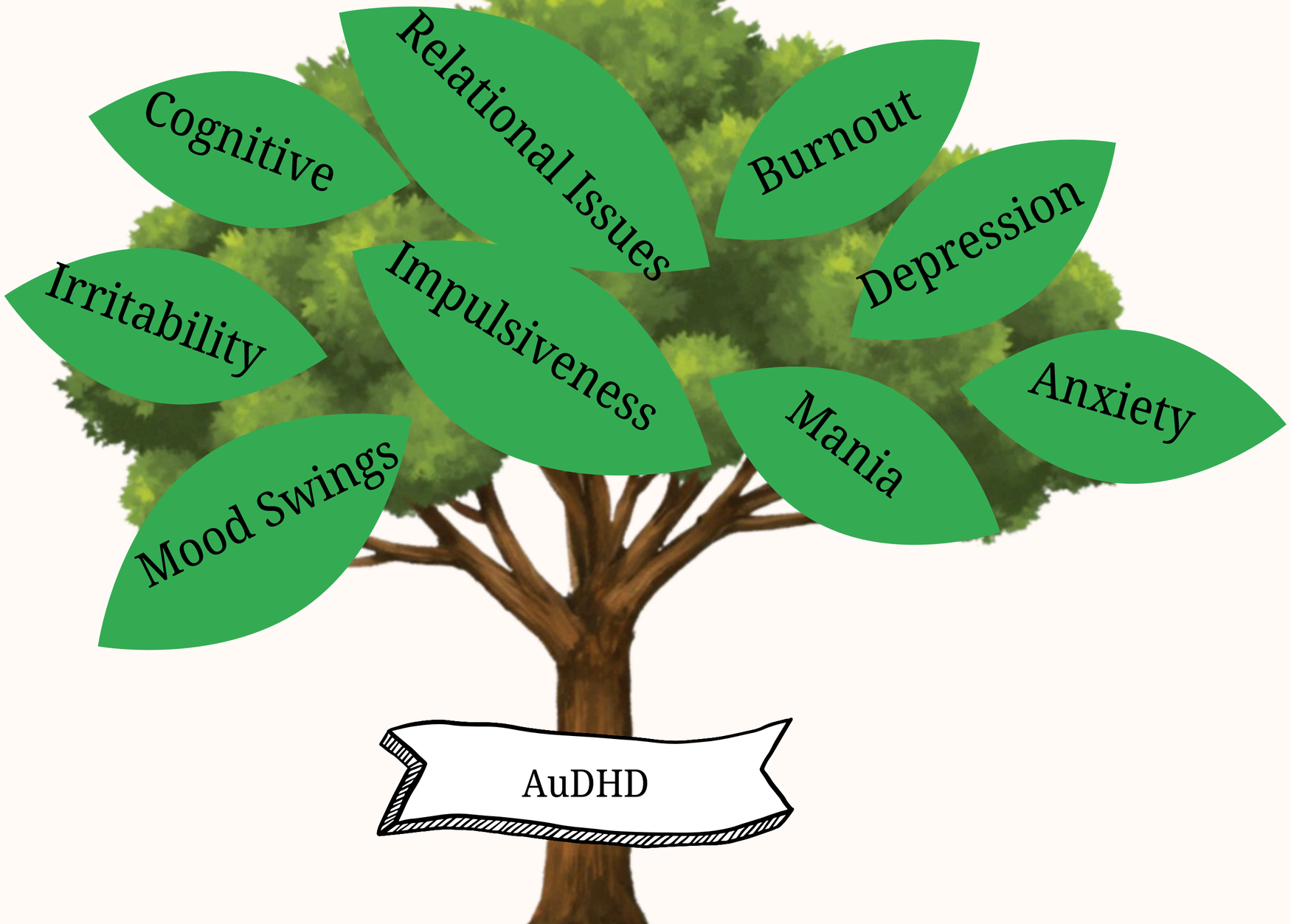
Sensory and Emotional Overwhelm:
Living in a world not designed for them, and trying to act neurotypical, leads to chronic sensory overload and emotional dysregulation.

Epistemic Injustice: Being denied the understanding of their own mind.

Systemic Misdiagnosis: Frequently misdiagnosed with borderline personality disorder (BPD) or bipolar disorder, instead of ADHD or autism.

Relief and Grief: A late diagnosis can bring immense relief (validation) but also profound grief for the "lost" years.

Misdiagnosis Metaphor



StoryTime

Late Diagnosis & Identity Formation

PRE-DISCOVERY → DISCOVERY → INTEGRATION → ACCEPTANCE

Grief Work

Identity Reconstruction

Mental Health & Neurodivergence

The Statistics

70% of autistic adults have experienced depression
50% of autistic women have anxiety disorders
4x higher eating disorder rates in autistic women
Elevated rates of PTSD, OCD, and substance use

Treating the "comorbidity" without addressing the underlying neurodivergent experience often leads to treatment resistance.

The Therapeutic Relationship as Clinical Strategy

What does an affirming space actually look and feel like?

- Predictability and structure
- Direct communication over inference and implication
- Normalizing stimming, eye contact variations
- Not pathologizing the communication style itself
- Explaining your reasoning or telling the client when you want to be more direct about something

AFFIRMING ASSESSMENT

(De-Colonizing Diagnosis)

Medical Model	Neurodiversity-Affirming Model
Defines neurodivergence as disorder/deficit	Sees neurodivergence as natural variation
Focuses on symptoms to be treated	Focuses on support needs and strengths
Measures against neurotypical "norm"	Questions what "normal" serves
Expert-centered (clinician knows best)	Client-centered (lived experience is expertise)
Diagnosis = access to treatment	Diagnosis = access to understanding & support

Affirming Assessment Practices

Ask About Childhood Differences
Explore Masking History
Understand Current Accommodations
Assess for Autistic Burnout
Consider Intersectionality
Trust Lived Experience

Important Caveats: Most tools were developed on male populations. High-masking individuals may score below thresholds despite significant support needs. Use tools as conversation starters, not gatekeepers. Ask about menstrual cycle and symptom fluctuation (ADHD).

NAVIGATING THE DIAGNOSIS QUESTION

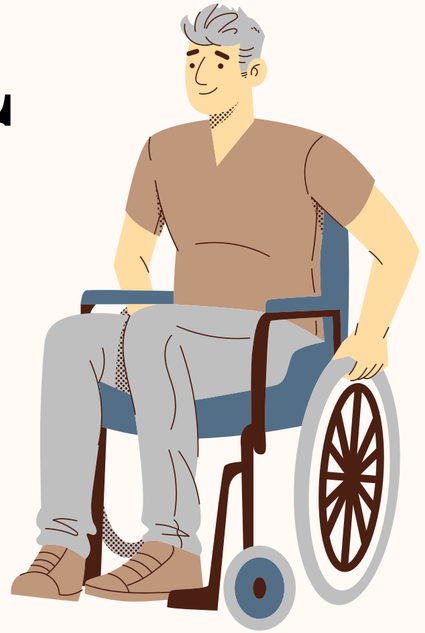
Barriers to Formal Diagnosis

- Cost: $2,000-5,000+ out of pocket
- Long waitlists: 1-2+ years in many areas
- Clinician bias and lack of training in female presentations
- Potential discrimination risks (custody, employment, insurance)
- Fear of invalidation or dismissal

Validity of Self-Identification

- Research supports accuracy of self-diagnosis in autism
- Lived experience is valid expertise
- Community recognition and belonging
- May be political act of decolonization
- Doesn't require "permission" to access identity

Cultural and Ethical Considerations



Who gets seen, who gets missed,
and what we owe the people we serve?

INTERSECTIONALITY

- Race, class & culture shape who receives diagnosis and who is dismissed
- Black & Brown women face compounded barriers: racial bias + gender bias in assessment
- Poverty limits access to evaluation; insurance rarely covers adult ND assessment
- Immigration status, language, and cultural norms affect how traits are interpreted

NASW CODE OF ETHICS

- Competence (1.04): Know the limits of your training; consult or refer
- Non-maleficence: Misdiagnosis and missed diagnosis cause real harm
- Social Justice (6.04): Challenge systems that produce diagnostic inequity
- Dignity & Worth: Every client deserves accurate understanding of themselves

Cultural and Ethical Considerations

Who gets seen, who gets missed,
and what we owe the people we serve?

CLIENT RIGHTS & SELF-DETERMINATION

- Clients have the right to an accurate clinical picture — not just a convenient one
- Honor self-identification; lived experience is valid diagnostic data
- Diagnosis is a tool for access and understanding, not a label imposed by clinicians
- Clients decide what to do with their diagnosis — including nothing

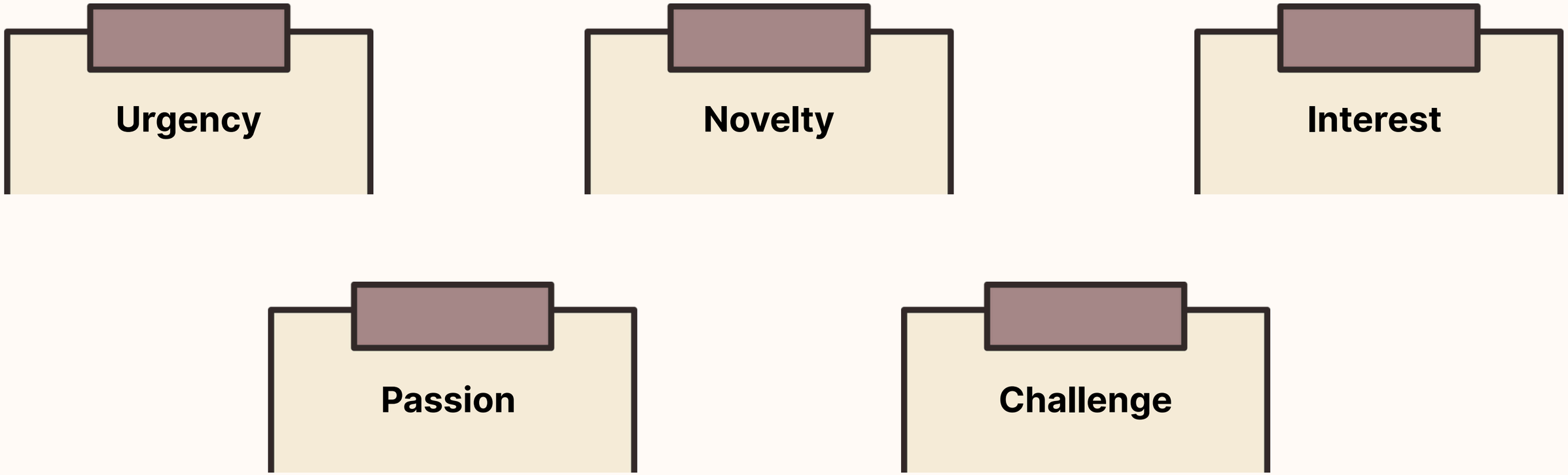
CULTURALLY HUMBLE ASSESSMENT

- Ask, don't assume: explore what traits mean within the client's cultural context
- Use tools as conversation starters, not gatekeepers
- Recognize that 'masking' looks different across cultural contexts
- Ongoing self-reflection: what biases do you bring to this assessment?

Interventions

The 5 Motivating Factors for ND Brains

ND clients often struggle with tasks that neurotypical motivation systems handle automatically. Activation happens when one or more of these is present:



Interventions

Rethinking "Homework" and Goal Setting

The goal is completion, not perfection — obstacles are data, not failure.
Break goals down until they are almost too small to fail.
Ask the client: Is this small enough? Do you want to make it smaller?
Prime clients to expect overwhelm — normalize it as part of the change process rather than evidence they can't do it.

Executive Function — Practical Interventions

Habit stacking: attaching new behaviors to existing ones rather than building from scratch. Timer use: not just for time management but as a mindfulness and self-check-in tool. The 5 motivating factors for ND brains. Gamifying tasks and chores. Music and sensory motivators as legitimate regulation tools.

Interventions

Expanding What Mindfulness Means

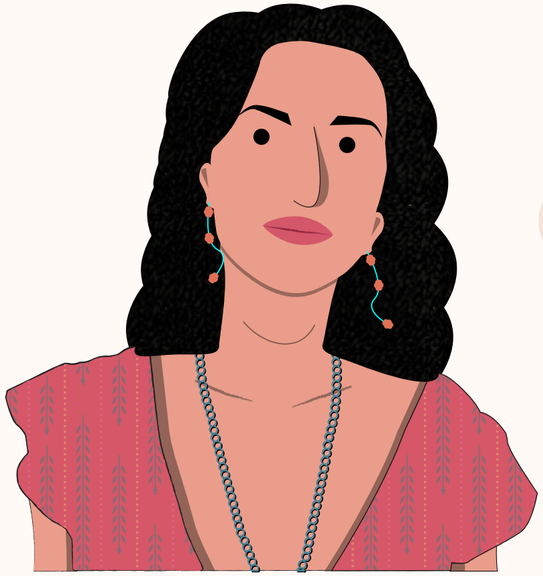
Mindfulness is not stillness. For ND clients it might be a walk, putting the phone down, pausing during a meal to notice sensation. Meet the nervous system where it is rather than where the DBT manual says it should be.

The Invisible Struggles — Naming What Others Don't

Hygiene and self-care as executive function challenges, not laziness or depression symptoms. Time transitions and task switching. Procrastination and avoidance reframed through an ND lens. Positive reinforcement for maintenance, not just change.

Let's Practice Ethics Together

VIGNETTE 1: Claudia



VIGNETTE 2: JORDAN

VIGNETTE 3: DIANE

KEY TAKEAWAYS

ND women are missed because the system was not built to see them

Masking is survival, not deception.
The cost accumulates over a lifetime.

Late diagnosis is not just a clinical event;
it is an identity event requiring grief work and reconstruction.

Affirming practice is an ethical obligation, not an optional approach.

Intersectionality determines who gets seen.
Race, class, and culture are never separate from diagnosis.

YOUR CALL TO ACTION

1. Ask one more question before you accept the referral diagnosis
2. Learn to recognize masking — in your clients and in yourself
3. Build ND-affirming language into your intake and assessment process
4. Seek supervision or consultation when you suspect a missed diagnosis
5. Advocate for clients' right to accurate understanding — even when systems resist

Thank you for Being Here!