BODY BELONGING CLINIC

CLINICAL FRAMEWORK · WHITE PAPER

The Body Belonging Model

ADHD regulation from the inside out

An integrative, neurodivergent-affirming and eating-disorder-safe framework for adult ADHD care — organised around interoception, safety and belonging.

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Body Belonging Clinic, Nedlands WA · Version 1.0 · July 2026 · **Working paper — for professional discussion**

Summary

Australian ADHD care is bottlenecked at diagnosis and medication, and its psychosocial tier — the support that builds skills, self-understanding and environment — is under-delivered, despite being recommended by national guidelines. The **Body Belonging Model** is a practice framework for the psychosocial care of adults with ADHD that treats attention, emotion and eating not as three separate problems but as outputs of a single system: the body's capacity to sense and regulate its own internal state (**interoception**). The model proposes a four-movement clinical pathway — **Safety → Notice → Regulate → Belong** — that is neurodivergent-affirming by design, eating-disorder-safe by architecture, and culturally grounded. This paper sets out the model, its mechanism, its evidence base with honest strength ratings, and its limitations. It is offered as a clinically useful, mechanism-informed scaffold — not as a proven cause of ADHD or a stand-alone treatment.

1 The problem this model answers

Diagnoses of ADHD in Australia have risen sharply, with medication use roughly doubling in five years and adult and female presentations driving much of the growth.[1] Yet access to assessment is gated by cost and year-long waits,[2] and ADHD sits outside the National Disability Insurance Scheme, making support overwhelmingly self-funded. Australia's first national clinical guideline recommends *multimodal* care — medication alongside a substantial psychosocial tier of skills, coaching, lifestyle and family support[3] — but that tier is structurally under-delivered, because the workforce delivering diagnosis and prescribing has neither the time nor the funding model to provide it.

The result is a large population who have a diagnosis and, often, a prescription — and still feel that the hardest parts were never addressed: the emotions that arrive fast and loud, the shame accumulated over years, and, for a substantial minority, a fraught relationship with food. The largest long-term trial of ADHD treatment found that the early advantage of medication alone narrowed over time;[4] medication reliably treats symptoms, but it does not teach skills, repair self-worth, or change the environment a person lives in. The Body Belonging Model is a framework for that missing tier.

2 The thesis

> ADHD is a difference in self-regulation, and self-regulation runs through the body. A brain cannot regulate its attention, its emotions or its eating from a nervous system that does not feel safe, and it cannot learn while it is drowning in shame. So rather than overriding the ADHD brain with control, we build regulation from the inside out — through safety, body-awareness and belonging — until managing attention, emotion and eating becomes possible.

Emotional dysregulation is now widely understood to be a core feature of ADHD rather than an incidental one,[5] and self-regulation — of attention, emotion, motivation and action — is the more accurate organising construct than "attention deficit." The Body Belonging Model takes the further step of locating that self-regulation in the body, and names the mechanism that connects its parts.

3 The mechanism: interoception

Interoception is the perception and neural representation of the body's internal physiological state — cardiac, respiratory, gastrointestinal, thermal, and hunger/satiety signals — integrated in the insular cortex and central to the construction of feeling.[6,7] Contemporary work distinguishes interoceptive *accuracy* (objective performance), *sensibility* (self-reported attention to bodily signals) and *awareness* (the correspondence between the two); these dimensions dissociate, so interoception must be treated as multi-dimensional rather than a single trait.[8]

Interoception matters here because it is the thread connecting the three domains the clinic treats:

Emotion. The link between interoception and emotional experience and regulation is well established; bodily signals shape the intensity and labelling of feeling.[7,9] **(Strong.)**

Eating. Disturbed interoceptive awareness — of hunger, fullness and bodily state — is one of the most robustly replicated features of eating disorders, on self-report and neural measures.[10,11] **(Strong on self-report; mixed on objective accuracy.)**

ADHD. A young but converging literature suggests interoception tends to be *diminished* in ADHD, consistent with its emotional-regulation and impulsivity features.[12,13] **(Emerging — held lightly.)**

Interoception is a recognised *transdiagnostic* mechanism cutting across anxiety, depression, addiction and eating disorders,[14] with a shared neural substrate in the insula. That is precisely enough to justify an integrative, body-aware model — provided we do not overstate it. Interoception is a *lens and a candidate target*, not a proven single cause of ADHD and not a cure. The ADHD evidence in particular is early and correlational.

4 The model: one body, four dials — four movements

One body, four dials

Everything the clinic treats is a way the body regulates, read through interoception: **attention** (an interest-based nervous system), **emotion** (fast, loud feeling), **appetite** (hunger and fullness; eating rhythm), and **arousal** (nervous-system state, from overwhelm to shutdown). One system, four dials — which is why a person's ADHD, emotional overwhelm and relationship with food are not three coincidences in three clinics, but one regulation system.

The pathway: four movements

The clinical sequence is the model. It also names its own destination.

MOVEMENT 1

Safety

Regulation, learning and connection are preconditioned on a felt sense of safety. Perceived threat activates stress systems that impair the prefrontal functions ADHD already strains; safety restores them, and children and adults regulate first through attuned, co-regulating relationships.[15,16] Care therefore begins with cultural safety, identity affirmation and the removal of shame — before any skill. For eating-disorder safety this is a hard rule: body-focus is never forced on a nervous system that is not ready.

Evidence: felt safety → regulation/learning **(Moderate–Strong; attachment, co-regulation, stress physiology).** Note: "window of tolerance" and polyvagal language are useful clinically but are heuristic/contested — claims here rest on the better-supported science, not on those models.[17]

MOVEMENT 2

Notice

We help clients read the body's signals — rising tension, hunger, the edge of overwhelm — with *curiosity and acceptance, not accuracy-drilling*. This distinction is clinically load-bearing: body-awareness interventions appear to help mainly by changing a person's *relationship* to sensations (less threat, more acceptance) rather than by improving perceptual accuracy,[18] and forcing precise body-focus can be harmful in eating disorders. Noticing is always gentle, optional and safety-gated.

Evidence: body-awareness/mindfulness training improves self-reported interoception **(Emerging; small-to-moderate, mainly attitudinal).** Interoceptive exposure is well-supported only in panic disorder.[18]

MOVEMENT 3

Regulate

The practical skills a prescription cannot teach: emotional-regulation strategies; an eat-by-the-clock rhythm drawn from CBT-E for the appetite dial (eating by the clock, not by hunger, is especially apt given atypical interoception and stimulant appetite-suppression); and executive-function and coaching support that works *with* the interest-based nervous system. This is where "medication is not the whole story" becomes concrete.

Evidence: psychosocial/CBT approaches for adult ADHD show modest but real benefits, strongest for functioning;[19] regular-eating is a core, established component of eating-disorder treatment. Competence-building is consistent with Self-Determination Theory.[20]

MOVEMENT 4

Belong

Change lasts when it is held by belonging. Self-compassion — self-kindness, common humanity, mindfulness — is strongly protective against depression, anxiety and disordered eating, and directly counters the self-criticism and low self-worth that ADHD accumulates across a lifetime of corrective feedback.[21,22,23] Social connection is among the most robust predictors of health,[24] and for Aboriginal and Torres Strait Islander clients, cultural connectedness — to family, community, culture and Country — is a recognised protective factor within the Social and Emotional Wellbeing framework.[25]

Evidence: self-compassion ↔ less psychopathology and disordered eating **(Strong, meta-analytic);** ADHD-specific application **(Emerging).** Social connection & health **(Strong).** Cultural connectedness & SEWB **(Moderate; policy-endorsed, Aboriginal-led paradigm).**

Safety → Notice → Regulate → Belong. Four movements, one direction: inside out. Self-Determination Theory provides the motivational spine — autonomy, competence and relatedness are basic needs whose support predicts durable engagement and wellbeing[20] — giving an evidence-based rationale for a strengths-based, neurodivergent-affirming stance rather than a deficit or compliance model.

5 Evidence base and honest limitations

A framework's credibility rests on telling the truth about its own evidence. The model's claims are rated below.

Claim	Strength	How it is stated

Emotional dysregulation is core to ADHD	Strong	Assert
Interoception underlies emotional experience	Strong	Assert
Interoceptive disturbance in eating disorders (self-report)	Strong	Assert
Interoception altered in ADHD	Emerging	"early but converging"
Felt safety precedes regulation/learning	Moderate–Strong	Assert (attachment/stress science)
Self-compassion protects mental health & eating	Strong	Assert
Self-compassion specifically in ADHD	Emerging	"extrapolated"
Belonging / social connection & health	Strong	Assert
Cultural connectedness & Aboriginal SEWB	Moderate	Cite Aboriginal-led scholarship
Body-awareness interventions	Emerging	"adjunctive scaffold"

Four guardrails (the model's integrity conditions)

1. Interoception is a lens and a target, **not a proven cause of ADHD and not a cure**; the ADHD evidence is the youngest and is held lightly.

2. "Notice" is **acceptance-based, not accuracy-drilling** — because forcing body-focus can harm people with eating disorders. This safety-first architecture is what makes the model eating-disorder-*safe* rather than eating-disorder-*risky*.

3. Popular constructs are used as **language, not settled science**: Rejection Sensitive Dysphoria and polyvagal theory are resonant clinically but are not validated; the model's truth-claims are routed through the better-supported self-regulation, attachment and stress-physiology evidence.

4. The Social and Emotional Wellbeing dimension is held **respectfully** — cited to Aboriginal-led scholarship, in its own language, under appropriate First Nations governance.

6 Relationship to existing models

The Body Belonging Model does not replace the leading accounts of ADHD; it integrates them. It takes **self-regulation and emotional dysregulation** as core (after Barkley), locates them in the body via **interoception** (after Craig, Critchley & Garfinkel, and the transdiagnostic "roadmap" of Khalsa and colleagues), grounds its stance in **Self-Determination Theory** (Deci & Ryan) and **self-compassion** (Neff), and holds belonging within both the global **social-connection** evidence (Holt-Lunstad) and the Aboriginal **Social and Emotional Wellbeing** framework. Its contribution is the *integration*: naming interoception as the shared thread across attention, emotion and eating, and building an explicitly eating-disorder-safe, neurodivergent-affirming and culturally grounded clinical pathway on it. To the author's knowledge, this specific synthesis is not currently named in Australian ADHD practice.

7 Application & future directions

The model is delivered as psychosocial therapy and support (not diagnosis or prescribing), with clear referral pathways to medical assessment and to an eating-disorder-informed Accredited Practising Dietitian. It is

expressed in client-facing tools — including a gentle, non-numeric eating-rhythm companion app that operationalises Safety→Notice→Regulate→Belong — and is intended to be teachable to other practitioners.

A priority for future work is a small, ethically-approved **service evaluation** of client-reported outcomes, ideally in partnership with a Western Australian university, to move the model from a coherent, evidence-informed framework toward its own evidence trail. The interoceptive-ADHD literature is developing quickly and should be monitored; claims about the ADHD dial in particular should be updated as it matures.

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