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Seeing Each Other Clearly: A Dual Perspective on Providing Healthcare to Neurodivergent People

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Abstract: Neurodivergent people face distinctive challenges in Health Care, where environments, routines, and communication styles are often poorly attuned to their needs. This paper, written jointly by a neurotypical physician and a neurodivergent patient, offers unique perspectives on how these dynamics can generate misattunement and mistrust. Drawing on reflective narrative accounts and their analysis through the concepts of epistemic injustice and double empathy issues, the paper shows how behaviours such as silence, detailed explanation, or avoidance of eye contact are easily misinterpreted. Patients may be disbelieved or blamed, while clinicians, under systemic pressures of time and workload, may resort to defensive practices. Addressing these challenges requires valuing difference, adapting responsively, and fostering inclusive communication, supported by system-level reforms that embed co-production, training, and accessible environments. We demonstrate how this can be achieved in clinical practice to the mutual benefit of both neurodivergent people and those caring for them.

Keywords: autism, neurodivergence, ADHD, morbidity, mortality, outcomes, healthcare.

INTRODUCTION

Autistic people experience disproportionately poor health outcomes, with evidence showing accelerated ageing, higher rates of physical and psychiatric morbidity, and markedly reduced life expectancy (1-4). Premature mortality is a consistent finding (5), with particularly adverse outcomes among autistic women, whose odds ratio for premature death was 3.64 compared with non-autistic women (6). Contributing factors include impaired sleep (7), elevated rates of suicide and self-harm (8, 9), substance use (10), and increased risk of dementia (11). Neurodivergent people are also disproportionately represented in institutional settings such as hospitals (12) and prisons (13), where outcomes are frequently compromised. A review confirmed substantial increases in suicidal ideation and intent among autistic females (8), while ADHD medications have recently been shown to lower risks of suicide, aggression, and criminality - outcomes chosen as priorities by people with lived experience (14).

Healthcare encounters play a pivotal role in shaping these trajectories. Yet for neurodivergent patients, they often unfold in environments poorly attuned to difference. Overstimulating environments, rigid routines, and fragmented pathways create significant barriers to engagement (15, 16). Awareness of autistic traits among healthcare professionals remains low (12), despite recent reminders (17). Silence, detailed explanation, or avoidance of eye contact are easily misinterpreted as evasive, pathological, or “non-compliant.” One patient described being diagnosed with borderline personality disorder 20 years before her

underlying neurodivergence was recognised (18). Such experiences are common among females with ADHD (19), reflecting overlapping presentations and gender biases in diagnosis (20).

These difficulties should be understood relationally rather than seen as deficiencies. Milton's (21) *double empathy problem* reframes communication breakdowns as bidirectional, arising from divergent lifeworlds. A *triple empathy problem* occurs when a neurodivergent patient and neurotypical clinician struggle to appreciate the other's perspective (22). Clinicians themselves may feel uncertain or even fearful of treating neurodivergent people, citing previous adverse experiences as barriers to care (23, 24, 25). Changing constructs of autism and ADHD can influence clinical relationships (26). Professional guidance has reinforced these concerns: a Royal College of Psychiatrists report described autistic patients as lacking insight, responsibility, and potentially making vexatious complaints (27). Meanwhile, the General Medical Council acknowledged limited insight into neurodivergence when evaluating allegations against doctors, only later incorporating neurodiversity awareness into its training (24, 28). These events have the capacity to foster mistrust bilaterally, with serious consequences for patients and clinicians alike. Healthcare provision presents distinctive challenges. This paper brings together both perspectives, drawing on narrative accounts of a physician (CK) and a neurodivergent patient (JD). Analysing these via a framework of epistemic injustice and mutual empathy, we examine how cycles of mistrust develop and identify pathways towards more attuned and humane clinical practice.

METHODS

This paper adopts a qualitative, dialogical, and narrative methodology to explore the relational dynamics of healthcare as experienced by neurodivergent patients and clinicians. Our collaboration is dialogical in nature, allowing knowledge production to emerge through iterative exchange, reflection, and negotiation between professional and personal forms of expertise (29-32). This approach involves both authors as co-analysts of experience, avoiding hierarchical separation between clinical and patient roles.

Narrative Inquiry

We use narrative accounts to gain insight into the nuances of our experiences in healthcare settings. Narrative inquiry is particularly suited to examining how individuals construct identity through stories situated in social and institutional contexts (33, 34). Our narratives are presented in the Results section, followed by an analysis identifying shared themes as well as tensions and nuances. Rather than treating single events in isolation, we focus on how stories of healthcare encounters reveal broader relational dynamics, systemic pressures, and the diverse lived consequences of misattunement or recognition.

Reflexivity

We engage in reflexive practice, critically considering how our perspectives are shaped by professional training, lived experience, and positionality within healthcare systems (35,36). For CK, reflexivity has involved recognising the constraints of medical training, time

pressures, and the institutional norms that shape clinical practice, along with personal experience of challenging encounters. For JD, this involved reflecting on experiences of medical care, including epistemic injustice and misrecognition of his neurodivergence, and how this may impact his recollection and interpretation of past events.

Epistemic Justice as a Guiding Principle

Our methodology is underpinned by the principle of epistemic justice (37). Two forms are particularly relevant: testimonial injustice, where patients' accounts are dismissed or undervalued; and hermeneutic injustice, where interpretive frameworks are inadequate, leading to people's experiences being misrepresented or misunderstood (38, 39). These risks are greater for neurodivergent people (40, 41). Our methods redress this by centering neurodivergent lived experience alongside professional knowledge, assigning them equal value to generate co-produced interpretations and recommendations (42). We resist reductive labels, such as "hard to help," and instead promote a relational ethics characterised by curiosity, respect, and collaboration, rather than conflict or blame (43, 44). Our analysis illustrates the complexity of healthcare encounters for neurodivergent patients and clinicians alike, offering experientially grounded evidence-based insights to inform more inclusive, equitable practice.

RESULTS

Section 1: Shared Spaces, Divergent Worlds

Personal Narratives

JD: I have been admitted to hospital many times for different reasons: psychiatric crises, eating disorders, and problems arising from Ehlers Danlos Syndrome. I live with autism and ADHD, and my experiences of healthcare have been shaped as much by how I am received as by my symptoms. One of the hardest things is not being believed. There have been times when I knew exactly why I needed help, and other times when I had little idea. My interoceptive awareness is inconsistent. When clinicians ask me to describe my pain, its location or its intensity, I often struggle to explain in ways that are taken seriously. The mismatch between what I say and what is expected of me has led to suspicion. I have felt that my credibility as a witness to my own body was challenged.

The hospital environment itself is challenging. The noises, alarms, and sudden announcements build into an unbearable sensory backdrop. Staff changes with no explanation of who is responsible for me or what will happen next leave me very vulnerable. I am left not knowing when it is acceptable to ask for help, who to approach, what I am allowed to do. I rely heavily on routines around food and drink, but in hospital I cannot access what I need to feel safe. When the rhythms of daily life are so unpredictable, I've felt trapped. If the environment is intolerable, I have discharged myself against advice.

CK: I have been a Consultant Physician for decades and my family and I have successfully supported many neurodivergent people, both professionally and personally. Clinicians may be cautious in their dealings with neurodivergent patients, especially if their medical records contain a history of challenging consultations. Anxiety evolving to argument is not a rare experience, and doctors may resort to defensive medical practice consequently. This

might appear to reduce the risk of complaints against doctors, but it may also promote adverse outcomes for patients if diagnosis or decisions are delayed.

Several clinicians have reported adverse experiences from supporting neurodivergent people. Serious professional consequences may follow a breakdown in the relationship, with damage to a doctor's reputation resulting from false or exaggerated complaints. The General Medical Council (GMC) have openly admitted being weaponised against doctors, while the Medical Practitioner Tribunal Service (MPTS) have recently incorporated training on neurodivergence and how it can influence allegations against doctors. Although few neurodivergent people behave like this, fear of being misinterpreted or misrepresented may inhibit doctors from effectively managing the many social, physical and mental health issues for which neurodivergent people seek help. Yet, experience supporting multiple neurodivergent people over many years has shown how they can thrive socially and medically with the right support.

Co-Analysis

These narratives illustrate how hospital encounters are pre-shaped by both structural conditions and subjective experiences. From the clinician's side, encounters with patients are often compressed into short consultation windows in overstretched clinics or noisy wards. Studies of decision-making show that time scarcity and systemic pressures foster premature closure of dialogue (45), while culture limits clinical encounters (46, 47). Clinicians may default to routinised practices as a form of self-protection against overwhelming demands (25). It may be easier for the clinician to follow standard operating procedures than to explore the patient's agenda, which often differs. The neurodivergent patient's perspectives are shaped by sensory strain and uncertainty. Interoceptive differences complicate the basic medical task of reporting symptoms. Inconsistency is not evidence of unreliability but a reflection of embodied differences. Yet when viewed through medical eyes, these differences risk being misinterpreted as exaggeration, vagueness, or dishonesty. Serious self-harm is common in autistic people, as is substance abuse. They may feel so misunderstood that life is not worth living, or they use alcohol or recreational drugs to suppress social anxiety. Doctors should explore the psychosocial circumstances contributing to self-harm. Neurodivergent patients need time to describe their symptoms. Listening, explanation, validation and support are often more valued than medication.

Research confirms that autistic people frequently experience healthcare environments as "inaccessible" due to sensory overload, unpredictable routines, and hostile atmospheres (48-51). Rejection sensitivity is very common among autistic people, and this can lower the threshold for conflict in both professional and personal settings. Anticipatory emotions are shaped by previous experiences. Clinicians recall past complaints or litigation risk, while patients remember prior dismissal or misdiagnosis. As research on epistemic injustice in healthcare notes, once testimonial credibility is undermined, both parties mutually reinforce mistrust (37, 52). Taken together, these elements show that clinical encounters are not neutral starting points, but emotionally loaded encounters shaped by institutional pressures, and previous lived experience. Occasionally a clinician's motives and actions can be misrepresented. Whilst such adverse experiences might lead clinicians to avoid other neurodivergent people, an alternative response is to address and understand the issues behind such behaviour and use lived experience to provide targeted support for

other neurodivergent people. As this narrative paper shows, much benefit can ensue for patients by developing an informed and reflective response to serious adversity.

Section 2: Misattunement and the Double Empathy Problem

Personal Narratives

JD: I've experienced not being believed by healthcare professionals, even when I've been acutely unwell. The opening questions were so broad that they felt impossible to answer. I needed a tangible entry point to begin a conversation. Sometimes I feel overwhelmed or can't adhere to treatment when I haven't had the rationale of treatment explained, despite presenting as highly articulate and knowledgeable from my days as a medical student. This has sometimes been met with suspicion or blame, as though I should know better than to develop disordered eating or attempt suicide.

My apparent competence disguises my distress, which can appear suddenly and cause alarm even though it is directed inwardly. When I can no longer mask this, I tend to remove myself from the clinical environment. Small details are often misread, too. I often feel uncomfortable with direct eye contact. I have struggled since childhood to ask for help, even when I've been in danger, because I don't want to cause anyone trouble. I sometimes misinterpret clinicians too. If a doctor sighs or interrupts, I can assume they don't care or don't believe me. Both sides can misconstrue the other's behaviour.

CK: As many neurodivergent patients have already experienced disappointment with outcomes of previous healthcare appointments, they may quickly become disenchanted or angry. This can spiral into argument if the patient and clinician blame each other. Such antagonism can adversely affect consultations and may bias the clinician against other neurodivergent patients, while the patient may be wary of sharing their symptoms with other healthcare workers, fearing further rejection.

Clinicians describe a sense of '*walking on eggshells*' with some patients, concerned that they may inadvertently trigger an adverse response. My experience supporting both neurodivergent friends and patients has taught me to be less forceful and more tolerant. I've learned that their adverse earlier experiences and recollections of emotional and physical distress produces heightened sensitivities and sometimes suspicion. Rather than questioning, challenging or criticising, I now encourage an open general dialogue assuming the role of active listener, although appointment schedules allow limited leeway for significant accommodation or a long list of prepared questions. Likewise, anxiety or sensitivity might extend the time needed to conduct a full examination, especially if symptoms span several systems. If the patient has heightened sensitivity to light, noise, touch or smell, changes to the structure of the consulting room or to the personnel may be required during the consultation.

Co-Analysis

Our accounts reveal how easily healthcare encounters between clinicians and neurodivergent patients can become sites of *misattunement*. The double empathy problem (21) emphasises that communication difficulties are not rooted in a unilateral deficit but in mutual misunderstanding. Neurodivergent people may not understand emotions

(alexithymia) and have heightened sensitivity to what others say (rejection sensitivity dysphoria), potentially precipitating avoidable conflict. Likewise, testimonial and hermeneutic injustices can result from doctors' assumptions about anxiety, attention-seeking, or competence (37, 52), or when interpretive frameworks cannot make sense of a patient's way of communicating. Patients are rendered less credible, while clinicians' uncertainties are masked by defensive practice. Both parties may conclude that the other simply doesn't understand or doesn't care.

The consequences are cumulative. Patients, already wary of being dismissed, may under-report symptoms. Clinicians may approach neurodivergent patients with scepticism. This cycle not only erodes the therapeutic relationship but also compounds health risks. Neurodivergent people have an increased prevalence of inflammatory bowel disease (53) and may demonstrate sensitivity to gluten or lactose. Multiple allergies may indicate mast cell activation. Doctors should be aware of these associations and explore them sensitively when relevant. Eating disorders may be associated with vomiting, which isn't always self-induced. Deaths have occurred from aspiration following nasogastric tube feeding in a missed diagnosis of gastroparesis (54). A careful history and examination will help to avoid this.

At its core, misattunement here is relational rather than individual. It arises not from an absence of effort but from structural conditions that prevent mutual understanding from developing. Addressing these challenges requires more than encouraging patients to self-advocate or clinicians to "listen better." It calls for systemic shifts to enable both parties to meet one another differently - recognising difference as meaningful, embedding flexibility, and treating neurodivergent experience as legitimate.

Section 3: Reframing the Encounter - Opportunities For Alliance

Personal Narratives

JD: Alongside many difficult healthcare encounters, I have also experienced positive restorative episodes of care. These were different because my needs were recognised. Simple gestures such as offering to write things down, reminding me that eye contact was not expected, or allowing me time to formulate a response, transformed the dynamic completely. What mattered most was not that these clinicians solved everything, but that they showed curiosity and respect, with a willingness to understand my perspective. This gave me permission to be more open about my experience and, in turn, helped us generate a shared understanding of my clinical presentation and needs.

Receiving late diagnoses of autism and ADHD has changed the way I navigate encounters. Rather than seeing these as labels that impose limitations on my ability to participate in care and take responsibility for my health, I have come to use diagnoses as ways of explaining myself and negotiating adaptations. In practice, this means balancing self-knowledge with shared responsibility: I can say, "This is what helps me," but I still want clinicians to meet me halfway. When that happens, the encounter feels collaborative rather than adversarial, and I leave with a sense of being understood rather than judged.

CK: Many neurodivergent people do exhibit obsessive traits and are often understandably anxious and wary in a healthcare environment. For a time-pressed and results-oriented clinician, such a patient often presents challenges. However, with careful planning this can

be avoided. Allocating extra time and resources can then be justified, as happens in other consultations e.g. when an interpreter is needed, or a patient is wheelchair-dependent. Enquiring about sensitivities, preferred pronouns and exploring patient expectations all hugely improve the chances of a satisfactory outcome for both parties.

A self-introduction, a check that the patient is physically comfortable in their surroundings and an invitation for them to involve a family member or friend helps establish empathy. An open-ended invitation from the clinician to '*tell me everything you want me to know about yourself and the way you feel*' allows the patient to relax into the consultation before more specific information is sought. Special attention to lighting conditions, privacy, and an unhurried approach with an open posture are welcome. Active listening is itself therapeutic, avoiding interruption and providing encouragement when needed. Physical examination needs to be conducted with care and sensitivity, often with a chaperone.

Co-Analysis

The focus shifts to positive outcomes when curiosity and adaptation are present. A clinician should recognise that 'pain' may be experienced differently. The pain of a fracture has different causes, treatments and outcomes to pain arising from abandonment or grief. Each are equally valid although there may be few physical signs. By listening and allowing JD to shape the record of the encounter, clinicians restored credibility to his testimony. By engaging with his neurodivergence they supplied resources that enabled his experiences to be intelligible rather than dismissed as incoherent or exaggerated. What might otherwise have been misread as resistance became legible as coping.

In an outpatient setting, dictating the letter to the referrer with the patient actively contributing to the process builds trust reinforced by offering the patient a copy of the correspondence. An unhurried explanation of next steps and likely timeline, followed by an opportunity to ask questions is an excellent way to conclude consultations. Forwarding further information and links to relevant support by email to the patient allows time for subsequent reflection on the part of the patient. We have prepared podcasts and papers on various relevant subjects for this purpose. Downs et al have previously described opportunities for meaning-making as inherently dialogical, emerging through the interplay of perspectives rather than the dominance of one (44). In this light, the practices of slowing down, recording in writing, validating the patient's agenda, and co-dictating letters, are not minor adjustments but ethical acts of recognition. They redistribute authority in the encounter, inviting the patient into the role of collaborator rather than passive recipient. Validating the patient's lived experience by recording it verbatim reinforces their credibility and autonomy, facilitating diagnosis and management.

Having learned much from supporting neurodivergent friends and patients over the years, CK notes that many say that this helps them finally feel validated. This is an essential step to addressing their social and medical concerns. Ultimately, these opportunities show that attunement is not about erasing asymmetries but about negotiating them. When clinicians meet neurodivergent people with curiosity and openness, when patients can bring their own frameworks of self-understanding, and when meaning is co-created through dialogue with respect, encounters can move from alienating to reparative.

Clinical Implications: Attuning Care in a Neurodiverse World

Writing this article has not been easy, but is very relevant (55). Practical strategies to improve healthcare for neurodivergent patients have been highlighted across recent research. Simpson (48) emphasised the importance of reasonable adjustments such as modifying sensory environments and adapting modes of first contact. Greenwood et al.'s (50) scoping review of hospital experiences identified that positive change can be facilitated through clear care pathways, collaborative partnerships with families, and inclusive systems that build flexibility and predictability. Davenport et al. (51) extend this by describing what "autism-friendly" care should mean in hospital contexts. Their analysis points to three domains - people, place, and time - all underpinned by flexibility. Straus et al. (49) showed that targeted interventions such as diversion techniques, comfort positioning, visual schedules, and communication aids, can improve psychosocial adjustment across healthcare.

Approaching this subject in the spirit of mutuality recognises that many healthcare professionals are also neurodivergent, and face parallel challenges of stigma, disclosure, and masking within their own training and workplaces. Evidence shows that these pressures contribute to burnout (56, 57). At the same time, initiatives led by neurodivergent doctors have demonstrated tangible benefits: hospital staff who received training from neurodivergent colleagues reported greater confidence, reduced bias, and improved acceptance of autistic patients (58). Although neurodivergent people are more likely to be arrested (59) and imprisoned (60), this in part reflects their tendency towards misinterpretation of social and emotional circumstances, and in part the failure of the legal system to make appropriate allowances for this. To minimise the risk that misunderstanding might precipitate adversity between neurotypical and neurodivergent individuals, our lived experience suggests that shared learning and adjusted attitudes are much more effective than allowing escalation into conflict (61).

Lastly, it is also important to recognise that neurodivergence is not uniformly experienced across diverse groups. Evidence on how best to support neurodivergent people across intersections remains limited, and our own accounts cannot capture every challenge faced in each of these contexts. As such, clinicians must therefore rely on guiding principles, such as those we have suggested below, to ensure that care is responsive to the diversity of lived experiences and does not inadvertently reproduce inequity (62, 63).

Summary of Recommendations

Table 1, below, summarises some key recommendations for treatment provision derived from our evidence-based and experience-informed analysis. These are intended as guiding principles and practical strategies to support more responsive and inclusive care for neurodivergent patients:

Table 1: Recommendations for principles, practices and systems to improve hospital care for neurodivergent patients

Principles	1. Value difference
	Recognise neurodivergent expressions and experiences as valid, meaningful, and a source of clinical insight. Adopt a stance of difference not deficit, grounded in curiosity and non-judgement.
	2. Take responsibility to adapt
	Responsiveness to patient needs should be seen as central to duty of care, not as an inconvenience. Providers should ask "what can we do to make this work?" and adjust accordingly.
Practices	3. Communicate inclusively
	Use clear, concrete, and flexible communication. Provide written or visual materials, avoid ambiguity, and engage in collaborative checking of understanding. Involve caregivers/supporters where appropriate to bridge gaps.
	4. Create sensory and temporal safety
	Adapt environments to minimise sensory overload (e.g. noise, lighting, clutter) and offer quiet/alternative spaces. Build temporal flexibility by allowing extra time, pacing interventions, and permitting silence and tangents.
Systems	5. Resource accessibility
	Invest in environments, staffing models, further research, and reasonable adjustments to make inclusive and accessible care the norm in clinical practice, rather than an additional task to implement in each case.
	6. Build co-produced knowledge
	Provide staff with neurodivergence-affirming training, embed a range of interpretive resources, and develop research that attends to intersectional needs. All of these need to be meaningfully co-produced with people with lived experience.

CONCLUSION

Healthcare provision presents particular challenges for neurodivergent people as clinical environments, communication styles, and institutional routines are often poorly attuned to difference. Through reflective narratives and analysis, this paper illustrates how misattunement can escalate into cycles of mistrust. These dynamics can become cumulative, with consequences that can influence patients' willingness to seek care and clinicians' preparedness to provide it. The recent inclusion of neurodiversity awareness and training by the GMC and MPTS acknowledges their past deficiencies and reaffirms that patients and professionals deserve more informed and evidence-based decision making. Addressing these challenges requires both systemic and relational change. Our review contributes to this agenda by modelling how lived experience can be centred to highlight clinical challenges and create opportunities for rethinking communication, environment, and clinical interaction. Our experiences both within and without healthcare environments reinforce the need for all parties to learn from each other and replace antagonism with constructive dialogue. By reframing responsiveness and adaptation as central, healthcare

systems can move towards more equitable, dignified, and effective provision for neurodivergent people while supporting those who care for them.

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