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The Many Ways of Being Human

From Diagnosis to Human Diversity & Back to the Person

Lotta De Coster

Hello everyone,

We have already been talking about diversity through the lens of a professional practice and through the lens of culture, and about what diversity asks of us as psychologists: curiosity, humility, an awareness of context, and a willingness to question our assumptions.

I would like to carry that same spirit of curiosity into another dimension of human diversity: neurodiversity. Because what we see depends on the lens through which we look. To understand a person well, we need to change the distance from which we look. We need to zoom in, we need to zoom out, and eventually, we need to come back to the person.

So, although I will talk about ADHD, autism, and other forms of neurodivergence, this keynote is not really about diagnostic categories, it is about how we see people.

1. Starting with the Map: Diagnosis

Let us begin with a thought experiment. Imagine two skilled psychologists. Both assess the same person and conduct a rigorous assessment. The first writes: ADHD, Combined Presentation - 314.01 (6A05.2), Generalised Anxiety Disorder - 300.02 (6B00), Obsessive-Compulsive Disorder - 300.3 (6B20) along with the corresponding diagnostic DSM-5-TR codes and ICD-11 codes.

The second psychologist reaches exactly the same diagnoses, but then continues: Someone who has difficulty regulating attention when many things compete for it, whose nervous system becomes easily overwhelmed by uncertainty, and who learned quite early that being different could feel unsafe. Someone who discovered that

rituals could temporarily create predictability. Someone remarkably creative, conscientious, and deeply committed to doing things well.

We are talking about the same person, with the same diagnoses, but somehow, we are given a different picture. And when our understanding changes, therapy may change as well.

Diagnostic systems have given psychology and psychiatry a very useful shared language. They facilitate research and scientific communication, guide evidence-based interventions, and provide access to treatment, services, and accommodations.

And for many people, receiving a diagnosis is deeply validating. It can bring coherence to years of confusing experiences and self-blame. It can replace “Why can’t I just handle or do this?” with “Ah. Perhaps there is a reason this is difficult for me.” I often hear from my patients that receiving a diagnosis feels less like being placed in a box and more like finally being given a map.

But even a very good map cannot tell us everything about the landscape.

A diagnosis can help us answer important questions: What pattern are we observing? When did it begin, and how persistent is it? How frequent and severe are the difficulties? In which areas of life do they interfere with functioning? And does the overall pattern meet established diagnostic criteria?

But as therapists, we need to ask additional questions. How did this pattern develop in this particular person, and why might it make sense? What triggers or maintains the difficulties? In which contexts do they become more or less pronounced? What matters to this person, and what helps them cope?

These are no longer primarily questions of diagnosis, they are questions of formulation.

2. Beyond the Label: Case Formulation

This is where case formulation becomes so important. Diagnosis helps us recognise meaningful patterns. Case formulation asks us to understand what that pattern means in this particular life and restores individuality.

Case formulation brings together interconnected dimensions: biology, temperament and the nervous system; developmental history and learning experiences; cognition, emotions, sensory processing and executive functioning; family and relationships; school, work and other environments; social expectations, socio-economic conditions, community and culture; and the person's vulnerabilities, strengths, values and coping strategies.

None of these dimensions alone can explain a human being, but together, they begin to tell a coherent and individual story. Formulation is about understanding how these dimensions interact in this particular person's life. The diagnosis does not disappear; it becomes part of a much richer picture.

Formulation also reminds us that similar difficulties or symptoms can reflect different underlying mechanisms.

Imagine different patients who all say, "I can't concentrate." One may be struggling primarily with the executive and attentional regulation difficulties associated with ADHD. Another may be hypervigilantly scanning the environment for threat following trauma. Another may be caught in anxious rumination or in intrusive obsessive thinking loops. For other patients, concentration difficulties may find their origin in fatigue or exhaustion related to sleep issues, hormonal changes, depression, illness, or medication.

From the outside, we see a similar cognitive symptom: difficulty concentrating. But when we zoom in, we may discover very different experiences, mechanisms, and therapeutic needs.

Clinical work constantly asks us to change our distance from the picture. Sometimes we need to zoom in - to the individual level - to understand how a person experiences, processes and responds to the world. And sometimes we need to zoom out - to the wider contextual levels - to understand how relationships, environments and social expectations shape those experiences.

Neither perspective is sufficient on its own. We need to move between them. Good case formulation may be precisely this capacity to move between levels without losing sight of the person.

And once we zoom out far enough, an interesting question appears: in what ways do human beings differ in the first place?

3. The Wider Landscape of Human Diversity

Human beings vary enormously across almost every aspect of psychological functioning. We differ in how we regulate attention, experience emotions, process sensory information, adapt to change, communicate and learn. We also differ in how we organise ourselves, recover from stress, what motivates us, and how much stimulation or predictability we need.

Most of these characteristics vary along dimensions rather than falling into simple binary categories. And each person has a particular combination of characteristics across those dimensions.

In everyday language, we use the word *spectrum* to describe variation along a continuum. But when we speak about the autism spectrum, the meaning is more specific. It refers to a diagnostic category encompassing a wide diversity of presentations that share certain defining characteristics: differences in social communication and interaction, alongside restricted and repetitive patterns of behaviour, interests or activities, which may include differences in sensory processing.

So the autism spectrum is not simply a line running from “a little autistic” to “very autistic.” Nor does dimensional variation mean that “we are all a little autistic.” Having characteristics such as a preference for routine or finding certain sounds overwhelming does not, in itself, indicate a diagnosis.

Clinical significance depends on the overall pattern, early developmental history, persistence, intensity, functional impact and support needs.

When we consider several dimensions together, we begin to see a person’s individual profile. Some profiles are relatively even, while others show pronounced strengths alongside significant difficulties — sometimes described as *spiky profiles*.

In neuropsychological research, a *spiky cognitive profile* refers to uneven performance across cognitive tests. Here, we use the image more broadly to illustrate how different psychological characteristics can coexist within one person. Two people can therefore belong to the same diagnostic spectrum while having very different individual profiles.

The spectrum reminds us of diversity within a diagnostic category. The profile reminds us of individuality within that diversity.

Recognising this individuality does not diminish the value of diagnosis. Diagnosis helps us identify clinically meaningful patterns, but understanding a person's experience also requires us to consider their developmental history, relationships and environment. This is where a biopsychosocial perspective becomes essential.

And this brings us naturally to the concept of neurodiversity: the recognition that neurological and cognitive differences are part of the natural variation in how human minds function.

4. From Neurodiversity to Neurodivergent Experience

What exactly do we mean by neurodiversity and by neurodivergence?

Neurodiversity refers to variation among human minds and brains at the level of a population.

Neurodivergence refers to neurological or cognitive functioning that differs from what is generally considered typical. It is a broad, non-diagnostic concept whose boundaries are not universally agreed upon.

The term is most commonly associated with autism, ADHD, dyslexia and other neurodevelopmental differences, including Tourette syndrome. In broader uses, it may also include conditions such as OCD.

It is important to distinguish neurodivergence from the DSM-5-TR category of *neurodevelopmental disorders*. The two concepts overlap, but they are not identical.

But the terminology is less important to me today than the underlying idea: there is no single way of being a human mind.

And there is enormous diversity even within diagnostic groups. There is no single autistic profile, just as there is no single ADHD profile.

Two people with the same diagnosis may differ profoundly in their executive functioning, sensory processing, emotional regulation, strengths, vulnerabilities and support needs. This is another reason formulation matters so much.

Diagnoses belong to clinical groups, whereas formulations belong to specific people. And if we want to preserve that individuality, we also need to be careful about the language we use.

For many years, neurodevelopmental differences were described almost exclusively through the language of deficits and disorder.

More recently, some of that language has swung towards strengths, and even towards the idea of neurodivergence as a *superpower*. We can understand why. For people who have spent years hearing what is wrong with them, discovering that their way of thinking may also encompass abilities, interests, and strengths can be profoundly reparative.

But I do not think we need to replace one simplification with another. Not every difficulty is secretly a strength, and not every neurodivergent person has an exceptional talent. Nobody should have to be exceptional in order for their differences to deserve understanding and acceptance.

Diversity-affirming care does not require us to tell a more positive story about someone; it requires us to tell a more accurate one: one in which strengths can genuinely be strengths, difficulties can genuinely be difficulties, and neither needs to cancel out the other.

Difference, disability and strengths can coexist. Acceptance and treatment can coexist. Medication and accommodation can coexist. Understanding that a difficulty may arise partly from the way a person's nervous system is organised does not make the difficulty any less real. But it can change the meaning we give to it. We move from judgement to curiosity, from "*What is wrong with this person?*" to "*What makes this difficult, and what might help?*" And that understanding can open up more appropriate possibilities for change - in the person, in the environment, or in the interaction between the two. And this brings us to something important.

5. The Person in the Environment

To understand the neurodivergent experience fully, we need to widen the frame once more. Because people do not function in isolation, they function in environments and environments are not neutral.

Consider attention.

Someone may be perfectly capable of sustaining attention during a structured assessment: clear instructions, one task at a time, limited distractions, explicit priorities, and a defined endpoint.

Place that same person in everyday working life, with implicit expectations, messages arriving, colleagues interrupting, frequent task-switching, several unfinished tasks competing for attention, and fatigue accumulating, and their functioning may look completely different. The underlying ability has not disappeared, but the conditions have changed - and so has the person's capacity to access it.

The same is true in many other areas.

A child who appears profoundly dysregulated in a noisy and unpredictable classroom may function very differently when given structure, visual support, and predictable transitions.

An autistic person who finds eye contact demanding may communicate much more freely once eye contact is no longer expected.

Sometimes, relatively small changes make a surprisingly large difference.

This does not mean that every difficulty is created by the environment or can be addressed simply by changing the conditions. Some difficulties remain substantial across environments and require treatment, support, or both. But it does mean that, if we look only at the level of the person, we miss part of the clinical picture.

I increasingly find it helpful to ask: What happens when this particular person, with this particular nervous system, encounters this particular environment? Because environments can lower or raise barriers.

With my patients, I like to think of these as walls.

- Sometimes we do help patients develop the skills they need to climb a wall that cannot simply be removed - for example, helping someone with ADHD develop external strategies for planning or time management. But our task is not always to teach people how to become better at climbing walls.

- Sometimes treatment can lower the wall or reduce the difficulty itself — psychostimulant medication may improve attentional regulation, for instance, or ERP may help someone with OCD tolerate uncertainty without relying on compulsions.
- Sometimes we can provide support or adapt the environment so that the wall becomes easier to overcome: reducing distractions in a workspace, or allowing someone to use headphones when sensory input becomes overwhelming.
- And sometimes there may be another route to the same meaningful destination. If a student has difficulty with long written assignments, an oral presentation may allow them to demonstrate the same knowledge in a different way.

Good psychological care will often involve several of these at once: developing skills, treating difficulties, providing support, and adapting the environment.

- But there is one more possibility. Sometimes we need to question the wall itself. If an autistic person can listen and communicate more freely without maintaining eye contact, perhaps eye contact was never essential to meaningful communication in the first place.

And that leaves us with an important question: Before helping someone climb a wall or find a way around it, should we sometimes ask whether that wall needs to be there at all?

6. Coming Back to the Person

Bringing Diversity Into the Therapy Room

And this brings me back to where we started. Two psychologists. One person. We have explored diagnostic patterns, individual profiles, neurodiversity and the individual neurodivergent experience, and the relationship between a person and their environment.

The diagnosis has not disappeared. Our field of vision has changed.

We now see not only a diagnosis, but also a developmental history, a nervous system, relationships, a cultural context, vulnerabilities, strengths, coping strategies and

values. And, above all, a human being trying, like all of us, to find a workable way of moving through life.

When working with neurodivergence, it is important to remember that what we see from the outside does not always tell us what an experience costs on the inside.

People can become remarkably good at adapting, compensating, masking and appearing fine. But appearing fine, or being described as “high functioning”, is not evidence that something is easy. Sometimes, it tells us how hard someone has worked.

So perhaps we need to ask not only, “Can this person do this?” but also, “What does it cost them? How much effort does it take? What happens afterwards? And what does it take to sustain it?”

And equally: “When does life feel easier? What gives them energy?”

Formulation should help us understand not only the conditions of suffering — the difficulties, vulnerabilities and risk factors - but also the conditions for flourishing — the strengths, resources, and protective factors.

Perhaps one of the things therapy can offer is a space in which people gradually begin to write their own owner’s manual: *How does my system work? What overwhelms me? What helps me regulate? What do I need? What matters to me? And where can I function well and feel more fully myself?*

Perhaps that is ultimately the heart of diversity-sensitive and diversity-affirming psychological care: “Let us understand how you work. Let us notice what makes things harder and what makes them easier. Let us build on your strengths, develop skills where they are needed, and remain honest about what is genuinely difficult — without allowing those difficulties to define you.”

The aim is not to abandon diagnosis, minimise difficulties or suffering, or romanticise neurodivergence. It is to recognise the diagnosis, and then keep looking.

Diagnosis is a starting point and gives us a map. But psychological care takes place in the landscape.

Our responsibility as psychologists is therefore not only to know the map well, but to move through that landscape with enough scientific knowledge to recognise meaningful patterns, enough clinical skill to understand and hold suffering, and enough curiosity and humility to remain genuinely interested in the particular person in front of us.

And through all of this, to remember something fundamental: there are many ways of being human.

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She has been part of Psygroup since 2022, where she provides psychological care to children, adolescents and adults. She has extensive experience in psychological and developmental assessment, psychotherapy, and parental guidance in Belgium and Canada. She taught at the Université Libre de Bruxelles and the Université de Montréal between 2007 and 2022. Her clinical interests include neurodivergence, anxiety, obsessive-compulsive disorders, and diversity-sensitive psychological care for children, adolescents, and adults.

Lotta integrates evidence-based Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Compassion-Focused Therapy (CFT) within a diversity-sensitive and diversity-affirming framework. Her work is guided by the belief that effective psychological care begins with recognising the person beyond diagnostic labels and appreciating each individual's unique strengths, vulnerabilities, and lived experiences.