

The experiences of neurodivergent midwives in Aotearoa: An appreciative inquiry

Amy Ria Taylor

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Supervised by Suzanne Miller, Annabel Farry.

Te Kura Atawahai ka Kaiākapono te Hākuitaka | School of Midwifery, Te Kura
Matatini ki Otago | Otago polytechnic

30th September 2025

Declaration of Originality

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Abstract

As awareness of neurodivergence grows and diagnostic pathways improve, increasing numbers of health professionals are identifying as neurodivergent (ND). However, little is known about the experiences of ND kahu pōkai (midwives) in Aotearoa New Zealand. This study explores how ND kahu pōkai navigate their professional environments, the strengths they bring to their practice, and what supports could help them thrive.

Using Appreciative Inquiry, a strengths-based methodology, data was collected through semi-structured interviews with 15 ND kahu pōkai, followed by a four-day asynchronous online focus group. Person-orientated research ethics were employed to minimise barriers to engagement for ND participants. Reflexive thematic analysis revealed five key themes that illuminate the lived experiences of ND kahu pōkai.

The first theme described how ND kahu pōkai felt that they built strong therapeutic relationships with whānau, drawing on their unique communication styles, deep empathy, and cognitive strengths. Participants believed that the care they provided was emotionally safe, affirming, and grounded in authenticity and lived experience, thus they positioned their neurodivergence as a relational asset within their practice. The second theme explored the concept of “spiky” skill profiles, where participants balanced exceptional abilities with specific challenges. They navigated clinical and interpersonal demands using tailored strategies and supportive feedback, highlighting the need for nuanced understanding of ND capabilities.

The third theme described a personal journey of finding a workplace that suited participants sensory and cognitive needs. This involved discovering environments that aligned with their preferences and developing customised tools and routines to manage energy levels and overstimulation. Theme four focused on fostering ND kahu pōkai culture and leadership. Participants embraced neurodivergence as a cultural reclamation and strength, advocating for inclusive leadership, peer support, and affirming workplaces that dismantle stigma and elevate ND visibility.

Finally, theme five challenged rigid perceptions of midwifery, showing that systemic inflexibility—rather than neurodivergence itself—created barriers to inclusion. Participants called for more adaptable roles that prioritise contribution over conformity, supporting sustainability and diversity within the profession.

Across all themes, participants consistently viewed their neurodivergence as an asset, particularly in relational care, but faced barriers rooted in ableist workplace norms. They proposed tailored accommodations to better support ND professionals in healthcare settings. This research offers novel insights into the lived experiences of ND kahu pōkai in Aotearoa, challenging neuro-normative assumptions and advocating for inclusive practices. The findings will inform educational and clinical frameworks to foster ND inclusion, visibility, and leadership across the kahu pōkai profession.

To enhance accessibility for neurodivergent readers, I incorporated wayfinding visuals—using both colour and icons—throughout my thesis. Icons used are source from “[The Noun Project](https://creativcommons.org/publicdomain/mark/1.0/)”, Public Domain, under Creative Commons Licence:

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Glossary

Words in Te Reo Māori, unless otherwise stated have been taken from Te Aka Māori Dictionary (<https://www.maoridictionary.co.nz/>)

Ableism: A system of discrimination experienced by the disabled community, fuelled by socially constructed beliefs on 'normalcy, productivity, desirability, intelligence and fitness' (Lewis, 2022).

Accommodation: Strategies and tools utilised to create an equitable environment for a disabled person (Cooper et al., 2018)

ADHD/ADHDer: Attention Deficit Hyperactivity Disorder, a neurodevelopmental condition with inattention, impulsivity and overactivity as the central features; these persist over time and result in significant impairment (American Psychiatric Association, 2013).

Alexythymia: Difficulty in recognising, describing, and processing one's own emotions (Bagby et al, 2025).

Autism: A neurodevelopmental condition characterised by challenges with social interaction and communication, and by restricted or repetitive patterns of thought and behaviour (American Psychiatric Association, 2013).

Double empathy problem: A mutual breakdown in understanding between people of differing neurotypes, especially between autistic and non-autistic individuals, where both parties struggle to empathise with each other due to different ways of experiencing the world (Milton, 2012).

Dyslexia: A specific learning disability of neurodevelopmental origin; it impacts a person's ability with reading, writing and numeracy; verbal and visual processing skills can also be impacted (Cooper et al., 2018).

Dyspraxia: A neurodevelopmental condition that affects gross and fine motor skills, coordination and cognitive function (Walker et al., 2021)

Executive functioning: A set of neurocognitive skills that enable conscious, goal-directed control of thoughts, actions, and emotions, including working memory, cognitive flexibility, and inhibitory control (Zelazo & Carlson, 2020).

Info-dumping: A communication style, often seen in ND individuals, involving the enthusiastic sharing of detailed information about a special interest (Bennie, 2025).

Kahu Pōkai (noun): The te reo Māori word for midwife.

Kanorau ā-roro (noun): neurodiversity, translated as “diversity of the brain and/or emotions” (Opai, 2019).

Koha (noun): gift, present, offering, donation, contribution - especially one maintaining social relationships and has connotations of reciprocity.

Kupu (noun): word, vocabulary, saying, talk, message, statement, utterance, lyric.

Mana (noun): prestige, authority, control, power, influence, status, spiritual power, charisma - mana is a supernatural force in a person, place or object

Managing Spoons: A self-regulation strategy based on Spoon Theory, used by neurodivergent individuals to monitor and allocate limited energy resources throughout the day. It helps in pacing activities, setting boundaries, and preventing burnout by recognising that everyday tasks consume varying amounts of energy ("spoons") (Neff, 2022).

Masking: The conscious or unconscious suppression of natural ND traits and adoption of socially acceptable alternatives, often to avoid stigma or to fit in, which can lead to emotional exhaustion and identity confusion (Pearson & Rose, 2021).

Mātauranga Māori: Māori knowledge.

Monotropism: A cognitive tendency to focus intensely on a limited number of interests or stimuli at a time, often associated with neurodivergence. It explains how ND individuals may experience deep engagement in specific interests while finding it difficult to shift attention between tasks or stimuli (Dwyer et al., 2024).

Neuro-affirming: Active rejection of the medical model and its focus on "fixing" deficits in neurocognitive functioning. Neuro-affirming practice embraces difference, recognises strengths and co-creates accommodations that serve to increase participation and inclusion (Walker, 2021).

Neuroception: The brain's unconscious process of detecting safety, danger, or threat in the environment, influencing physiological and emotional responses without conscious awareness. It plays a key role in social behaviour and is particularly

relevant in understanding sensory and emotional processing in ND people (Proff et al., 2021).

Neurodevelopmental Disorder: A range of lifelong conditions characterised by impairments in cognitive, communication, behaviour and/or motor skills (American Psychiatric Association, 2013).

Neurodivergent: An umbrella term that describes individuals with a brain that diverges from what is typical; this may include autism, ADHD, dyslexia and dyspraxia among others (Doyle, 2020).

Neurodiversity: The diversity in human minds, the inexhaustible variation in neurocognitive functioning within the human species (Walker, 2021).

Neurominority: A group of individuals whose neurocognitive functioning diverges from the societal norm, including conditions like autism, ADHD, dyslexia, and others (Doyle, 2024).

Neurotype: A type of brain wiring, in relation to how a person processes cognitive, sensory and social information. For example, ND people are more likely to share the same neurotype (Silberman, 2015).

Neurotypical: An individual whose cognitive, sensory and social functioning conforms within normative standards (Doyle, 2020).

Polytropism: A cognitive style characterised by the ability to attend to multiple stimuli or interests simultaneously. It contrasts with monotropism and is often associated with ADHD, where individuals may shift attention rapidly and engage with several tasks or ideas at once (Dryden, 2024).

Radical acceptance: A psychological strategy that involves fully acknowledging and accepting reality and emotions as they are, without judgment or resistance. It is used to reduce emotional suffering by fostering nonjudgmental awareness and emotional regulation (Segal et al., 2025).

Rejection sensitivity: A heightened emotional response to perceived or actual rejection or criticism, often resulting in intense feelings of shame, anxiety, or dysphoria. In ND individuals, it can lead to masking, withdrawal, and impaired social functioning (Rownet-Smith et al., 2024).

Rōpū: group, party of people, company, gang, association, entourage, committee, organisation, category.

Sensory avoidant profile: A neurodivergent sensory processing pattern where individuals actively avoid sensory input that feels overwhelming or distressing. This profile is common in autism and may involve withdrawal from environments, activities, or interactions that trigger sensory discomfort, often impacting communication, behaviour, and quality of life (Kapp, 2025).

Sensory seeking profile: A sensory processing pattern where individuals actively seek out intense or frequent sensory input to regulate their arousal or emotional state. Common in ND people, this profile may involve behaviours like touching objects, making loud noises, or engaging in movement to fulfill sensory needs (Crasta et al., 2020).

Stimming: A self-stimulatory behaviour characterised by repetitive actions or movements of the body—such as hand-flapping, rocking, or tapping. These behaviours can help individuals regulate sensory input, manage anxiety, or express emotions (Walker, 2021).

Special interest: An intense and focused interest in a specific topic or activity, often seen in autistic individuals. These interests are typically more intense, enduring, and consuming than typical hobbies, and can be a source of joy, comfort, and identity, though they may also interfere with daily functioning (Nowell et al., 2021).

Tangata Tiriti: people of the Treaty (non-Māori) (Orange, 2023).

Tangata whenua: people of the Treaty (Māori) (Orange, 2023).

Tauīwi (noun): foreigner, European, non-Māori, colonist.

Te Ika-a-Māui - North Island of Aotearoa New Zealand.

Te Tiriti o Waitangi: the Māori-language version of the foundational 1840 agreement, was signed by representatives of the British Crown and more than 500 Māori chiefs. Unlike the English Treaty of Waitangi, it emphasises Māori sovereignty and sets the framework for the relationship between Māori and the Crown. (Came et al., 2020; Orange, 2023)

Te Waipounamu: South Island of Aotearoa New Zealand.

Whakamāhi (verb): to set to work, cause to work, operate, put to work, employ, use.

Whakawhanaungatanga (noun): process of establishing relationships, relating well to others.

Whānau (noun): extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members.



Chapter One: Introduction

Whakataukī

Kei tēnā, kei tēnā, kei tēnā
anō tōna ake āhua, tōna
ake mauri, tōna ake mana.

Each and every one has
their own uniqueness, life
essence and presence.

Although the origins of this whakataukī are not formally attributed, I include it with respect for its place as a taonga in both Māori and disability contexts, and for the way its meaning aligns with my own positionality and intentions as tangata Tiriti. It provides the lens through which this chapter—and the research that follows—begins.

Introduction

This chapter introduces the context and scope of this research by briefly outlining the neurodiversity movement and the contemporary nature of midwifery in Aotearoa New Zealand. It then presents my personal rationale for choosing this topic and establishes my positionality as a researcher. In alignment with ethical research practices in Aotearoa, I reflect on how this work engages with Te Tiriti o Waitangi. I also explain the language choices used throughout the thesis and highlight the importance of applying intersectional frameworks. The chapter concludes by stating the purpose, aim, and objectives of the study, followed by an overview of the thesis structure.



Background

The Neurodiversity Movement

This thesis is situated within the emerging field of Neurodiversity Studies, a critical paradigm that challenges traditional conceptions of cognitive normativity (Yergeau, 2018). Much like the recognition that there is no singular correct gender, sexuality, or ethnicity, neurodiversity acknowledges natural variations in cognitive, social, and sensory functioning as intrinsic aspects of human diversity (Rosqvist et al., 2020). Central to this paradigm is a rejection of the idealised rational subject; it invites a fundamental rethinking of what it means to be human (Yergeau, 2018). The term neurodiversity first gained traction in the 1990s, largely through online platforms that enabled autistic individuals to connect and advocate for their rights (Botha et al., 2024). Judy Singer, an autistic sociologist from Australia, played a pivotal role in formalising the concept during her Honours research, where she critiqued the medicalisation of autism and argued against the notion that it required a cure (Singer, 2002). By the early 2000s, the neurodiversity framework began expanding beyond the autistic community to encompass a broader range of neurodevelopmental conditions (Antonetta, 2007; Kirby, 2004). Around this time, activist Kassiane Asasumasu (UMass Office of the President, n.d) coined the term neurodivergent to describe individuals whose cognitive functioning diverges from dominant societal norms. This umbrella term encompasses conditions such as autism, ADHD, dyslexia, and dyspraxia, among others (Doyle, 2024). In contrast, individuals whose neurocognitive profiles align with socially normative standards are referred to as neurotypical (NT). Today, these online discussions and explorations have culminated into a growing body of theory, debate, and research now referred to as neurodiversity studies (Dwyer et al., 2024).

Neurodivergent conditions are typically assessed using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (American Psychiatric Association, 2013) which reflects the principles of modern psychology and is grounded in positivist scientific traditions. This model emphasises observable behaviours and external traits, often focusing on deviations from statistical norms. For instance, autism is diagnosed based on persistent challenges in social communication and interaction, alongside restricted and repetitive behaviours, all



expected to appear early in development (Botha, 2021). Psychological research has historically centered on populations that fit within the statistical average—those considered “normative”—which has led to the exclusion of individuals with atypical cognitive profiles (Harden, 2021; Kirby, 2022; Raper, 2019). This has contributed to a skewed understanding of human psychology, where white, male, able-bodied, neurotypical individuals are often treated as the default (Roberts & Mortenson, 2022). As a result, ND people are frequently pathologised, and standardised assessments—often validated on non-diverse samples—can misrepresent their experiences and lead to inappropriate interventions (Cascella, 2009; Fletcher & Navarrete, 2003; Pearce & Williams, 2013).

Te ao Māori Perspectives on Neurodivergence

Research into neuro-developmental conditions often lacks ethnic diversity, and diagnostic tools have consequently failed to incorporate the unique constructs of Indigenous Peoples (Simpson, 2021). Māori scholars have highlighted that the concept of neurodiversity closely aligns with their own views on disability. Bevan-Brown (2013) found that tāngata whaikaha are seen by Māori as “*special and precious with their own personal mana*” (p 576); autistic whānau members are considered a variation on normal with their own strengths and challenges. Kanorau ā-roro is the kupu Māori for neurodiversity and is translated as “diversity of the brain and/or emotions” (Opai, 2020). Simpson (2021) highlighted that culture is integral to the way kanorau ā-roro is experienced, defined and managed. A positive neurodivergent and indigenous self-identity is possible and can even be a protective mechanism for improved mental and physical health outcomes (Simpson, 2021). Māori scholars argue that this requires a shift from our current pathologised model towards a decolonised strength-based approach that closely aligns with the neurodiversity model (Bevan-Brown, 2013). As a Tangata Tiriti researcher working towards epistemological justice, I recognise the importance Kaupapa Māori research within the ND space.

The Wider Disability Context of Neurodivergence

The neurodiversity movement is positioned within the human rights model of disability. Rather than viewing neurodivergence as a disorder, it frames disability as a result of societal barriers and systemic ableism (Rosqvist et al., 2020). This model emphasises autonomy, inclusion, and self-identification, allowing individuals to see



themselves as ND without needing a formal diagnosis (Elsherif et al., 2022; Kapp et al., 2013; 2022; Walker, 2021). In Aotearoa New Zealand, neurodivergence is legally recognised as a form of disability under the Human Rights Act (Te Kāwangatanga o Aotearoa | New Zealand Government, 1993), which includes psychological and psychiatric conditions. However, whether an ND person identifies as disabled is a personal decision (Accardo et al., 2024). While the law provides protections and rights, the neurodiversity paradigm prioritises individual agency and lived experience over clinical categorisation.

This research adopts a broad neurodiversity framework by examining ND conditions collectively rather than focusing on a single diagnosis such as autism. This approach reflects the growing recognition that neurodevelopmental traits often overlap across diagnostic categories (Doyle, 2020). Studies have identified cognitive continuities between conditions such as autism and dyslexia (Williams & Casanova, 2010), ADHD and dyslexia (Sánchez-Morán et al., 2018), and borderline personality disorder and autism (Dudas et al., 2017). Genetic research further supports this interconnectedness, revealing shared mutations and risk factors across multiple neuropsychiatric conditions, including ADHD, autism, schizophrenia, and bipolar disorder (Brainstorm Consortium et al., 2018; Cabana-Domínguez et al., 2022; Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013, 2019; Zhu et al., 2014;). Some scholars even propose a unified neurodevelopmental spectrum influenced by epigenetic factors such as environment, stress, and lifestyle. By considering these conditions together, this study aims to better understand the shared and distinct needs of ND individuals within a holistic framework.

Neurodivergent People in the Health Professions?

Understanding neurodivergence as a spectrum of interconnected conditions highlights the importance of examining how societal structures, such as healthcare professions, respond to difference. A key lens for this is ableism - a systemic form of discrimination experienced by disabled communities, driven by socially constructed ideals of “normalcy, productivity, desirability, intelligence and fitness” (Lewis, 2022, para. 4). Within healthcare and other professional fields, ableism often manifests in assumptions that ND individuals may be unsuitable due to perceived deficits in cognitive or communication abilities (Bury et al., 2021; Hedlund, 2023). Emerging research challenges these deficit-based assumptions, reframing communication



differences between ND and NT individuals as mutual rather than one-sided. This concept, known as the “double empathy problem” (DEP), suggests that misunderstandings arise from differing cognitive and communicative styles rather than inherent impairments (Milton, 2012; Morrison et al., 2019).

Further complicating the overall understanding of neurodivergence in professional contexts is a longstanding research bias that centers white male experiences, leading to the underdiagnosis of ND women and gender-diverse individuals. These so-called “lost generations” (McDonald, 2020; Young et al., 2020) often internalise their ND traits (Galea, 2021), engage in masking or camouflaging behaviours to navigate social expectations (Nussbaum, 2012; Young et al., 2020), and may present with higher verbal and social skills or pursue gender-normative interests such as caregiving and animal-related activities (McDonald, 2020; Young et al., 2020). As awareness of neurodivergence grows and shifts towards more affirming and inclusive understandings, increasing numbers of individuals are seeking assessments later in life. Given that midwifery is a predominantly female profession, it is likely that some kahu pōkai are themselves navigating this journey of ND self-discovery.

Aotearoa New Zealand Perinatal Context

Understanding the experiences of ND kahu pōkai in Aotearoa New Zealand requires an appreciation of the professional and systemic context in which they practice. Midwifery in Aotearoa is a self-regulated profession, with Te Tatau o te Whare Kahu | Midwifery Council of New Zealand (MCNZ) overseeing registration, Scope of Practice, Code of Conduct, competency standards, cultural competence (Tūranga Kaupapa), and continuing education (MCNZ, n.d.). Te Kāreti o Nga Kaiwhakawhanau Ki Aotearoa | The New Zealand College of Midwives (“The College”) provides practice guidance through the Midwives’ Handbook for Practice, including the midwifery philosophy, Code of Ethics, and Standards for Midwifery Practice (NZCOM, 2018). Five institutions currently deliver a direct-entry undergraduate degree that integrates academic and clinical learning, preparing kahu pōkai to work autonomously (Gilkison et al., 2016; Te Kāwangatanga o Aotearoa | New Zealand Government, 2024). More recently, the University of Waikato introduced a Graduate Entry Masters (GEM) in Midwifery - the Master of Clinical



Practice (Midwifery) - as a pre-registration pathway for those with (non-midwifery) health professional qualifications to transition to midwifery registration.

The national perinatal system supports kahu pōkai-led continuity of care, allowing a single kahu pōkai or practice to provide holistic care from pre-conception to six weeks postpartum (NZCOM, 2018). When complications arise, multidisciplinary collaboration ensures comprehensive care. Aotearoa's perinatal model is internationally distinctive, with 95% of whānau engaging a Lead Maternity Carer (LMC), most of whom are kahu pōkai contracted to provide continuity of care without charging fees, instead claiming through the national maternity contract (Health NZ | Te Whatu Ora, 2024; Manatū Hauora | Ministry of Health, 2021). Within the workforce, 31% of kahu pōkai provide case-loading LMC care, while 46.6% are employed in rostered shifts across hospital settings. A small proportion (2.6%) of employed kahu pōkai offer continuity of care within regional health services but are not required to be on-call for births. The remaining 13% work in education, management, or research roles (Te Tatau o te Whare Kahu | Midwifery Council, 2023).

Caseloading kahu pōkai often report working over 40 hours per week yet also report higher job satisfaction despite lower work-life balance scores (Dixon et al., 2025). Hospital-based kahu pōkai, while working fewer hours, face higher workloads due to the unpredictable nature of acute perinatal care. Aotearoa currently faces a kahu pōkai workforce shortfall of approximately 1,050 full-time equivalents—around 40% of the required workforce (Te Whatu Ora | Health New Zealand, 2024). Globally, midwives face similar challenges, including high workloads, limited autonomy, exposure to trauma, and insufficient resources, all contributing to burnout and reduced job satisfaction (Albendín-García et al., 2021; Hansson et al., 2022; Hunter et al., 2019; 2022; Sidhu et al., 2020). Gaining insight into the lived experiences of kahu pōkai is essential for developing strategies that enhance retention, foster inclusion, and address workforce shortages through more supportive and sustainable working environments.



My research interest

My interest in exploring the experiences of ND kahu pōkai is both scholarly and deeply personal. I was first diagnosed as ND during my initial year of practice as a newly graduated LMC. The journey began with an autism diagnosis and later expanded to include ADHD, dyslexia, dyscalculia, and multiple sclerosis. This period was marked by professional uncertainty and profound shifts within my whānau, as both my daughters experienced what we later came to understand as autistic burnout - a syndrome characterised by chronic, pervasive exhaustion, loss of skills or functioning and reduced tolerance to sensory stimuli, often resulting from prolonged stress and inadequate support (Raymaker et al., 2020). Our diagnostic journeys—mine and theirs—revealed the gendered dimensions of neurodivergence and the systemic barriers to recognition and support. While receiving a diagnosis offered valuable insight into my lived experience, navigating the professional landscape as an “out” ND kahu pōkai has often felt isolating. Early disclosures were met with dismissive remarks like “you don’t look autistic” and “well, we’ve all got problems,” highlighting a pervasive lack of awareness and support within the midwifery community. Connecting with fellow ND kahu pōkai Bronwyn Rideout was a turning point. Together, we launched peer-led initiatives such as neurodiversity education days and The Neurobirth Podcast (2023), creating spaces for visibility, solidarity, and community. This research is driven by a commitment to illuminate the realities of ND kahu pōkai, to foster a more inclusive professional culture, and develop the kind of resource I wish had existed when I began my journey.

Positioning

Alongside my neurodivergent identity, I also identify as queer and non-binary. These facets of who I am shape the way I interact with the world and influence my approach to research. Furthermore, I recognise the privilege I hold as a white person who is frequently perceived—based on outward appearance—as heterosexual, non-disabled, and cisgender. This perception grants me access to unearned advantages within the colonised societal structures of Aotearoa New Zealand. My educational background, lived experiences, and professional role as a kahu pōkai are all informed by this complex positioning.



In qualitative research, it is widely accepted that a researcher's positionality plays a crucial role in ensuring the integrity and trustworthiness of the study (Braun & Clarke, 2022; Jacobson & Mustafa, 2019). The perspectives and experiences a researcher bring to their work influences every phase of the process—from shaping the research questions and selecting methods, to interpreting findings and offering practical insights (Secules et al., 2021). By openly acknowledging these influences, researchers contribute to greater transparency and offer a clearer understanding of the context in which the research is situated.

As someone who is Tangata Tiriti, I am committed to upholding my responsibilities under Te Tiriti o Waitangi in both my personal life and professional practice. Te Tiriti o Waitangi is central to research conducted in Aotearoa New Zealand, shaping ethical responsibilities and guiding engagement with Māori communities. Although originally intended to establish a partnership and protect Māori rights, historical mistranslations and the exercise of colonial dominance have led to enduring inequities (Human Rights Commission, n.d; Tahere & Tupara, 2020). As a Tauīwi researcher, I acknowledge my role in upholding Te Tiriti across personal, professional, and academic contexts, particularly within health research where the impacts of colonisation continue to shape outcomes and perpetuate disparities (Health Research Council of New Zealand, 2019). This commitment involves an ongoing journey of self-reflection and actively working to challenge and dismantle colonial structures within the spaces I inhabit and influence (Came et al., 2023).

Insider Status

My dual positioning as both a kahu pōkai and a ND person situates me as an 'insider' within the participant group. This insider status offers a unique epistemological advantage, allowing for deeper, more authentic engagement with participants and a richer understanding of their lived experiences. The inclusion of ND researchers in neurodivergent-focused research has been shown to reduce ableist assumptions and enhance the relevance, nuance, and quality of findings (Botha & Cage, 2022; Urbanowicz et al., 2019). Historically, research on neurodivergent people has often been conducted from an outsider perspective, focusing on observable traits with the aim of diagnosis, normalisation, or cure. This approach has frequently excluded the voices of those being studied, reinforcing deficit-based narratives. However, there is a growing movement toward participatory and community-led research, where



neurodivergent scholars are reclaiming the narrative and reshaping the research agenda (Azevedo et al., 2022; Botha, 2021; Matheiken, 2024).

Insider research has the power to illuminate the neurodivergent experience from within, offering insights that are often inaccessible to external observers. This shift enables research to move beyond pathologising frameworks and toward understanding how to meaningfully support and improve the lives of neurodivergent individuals. By embedding lived experience into the research process, this study aims to contribute to a more inclusive and transformative body of knowledge (Botha, 2021).

Intersectionality

Neurodivergent individuals, who are part of the broader disabled community, often find that their identities are narrowly defined by their neurological differences. This reductionist view can overshadow other important aspects of who they are, such as their gender identity, sexual orientation, or cultural background (Cascio et al., 2020). For example, the concept of “neuroqueer,” introduced by autistic scholar and advocate Nick Walker (2023), highlights the meaningful overlap between neurodivergent and LGBTQIA+ communities. Living in a society structured around neurotypical norms—especially within professional environments—can intensify the challenges faced by ND individuals who also belong to other marginalised groups (Cascio et al., 2021). These intersecting identities can heighten participants’ vulnerability in research settings, making it essential to approach such work with sensitivity and care.

This study was grounded in an intersectional framework, ensuring that diverse identities were acknowledged and respected throughout the research process. A key part of this approach involved ongoing reflection on whose voices were included or excluded. To honour the multifaceted identities of participants, the research design incorporated gender-inclusive language and Kupu Māori, recognising the cultural and linguistic dimensions that intersect with neurodivergence. These choices were not only inclusive but also reflected a deliberate commitment to Te Tiriti o Waitangi aligned practice. Tiriti-aligned approaches are inherently intersectional, fostering environments of belonging, respect, and shared authority-principles that guides both the language used and the broader research ethos.



Language

Language holds transformative power in shaping how identities are understood, respected, and valued. In this thesis, I have intentionally prioritised the use of the term kahu pōkai in place of “midwife” or “midwives,” and whānau instead of “women” or “consumers.” While these terms are not used exclusively, their inclusion reflects a commitment to culturally affirming language that honours te reo Māori and upholds the principles of Te Tiriti o Waitangi.

Whānau is an inclusive Māori term that acknowledges the diversity of individuals within their social and relational contexts. Crucially, the definition of whānau is determined by whānau themselves—this autonomy is essential to preserving the integrity and full meaning of the term. Whānau are the rightful determiners of what health and wellbeing mean for them. Recognising the collective does not diminish individual rights and interests; rather, it situates them within a broader, relational framework (Te Tatau o te Whare Kahu | Midwifery Council, n.d.-b). These language choices align with the terminology used in Whānuitanga o Te Mahi | Midwifery Scope of Practice (Te Kāwanatanga o Aotearoa | New Zealand Government, 2024). They represent not only a political and ethical stance, but also a methodological one—affirming that the language we use shapes how we see, understand, and value people.

This same principle applies to how neurodivergent identities are named and understood. As Sainsbury (2000, p. 12) powerfully states: “We are not people who ‘just happen to have autism’; it is not an appendage that can be separated from who we are as people, nor is it something shameful that has to be reduced to a sub-clause.” This perspective challenges deficit-based framings that treat neurodivergent conditions as needing to be fixed or cured and instead affirms it as a core part of identity. By embedding this understanding into the language and structure of the research, this thesis resists the historical tendency to observe ND people from the outside. Instead, it centres insider knowledge and lived experience, using language that reflects the richness and complexity of participants’ identities (Bottema-Beutal et al., 2021). For example, rather than using person-first language such as “person with autism,” this thesis adopts identity-first language, referring to “autistic people” to affirm autism as an integral aspect of identity rather than a detachable condition.



Wayfinding Visuals

To enhance accessibility for neurodivergent readers, I incorporated wayfinding visuals—using both colour and icons—throughout the main chapters of my thesis. Large academic documents can be cognitively demanding, especially for ND individuals, who may experience challenges with working memory, sequencing, and maintaining focus (Taylor, 2021; Nicolson & Fawcett, 2008). Many ND people also possess enhanced visual-spatial skills and benefit from visual scaffolding that supports comprehension and navigation (Eide & Eide, 2011). These visual cues allow readers to orient themselves within the document, even when engaging with isolated chapters, by providing consistent reminders of their location in the broader structure. This approach reduces cognitive load and increases independence, making the thesis more inclusive and user-friendly (Jaleniauskiene & Kasperuniene, 2023; Joyful Soul Psychology, 2025). The icons used to represent each chapter were obtained under license from The Noun Project (n.d.), an extensive repository of professionally curated, high-quality vector graphics produced by a global community of artists. The surrounding colour wave motifs were independently designed and created by myself.

Research Aims and Objectives

This study sought to explore the experiences of ND kahu pōkai in Aotearoa New Zealand, with the overarching aim of increasing their visibility within the profession and highlighting the unique strengths they contribute to kahu pōkai practice. A further objective was the co-creation of a guidance document that outlines strategies for fostering neuro-inclusive workplaces and enhancing the professional wellbeing of ND midwives. Central to this research is the recognition of the emotional and professional needs of midwives. Previous studies have shown that feeling valued and acknowledged in their roles significantly enhances emotional wellbeing (Dixon et al., 2017; Mharapara et al., 2024). Moreover, a strong sense of purpose and meaning in their work is closely linked to job satisfaction, reinforcing the importance of cultivating environments where midwives feel respected and fulfilled (Hansson et al., 2022). In the context of rising attrition and burnout across the kahu pōkai workforce, promoting diversity and inclusion is a critical kaupapa. Understanding the lived experiences of ND kahu pōkai is also a foundational step toward building a



more equitable and responsive health system. As the UK's General Medical Council (2021) asserts, "A diverse population is better served by a diverse workforce that has had similar experiences and understands their needs."

To guide this inquiry, the following research questions were developed:

- What are the experiences of ND kahu pōkai in Aotearoa New Zealand, and what strengths do they feel they bring to the profession?
- What neuro-affirming changes or improvements would ND kahu pōkai like to see in the profession, and what strategies do they believe would help achieve these goals?

To address these aims, a qualitative research design was adopted, well-suited to exploring under-researched areas and capturing diverse lived realities (Kivunja & Kuyini, 2017; Levers, 2023), because this is essential for understanding the varied experiences and perspectives on ND kahu pōkai within their professional context. A relational constructivist approach informed the study, allowing for co-constructed knowledge and acknowledging the researcher's insider position (van der Haar & Hosking, 2004). This perspective supported a collaborative and participatory process of meaning-making with ND participants; these aspects are defined and explored later in the research methodology chapter.

The research process was designed to be affirming and empowering for all involved. Appreciative Inquiry was employed to centre strengths-based insights and challenge deficit-based narratives. Guided by the AI 4-D cycle—Discover, Dream, Design, Destiny (Brookes, 2017; Cooperrider & Whitney, 2005)—the study used affirmative questioning to explore participants' experiences and aspirations.

Data collection occurred in two phases:

1. Semi-structured interviews aligned with the Discover, Dream, and Design stages. Participants shared what they valued about being ND kahu pōkai, the strengths they brought to their work, and their visions for a neuro-affirming career.
2. An asynchronous online focus group enabled participants to review and respond to themes generated from Phase One using reflexive thematic analysis. This continued the Design stage, allowing for collaborative refinement of strategies to support ND kahu pōkai. The Destiny stage focused



on shaping a guidance document to share these insights with the wider kahu pōkai community.

Grounded in the neurodiversity paradigm and informed by disability-affirming, person-oriented research ethics, the study was designed to respect neurocognitive diversity throughout both participation and knowledge creation. Recognising that conventional qualitative methods may pose barriers for ND individuals, methodological adaptations were incorporated to support diverse communication and processing styles. Drawing on practices developed by disabled academics, the study offered flexible participation options and responsive design features to foster an inclusive research environment.

Thesis Overview

Chapter One: Introduction

The opening chapter establishes the foundation of the study by outlining its purpose, aims, and objectives. It contextualises the research within contemporary midwifery in Aotearoa New Zealand and introduces the neurodiversity movement's historical background. The chapter also explores how neurodivergence and disability intersect, particularly within health professions such as midwifery, through an intersectional feminist lens. The researcher's positionality is articulated, and the relevance of Te Tiriti o Waitangi in shaping ethical research practices in Aotearoa is emphasised.

Chapter Two: Literature Review

Given the limited research on ND kahu pōkai, this chapter broadens the scope to examine what is currently known about the workplace experiences of ND healthcare professionals. Through a critical review of existing literature, it identifies a significant gap that underpins the study's rationale. This review, previously published in the New Zealand College of Midwives Journal (Taylor et al., 2024) and reprinted in this thesis with permission (Appendix One), contributes to the emerging discourse on neurodiversity in healthcare.

Chapter Three: Methodology

Here, the methodological approach is outlined, with a focus on creating a process that is affirming for all involved. Appreciative Inquiry is introduced as the guiding



methodology, supported by theoretical foundations and adapted through the Person-Oriented Research Ethics framework—developed by disabled scholars to support neuro-inclusive research. The chapter details recruitment, data collection, and analysis methods, all designed to honour neurocognitive diversity in both participation and knowledge creation.

Chapter Four: Findings

This chapter presents five interrelated themes that capture the lived experiences of participants as ND kahu pōkai. It highlights the strengths they bring to the profession and their visions for a more inclusive midwifery landscape. These themes offer insight into both the systemic challenges and the transformative potential of ND perspectives in midwifery.

Chapter Five: Discussion

Building on the findings, this chapter revisits the study's aims and research questions, offering a synthesis of key insights. It then situates these findings within the broader body of international literature on ND healthcare professionals, as well as recent contributions from scholars working within the neurodiversity paradigm. This comparative analysis deepens the understanding of how the study's findings align with or diverge from existing research.

Chapter Six: Conclusion

The final chapter reflects on the study's strengths and limitations, offering recommendations for kahu pōkai practice and identifying opportunities for further research. It concludes with final remarks and a personal reflection, underscoring the significance of the research journey and its contribution to advancing neuro-inclusive approaches in midwifery and beyond.

Chapter Summary

This chapter has laid the groundwork for the thesis by introducing the broader context in which the research is situated, including a brief overview of the neurodiversity movement and the current landscape of kahu pōkai in Aotearoa New Zealand. It has outlined the personal motivations behind the study and established my positionality as a researcher, acknowledging how my lived experience as a



neurodivergent individual and my role as a kahu pōkai contribute to the insider perspective that informs this work. The chapter also reflects on the importance of honouring Te Tiriti o Waitangi within research practice, particularly in relation to equity and ethical responsibility. Key decisions around language use and the application of intersectional frameworks have been explained, highlighting their relevance to both the research topic and methodology. Finally, the chapter has presented the study's purpose, aim, and objectives, and provided a roadmap for the structure of the thesis. The next chapter builds on this foundation by critically engaging with existing literature on ND healthcare professionals. In doing so, it broadens the scope beyond kahu pōkai to explore the wider context of neurodiversity in healthcare workplaces, identifying key gaps that inform the rationale for this study.



Chapter Two: Literature Review

Building on the groundwork laid in Chapter One, which introduced the broader context of this research—including the neurodiversity movement, the current landscape of kahu pōkai in Aotearoa New Zealand, and my own positionality as a ND researcher—this chapter presents literature relevant to the experiences of ND health professionals. This is done through the inclusion of a previously published article, which appears in full (see Appendix One for reprint permission information). The article was published in the New Zealand College of Midwives Journal in 2024 (Taylor et al., 2024). As a reprint, some content may overlap with material already discussed in Chapter One and elsewhere in the thesis. The article was co-authored by my research supervisors and contributes a foundational perspective that informs the subsequent chapters.

Introduction

Underdiagnosis of neurodivergent (ND) conditions for people assigned female at birth plus non-disclosure due to stigma obscures the true incidence of neurodivergence within our society (Drysdale & van der Meer, 2020; Grove et al., 2023; Radulski, 2022; Young et al., 2020;). Aotearoa New Zealand has no national register on the adult incidence of ND conditions (Drysdale & van der Meer, 2020). Estimates from overseas suggest that neurominorities may account for around 20% of the general population: this is a significant minority group (Cooper et al., 2018; Doyle, 2020; Moore, 2021). A report recently published by the Ministry for the Environment highlighted that ND people are an untapped talent within Aotearoa's workforce (Hammond, 2022). As awareness and diagnosis of ND conditions increase, more health professionals, including midwives, may be discovering their ND identity (Shaw, Doherty et al., 2023). Currently, there is a dearth of research exploring the experiences of ND midwives; this literature review therefore casts a wider net and asks: what is known about the workplace experiences of ND healthcare professionals?

Positioning

Identity-first language has been used throughout this paper (“autistic person” instead of “person with autism”) in light of evidence demonstrating ND people's preference



for identity-first language (Bottema-Beutal et al., 2021). The lead author (AT) is a Pākehā kahu pōkai and Master of Midwifery candidate. They are an autistic, ADHD, dyslexic person diagnosed in their new-graduate year. Including ND academics in ND research has been associated with reducing ableist constructions and improving the scope and quality of the published findings (Botha & Cage, 2022; Urbanowicz et al., 2019). Co-authors (LD and SM) are Pākehā midwifery academics who are both neurotypical, supporting AT as research supervisors.

Rationale for Literature Review

Understanding the experiences of ND health professionals could be a step in the right direction towards a more inclusive and equitable health service. As noted by the UK's General Medical Council, '*A diverse population is better served by a diverse workforce that has had similar experiences and understands their needs*' (General Medical Council, 2024, para. 5). This paper positions itself within the relatively new critical paradigm known as Neurodiversity Studies (Yergeau, 2018). Just as there is no one "correct" gender, sexuality or ethnicity, intrinsic neurotype variations can be seen in cognitive, social and sensory functioning (Rosqvist et al., 2020). The neurodiversity paradigm opposes the notion of an ideal rational person; ontologically, it asks us to reconsider what it means to be human (Yergeau, 2018). The concept of neurodiversity emerged online during the 1990s; the growth of the internet provided a platform for the ND community to connect and establish a self-advocacy movement (Silberman, 2015). An autistic Australian sociologist, Judy Singer, further championed the understanding of neurodiversity in 1998 to challenge the prevailing paradigm that certain neurodevelopmental conditions were pathological and required a cure (Singer, 2002). 'Neurodivergent' is an umbrella term that describes individuals with a brain that diverges from what is typical; this may include autism, attention deficit hyperactivity disorder (ADHD), dyslexia and dyspraxia, among others (see glossary). Neurodivergent symptoms or features are understood to overlap between various conditions (Doyle, 2020). An individual whose neurotype conforms to normative cognitive, sensory and social functioning standards is described as neurotypical (NT).

Instead of employing the medical model and its focus on disorder and deficit, neurodiversity scholarship is rooted in the human rights model of disability, where ableist barriers within society create inequities for ND people (Rosqvist et al., 2020;



Te Whatu Ora, 2023). Neurodivergent people therefore have agency to choose whether they consider their neurodivergence as a disability or not. Ableism is a system of discrimination experienced by the disabled community, fuelled by socially constructed beliefs around “normalcy, productivity, desirability, intelligence and fitness” (Lewis, 2022, para 4). An example of ableism in action is the pervasive idea that ND people may be unsuitable for healthcare occupations due to deficits in cognitive and communication skills (Bury et al., 2021; Hedlund, 2023). However, recent research highlights that interpersonal misunderstandings between neurotypes are instead a two-way problem (Morrison et al., 2019); challenges occur due to differing cognitive and communication styles, known as the “double empathy problem” (DEP) (Milton, 2012, p. 884).

Research bias in favour of white males, alongside pervasive stereotypes, has contributed to the underdiagnosis of ND women and gender-diverse people. These so-called “lost generations” (McDonald, 2020; Young et al., 2020) tend to internalise ND features (Galea, 2021), camouflage or mask traits as a social survival strategy (Nussbaum, 2012; Young et al., 2020), display higher verbal and social skills, and partake in gender normative special interests such as care activities with people and animals (McDonald, 2020; Young et al., 2020). As the understanding of neurodivergence shifts towards a neuro-affirming world, more people are pursuing ND assessments later in life (McDonald, 2020; Young et al., 2020), and, as a predominantly female profession, there may be midwives traversing this journey of self-discovery.

Intersectionality

Neurodivergent people, as part of the disabled community, are often reduced to their condition, with other facets of their identity, such as sexual orientation, gender identity and ethnicity, being neglected (Cascio et al., 2020). For example, the term “neuroqueer”, coined by the autistic academic and advocate Nick Walker (2023), speaks to the significant intersection between the LGBTQIA+ and ND communities. Navigating a neurotypical world, including the workplace, likely adds additional layers of burden to the lived experience of ND people with intersecting identities (Cascio et al., 2021).

An individual’s experience of belonging to multiple minority groups can create



research environments of increased vulnerability for participants. This research will embed intersectional awareness throughout the study design; this requires regular reflection on, “*who is and is not in the conversation*”. Kupu Māori and gender-inclusive language will be woven throughout the research design as an acknowledgement of the significant axis between neurodivergence and other identities the participants may carry

Māori Perspectives on Neurodivergence

The combination of being Māori, female, ND and a kahu pōkai presents a unique intersection of identities that likely brings its own unparalleled experiences. According to Simpson (2021, p. 417), “...factors such as ethnicity, disability and gender can, separately, pose difficulties [and] “...when combined...can develop into insurmountable difficulties”. Neurodivergent Māori experience systemic inequity in access to neurocognitive assessments despite many international studies confirming that neurodivergence spans equally across all ethnicities. Research into neurodevelopmental conditions lacks ethnic diversity, and diagnostic tools have consequently failed to incorporate the unique constructs of Indigenous peoples (Simpson, 2021); this compounds underdiagnosis for ND wāhine (female) Māori. Interestingly, te reo Māori can be seen to align with the neurodiversity paradigm. The kupu Māori for neurodiversity is kanorau ā-roro and it translates to “the many faces of the mind” (Riwai-Couch, 2021). Autism is known as takiwātanga, meaning “in my/his/her own time and space”; ADHD is called aroreretini or “mind/attention on many things” (Opai, 2020). In addition, research within the educational sector highlights that for Māori, tāngata whaikaha, meaning “differently abled people”, are seen as “special and precious with their own personal mana” (Bevan-Brown, 2013, p576). Simpson (2021) highlights that Māori culture is integral to the way kanorau ā-roro is experienced, defined and managed; autistic whānau members are considered a variation of normal with their own strengths and challenges. Understanding the unique experiences of an ND Māori kahu pōkai is a vital research kaupapa (topic) that currently does not exist in the literature.

Method

This integrative review aimed to explore current knowledge on the workplace experiences of ND healthcare professionals. The intention was to provide a



descriptive mapping of the existing data and identify areas for future research (Grant & Booth, 2009). Four databases were explored for this literature review, including Google Scholar, PubMed, CINAHL and ProQuest. The initial search was conducted in June 2023 and then repeated in September 2023. Search terms included (midwi* OR nurs* OR doctor* OR healthcare professional) AND (employment OR experiences OR and perceptions) AND (neurodiver* OR autism* OR aspergers OR ADHD OR dyslexia OR dyspraxia OR disability). Boolean operators were utilised to find publications across the full scope of ND identities and various healthcare professions.

Inclusion criteria

The inclusion criteria were peer-reviewed qualitative and quantitative primary studies published in English from 2015 to 2023, reporting on workplace experiences of ND healthcare professionals. Commentaries, opinion pieces and editorials were excluded, as were papers focusing on the academic trajectory of ND healthcare students. Reference lists from garnered studies were hand-searched, and more relevant papers were found. The final nine studies were assessed and regarded as satisfactory for eligibility using a number of different checklists from the Critical Appraisals Skills Programme (CASP), i.e. chosen appropriate to the methodology of each study (CASP UK, n.d.). A PRISMA flow chart provides a visual reference to the integrative review process (Figure 1).

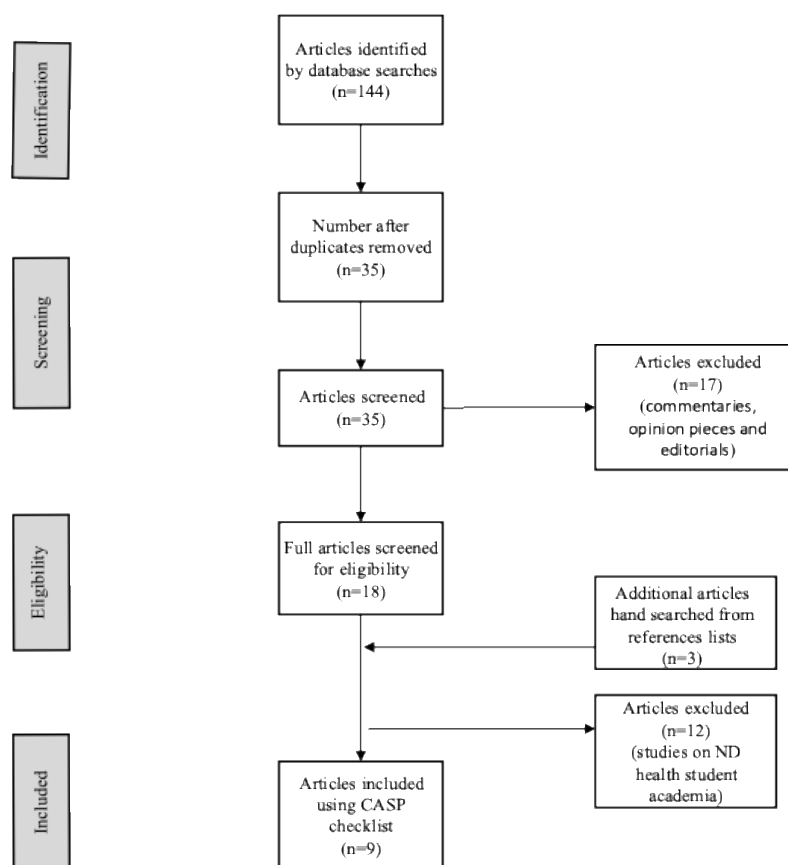


Figure 1. PRISMA Diagram

Findings

Overview

Nine studies (Table 1) have been included that investigate the experiences of a variety of ND healthcare workers (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes et al., 2021; Locke et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021). The ND identities explored within these studies included dyslexia ($n = 3$), autism ($n = 2$), ADHD ($n = 2$), dyspraxia ($n = 1$) and disability with the inclusion of a range of ND conditions ($n = 1$). The range of health professions included: doctors ($n = 6$), nurses ($n = 2$), unspecified healthcare workers within the United Kingdom's National Health Service (NHS) ($n = 1$); nursing and midwifery students in clinical placement ($n = 1$).

Within the included studies, the findings coalesced around two main concepts, each with associated sub-topics:



- (1) *The Internal Experience: Diagnosis and Disclosure, Strengths Associated with Neurodivergence, Sensory Processing and Executive Function.*
- (2) *Navigating a Neurotypical World: Social Dynamics, Self-Management Strategies and Accommodation in the Workplace.*

The Internal Experience

Diagnosis and the Disclosure Dilemma

Autistic doctors in Price et al. (2017) experienced their adult diagnosis as a “double-edged sword”; it provided much needed validation and insight into personal challenges and generated fear over potential stigma upon workplace disclosure. Until their diagnosis, ADHD doctors spoke of not realising how much their daily lived experience differed from their NT colleagues; participants were hesitant about disclosure to their peers but not to people outside the medical profession (Godfrey-Harris & Shaw, 2023). In a New Zealand-based study, almost all the nurses included chose not to disclose their disability (Hughes’ phrasing) at work due to concerns about confidentiality and doubts about receiving fair treatment (Hughes, 2021). Dyspraxic doctors wanted to disclose their diagnosis to access support and accommodations; they also described feeling vulnerable and worried they would be seen as constituting a weakness within the team (Walker et al., 2021). Doctors in Godfrey-Harris & Shaw’s study (2023) described a fear of “weaponised professionalism”, where inherent features of ADHD, such as fidgeting and reduced eye contact, would be perceived as unprofessional or improper (Godfrey-Harris & Shaw, 2023).

Price et al. (2017) reported that disclosure positively impacted communication and feedback channels, but overall responses were mixed, with some participants describing the experience as distressing. Neurodivergent healthcare workers across all nine studies expressed having to face widespread misconceptions regarding ND features and reported workplace discrimination in response to their disclosure (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Lock et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021). Nurse participants in Hughes’s study (2021) also highlighted the extra stigma associated with an invisible disability. In preference to disclosure, many ND workers concealed or masked their ND features. The ADHD doctors in Godfrey-Harris and Shaw’s study (2023) described masking as a strategy



to reduce potential discrimination and balance the inequity they experienced compared to their NT colleagues. However, participants felt that maintaining this “protective shield” consumed vast amounts of energy, negatively impacting their daily lives, such as their mental health, eating and relationships.

Strengths Associated with Neurodivergence

Neurodivergent healthcare workers across all the studies expressed confidence in creating a strong therapeutic relationship with clients. Participants in Rowe et al.’s research (2021) described deep satisfaction with their ability to build person-centred, collaborative relationships, motivated by their passion for working in healthcare. Midwifery and nursing students believed they had strong interpersonal skills with patients; clinical supervisors validated this with additional comments made about exemplary care provision (Crouch, 2019). Dyspraxic doctors positioned themselves within the social model of disability; they felt determined to achieve and viewed their dyspraxia with associated strengths rather than deficits (Walker et al., 2021). Disabled nurses from New Zealand expressed a similar stance; the only factor that impacted their ability to work was co-workers' attitudes towards their condition (Hughes, 2021). An internalised normalisation of difference was also evident in ADHD healthcare workers who described strengths such as creative thinking, hyperfocus, working well under pressure and being highly motivated on a project (Godfrey-Harris & Shaw, 2023; Rowe et al., 2021). Autistic doctors in Shaw, Fossi et al.’s study (2023) reported that the medical professions may even self-select for common ND features such as pattern recognition and attention to detail. However, scepticism about the “superpower rhetoric” was expressed by ADHD doctors; they felt like it idealised and glamourised ND features that they personally struggled with, which paradoxically minimised rather than increased their sense of agency (Godfrey-Harris & Shaw, 2023).

Sensory Processing

Healthcare environments are bustling, dynamic places where ND professionals manage innumerable sensory inputs. The ADHD health workers in Rowe et al.’s research (2021) described processing and filtering external stimuli as a daily onslaught for the senses; the noise was overwhelming. Seventy-five per cent of autistic doctors in Shaw, Fossi et al.’s research (2023) reported experiencing sensory challenges in their workplace environments. Dyslexic junior doctors



highlighted being distracted from their work by noises (Anderson & Shaw, 2020); dyslexic nursing and midwifery students found it challenging to document in loud environments (Crouch, 2019). Many ND healthcare workers highlighted that their sensory sensitivities impacted concentration, organisation and contributed to anxiety and being overwhelmed in general (Anderson & Shaw, 2020; Rowe et al., 2021; Walker et al., 2021). Rowe et al. (2021) found that some ADHD health workers sought acoustic isolation to manage noise sensitivity; participants adapted to their environment by wearing headphones or seeking separate spaces to minimise sensory stimulation. However, such strategies created additional anxiety for participants due to feeling socially isolated from colleagues.

Executive Function

Impairments in executive functioning at work were reported in all the workplace studies. For example, dyslexic midwifery and nursing students experienced difficulties with multi-tasking; labour attendance was incredibly challenging when juggling care provision and documentation requirements (Crouch, 2019). Most (77%) of the autistic doctors in Shaw, Fossi et al.'s study (2023) reported executive functioning challenges at work. Multi-tasking has cascading effects on concentration and cognitive processing speeds, feeding into anxiety and reducing confidence levels (Crouch, 2019; Hayward et al., 2019; Price et al., 2017; Rowe et al., 2021; Walker et al., 2021). Dyslexic doctors reported challenges in structuring written documentation such as referrals, prioritising tasks, keeping time during appointments and organising handover information to pass on to colleagues (Locke et al., 2016). In addition, dyslexic junior doctors experienced difficulties processing verbal information, especially over the phone (Anderson & Shaw, 2020). Dyspraxic doctors felt disorganised and self-conscious due to their need to take extra time with tasks such as completing ward rounds (Walker et al., 2021). In most studies, ND participants expressed that time pressure worsened their executive functioning (Crouch, 2019; Hayward et al., 2018; Locke et al., 2016; Walker et al., 2021). Dyspraxic doctors (Walker et al., 2021), ADHD healthcare workers (Rowe et al., 2021) and dyslexic junior doctors (Anderson & Shaw, 2020) all utilised their time outside of work to complete professional obligations such as completing documentation.



Navigating a Neurotypical World

Social Dynamics

Multiple studies outlined workplace challenges for ND people, particularly in communication and social interaction; the most common difficulties included verbal processing and understanding implicit/explicit meanings (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Price et al., 2017; Rowe et al., 2021; Walker et al., 2021). Junior doctors with ADHD described struggling to read the unspoken social map of workplace dynamics. In addition, participants commented that low self-esteem, combined with affective and functional difficulties, negatively impacted professional interactions (Godfrey-Harris & Shaw, 2023). For ADHD health professionals working within the UK's NHS, collegial relationships were described as difficult and often disempowering; participants felt misunderstood, with unequal power dynamics impacting self-esteem and confidence at work (Rowe et al., 2021). Dyslexic junior doctors reported workplace bullying from peers (25%) and clinical supervisors (23%); female doctors were more likely to feel the brunt of this (Anderson & Shaw, 2020). Godfrey-Harris and Shaw (2023) reported that ADHD doctors experienced daily microaggressions in interactions with colleagues, leading to feelings of shame and internalised ableism. Seventy-six per cent of the autistic doctors in Shaw, Fossi et al.'s study (2023) reported communication struggles with peers, 74% with clinical supervisors and 75% with hospital management but only 21% with patients.

Self-management Strategies

Participants in all the included studies described various self-management strategies developed over time to suit their precise needs. Healthcare workers took it upon themselves to manage this using various cognitive, organisational, pharmacological and physical coping strategies. Hughes (2021) mentioned that most of the tools utilised cost little or nothing. For example, dyslexic doctors created writing templates and colour codes to identify priorities and checklists; assistive technologies were also utilised, including medical apps for drug checking and speech recognition software (Locke et al., 2016). Dyslexic nursing and midwifery students orchestrated elaborate colour-coding systems to assist with drug administration (Crouch, 2019). Most ADHD health workers in Rowe et al.'s study (2021) took stimulant medication; this improved organisation, concentration and self-esteem, although participants needed to



collaborate with their health team to plan medication dosage when working night shifts. Dyspraxic doctors expressed pride regarding their self-developed strategies (Walker et al., 2021); a standard driver for ND healthcare workers across all the studies was the determination to ensure patient safety (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Lock et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021).

Registered nurses spoke of needing to be “double-double” safe or “triple safe” in clinical settings (Hughes, 2021). Dyslexic doctors described spending much time checking and re-checking to avoid making mistakes (Locke et al., 2016). ADHD healthcare workers experienced constant cognitive hyperactivity with a tendency to analyse and ruminate on possible mistakes (Rowe et al., 2021). The ADHD doctors in Godfrey-Harris and Shaw’s study (2023) explained that internalised shame regarding their ND identity led to perfectionist behaviours at work. Dyslexic midwifery students experienced hypervigilance behaviours driven by fears around safety consciousness. However, none of their interviewed clinical supervisors reported drug errors; students were described as exceptional and reliable (Crouch, 2019).

Dyspraxic doctors noticed a tendency to overcompensate for their perceived impairments: many reported feeling stupid (72%) and inadequate (66%). One doctor described starting his shift earlier to complete a pre-ward round; he did this to improve his confidence and efficiency for the official round later (Walker et al., 2021). Constant overcompensating and hypervigilance, however, comes at a price, with many ND healthcare workers reporting increased mental fatigue due to excessive cognitive demands; job burnout was a common fear expressed (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris, 2023; Locke et al. 2016; 2017; Shaw, Fossi et al. 2023; Rowe et al., 2021; Walker et al., 2021).

Accommodation in the Workplace

Neurodivergent healthcare professionals highlighted a variety of potential workplace accommodations they felt they could benefit from, including increased awareness and acceptance of neurodivergence, condition-specific adjustments and flexible work arrangements such as part-time work options (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021) For example, 50% of the autistic doctors in Shaw, Fossi et al.’s research (2023) had opted to work part-time. Social supports were



beneficial (OR 1.34, 95% CI 1.06, 1.69, $p = 0.015$) and included reduced social expectations and a preference for communication via email. Disabled nurses in New Zealand reported a dearth of organisational disability support; participants had no idea who or where to go to ask for help and commented on missed opportunities to provide accommodations (Hughes et al., 2021). Dyspraxic doctors reported receiving no workplace support (92%); they wanted psychological and pastoral support, and a peer support group (Walker et al., 2021). Autistic doctors in Shaw, Fossi et al.'s study (2023) wanted to share their experiences with others like them; 84% reported improved mental health after joining an international peer support group known as Autistic Doctors International. The participants from Shaw, Fossi et al.'s research (2023) also wished for access to positive ND role models, to help boost self-esteem and provide examples of neuro-affirming practice.

Multiple studies found that organisations often fail to implement equality policies for ND workers. For example, nurse participants in Hughes' study (2021) noted an absence of antidiscrimination and inclusion policies; they reported that this resulted in the concealment of difficulties and subsequent mistrust of the organisation. Of those who disclosed their ND identity, none of the ADHD doctors in Godfrey-Harris and Shaw's research (2023) was offered workplace accommodations; after multiple support requests, participants stopped asking. Godfrey-Harris and Shaw (2023) described a "learnt helplessness" experienced by the ADHD doctors in the absence of workplace support; this led to a significant deterioration in their mental health. When workplace adjustments were offered, they tended to be below par and focused on the individual rather than tackling systemic barriers (Hughes, 2021). Shaw, Fossi et al. (2023) also demonstrated an association between workplace challenges and poor mental health outcomes. When mental health statistics among their participants were compared alongside the general autistic population and the medical profession, Shaw, Fossi et al. (2023) found autistic doctors reported a significantly higher prevalence of suicidal ideation (77%) and self-harming behaviours (49%). Concerningly, female and gender-diverse participants reported a significantly higher level of self-harm (between 51 and 73%) than their male counterparts (17%, $p < 0.001$).

However, some of the literature demonstrated examples of workplace adjustments. For example, ADHD healthcare workers experienced improved productivity, self-esteem and confidence when their managers embodied acceptance and



understanding; helpful strategies were co-planned and included allocation of shifts within various clinical settings to improve motivation and the minimising of low stimulation tasks like attendance at long meetings (Rowe et al., 2021). Dyslexic doctors valued extra time and space to complete documentation (Locke et al., 2016). Dyslexic midwifery students were assisted by visual poster guidelines developed at an organisational level; these were especially helpful during clinical placements (Crouch, 2019). Future investigation into the benefit of assistive technology, such as the use of drug calculation apps, was also recommended within much of the literature (Crouch, 2019; Lock et al., 2016; Wissell et al., 2022). New graduate preceptorship was highlighted as an essential source of support by dyslexic students and their mentors; recommendations were made to investigate the value of extending this beyond the first year of practice (Crouch, 2019). Price et al. (2017) investigated a one-of-a-kind pilot program developed for supporting autistic doctors in the UK. This programme involved assigning a specific mentor to each doctor plus access to a specialist team, including a psychologist and occupational therapist. Participants benefited from the tailored support, utilising it to build on their strengths (such as attention to detail) and work on strategies for managing social and executive functioning challenges. Multiple studies emphasised the limitation of workplace accommodations without simultaneous disability training for all mentors, educators and colleagues across levels of the professional hierarchy (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021).



| Author (year), country | Aim | Demographics | Research design and method/s | Summary of findings | Inclusion of ND researchers |
|----------------------------------|--|--|--|---|-----------------------------|
| Anderson & Shaw (2020), UK | To explore the experiences of junior doctors with dyslexia | 75 dyslexic junior doctors | Mixed methods online survey | 72% reported feeling stupid, 66% a sense of inadequacy, 25% reported bullying, 92% had no workplace supports; females experienced greater levels of discrimination ($p < 0.05$); request for pastoral support | Yes |
| Crouch (2019), UK | To understand the impact of dyslexia on nursing and midwifery students | 12 dyslexic nursing and midwifery students, 22 clinical mentors | Qualitative, semi-structured interviews; plus analysis of student portfolios and evaluative comments from mentors collected; Glasarian grounded theory data analysis | Perceived difficulties with multi-tasking (especially during labour care provision), slow task speed (e.g., documentation), poor organising skills; fear/hypervigilance regarding safety (e.g., drug administration) but no reported errors; described by mentors as <i>reliable, caring and exceptional</i> | No |
| Godfrey-Harris & Shaw (2023), UK | To investigate the experiences of junior doctors with ADHD | 6 junior doctors with ADHD (4 female, 1 male, 1 non-binary) | Qualitative, interpretative, phenomenological; semi-structured interviews; thematic analysis | Diagnosis provided professional validation; strengths included hyperfocus and working well under pressure; different communication style to neurotypical colleagues; workplace bullying; fears of weaponised professionalism; masking as a protective shield; mental health deteriorated in the absence of workplace support; request for ND peer support | Yes |
| Hughes et al. (2021), NZ | To uncover the experiences of nurses practising with a disability | 10 nurses (9 female, 1 male); 5 out of 10 participants with various ND conditions | Qualitative, descriptive; semi-structured interviews; thematic analysis | Disclosure anxiety due to fear of workplace discrimination; feeling unseen with invisible disability; lack of overall organisation-wide support; no pathway to request workplace support; reliance on self-management strategies | No |
| Locke et al. (2016), UK | To explore the experiences of dyslexic doctors and how they perceive the impact of dyslexia on their clinical practice | 8 dyslexic doctors, 5 professional support mentors | Qualitative; 3 data collection methods (semi-structured interviews on 6 doctors, 2 interviewed 'in situ', and semi-structured interviews with 5 members of professional support team); thematic analysis | Disclosure often avoided; embarrassed to seek help; difficulties with written work (e.g., documentation), reading, verbal processing, poor short-term memory, organisational skills; each doctor developed unique self-management strategies | No |
| Price et al. (2017), UK | To understand the impact of an autism diagnosis on doctors | 3 autistic junior doctors, 3 case managers, 4 specialist support staff | Qualitative; case study methodology; semi-structured interviews; thematic analysis | Diagnosis helped develop insight into life-long challenges but also a double-edged sword; responses to disclosure often negative and distressing; widespread misconceptions about autism; positive qualities include high intelligence and attention to detail | No |
| Rowe et al. (2021), UK | To identify the professional challenges and benefits of living with ADHD as a healthcare professional | 7 health professionals with ADHD | Qualitative; interpretative phenomenological inquiry; funnelled semi-structured interviews; thematic analysis | Professional-professional social dyad challenging/confusing vs. professional-patient dyad rewarding/satisfying; sensory overload in hospital environments; fatigue from masking; ADHD brain is wired for adventure/excitement and challenged by tasks of a sedentary/repetitive nature | No |
| Shaw, Fossi et al. (2023), UK | To understand the experiences of autistic doctors | 225 autistic doctors (81.3% female, 11.9% male, 6.8% gender diverse); respondents mostly from UK, Australia, USA, Canada | Quantitative; cross-sectional online survey; pilot group utilised to refine questions; statistical analysis | 76% experienced challenging communication with colleagues vs. 21% with patients; 50% worked part-time; 46% requested workplace adjustments, half of which were implemented; 77% had considered suicide; 29% attempted suicide; 49% had self-harmed; membership to a peer support group improved overall mental health ($p = 0.017$) | Yes |
| Walker et al. (2021), UK | To explore the experiences of junior doctors with dyspraxia | 3 dyspraxic junior doctors (all male) | Qualitative; interpretive phenomenological inquiry; semi-structured telephone interviews; thematic analysis | Determination to succeed and model success in order to prove misconceptions wrong; normalisation of dyspraxia as difference, not disorder; pride in highly tuned coping mechanisms; concerns regarding clumsiness, ensuring safety, disorganisation and needing extra time for most tasks | Yes |

Table 1. *Findings of literature review*

Discussion

All nine studies included in this review highlighted workplace challenges for ND healthcare workers related to social, sensory and executive function behaviours; such findings are in keeping with current diagnostic profiles of ND conditions



(American Psychiatric Association, 2013). Neurodivergent health professionals also commented on strengths they associated with their ND identity: these included attention to detail (Shaw, Fossi et al., 2023), cognitive dynamism (Godfrey-Harris & Shaw, 2023; Rowe et al., 2021) and the ability to create collaborative, empathetic partnerships with clients (Crouch, 2019; Rowe et al., 2021). Diagnosis provided some ND health professionals with validation of their strengths as well as insight into their struggles at work. However, this personal experience of internal affirmation was often in contrast to the external and often detrimental experience around disclosure (Godfrey-Harris & Shaw, 2023; Price et al., 2017). All nine studies demonstrated widespread workplace discrimination; this was fuelled by misconceptions and ignorance amongst colleagues and employers (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Locke et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021). A UK public sector study by Cooper et al. (2018) surveyed over 600 neurodivergent respondents on their workplace experiences; only 27% of the ND participants chose to disclose their diagnosis; 49% regretted this decision. Workplace discrimination following disclosure was further compounded for ethnic minority groups (66%, $p < 0.04$), demonstrating the existence of additional layers of burden across intersecting identities among participants.

Many participants concealed or masked their ND features at work; this negatively impacted their mental health (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Lock et al., 2016; Rowe et al., 2021; Shaw, Fossi et al., 2023) and generated fears regarding job burnout (Godfrey-Harris & Shaw, 2023; Rowe et al., 2021). Outside the employment literature, masking or concealment of ND traits has also been associated with poor mental health, as well as higher rates of burnout and suicide. However, the strength of the association between these factors needs more empirical investigation before causation can be determined (Cassidy et al., 2018; Hull et al., 2021).

Instead of disclosure, ND healthcare workers developed nuanced self-management strategies to ensure success and safety. Examples of workplace accommodations from employers were limited, but when utilised, they assisted ND workers in not only managing their challenges but also playing to their strengths (Crouch, 2019; Price et al., 2017; Rowe et al., 2021). A general workplace study by Harvery et al. (2021) also highlighted the importance of workplace adjustments; the autistic participants in this



study were significantly more likely to be appropriately utilised (rather than under or unemployed) when receiving accommodations. Harvery et al. (2021) recommended potential workplace supports including increased collegial awareness and acceptance of neurodivergence, condition-specific adjustments and flexible work arrangements such as part-time work options.

A recently published scoping review, looking into the workplace experiences of nurses and midwives practising with a wide range of disabilities, reported similar themes of employment discrimination, disclosure issues and hypervigilance regarding patient safety (Baker et al., 2023). Furthermore, when workplace environments failed to provide adequate accommodations, the impact of these unsupported environments led to job burnout, and a decision to leave the healthcare profession entirely. How might ND midwives in Aotearoa be coping given the current climate of high professional attrition and burnout?

Within the healthcare worker literature, most participants received their diagnosis in adulthood, generally during a crisis when workplace and personal life demands overwhelmed their coping mechanisms (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Locke et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021). With the exception of the studies carried out by Shaw, Fossi et al. (2023) and Godfrey-Harris & Shaw (2023), all the research participants were in the early stages of their work in a healthcare profession, so a further opportunity exists to research whether midwives would report different workplace experiences as they advanced through their careers.

Neurodivergent scholars must become the drivers of research to facilitate a shift of epistemic norms that connect perspectives between the internal experience and observations of what ND looks like from the outside (Kourti, 2021). Within the literature, four studies included ND researchers (Anderson & Shaw, 2020; Godfrey-Harris & Shaw, 2023; Shaw, Fossi et al., 2023; Walker et al., 2021); the remaining did not, although their study designs were positioned within the social model of disability.



Limitations

The neurodiversity paradigm equally values evidence from the lived experience of ND people and the quantitative medical sciences (Rosqvist et al., 2020). Within the current literature, qualitative work is predominant (Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes, 2021; Locke et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021): such small cohorts provide valuable findings, but they are not generalisable. However, themes uncovered through these initial subjective lenses can drive future empirical inquiry.

Despite an extensive search strategy, this integrative review did not include the full breadth of ND identities. This was in part due to the innate limitations of needing to choose a sustainable number of search terms. As the research community shifts toward study designs that incorporate the neurodiversity paradigm, it is likely that the recruitment of participants will become increasingly more representative of the entire ND umbrella (Cooper et al., 2020).

Finally, eight out of the nine ND healthcare worker research articles were published in the UK (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Locke et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021) and just one being a New Zealand-based study by Hughes (2021). Interpretations will, therefore, lack the context of Aotearoa's unique midwifery model of care and our bicultural identity.

Conclusion

This integrative review highlights that ableist barriers to equitable employment experiences can be pervasive throughout healthcare workplace settings. How these experiences relate or differ for ND midwives in Aotearoa is yet to be investigated. We do not yet know how the hospital-based midwife might navigate inclusion within an employed setting or where a self-employed lead maternity carer (LMC) midwife might seek advice about the provision of workplace accommodations. The results of this review highlight the need for future research. Furthermore, expanding our knowledge of neurodivergence within our midwifery profession may also pave the way towards improved understanding of perinatal care provision for ND birthing people and whānau.



Chapter Summary

These gaps in the literature not only highlighted the need for further investigation into the experiences of ND kahu pōkai in Aotearoa but also prompted me to consider what lies beyond the challenges. I began to wonder what strengths, supports, and affirming practices might exist—or could be cultivated—to enable ND kahu pōkai to thrive in their roles. This shift in focus informed the development of the research design and methodology, which is outlined in Chapter Three. The chapter details the philosophical foundations, ethical considerations, and methods chosen to explore these questions, with a commitment to centring ND voices and honouring Te Tiriti o Waitangi.



Chapter 3 Methodology

Introduction

The literature review in Chapter Two revealed that ND health professionals often face pervasive ableist barriers within healthcare settings, including midwifery. These findings underscored the need to explore not only the challenges but also the strengths and supports that enable ND kahu pōkai to thrive. This insight shaped the direction of the research and informed the development of a methodology that prioritised neuro-inclusion and affirming practice. In designing this research, it felt important to craft a process that was affirming for myself, the participants, and future readers. I sought to design a study that respected and valued neurocognitive diversity in both participation and knowledge creation. This chapter details the theoretical foundations and methodological steps I took to foster a neuro-inclusive research process. By sharing these considerations and approaches, I hope to contribute to a broader discourse on accessibility and neuro-inclusion within kahu pōkai and health professional research.

Theoretical Underpinnings

Subjective Relativism

“If you have met one person with autism, you’ve met one person with autism.”
(Shore, 2018)

Autistic advocate, Dr Stephen Shore’s popular quote has been widely adopted throughout ND and disability communities; it highlights that each neurodivergent and/or disabled individual is distinct, with their own unique traits and characteristics. From an ontological perspective, the intention of this research was to understand the “lived experiences” of neurodivergent midwives working in Aotearoa New Zealand. Its purpose was not about uncovering a universal truth but was instead about attempting to interpret the varied experiences of each individual study participant (Levers, 2013). The data generated from this piece of research assumed as many differing realities as there were participants; relativism positions itself from the perspective of there being multiple realities rather than that of a single reality (Denzin & Lincoln, 2005). I chose this social science qualitative lens with the intent to acquire



knowledge that was contextually unique and value-laden (Moon & Blackman, 2014). This research embraced the concept that reality is a subjective experience, constructed within the human mind (Stajduhar et al., 2001).

Relational Constructivism

In chapter 2, I reviewed the international literature on the experiences of ND health professionals; the absence of literature specific to the unique contextual experiences of ND midwives in Aotearoa New Zealand signified the scope for future. Therefore, for this research, a qualitative inquiry felt like a valuable choice for initial knowledge construction (Kivunja & Kuyini, 2017). Interpretations of the subjective data are however not generalisable (Moon & Blackman, 2014), instead, a process of “sensemaking” was guided by a relational constructivist approach (van der Harr & Hosking, 2004). This recognised that knowledge was created through the interaction of myself, as an ND kahu pōkai and that of the ND kahu pōkai participants. My ability to conceptualise and understand the data was not and could not be a completely objective process (Olssen, 1995); on one hand I stood separate from the observable phenomena but on the other, my interpretations of the data were heavily influenced through my interactions with participants including any societal influences that fed into their reality (Moon & Blackman, 2014). Relational constructivism deviates from social constructivism in that the former embraces inter-dependency and relational realities (van der Haar & Hosking, 2004); the two epistemological paradigms however do share a common premise that knowledge is constructed rather than discovered. In this way, knowledge acquisition for this research study was an active, adaptive and cognitive process (Olssen, 1995).

Appreciative Inquiry

The methodology chosen for this research was Appreciative Inquiry. Appreciative inquiry is based on a social constructivist reimagining of postmodern theory, as an action-based approach it is premised on the assumption that organisations are socially constructed realities constrained only by human imagination (Cooperrider & Whitney, 2005). As a relational process, Appreciative Inquiry fully embraces the unique positioning of the researcher as part of the knowledge acquisition process. I saw Appreciative Inquiry as an intentional way to generate strengths-based data that challenged pervasive stereotypes. The intention was to facilitate a constructive



process of challenging neuro-normative assumptions and standards within the dominant neurotypical kahu pōkai culture; to ask for “reconsideration of that which is ‘taken for granted’” (Gergen, 1978, p.1246). Rather than focus on problems, Appreciative Inquiry research aims to evoke systemic and structural change through the collaborative discovery of a ‘positive core’ of a group or organisation (MacCoy, 2014).

The 4-D Process

When using Appreciative Inquiry as a research methodology, inquiry and change is understood to occur simultaneously and iteratively through what is known as the 4-D process (Brookes, 2017; Cooperrider & Whitney, 2005); the researcher and participants continually work through the following reflective cycles (Dewar et al., 2020):

1. ‘Discover’ seeks to illuminate what is valued and what is working well (Dewar, 2012). This research sought to understand and appreciate what strengths the ND midwives interviewed felt they brought to the profession.
2. ‘Dream’ is about imagining what an ideal future could look like (Bushe, 2011). This research asked what did the ND midwives want to see more of and what neuro-affirming midwifery would look like?
3. ‘Design’ seeks ideas on how to make the vision a reality (Bushe, 2011). This research explored what strategies the ND midwives thought would assist in achieving their vision of neuro-affirming midwifery.
4. ‘Destiny’ involves how to embed and sustain change. The objective in this research was to develop a resource for what the ND midwives interviewed needed to thrive. Recommendations informed by this guideline would hopefully lead to affirmative change with optimised visibility and inclusion of ND midwives within the profession.

Critiques of Appreciative Inquiry

The in-person application of Appreciative Inquiry was a learning curve for me, especially as a novice researcher. Appreciative inquiry has been criticised for fostering an idealised and unrealistic picture of the human experience (MacCoy, 2014). Critics have commented that it can negate the nuanced shadow-sides of life; negative phenomena and human suffering are therefore glossed over and repressed



in preference for a form of toxic positivity (Bushe, 2011; Fitzgerald et al., 2010; Johnson, 2013). Some participants in Appreciative Inquiry studies have also commented on feeling hesitant to disclose anything negative during the data collection process. This has led to frustration because meaningful conversations have felt stifled (Bushe, 2011; Fitzgerald et al., 2010). This was something I regularly reflected on, especially throughout the recruitment and data collection stage: I wanted the ND participants to feel like they could engage with this research as their authentic selves and not need to conceal and/or mask any challenge areas.

In response to these Appreciative Inquiry critiques, Cooperrider and McQuaid (2012) highlighted that ignoring the negative is a mistaken interpretation and application of the Appreciative Inquiry process. Cooperrider and McQuaid (2012), as one of the original founders of Appreciative Inquiry, argue that the intention is to reverse the pervasive 80/20 deficit bias within current research discourse. Rather than ignore problems, Appreciative Inquiry seeks to constructively reframe them by asking participants what they want to see more of. Bushe (2011) further clarifies that with skilful application, researchers can ensure that deficits do not monopolise the dialogue but are instead steered towards co-creating active strategies for the future (Bushe, 2011; Fitzgerald et al., 2010; Johnson, 2011; Cooperrider & McQuaid, 2012). I recall moments from the one-to-one interviews where participants described negative workplace experiences and I would actively listen and empathise for however long it felt right to do so. I would then ask the participant how or what would have made their experience more neuro-affirming; these moments often ignited valuable new insights and ideas that I feel added a richness to the data.

The Neurodiversity Paradigm

I situated this research within the relatively new critical paradigm known as neurodiversity studies. From the onset of the twentieth century, the empirical sciences have been focused on trying to understand a single reality of what it means to be human. Knowledge advancement during this time has been heavily informed by cognitive and developmental psychology, as well as neuroscience (Rosqvist et al., 2020). Neurodiversity studies however, oppose- the notion of an ideal rational person and the 'universality' of propositions about human nature (Yergeau, 2018; Rosqvist et al., 2020). It is asking us to reconsider the 'nature of being'; this is an ontological consideration at its very core. Such a paradigm shift requires a new theorisation of



neuro-developmental disorders that are understood as impacting on the individual's sense of identity, alongside differences from normative forms of cognitive, social and sensory behaviours (Doyle, 2020). The Neurodiversity paradigm is a multi-disciplinary field informed by sociology, critical psychology, critical medical humanities, critical race theory, disability, feminist and queer studies (Yergeau, 2018). Critics of the neurodiversity paradigm have challenged the value of 'labelling' people as either neurodivergent or neurotypical; the rationale is that everyone is different so why can't we embrace that without the need to 'cognitively other' (Rosqvist et al., 2020). Rosqvist et al. (2020) argues that such boundaries at this stage in our human evolution serve to decentre dominant perspectives; our understanding of neurodiversity should be seen as an open and iterative process as new forms of cognitive divergence are recognised (Kourti, 2021).

“Insider” Research

The field of neurodiversity studies equally values evidence from the lived experience of neurodivergent people alongside the quantitative medical sciences (Rosqvist et al., 2020). It asks for a new kind of objectivity, involving a shift of epistemic norms that connect perspectives between the internal experience of being neurodivergent as well as observations of what it looks like from the outside. This requires an acknowledgement of epistemological violence every time a piece of research is conducted without consultation from within the neurodivergent community. Neurodivergent scholars, like me, must be the drivers of neurodivergent research if we are ever going to achieve epistemological integrity (Kourti, 2021). From an axiological perspective, without these changes, our understanding will remain limited to only what is observable from the outside and will potentially miss the opportunity for increased inclusion of the neurodivergent community (Kourti, 2021; Rosqvist et al., 2020). Including ND academics in ND research has been associated with reducing harmful ableist constructions and improving the scope and quality of the published findings (Botha & Cage, 2022; Urbanowicz et al., 2019). I also hope that my choice of Appreciative Inquiry with its participatory approach also served to bridge some of the epistemological gap between the internal experience of being an ND kahu pōkai and observations of what it looked like from the outside (Dewar et al., 2020).



Ethical & Cultural Considerations

Ethics approval (see Appendix Two) under Category B was granted by the Ethics Committee at Otago Polytechnic on the 15th of August 2024 (reference number 012).

Person-Orientated Research Ethics

Research ethics considers disabled people to be vulnerable participants in research. In contrast, disabled academics argue that disabled people are also vulnerable to inequitable exclusion from participation in research and that this needs to be balanced alongside the right to protection and harm minimisation. Disabled people's "right to science" is enshrined in the United Nations Convention on the Rights of Persons with a Disability (2006); this includes the right to have their lived experience represented and to participate in research that could benefit themselves and the communities they belong to. Modes of communication can be enabling or disabling for ND people (Howard & Sedgewick, 2021). Qualitative methods such as interviews and focus groups have the potential to restrict data elicitation; methodological adaptations for this research were therefore critical. The disabled academic community have developed a range of strategies, collectively known as person-orientated research ethics, to minimise barriers to participation and engagement for disabled participants in research (Cascio et al., 2020).

This study employed several of the recommended practical strategies, including preparing participants in advance, considering the social and sensory environments, and providing multiple means of communication (Cascio et al., 2020; 2021). For example, data was collected in person or via computer-mediated communication such as email, instant text messaging, video calls and social networking platforms (Elam & Fenton, 2003). Interviews were not all conducted sedentary; I offered a novel method that has shown promise within mental health sector research known as walking/go-along interviews for participants who prefer movement (Bartlett et al., 2023). Through offering a variety of options in this research process, I aimed to allow for greater cognitive and expressive diversity (Rakime et al., 2011), especially for the ND participants who, by diagnostic standards, communicate in different ways (American Psychiatric Association, 2013). The improvisational nature of the Appreciative Inquiry approach also enabled this project to adapt its design in response to each participant's support needs (Bushe, 2011).



Intersectionality

An individual's experience of belonging to multiple minority groups can create research environments of increased vulnerability for participants. This research embedded intersectional awareness throughout the study design; this required regular reflection on, "*who is and is not in the conversation?*" (Windsong, 2018). Kupu Māori and gender-inclusive language were woven throughout the research design as an acknowledgement of the significant axis between neurodivergence and other identities the participants may experience.

Te Ara Tika

I am mindful that Māori kahu pōkai are significantly under-represented within the midwifery workforce; I wanted to do the mahi required and design this project in a way that would be affirming for Māori ND participants. The 2022 Midwifery Workforce Survey identified that only 12.2% of midwives in Aotearoa, New Zealand identify as Māori (Te Tatau o te Whare Kahu | Midwifery Council of New Zealand, 2022). Recent Kaupapa Māori research attributes this workforce gap to a variety of culturally specific factors, including the failure of the pākehā dominant profession to include te ao Māori perspectives (Tupara & Tahere, 2020). As a Tangata Tiriti researcher, I recognise the importance of cultural humility and seeking cultural guidance throughout the research process. This research was therefore informed by Te Ara Tika principles of;

- Whakapapa (relationships),
- Tika (research design),
- Manaakitanga (cultural and social responsibility) and,
- Mana (justice and equity) (Hudson et al., 2010).

I found consultation with Kaitohutohu extremely valuable; I appreciated their insights, guidance and reassurance around weaving Te Ara Tika principles throughout the research design. I reached a deeper clarity that my choice of person-orientated research ethics would also be beneficial when working alongside Māori participants; a central tenet of person-orientated research ethics is relationship building with participants and taking the time required to adjust and accommodate in response to each person's access needs. This felt like it aligned well with the key value of



“whanaungatanga” embedded within Te Ara Tika. It was also my intention that the strength-based stories described by Māori ND participants would assist to steer them towards insights that best served their taonga tuku iho: their cultural aspirations.

It was vital that Māori ND participants in this research felt confident that their contributions would lead to positive outcomes for themselves, their ND colleagues and their whanau, hapū and iwi. This required ongoing conversations with participants that revisited the research aims, objectives and the informed consent process. For further guidance I regularly referred to an article by Came (2013): Doing research in Aotearoa: a Pākehā exemplar of applying Te Ara Tika ethical framework. I also incorporated tikanga protocols, such as the use of karakia as a natural part of each interview and focus group; kanohi-ki-te-kanohi (face to face) data collection methods were also offered where possible. I was acutely aware of the significance of Māori data sovereignty for tāngata whenua research participants; this was upheld according to the principles of Te Mana Raraunga and the United Nations Declaration of the Rights of Indigenous Peoples (2007). Data generated by Māori ND participants in this research is seen as taonga (treasure); they had guardianship regarding what data they chose to have private and controlled (tapu) versus open (noa) access.

Harm Minimisation

From an axiological perspective, interpreted phenomena from this research study needed to be constructive and meaningful for the participants themselves as well as for the wider kahu pōkai community. My hope was that a carefully considered methodological approach would provide a safe and ethical foundation for the research, guided by both the outcomes it aimed to achieve and the moral responsibilities embedded in the process, as described van der Haar and Hosking (2004). My choice of appreciative inquiry was an intentional way to generate strengths-based, mana-enhancing data that could be used to challenge pervasive stereotypes. There are significant, historical power imbalances within disability-based research; the participatory nature and “insider status” of this project was hopefully a small but significant way to address this. The exploratory nature of this research did render some of the benefits and harms difficult to fully anticipate (National Ethics Advisory Committee, 2019). By design, I aimed to minimise potential harm in response to research participation, for example through disclosure of workplace discrimination and any damage to professional relationships that could



have occurred as a result. Transparency around data interpretation was a central moral concern; participants had the opportunity to cross-check their raw data for accuracy or sensitive information (Kivinja & Kuyini, 2017). Conscious implementation of ethical considerations upholds respect for each study participant and their fundamental human rights (Patterson & Williams, 1998).

Internationally, research participants have reported a sense of empowerment from being given the opportunity to tell their story through qualitative data collection (East et al., 2010); navigating deeply personal topics however required an active and rigorous ethical approach to protect the well-being of everybody involved (Zigon & Throop, 2021). A trauma-informed approach was essential. Despite the affirmative questioning approach, topics containing discrimination and trauma still arose and needed to be navigated with sensitivity and compassion. Participants were encouraged to engage with their personal and professional support networks before, during and after participation. I provided each participant with resource guidance for where they could seek further neuro-affirming support, including te ao Māori led organisations. I also completed a mental-health first-aid training via Co-Liberate (n.d.) prior to commencing data collection; this gave me more confidence in being with and supporting someone experiencing mental distress.

Confidentiality

Midwifery in Aotearoa, New Zealand is a small community; *kia tūpato* (to be careful) with privacy and confidentiality was therefore of paramount importance. However, it was not assumed that participants would want their identity concealed; they were asked about their preferences during the recruitment stage. The level of confidentiality designed into this research therefore reflects the preferences of the unique cohort that participated and their desire to be acknowledged as knowledge keepers and generators. Each participants' sense of trust and choice about their identities and data was encouraged by frequently returning to the conversation of informed consent. Several strategies were utilised, such as careful presentation of demographic information, using codes or pseudonyms and 'cleaning' the data by intentionally concealing personal information that could have resulted in revealing identities. As a researcher, I am in a position of privilege to be able to collect data from the participants; each transcript tells a story and is precious. Data sovereignty therefore needed to be carefully considered, and participants had the opportunity to



check their transcript to ensure it accurately reflected their story.

Other significant axiological elements to consolidate were around how the data would be stored and ensuring its security (Kivinja & Kuyini, 2017). Careful planning was required when choosing the artificial intelligence transcription and coding software; I found apps with transparent and robust data privacy policies. Digital audio recordings were deleted once the verified transcript was agreed. The transcripts were stored on a secure on-line platform alongside transparent communication with participants. Hard copy material (e.g. signed consent forms) is in a locked cabinet; electronic material is stored in my password protected laptop. Data from this research will be stored for seven years and deleted/destroyed after that time.

Study Methods

Recruitment

Participants were recruited through purposeful sampling from Aotearoa New Zealand's kahu pōkai community. A recruitment infographic (See Appendix Three) was disseminated online via the social media pages Kiwi Midwifery, Neurodivergent Midwives Aotearoa and Ngā Maia Midwives; each post was reviewed by the page moderator prior to publishing. The design of recruitment material embedded intersectionality with gender-inclusive language and kupu Māori used throughout. Within 24 hours of publishing the recruitment material, I was surprised to have received over 30 communications expressing interest. Potential participants requested to communicate with me via a range of communication platforms including email, instant messaging, phone-call, voice messaging and in-person. I used email to send each potential participant the 'Participation Information Document' and 'Phase One: One-to-one Interview Consent Form' (See Appendix Four, Five and Six). Potential participants progressed to the one-to-one interview phase on a first come first served basis after signing the consent form. While this approach ensured efficiency, it may have inadvertently favoured those who were able to respond quickly, potentially limiting the diversity of voices represented.

Easy to Read Documents

All documents disseminated to study participants throughout the data collection period were designed in accessible, easy-to-read formats with supporting visuals.



The materials followed accessible formatting recommendations from the Ministry for Social Development (Te Manatū Whakahiato Ora | Ministry of Social Development, n.d.) and were reviewed for accessibility by disabled peers working in the disability sector. My intention was to create documentation that optimised comprehension and minimised form fatigue and anxiety. Images were used as signposts within the text and to assist with navigational choices: this is also known as wayfinding (Hirtle, 2018).

Participants

Inclusion criteria:

- Identified as neurodivergent*, whether clinically diagnosed or self-identified,
- Had practiced as a kahu pōkai in Aotearoa, New Zealand,
- Were available to participate in both phase 1 and 2 of the data collection.

**Neurodivergence was defined in the recruitment material as an umbrella term; including (but not exclusive to) autism, ADHD, Dyslexia, Dyspraxia, Tourette's, chronic mental health conditions such as bipolar disorder, obsessive-compulsive disorder, and acquired brain conditions such as multiple sclerosis and traumatic brain injuries.*

Data Collection & Analysis

Neuro-Affirming Methodological Adaptations

Offering a variety of data collection options to research participants is understood to enhance accessibility and engagement (Rakime et al., 2011), especially for neurodivergent people who by diagnostic standards communicate in different ways (American Psychiatric Association, 2013). When compared with face-to-face options, online platforms are a well-studied preference for communication by many within the ND community (Benford & Standen, 2009); research has found that online data collection tools can increase comprehension and self-expression for ND participants in research (Bury et al., 2021; Hayward et al., 2019). However, I was also mindful that online access also requires digital literacy and may have been a barrier to some potential participants without such skills (Katz et al., 2015); I made sure to offer technical assistance throughout the data collection journey and several participants



did request this. For example, one participant requested assistance with setting up a Discord account so I talked them through it via a video-call.

Interviews and focus groups strategies can be conducted in person, or via computer-mediated communication such as email, instant text messaging, video-calls and online networking platforms (Elam & Fenton, 2003). Providing options to the ND participants was therefore a central methodological adaptation for both the phase one semi-structured interview and phase two focus group stages of this project. During the consent process, participants were asked to select their communication preferences from list of options; I also asked the more open-ended question: 'is there anything else you need in order to fully participate?'. Participants were sent the interview and focus group questions one week in advance; this methodological adaptation allows for differences in cognitive processing speeds and gave the participants who needed it, the time to think and process what they might want to say (Nicolaidis et al., 2015). Participants were also invited to communicate any additional after thoughts via email, text or phone call.

Photo Elicitation

Person-centred research ethics advocates for methodological adaptations such as visual supports to enhance data collection; ND people can have strong visual skills (Cascio et al., 2020). Furthermore, a common trait within the ND community is difficulty identifying and describing emotions, known as alexithymia (Preece & Gross, 2023). Photo-elicitation can play to an ND person's visual strengths and bridge the gap of alexithymia (Cascio et al., 2020; Preece & Gross, 2023). Visual tools (See Appendix Seven) were offered during all phases of data collection as a way to reduce cognitive barriers and facilitate the articulation of complex issues and a deeper recall of experiences. (Roddy et al., 2019). Each participant received an electronic copy of images one week prior to their interview; in-person participants were also given a hand-held copy. I chose 20 photographs from a licensed and secure image repository known as iStock that depicted a range of kahu pōkai work related tasks.

Phase One: Semi-Structured Interviews

Appreciative inquiry methodology lends itself to semi-structured interviews as a data collection tool; affirmative questions are crafted to get to the 'positive core' of the



phenomena at hand (Brailas, 2025). Using my research questions as a guide, I generated a range of open-ended questions that I feel helped to elicit rich, deep sharing from the participants (See Appendix Eight). I was acutely aware that the depth of the data generated would be limited by how carefully I crafted these affirmative questions (Rakime et al., 2011) as well as my ability to build rapport (Zigon & Throop, 2021). The semi-structured interviews were designed to focus around the Discover, Dream and Design stages of the 4-D appreciative inquiry cycle:

- Discover invited participants to describe what they valued about being an ND kahu pōkai and what strengths they felt they brought to the profession.
- Dream asked participants to imagine what a neuro-affirming kahu pōkai career could look like.
- Design explored what strategies the participants thought would assist in achieving their vision of a neuro-affirming kahu pōkai career.

Participants were invited to bring their own sensory and/or stimulating items; I also brought a selection for shared use. A small koha (see Figure 2) was offered at the end of each interview; as an acknowledgment (and as a celebration) of their time and generous sharing, each participant received a neurodiversity themed lanyard and a stimulating/fidget tool of their choice.



Figure 2. *Photographs of Participation Koha*

Reflexive Thematic Analysis

Reflective thematic analysis (TA) was chosen as the method for recognising definable patterns within the data (Braun & Clarke, 2006; 2019) and to draw out explicit findings and implicit themes that may have remained hidden otherwise



(Braun & Clarke, 2022). Braun and Clarke (2006; 2019) have identified six phases of reflexive TA through which themes are constructed across the dataset in relation to the research question:

1. Familiarisation,
2. Coding,
3. Generating initial themes,
4. Reviewing candidate themes,
5. Defining and naming themes
6. Writing up the final analysis.

The interview audio-recordings were transcribed into raw written transcripts using Transkriptor, a secure transcription application. I used the paid version for its robust data protection measures, including SOC 2 (STSC) compliance, end-to-end encryption, and role-based access controls to ensure only authorised personnel could access sensitive data (Kudelski Communications Krzysztof Kudelski, 2024). The use complied with the Otago Polytechnic AI Policy as a reasonable use of AI tools for research purposes (Otago Polytechnic, n.d.). Initial familiarisation of the data occurred through careful listening to the audio recordings and cleaning up the verbatim transcripts. Written transcripts data were read and re-read; my workspace became an organised chaos of heavily annotated and highlighted transcripts. I also used my research diary to create visual maps and to brainstorm thoughts that arose through the familiarisation process. Once data analysis was complete, all files were permanently deleted from the Transkriptor service.

Fifteen interviews generated a large and rich dataset. To manage this volume and accommodate executive functioning challenges as an ND researcher, I used Delve, a secure coding software. Delve was chosen for its strong privacy and security features: user-submitted information remains researcher-owned, is never sold to third parties, and is only shared with trusted vendors to enable the service. Data is stored with Privacy Shield certified database providers under strict agreements, and security measures include encryption in transit and at rest, SSL certificates, and OAuth authentication for user logins (Twenty To Nine, LLC, 2020). The use also complied with the Otago Polytechnic AI Policy as a reasonable use of AI-assisted tools for research activities (Otago Polytechnic, n.d.). Interestingly, in a recent



publication, Braun and Clarke (2022) reflected on their prior stance that TA researchers should avoid assistive coding software; through a disability lens they have come to recognise that software can be a valuable tool for cognitively diverse researchers. Initially, I generated an overwhelming number of coding labels but through an iterative process of rereading the data and reflecting, I refined these to a more manageable number.

The next steps involved printing and cutting out each coding label; I used a large cork board to pin and compile the labels into clusters, looking for patterns specifically in response to my research questions. This was a very active and iterative process, including the times I spent just staring at the board not knowing what to try next. Seven initial themes were generated; these were then reviewed by going back through the original data set to check that the themes made sense and were a 'good fit' in relation to the coded extracts. During this time, I considered the relationship between the themes and how they might tell a story of ND kahu pōkai experiences. This development and reviewing stage led to the creation of five candidate themes which were then presented during the next phase of data collection.

Phase Two: Asynchronous Online Focus Group

Focus groups can be a useful data collection tool for generating new ideas and insights (Bushe, 2011). A four-day online asynchronous and text-based focus group was utilised; this methodological adaptation has been shown to increase accessibility for ND research participants by reducing barriers like social anxiety and accommodating for differences in information processing speeds (Frisch et al., 2025). As a participatory research project, this second phase of data collection enabled me to seek feedback from the rōpū around the refining, defining and naming of the candidate themes.

The focus group was also interested in exploring the Design and Destiny stages of the 4-D appreciative inquiry cycle:

- Design invited the ropū to collectively explore and refine strategies to enhance the experiences of ND kahu pōkai and ask how we might preserve the positive core of ND midwifery (Cooperrider & McQuaid, 2014).
- Destiny involved discussions around how to frame and structure a guidance document to disseminate throughout the wider kahu pōkai community.



An online communication platform known as Discord was chosen to host the focus group. Discord is a secure and free space that facilitates virtual communities through text, voice and video chat; participants had the option to access this via an app on their smartphone, tablet and/or desktop computer. I created a server on Discord named “Neurodivergent Midwives Aotearoa” and then generated several chat rooms within the server based on the candidate themes identified from the one-to-one interviews. All participants from the semi-structured interviews were invited to join; 13 out of the original 15 interview participants signed the consent and confidentiality forms and continued to the focus group stage. One month prior to the focus group start date, participants were emailed instructions explaining how to set-up an account and download the Discord app (See Appendix Nine), supported by visual screenshots. Additional tech assistance was offered as needed.

Discord was chosen for its comprehensive privacy and security framework; it operates under a clear Privacy Policy that states it does not sell personal information, uses TLS encryption for data in transit and at rest, and provides users with controls over their data. It participates in the EU-U.S. Privacy Shield framework and includes GDPR-aligned features such as consent mechanisms, account deletion options, and data export/portability support (although message deletion is manual). While Discord is not SOC 2 certified, its existing security measures - encryption, upper authentication, and server access controls - meet standard requirements for protecting confidentiality in academic research contexts (Discord Inc, 2024). The use of Discord complied with the Otago Polytechnic AI Policy as a reasonable use of AI-assisted tools (Otago Polytechnic, n.d.).

One week prior to the focus group start date, participants were emailed the following information:

- A confirmation of the group size,
- The five candidate themes, with a brief description of each,
- Five broad discussion topics for potential workplace accommodations.
- An invite link to the Discord server,
- Repeat instructions for how to set up a Discord account and download the app.



In a similar fashion to the one-to-one interviews, my aim was to provide information in advance in order to offer predictability and cognitive processing time for all participants.

Once the focus group was live, I took deliberate steps to reduce the executive functioning load on participants by sending out a daily email containing the server access link, a summary of recent discussions and a question to prompt further thinking. For participants who preferred verbal communication over written, I was available 'live' via video or voice chat on the focus group for an hour each day; this meant that participants could live chat with me and each other.

Reflexive Thematic Analysis

A written transcript from the Discord server typed discussions was simple to generate; the "Neurodivergent Midwives Aotearoa" server was then deleted. I also used the Transkriptor app to transcribe all voice notes and daily live discussions into a written form that I could embed into the final transcript. I then walked myself through the same familiarisation and coding process that I had used in the phase one of semi-structured interviews. I now had two cork boards: one with the coding labels and candidate themes generated from the interviews and a second board with the coding labels created from the focus group. I had initially thought that this process would produce yet more themes for me to grapple with, but I was surprised to discover that the focus group coding labels functioned to refine and define the original candidate themes from phase one. This involved a process of fine tuning the candidate themes and cross-checking between the two data sets for relevance and accuracy. I finished phase two of my data collection and analysis feeling confident and ready to write up my findings. Each theme had a clear demarcation with a strong core concept, but together they wove a rich narrative that answered my research question.

Chapter Summary

This chapter detailed the theoretical framework and methodological choices made to establish a neuro-inclusive research process. The design of this study was driven by a commitment to affirm the experiences of myself as the researcher, the participants, and future readers, while also respecting and valuing neurocognitive diversity in both participation and the creation of knowledge. It's crucial to understand that neuro-



inclusion and accessibility are not destinations but continuous journeys. Consequently, a commitment to inclusion requires humility and a learning mindset, consistently seeking improvements and valuing feedback. Throughout the process, if in doubt, I returned to the question ‘is there anything else you or I need to fully participate? In the following chapter, I present the research findings generated through reflexive thematic analysis. These findings reflect the voices and experiences of ND kahu pōkai participants, offering insight into the strengths they embody, the challenges they face, and the supports that enable them to thrive within midwifery practice.



Chapter Four: Findings

Introduction

Having established a neuro-inclusive research design in the previous chapter, the next step was to explore what emerged from the research itself. The methodological approach outlined earlier provided a foundation for meaningful engagement with participants, allowing their experiences to be shared in ways that honoured ND ways of knowing and being. This chapter presents the exciting part—what the participants shared with me. First, I introduce the participants, then I delve into the themes that were generated through reflexive thematic analysis of data collected during both phase one and phase two of the study.

Participants

Fifteen ND kahu pōkai participated in the first phase of this research and thirteen progressed to the second phase. Of the two ND kahu pōkai who did not participate in the second phase, one signed the focus group consent form but was unable to join due to unexpected life circumstances; the other I did not hear back from after the phase one interviews. Four of the participants opted to use a pseudonym, with three selecting their own and one requesting that I choose on their behalf. The remaining eleven chose to use their real name. Pronouns used were predominantly she/her, with one participant using they/them. The ND kahu pōkai participants lived across Aotearoa New Zealand, both Te Ika-a-Māui and Te Waipounamu, including both urban and rural locations. Two participants identified as Tangata Whenua, the rest as Tangata Tiriti; representing NZ European, African and Canadian ethnicities.

The participants disclosed a wide variety of neurodivergent conditions often with multiple diagnoses, including ADHD (n=11), autism (n=8), dyslexia (n=3), bipolar disorder (n=1), epilepsy (n=1), and acquired brain injury (n=1). The time since their diagnoses varied widely, from 1 to 40 years, with most being diagnosed in adulthood. Participants reported years of practice ranging from 1 to 35 years, with diverse kahu pōkai practice experiences, including roles as Lead Maternity Carers (n=5), core midwifery (n=4), community midwifery teams (n=2), clinical coaching (n=1), midwifery academia (n=1), return to practice program (n=1) and a career change away from midwifery (n=1).



During the recruitment and data collection phases, participants requested to communicate with me via a range of platforms including email, instant messaging, phone-call, voice messaging and in-person. For the semi-structured interviews, a wide range of options were selected, including video-call, in-person, walking/go-along, phone-call and via email. In addition, the ND kahu pōkai asked for a number of accommodations: sending reminders, following up verbal conversations with a written summary, extra processing time, sensory adjustments with lighting, space to move and assistance with managing distractions.

This research aimed to answer the following affirmative research questions:

- What are the experiences of ND midwives in Aotearoa New Zealand?
- What strengths do ND kahu pōkai feel they bring to the profession?
- What neuro-affirming changes or improvements would ND kahu pōkai like to see in the profession? What strategies do ND kahu pōkai think would assist in achieving this?

Through the process of reflexive thematic analysis (TA) described in the previous chapter, I developed five themes through which I will now share key findings.

1. ND traits facilitate strong therapeutic relationships with whānau,
2. Spiky skills profiles,
3. A journey: finding a workplace that suits my unique needs,
4. Fostering ND kahu pōkai culture and leadership,
5. Expanding our idea of what a kahu pōkai can be.

Theme One: ND Traits Facilitate Strong Therapeutic Relationships

With Whānau

Introduction

Theme one coalesced around two-subthemes that highlight how ND traits can enrich kahu pōkai practice:

- (1) ND traits facilitate strong therapeutic relationships with whānau; through authentic communication, deep presence, and adaptive relational skills that foster trust and connection.



- (2) Hard-won wisdom; shaped by personal adversity and marginalisation, cultivated empathy, radical acceptance, and a commitment to providing affirming, non-judgmental care.

ND Traits Facilitate Strong Therapeutic Relationships With Whānau

The ND kahu pōkai participants described how their ND traits enhanced their kahu pōkai practice, particularly in forming strong therapeutic relationships with whānau: “so at a relational level, I think being neurodivergent has been, is a gift in some ways” (Di). Each participant brought a unique blend of ND traits that they felt fostered meaningful connections.

Participants described divergent communication styles, such as building rapport by exchanging personal stories: “you know how we [ND people] do that thing that is like, we'll tell a story when they've told a story to, like, connect” (Michelle). Kōrerō was circular and associative, building connection through shared interests and experiences; this conveyed empathy and built trust: “I think I've noticed that it does make people feel comfortable because you're, you know, relating to them and to their experience. Potentially seeming more, it seems to, like, be more like, I'm on your level” (Michelle).

Participants also valued their honest and direct communication; which fostered a sense of safety by helping whānau clearly understand their situation:

[...] what I thought was a negative about [...] me being too honest and blunt, is actually, whānau respect it, people like it, and it's reassuring for them. I think it also means that my interactions with clients are a lot more genuine because I'm not hiding behind anything. (Lizz)

This approach was especially effective in informed consent discussions and advocacy: “What I've learned is that there is places for those voices and for me, midwifery is definitely one of those spaces where I can speak up” (Lizz).

Neurodivergent ways of thinking and processing information supported effective health communication: “[.] because of my brain and how it is wired [...] I'm translating it for myself, which helps translate it to whānau even better” (Nirvana). Neve also noted: “I think I'm giving them the same information, but helping them process it in a



different way [...] “. Info-dumping, driven by intellectual curiosity and a deep need to understand, also enhanced information sharing: “.... my mind just works that way [...] I think I'm intellectually curious’ (Tamsin). Participants described a profound and often life-long special interest in midwifery and reproductive justice: “It's not just a profession, it's part of, for me, a worldview” (Di). Together, their divergent cognitive styles, passion-driven knowledge, and immersive communication created a uniquely attuned form of care—one that translated complexity into clarity and which these kahu pōkai understood as enabling whānau to feel informed, understood, and deeply supported: “they feel they are in safe hands” (Tamsin).

Participants described masking and how it improved their adaptability and connection with diverse whānau:

... because I think being [neurodivergent] [...] each woman is different and you have to adapt to [...] you need to synchronise with them [...] but I actually think, you know, we make very good midwives because we [ND people] already know how to do that. (Karien).

Masking was described as an unconscious survival strategy, that resulted in unintended benefits when working with whānau: “I think the ability to stay calm [...] look really calm even if I'm shitting myself inside” (Michelle).

Participants also noted that monotropic cognition enabled deep focus and presence, enhancing personalised care:

This is what is happening. You are in the zone. This is your room. This is my job. This is what I'm doing. Forget about if I need to have a drink, if I need to go to the bathroom, if I'm tired. All of those things, go out the window and I focus on what is in front of me. (Lizz)

Many participants also reported that workplace environments enabling hyperfocus were their favourite places to work: “I experience a lot of joy with it” (Leila).

Monotropism also supported pattern recognition and attention to detail: “I'm the radar of trouble. I've always been really highly observant, and I call it my sixth sense - to develop, to detect” (Anna). Participants valued how this enhanced the safety and quality of the care they provided: “Knowing when to act before you even hit, you



know, hit the crisis point. I'm very, very good at noticing a deteriorating baby” (Tamsin). Participants shared clinical examples where their monotropic mind identified issues others had missed:

Because even though you've been told that it's right, being able to look at it objectively with the whole picture and go, you know, it's not right. And then being able to add, being able to gather evidence [...] This is just being a midwife in general but I mean, so many people had missed it [...]. (Hannah)

The participants believed that their meticulous attention to detail and ability to hyperfocus contributed to whānau feeling deeply reassured, and led them to perceive that they were in safe and capable hands.

Hard-Won Wisdom

Participants related to whānau through empathy shaped by personal adversity: “I think having some kind of adversity like being undiagnosed [ND] during your childhood is definitely, I think, an adversity and just makes you more compassionate and empathetic” (Amber). Experiences of stigma and marginalisation motivated participants to provide affirming perinatal care: “[...] having my own experiences of not being understood [...] makes me feel like not wanting to do that to someone else” (Kate). All the participants expressed a deeply held value of radical acceptance, shaped by being judged for atypical behaviours. They described assuming the best in others: “[...] like if someone doesn't show up for an appointment and in your head you might think, oh, that's inconsiderate, but then I'd always, like, bring it back to, well, hold on, there's probably a reason” (Kate). Their midwifery practice was described as a judgement-free space which they believed helped whānau felt safe and understood: “[...] and so a lot of the time, they feel comfortable to ask questions that they might not feel comfortable to ask otherwise” (Nirvana).

Participants took pride in supporting others through distress, drawing on their own emotional co-regulation skills:

And it's weird because I'm really awkward and really not an emotional person, but I can hold space for people and I can sit and I can listen [...] I spent so much



time co-regulating with my [ND] children that I can co-regulate with people, I can be people's calm in the storm. (Hannah)

Many were recognised within their teams as the best fit for working with clients experiencing distress or displaying atypical behaviours:

I'm often put in with tricky people in birth suite, like, 'oh, she's really anxious, she's this, she's that, she's a nightmare to work with'. And I'm often the midwife that's put in there with them and I don't find them really difficult to work with".

(Leila)

Participants especially valued working with ND whānau, noting a shared understanding and ability to anticipate unique needs: “[...] and we can talk about how we can deal with some of the big sensory inputs surrounding pregnancy, birth and postnatal, because for me, I have also done that” (Lizz).

Summary

Theme one explores how the ND kahu pōkai participants view their ND traits as valuable assets that enhance their kahu pōkai practice, particularly by enabling the formation of strong, therapeutic relationships with whānau. Drawing on rich narratives from participants, it highlights how divergent communication styles, such as storytelling and associative kōrerō, build empathy and trust. Participants' honesty, directness, and ability to translate complex health information into accessible language were seen as assets in informed consent and advocacy. Traits like hyperfocus, pattern recognition, and attention to detail supported high-quality, attuned care, while masking—though rooted in survival—enabled adaptability and connection. Personal experiences of adversity and marginalisation deepened participants' empathy and commitment to nonjudgmental, affirming care, particularly for ND whānau. Collectively, their unique cognitive styles and values created a model of midwifery grounded in radical acceptance, clarity, and deep relational presence.



Theme Two – Spiky Skill Profiles

Introduction

Theme two coalesced around two sub-themes that illuminate the unique challenges of ND kahu pōkai in clinical practice:

- (1) Spiky skill profiles; which capture the coexistence of exceptional strengths and significant challenges across domains of clinical and collegial interpersonal functioning; and
- (2) The value of judgment free feedback; which highlights the importance of neuro-affirming communication that fosters psychological safety and supports professional growth.

Spiky Skill Profiles

Compared to their NT peers, the ND kahu pōkai participants described navigating their work with a “spiky skill profile”— a term that resonated for its reflection of both exceptional strengths and areas requiring significant support. Differences in fine and gross motor coordination, and the clinical skills reliant on them, were commonly noted: “so it is the suturing, it is the cannulation, the venepuncture [...] it makes sense in my head, but then trying to get my muscles to do what I'm seeing in my head is different” (Lizz). Many clinical tasks required breaking down movements into smaller steps. Participants expressed a strong need for neuro-affirming clinical coaching, especially during undergraduate education. Kirsty shared: “I definitely didn't ask for more help during the degree because the time I did, it seemed clear that there wasn't actually much available. I used academic services but they couldn't help with clinical skills.” Achieving confidence in clinical skills often required more time, repetition, and self-directed problem-solving: “I need repetition, so much repetition, and a variety of methods of explanation so I can work out what works for me” (Hannah).

Participants also described challenges interpreting social cues and navigating workplace dynamics. Difficulty reading tone, body language, or implied meaning often led to uncertainty and self-doubt: “I find it very difficult if you're giving off a vibe or you're a little bit huffy when I've asked for help [...] I can't quite read that” (Ana). This uncertainty often led to a sense of disconnection and ongoing rumination: “I appear sometimes to fit in, and then all of a sudden, I don't, and I try to figure out



what I did and what I could have done”. For many, alexithymia and the associated longer processing speeds compounded these challenges, making debriefing emotionally complex:

Like, they [a colleague] might have had a short moment where they gave me something extra to think about and then it was gone. But I've thought about it and thought about it [...] and thought about it and got advice and then thought about it. (Neve)

Participants reported that they often needed to revisit debrief conversations days or even weeks later; colleagues had typically moved on, and attempts to re-engage sometimes resulted in discomfort or dismissal.

Executive functioning challenges were also common, affecting time management, task-switching, prioritisation, verbal processing, and attention in overstimulating environments. Impulsivity in speech—such as blurting or oversharing—was frequently mentioned: “Things are blurted out before you've had a chance to think about it” (Bec). Distractibility, especially in noisy settings, hindered documentation and focus: “I'd always be the last to leave because I couldn't do my work till the office was clear” (Leila). Hannah elaborated on the cognitive toll of interruptions: “It takes so long to get back into the train of thought. It's not just the two minutes you're asking a question. It derails you for ages” (Hannah). Clinical handover was particularly difficult due to sensory overload and the need for sustained attention:

I find it hard to focus on the clinical handover which stresses me out. I don't feel like I could say, 'Hey, this is a lot for me, could we please discuss this somewhere else?' I have one consultant who is happy to step into another space with me. (Lizz)

The Value of Judgement Free Feedback

Participants emphasised the value of factual, non-judgmental feedback. They felt most supported when colleagues approached them with curiosity rather than assumptions, allowing space for individual needs. As Anna noted, “In terms of understanding ND midwives, I think staff education needs to stress that generalising



traits and needs shouldn't happen. It's about curious enquiry, allowing each person to share what they need and what works for them." This approach fostered psychological safety and affirmed their identities, especially when feedback focused on observable traits rather than pathologising language: "It's just stating facts. [...] "Weird" is not a fact, that is not an appropriate describing word [...] you could talk about traits" (Nirvana).

Participants wanted a kahu pōkai culture that normalises ND traits and embraces diverse communication and work styles: "I want feedback about my work and not my personality" (Amber). Strategising around challenges was more effective in relationships marked by empathy, flexibility, and mutual respect. However, rejection sensitivity remained a challenge, especially when feedback lacked positive intent. Emotional regulation improved when feedback was constructive, respectful, and grounded in trust:

... and so to be able to go to someone who I know I can trust and say, this is the story, this is the experience I had, actually does help me and part of it is the strategising for next time. (Neve)

Di emphasised the importance of asking questions without fear of judgment:

It feels like I'm asking a really dumb question because I've forgotten things. Yeah and they think 'surely you know how?' Especially numbers or codes or I don't know 'how long have you been here? And you don't know that'. That can be really just incredibly diminishing [...] but it's the people who say [...] would you like some help? And they don't do it in a patronising way. (Di)

Participants also described how strengths in some areas led to unrealistic expectations in others. Bec reflected: "[...] and people will assume that I need 'managing'. It tips into disempowering really quickly when I'm not the one determining how I get to integrate my ADHD with my work". Michelle noted interpersonal strain when her needs didn't align with others' expectations: "Maybe she was expecting something else or expecting me to do certain things that I didn't do." Participants wanted to be seen as effective members of a neuro-affirming team,



where accommodations were viewed not as special treatment but as essential to inclusion:

... and I may be different, so you where you lack, I'm going to help you. [...] If I try to adapt and change things to make my work better, why can't they do the same to help and adapt this as well? Why do we have to always adapt to them?

(Karien)

Summary

Theme two explores how participants navigated their midwifery work with a “spiky skill profile” and highlighted the importance of judgment-free feedback. Participants described working within clinical environments while balancing exceptional strengths alongside significant challenges-particularly in motor coordination, executive functioning, and social communication. These differences often required more time, repetition, and personalised strategies to master clinical tasks and manage workplace dynamics. Emotional processing and collegial debriefing were especially complex, with many participants needing time and psychological safety to reflect and respond. The value of factual, empathetic, and non-pathologising feedback was emphasised, as it fostered trust, inclusion, and growth. Participants advocated for a neuro-affirming culture that recognises ND traits, approaches individual needs without assumptions, supports diverse communication styles, and views accommodations as essential for equitable practice.

Theme Three – A Journey: Finding the Right Workplace to Suit My Needs

Introduction

Theme three coalesced around two sub-themes:

(1) A journey: Finding the right workplace to suit my needs - Participants described a deeply personal process of trial and error in identifying work environments that aligned with their neurodivergent sensory, social, and cognitive profiles, highlighting the diversity of preferences from high-stimulation hospital settings to calm, structured community roles.



(2) Managing my spoons at work - Regardless of setting, participants developed individualised strategies to conserve energy and manage overstimulation, emphasising the importance of intentional breaks, sensory tools, and supportive environments to sustain their wellbeing and effectiveness in practice.

Finding the Right Workplace

Each ND kahu pōkai navigated a personal journey to identify a workplace that aligned with their unique sensory, social and cognitive profiles. This process often involved trial and error before discovering an environment that best supported their needs.

Some participants described a neuroceptive need for novelty, variety and stimulation. Karien, for instance, thrived with a busy LMC caseload: “[...] and the lack of structure and not being boring, and every day you think, oh, what's going to happen today, and then it's all different, you know” (Karien). Secondary and tertiary environments appealed to those who sought clinical complexity, fast pacing and unpredictability: “I get to see more interesting medical conditions, and I'm more interested in seeing weird and wonderful than super primary. And I know that's bad as a midwife, but I find it interesting. I find different interesting” (Hannah). Amber also noted: “But, yeah, I think the job suits us: the uncertainty, the level of crisis, you know? [...] I don't like things being super quiet”. Hospital environments were particularly well-suited to participants with sensory seeking profiles: “[...] an epidural pump, the SYNT, the CTG, the beeping [...] it's not my favourite type of birthing [for whānau], but in terms of the sensory, I love it” (Ana)

In contrast, other participants described a neuroceptive preference for predictability, structure and monotropic environments. These needs were met through various midwifery roles and settings. For some, small LMC caseloads offered greater self-determination. Participants described tailoring clinic hours to their most productive times and incorporating sensory accommodations into their clinic spaces:

For me, that is what I love about it is I work in a space that is sensory friendly for me. And that is calming. Yep. And I think that that is why I can also deal with a lot of the stress of the job. (Lizz)

Bec described her clinic as: “It felt like stepping into a home”.



Primary units or community-based midwifery teams intrinsically allowed for more autonomy in managing sensory, social and cognitive inputs: “I don't know, for me, it feels a lot safer than a big, a bigger and busier and more clinical space” (Di).

Compared to the unpredictability of on-call LMC work, the structure and routine of shift work was described as more sustainable for some participants' health and wellbeing. Many expressed a preference for working in smaller teams and focusing on one whānau at a time:

One to one works really well for me [...] So in the [hospital] ward, it's really common to have four women and four babies. That's eight people look after [...] that level of executive function is incredibly hard for me. (Leila)

Primary birth attendance enabled hyperfocus and greater control over sensory inputs: “The ideal birthing space [...] It is dark, it is quiet, it is warm [...] It is a very, very low stimuli environment and for me, that is a very, very safe place for me” (Lizz).

Homebirth was widely described as one of the most neuro-affirming environments:

“Because home is the antithesis of hospital, isn't it [...] It's welcoming. It's. You know, everybody's more relaxed. You know, there's that feeling of calm [...] there's sort of more control over things” (Michelle). Conversely, hospital environments posed significant challenges for participants with sensory avoidant profiles:

“I can't do lights and I can't do loud noises [...] and the beeping of the IV pumps and the CTG” (Leila).

Similarly, Anna commented: “[...] and the bells, all the bells would drive me nuts. And the uniform that we had to wear up there was super uncomfortable. I found it all just too overwhelming and demanding”. Some avoided working in hospital environments whenever possible.

“I can't bear being in small spaces with electric lights [...] It actually makes me feel sick. I can't. I get panicky. I kind of. It's horrible. Hospitals actually make me feel sick” (Di). Nevertheless, participants always prioritised clinical safety, and would transfer with whānau to hospital when needed, despite personal discomfort.

Participants with sensory avoidant profiles who remained in hospital settings often opted for night shifts to reduce sensory, social and cognitive demands:

“because of the lower kind of sensory and peopling input” (Hannah). As Nirvana

described: “[...] because you can turn off the lights and have just, like, a lamp on [...] it's not nearly as draining”.

Tamsin chose to exclusively work night shifts: “Less people, less noise, less interruptions. I can get things done because often the night shift is you are mopping up what couldn't get done during the day shift”.



Managing My Spoons

Participants described how clinical urgency consistently overrode their sensory, social, and cognitive needs—regardless of workplace environment—until immediate demands subsided. Their focus remained on ensuring whānau received safe and timely care, and this was accepted as an inherent part of the role:

[...] and there are some things that I accept that I cannot control [...] You may have to ring the emergency bell and the lights need to be turned on [...] I think in my mind, I'm like, the faster I get people in, the faster it will be done [...] Just do it. (Lizz)

Each participant developed personal strategies to conserve energy and remain functional under non-negotiable demands—collectively referred to as ‘managing spoons’. Hannah illustrated this with her humorous “fork theory,” imagining each fluorescent light or interruption as a fork being stuck into her. “The really loud announcement [...] that’s like a big old meat fork,” she said, describing how these stressors accumulated.

To reduce cognitive strain, participants created systems that supported focus and efficiency. Anna structured their workflow to be “the most efficient” so they could be fully present with whānau. Ana used digital prompts to ensure comprehensive care: “That is something I need within my practice to thrive.” Amber, aware of her forgetfulness, shared, “I have so many strategies to not miss things [...] it’s very rare I forget to send bloods or write a referral.” For Karien, who is dyslexic, AI-assisted documentation was transformative: “It’s been a game changer. I’m actually liking my job now.”

Participants also described strategies to manage sensory and social overload. Some used noise-reducing headphones or sought quieter spaces for documentation. All reported taking intentional breaks to regulate themselves—even those with sensory-seeking profiles. As Ana explained, “There’s a difference between having lots of stimulation and being overstimulated.” Neve likened these breaks to “building your reserves up again.” However, finding suitable spaces was challenging. Shared staff rooms often carried social expectations and sensory discomforts – conversation, clattering cutlery, food smells. Some retreated to their cars or toilets for quiet. Anna



emphasised the multi-purpose of these breaks: “It’s a social break, but also a noise break. Like, I get really overstimulated by noise. So just total quiet or just being able to put my headphones on and listen to something.” All participants valued the idea of intentional, multi-sensory spaces in every unit:

I think there should be two break rooms [...] one that is like a loud room I guess, where you can chat and heat up your food, and then a quiet room with a couple of arm chairs, you can use your phone with headphones, but no chatting and a space to rest or work quietly. (Kate)

While participants acknowledged the funding limitations withing the health system, they also saw the potential benefits of such spaces: “I could do twelve-hour shifts, but I can’t [...] I’m so exhausted and dysregulated by the end of the day.” (Hannah).

Summary

Neurodivergent kahu pōkai navigate diverse sensory, social, and cognitive needs in their search for suitable workplaces, often through trial and error. Some thrive in high-stimulation environments like hospitals or busy caseloads, drawn to unpredictability and clinical complexity, while others prefer structured, low-stimulus settings such as homebirths or small community teams that offer autonomy and sensory control. Regardless of setting, participants described the need to manage energy and overstimulation—referred to as “managing spoons”—through personalised strategies like workflow systems, sensory tools, and intentional breaks. Many emphasised the importance of quiet, neuro-affirming spaces to support wellbeing, highlighting both the challenges and adaptive strengths ND midwives bring to their roles.

Theme Four – Fostering ND Kahu Pōkai Culture and Leadership

Introduction

Theme four coalesced around three sub-themes:

1. Radical unmasking; a deliberate and empowering act through which ND midwives reject neurotypical expectations, embrace their full identities, and lead cultural change by modelling authenticity and inclusion.



2. I can be my most authentic self with ND colleagues; working alongside other ND colleagues fosters a deep sense of belonging, mutual understanding, and psychological safety, enabling ND midwives to communicate freely, self-regulate openly, and thrive both personally and professionally.
3. Feeling “othered”; despite efforts to be open about their neurodivergence, ND midwives often face stigma and exclusion in neuronormative systems, highlighting the urgent need to universal design, ND-led education, and structural reform to create truly inclusive workspaces.

Radical Unmasking

For the ND kahu pōkai participants, neurodivergence was not a diagnosis to be hidden or overcome—it was a fundamental part of who they were. It shaped how they experienced the world and how they contributed to it: “To me, it really means just a brain that’s wired a bit differently. Not something that’s right or wrong, but just a different version of a brain.” (Kate). Participants aligned with the neurodiversity paradigm, which rejects deficit-based models and instead affirms neurological difference as natural and valuable. They described their neurodivergence as inseparable from their identity: “It weaves through every part of me. It’s not just the way that I talk or the way that I, like, analyse information. It’s literally woven through my entire existence.” (Hannah). For many, neurodivergence was more than identity—it was culture.

A key expression of this cultural identity was the practice of radical unmasking: a deliberate and often difficult act of shedding the neurotypical façades in professional settings. Participants described this as a conscious form of resistance and reclamation. Nirvana added, “I’m very vocal about the fact that I’ve got ADHD [...] because then people feel more comfortable not masking with me.” For some, unmasking was also a matter of survival—the emotional and physical strain of constant masking had become unsustainable, and the cost of continued burnout was simply too high to bear. Bec also spoke to the liberating and transformative power of authenticity:

I can be better at my job if I'm not having to pretend to be something that I'm not [...] So just let me be who I'm going to be, and it's going to be a bit weird and



maybe a bit fun and [...] a bit more honest than you would expect, but we're going to do some really, really cool stuff together. (Bec)

Unmasking also fostered deeper connection and mutual care within teams. Kirsty described how being open about her neurodivergence allowed her to build trust and seek support: “Our team is small enough that I am establishing relationships with everyone which makes me feel comfortable to be myself and enables me to reach out to my colleagues when my neurodiversity is being challenging.” She added, “In fact my colleagues often remind me to take my meds or eat! Which is super helpful when I am hyperfocused on a task.”

Radical unmasking was not only personal: it was political. It became a form of leadership and advocacy. As Hannah explained: “It’s my way of making space for others to come out and join in. I think of it as education by demonstration”. The vision also extended beyond individual workplaces. Participants imagined a future where authenticity was the exception, but the norm. This future was not abstract—it was already being built. Some participants described neuro-affirming spaces they had helped create, where understanding and accommodations were embedded in the culture. As Kirsty reflected,

It has been insanely affirming to work in that environment because we just understand each other. [...] Understanding [...] of each others needs to turn off the radio when the phone rings, to go outside on breaks to change the stimulus, to go and sit in a different room when we need to concentrate.

Radical unmasking, then, was not just about individual expression—it was a collective act of cultural reclamation, a challenge to normative systems, and a blueprint for a more inclusive and affirming future in midwifery. Ana added: “I think more neurodivergent people should be midwives”.

I Can Be My Most Authentic Self With Other ND Colleagues

A powerful thread woven through participants’ reflections was the sense of ease, safety, and authenticity they experienced when working alongside other ND colleagues. These relationships were described as uniquely affirming: grounded in a shared culture and mutual understanding that required no translation or justification.



This sense of connection fostered an environment where participants felt free to engage in self-regulating behaviours such as stimming. Communication flowed more naturally, and many described feeling seen and accepted without needing to mask or explain themselves: “Shifts with my ND colleagues are the best! I feel so at home with them, understood and accepted.” (Kirsty). Importantly, this sense of belonging extended beyond emotional comfort and had tangible implications in clinical settings. Shared communication styles and intuitive understanding were seen to enhance teamwork, particularly in high-pressure situations:

I felt very safe and seen, and I found her very, very easy to communicate with, and I found that was really helpful in terms of communicating things quickly to her, you know, clinical things quickly. (Hannah).

For some, this recognition of shared neurodivergence was retrospective. Di, reflecting on decades of midwifery practice, came to realise that the colleagues she had felt most attuned to likely shared similar neurotypes: “I actually kind of look at them and think, hang on a minute. I think they're probably neurospicy too.”. There was also a broader sentiment that midwifery as a profession might naturally attract ND individuals: “But I feel like there's a lot of neurodiversity in midwifery. We're very special kind of people [...] and we attract each other.” (Neve).

The focus group component of this research was described as a rare and meaningful opportunity for ND midwives to connect. Kate referred to it as a “special opportunity” while Bec described her experience as: “it feels like a thought connection with ND midwives across the motu”. Participants were not only eager to share their experiences but also to build community, exchange resources, and validate one another’s realities. The focus group became a space of collective learning and mutual support: “I have loved this peer discussion with other ND peeps cos it has helped me identify/see, articulated more clearly some of my traits and struggles” (Di).

All participants expressed a strong desire for formalised ND peer support, viewing it as a vital tool for cultural change in midwifery: “I think that, given the abhorrent lack of clinical research, peer to peer support and education is our best chance at changing the culture in midwifery.” (Bec). Ana echoed this sentiment:



[...] we would be able to share tips and tricks on [...]. Just meeting up with someone once a month to be like, oh, my God, you get it. I said this thing, and I don't know if it landed well or not. Yeah, my filter disappeared for a moment.

(Ana)

Michelle commented “[...] my current manager is actually autistic himself [...] yeah, he thinks I'm amazing and, you know, and is really supportive”. Kate also noted: “[...] because when you can see someone else that's doing well and they're similar to you, it gives you, like, faith that you can get there”.

Finally, several participants noted that Te ao Māori spaces often felt more inclusive and neuro-affirming than mainstream, coloniser-dominated environments. These spaces offered a sense of cultural safety that resonated deeply with ND participants: “I say this as Tangata Tiriti, that te ao Māori spaces are often more neuro-affirming spaces for me.” (Di)

Feeling “Othered”

Participants described the complex emotional terrain of being “out” as ND in professional environments shaped by neuronormative expectations. While disclosure was often necessary to access accommodations, it also risked reinforcing a sense of being “othered.”:

What has been going around in my head for the last couple of days is around 'outing' oneself in order to ask for accommodations or support [...] On the other hand, how can I express my needs if I'm not open about it? (Anna)

This tension between visibility and vulnerability became a major kōrerō within the focus group. Bec commented: “The idea of 'outing' oneself is something that seems to be grounded in colonisation.” Anna agreed:

Outing myself as queer, non-binary and neurodivergent feels like a strategy to gain outward validation. On the other hand, it is an avenue for asking for reasonable accommodations, but risks being shamed or rejected for being 'needy' or othered. It's such difficult territory to navigate!



Participants frequently encountered ableist attitudes when requesting accommodations; one recounted being denied a simple request by her manager, who dismissed her needs with comments like “everyone’s got something” and “toughen up.” She concluded, “We need an advocacy role to turn to in situations like this.” Bec added poignantly:

Yeah, for sure. Everybody loses their keys. But, you know, it's more than just that. Does the fact that you consistently lose your keys affect your ability to have relationships and to find happiness in life? And, you know, because it does for me.

Despite these challenges, participants envisioned more inclusive approaches. Universal design emerged as a powerful strategy to reduce othering. Lizz described a moment of affirmation when a manager offered communication options to everyone: “It was a level of safety that I didn't have to explain. Like, it was just an option and it wasn't because I was neurodivergent. It was just an option.” Kirsty expanded on this:

I think a universal design enabling us all to identify how we are feeling each day and express our needs for the day to get through would be incredible. Even NT folks have crap days where they may just want to keep interactions to a minimum. If everyone is being encouraged to share these things maybe no one feels ‘othered.

Participants also offered practical, low-cost solutions. Hannah and Anna suggested using noise-reducing headphones as a visual cue in shared workspaces:

Managers would need to understand that we need that as accommodations and to make us feel comfortable to do that. I think that there would be concerns around safety with emergency bells and things like that. But I've never been able to find a pair of headphones so good at cancelling sound that they would cancel out the emergency bell. (Hannah)



Workforce education, especially when led by ND professionals, was seen as essential. Di described a shift in workplace culture after leadership attended ND-led training: “I have felt so much safer to out myself [...]. Hearing people’s stories seemed to create a re-evaluational moment when they realised how much of a disability being ND in the perinatal system can be.”

Participants emphasised the need for ND leadership to dismantle ableist norms from within. “We need more people with neurodiversity in leadership roles,” Lizz said. “Not as a token hire, but people who have earned it on their merit, who also happen to be neurodivergent. When those people start getting into that place, they can start influencing this stuff to change.” As Kirsty concluded, “Many things that accommodate our neurodiversity are beneficial to everyone.”

Summary

Theme four explores the transformative potential of fostering a ND kahu pōkai culture and leadership, grounded in the lived experiences of the ND kahu pōkai participants who wish to challenge deficit-based narratives and embrace neurodivergence as identity, culture, and strength. Central to this vision is the active practice of radical unmasking—a courageous act of shedding neurotypical façades in professional settings, reclaiming authenticity, and modelling inclusive leadership. Participants described how working alongside other ND colleagues created rare spaces of mutual understanding, where they could be their most authentic selves without fear of judgment or the need to explain. These affirming relationships not only enhanced emotional safety but also improved clinical collaboration and communication. However, the journey toward authenticity was often fraught with the pain of feeling “othered” in systems steeped in neuronormativity. Disclosure, while necessary for accommodations, risked stigma and marginalisation. Participants called for universal design, ND-led education, and structural change to dismantle ableist norms and foster environments where ND midwives can thrive. This theme illuminates a powerful vision: a kahu pōkai culture where neurodivergence is not merely accepted but celebrated, and where ND leadership drives systemic transformation for the benefit of all.



Theme Five – Expanding Our Idea of What a Kahu Pōkai Can Be

Introduction

Theme five coalesced around three sub-themes:

1. Disability is dynamic; participants framed their experiences through the social model of disability, highlighting how systemic inflexibility-rather than neurodivergence itself-created barriers to sustainable kahu pōkai work, especially when compounded by chronic health conditions, hormonal fluctuations and caregiving responsibilities.
2. Expanding our idea of what a kahu pōkai can be; participants called for an expanded vision of midwifery that embraces diverse strengths, flexible roles, and alternative career pathways-challenging rigid expectations of full-scope practice and advocating for a profession that values inclusion, sustainability, and the unique contributions of all midwives.
3. Disabled people can't be kahu pōkai, right? Participants described how ableist assumptions and narrow definitions of "fitness to practise" often excluded them from sustainable midwifery careers-despite their ongoing passion and capacity to contribute-calling for structures that enable disabled midwives to remain and thrive in the workforce.

Disability is Dynamic

The ND kahu pōkai participants framed their experiences through the lens of the social model of disability, emphasising that limitations often arose not from their neurodivergence but from inflexible systems: "It's only disability for them because they don't understand and they don't know what to do with it" (Karien). Alongside neurodivergence, many participants disclosed living with co-occurring health conditions such as Ehlers-Danlos Syndrome, chronic fatigue and long COVID. Hormonal fluctuations related to menstruation, perimenopause, and menopause added further complexity, often intensifying ND features and chronic health symptoms. Participants described how their ability to work fluctuated over time, influenced by health, energy levels, and environmental demands. "We get flares. So I will have several weeks where I'm absolutely hopeless to myself and have to really put myself on the line to accommodate my employment." (Neve). Many spoke of their



energy “ebbing and flowing,” and expressed a desire for workplaces to accommodate these natural rhythms.

To manage these dynamics, some participants opted for part-time or casual roles, valuing flexibility despite the trade-offs—reduced protections, no sick leave, and a sense of disconnection: “[...] and part of being casual is that horrible thing that you're not really relationally connected to the team” (Di). Others found that core midwifery roles with set hours and no on-call demands better supported their health. Kirsty, though a homebirth kahu pōkai at heart, shared: “Having a set number of hours that I work in a day [...] is really important for managing my illness.”

Participants working as LMCs emphasised the importance of reciprocity with practice partners, allowing them to adapt to fluctuating energy levels. Karien explained: “[...] so where you lack, I'm going to help you.” Ana benefited from a 12-hour on-call model: “So there's a really good amount of recovery time in there and it gives my brain the space to put all the energy into what it needs to do and then crash at the end of the 12 hours.” Despite the unpredictability of on-call work, LMCs valued the autonomy to manage their diaries, balancing workload and wellbeing. This flexibility enabled them to schedule predictable tasks—like antenatal and postnatal visits—around their capacity: “I can fit my timetable to what I need and still allow me to have decent rest time in between” (Lizz).

Several participants also highlighted the additional caregiving responsibilities they carried, often for neurodivergent children or whānau, which further shaped their capacity to meet the demands of the profession. Participants wished for disability-affirming rostering practices, including permanent shift rostering and the ability to adjust shift lengths. Participants emphasised that these were not simply preferences but essential needs to sustain themselves in the profession. “I may have stayed in the profession longer,” Kate reflected, “if I was able to work in a way that worked with the needs of my brain.” Kirsty added: “[...] things like consistent hours or times [...] are made out like they are some sort of luxury or insane demand in our work, but realistically they are necessary for many of us” (Kirsty)

Expanding Our Idea of What a Kahu Pōkai Can Be

Participants described finding their place in midwifery by aligning their roles with personal strengths rather than conforming to the full scope of practice. Amber



reflected: “[...] certain things that are considered deficits are positives in other situations”. Anna shared how working in elective theatres suited their health needs: “[...] due to circumstances with my mental health [...] I did a lot of work in the elective theatres. And strangely enough, I loved it” (Anna). They added: “I'm really good at this, so why can't I just do this all the time?”. For Tamsin, moving into academia offered a way to stay connected to the profession while recovering from burnout: “[...] I can just stay at home, look in my papers [...] I am a little bit burnt out, you know, from the clinical stuff” (Tamsin)

Participants expressed a desire for a profession that values diverse strengths rather than rather than a narrow standard:

I want to see everybody's strengths acknowledged. We all have different ones, and some will be academic and some will be the relationship with women and some will be all sorts of different things. But in our current environment, we recognise just a few things [...] And I think that there is a way for all, all of us to feel like we contribute and feel valued. (Neve)

Di echoed this, saying: “It's like I'm paddling my own little waka and no one really knows what it is”. Participants envisioned a culture that recognises excellence in many forms—clinical care, research, governance, leadership, and mentoring: “Because we have to fit into the specific box. A midwife looks like this and the midwife does this and the midwife does that. That's not always how everybody is” (Karien). Tamsin added: “Either you're going to be an LMC or you're going to be a core midwife” (Tamsin). Participants challenged the idea that all midwives must work across the full scope: “The rules are you have to do the gamut, and actually the gamut doesn't work for you,” (Neve). Others questioned leadership had not yet fully embraced more flexible models of practice:

[...] we have a council that hasn't quite, it's getting there, but it hasn't quite figured out how they deal with midwives like us [...] like the midwives who are just doing postnatal care [...] Maybe we also need to say, hey, look, not all midwives who get a degree can do everything or want to do everything.
(Tamsin)



Participants wanted clearer, more accessible career pathways that include roles in sexual health, abortion care, lactation consultancy, teaching, governance, research and more. These should not be seen not as exits, but as valid expressions of midwifery: “I so badly want expansion of my scope as a midwife. I want more work opportunities. I want to be able to use my skills in other spaces when I can’t do shift work anymore” (Kirsty). Expanding the vision of midwifery, they argued would make the profession more inclusive and sustainable: “I think, gosh, we’ve just got this increasingly diverse and, you know, literally disabled population” (Leila). Michelle added: “Cause I think also probably like, a whole like group of people that are neurodiverse but that think midwifery just could not be for them” (Michelle).

Disabled People Can’t Be Midwives, Right?

Many participants described encountering significant barriers as they navigated their kahu pōkai careers, particularly when considering their futures in the profession. A recurring concern was the uncertainty around sustainable career pathways when current work contexts became untenable due to disability. For some, this uncertainty felt like entrapment—being passionate about midwifery but unsure how to remain in the profession in a way that accommodated their needs:

I guess I just want options! Sometimes I feel like a caged bird when I’m exploring what jobs may be available to me that may fit my needs when the time comes. I will need a job that fits my neurodiversity but also my physical disability. I feel I still have so much to give to our profession but worry that soon enough my profession won’t want me. (Kirsty)

Participants expressed that midwifery, as a profession, had not yet meaningfully considered the inclusion of its disabled, tāngata whaikaha workforce. The dominant discourse remained focused on “fitness to practise” standards—seen as essential by participants for ensuring safe care for whānau—but largely ignored the wellbeing and sustainability of the midwives themselves.

I think there definitely needs to be a lot more support and I think even people that are not neurodiverse need that support [...] and I don't think there's always, kind of a feeling that you can share certain things. (Kate)



Some participants found themselves at a crossroads—questioning whether they could continue in midwifery at all: “I kind of feel like the wheels are coming off in my life at the moment. [...] So currently there's nowhere to go and get advice and support on what the hell to do.” (Leila). One participant had already left the profession, while another was returning to practice after recovering from burnout.

Participants wished for a pan-disability, neuro-affirming support structure—one that could offer guidance and advocacy: “[...] and their role could be actually that discovery of what us midwives can do other than being on the floor.” (Neve).

Participants envisioned a more inclusive profession that asked its members how they could continue contributing meaningfully:

So, I think it's being open to ask the questions of any midwife [...] How can we keep you around? What are your other interests in midwifery? Because sometimes, you know, you can take out your back and you can't practice as an LMC anymore. (Bec)

Summary

Theme five “Expanding our idea of what a kahu pōkai can be” challenges the narrow definitions of midwifery by centering the lived experiences of disabled and ND kahu pōkai. Participants emphasised that disability is dynamic shaped as much by fluctuating health and caregiving demands as by rigid systems that fail to accommodate diverse needs. Rather than viewing disability as a barrier, they described how aligning their roles with their strengths—whether in clinical niches, academia, or adjacent fields—allowed them to thrive and contribute meaningfully. However, many also faced systemic exclusion, with prevailing “fitness to practise” standards overlooking the sustainability and wellbeing of midwives themselves. The ableist assumption that disabled people can’t be midwives was deeply felt, leaving some feeling trapped or unsupported as their needs changed. Participants called for a profession that not only affirms diverse ways of practicing but also actively asks: How can we keep you in midwifery? By embracing flexibility, valuing contribution over conformity, and creating inclusive career pathways, the profession can become more sustainable, welcoming, and reflective of the communities it serves.



Chapter Summary

This chapter has presented the following five interrelated themes that illuminate the experiences of the ND kahu pōkai participants:

- 1. ND Traits Facilitated Strong Therapeutic Relationships With Whānau:**
Neurodivergent kahu pōkai used their unique communication styles, empathy, and cognitive strengths to build deep, trusting relationships with whānau, offering emotionally safe and affirming care rooted in authenticity and lived experience.
- 2. Spiky Skill Profiles:**
ND kahu pōkai balanced exceptional abilities with specific challenges, and relied on tailored strategies and supportive feedback to navigate clinical and interpersonal aspects of their work.
- 3. A Journey: Finding a Workplace That Suited My Unique Needs:**
Participants described a personal process of discovering work environments that aligned with their sensory and cognitive needs, using customised tools and routines to manage energy and overstimulation.
- 4. Fostering ND Kahu Pōkai Culture and Leadership:**
By embracing neurodivergence as a cultural reclamation and strength, ND kahu pōkai advocated for inclusive leadership, peer support, and systemic change to dismantle stigma and foster authentic, affirming workplaces.
- 5. Expanding Our Idea of What a Kahu Pōkai Could Be:**
This theme challenged rigid perceptions of midwifery, showing how systemic inflexibility—not neurodivergence—created barriers, and called for flexible roles that valued contribution over conformity to support sustainability and inclusion.

In these final chapters, I will revisit the aim, objectives and questions of this research, and provide a summary of the research findings. These findings will be contextualised with extant literature, and I will offer some recommendations both for individual ND kahu pōkai and for the profession.



Chapter Five: Discussion

Introduction

This chapter begins by reaffirming the core purpose of the research: to explore the experiences of ND kahu pōkai and their aspirations for a more inclusive midwifery profession in Aotearoa New Zealand. I then examine the five central themes—introduced in the previous chapter—through the lens of international healthcare research and recent scholarship within the neurodiversity paradigm. This analysis considers how midwifery can evolve to better support the diverse ways ND practitioners engage with their work and communities.

What Are the Experiences of ND Kahu Pōkai in Aotearoa New Zealand? What Strategies Do They Believe Would Support a Neuro-Affirming Kahu Pōkai Career?

In this research I believe I have achieved my aims of describing the experiences of ND kahu pōkai in Aotearoa New Zealand and have shed light on their perspectives about their individual strengths, and their visions for a more neuro-affirming professional environment.

ND Traits Facilitate Strong Therapeutic Relationships With Whānau

A consistent theme across participant narratives was the way they felt their ND traits enhanced their ability to form strong, empathetic relationships with whānau. Traits such as associative storytelling, honesty, directness, hyperfocus, info-dumping, masking, pattern recognition, and attention to detail were not incidental—they were central to how participants practiced midwifery and built trust and rapport. While previous studies have identified traits like hyperfocus, pattern recognition and attention to detail among ND healthcare professionals (Godfrey-Harris & Shaw, 2023; Rowe et al., 2021; Shaw, Fossi et al., 2023), they have not explicitly linked these traits to enhanced client relationships. However, given that the voices of whānau were not included in this study, we cannot draw conclusions about how these traits were experienced by those receiving care. Beyond healthcare, research within the neurodiversity paradigm underscores the distinctive workplace strengths



associated with a broad spectrum of traits experienced by neurominorities (Armstrong, 2010; Logan, 2009; Meilleur et al., 2015; Sedgwick et al., 2019). One such strength is associative storytelling, or “Show and Tell” communication (Monteiro, 2025)—a style that centres on the turn taking of facts and tangible experiences and where emotional energy is embedded within the subject at hand. This communication style is also associated with a tendency toward literal, direct, and honest expression and was seen by participants in this study as a strength in midwifery, particularly in building rapport and supporting informed consent. While NT midwives may also use associative storytelling, research suggests ND individuals engage in this mode more frequently (Grant, 2009) and that it can be a valuable ND trait within wider workplace settings for building relationships (Doyle, 2020; Eide & Eide, 2011).

Masking, though often used as a survival strategy, was also described by participants as an unintentional and unconscious means of adaptability—they felt that masking enabled them to engage with a wide range of people in nuanced and responsive ways. In the healthcare worker literature, masking was typically framed as a strategy for managing workplace social expectations, particularly with colleagues, and was associated with negative mental health outcomes and fears of burnout when sustained over time (Anderson & Shaw, 2023; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes et al., 2021; Locke et al., 2016; Rowe et al., 2021; Shaw, Fossi et al., 2023). While participants in this study also reported these challenges, they also identified unexpected benefits—most notably, enhanced relational flexibility. This nuanced perspective on masking, particularly its role in whānau care, represents a novel contribution to the literature.

Deep Focus, Deep Care: The Role of Monotropic Cognition in Midwifery

The theory of Monotropic Cognition proposes that ND individuals often exhibit highly focused attentional styles, enabling deep, sustained engagement with subjects that hold personal significance (Murray et al., 2005). In broader ND employment research, monotropic cognition has been linked to strengths such as hyperfocus, info-dumping, pattern recognition, and attention to detail (Armstrong, 2010; Doyle, 2020; Grant, 2009; Leather et al., 2011). Studies on ADHD and autism further demonstrate that when professional tasks align with an individual’s special interest, traits like hyperfocus can significantly enhance performance and job satisfaction



(Doyle, 2020). Participants in this study described midwifery not merely as a career, but as a lifelong passion—an identity-defining focus that shaped their clinical practice and professional values. This resonates with the ND concept of “special interests,” which are characterised not by limitation, but by intense focus, emotional investment, and intrinsic motivation (Milton, n.d.; Murray, 2018).

Traditional diagnostic frameworks such as the DSM-IV (1994) have historically pathologised these interests as “restricted” or “repetitive.” However, many ND individuals experience them as energising, meaningful, and sustaining—often serving as a source of resilience and excellence in professional contexts. Within existing healthcare worker literature, while several studies report that ND participants expressed strong passion for healthcare or a determination to succeed (e.g., Anderson & Shaw, 2023; Crouch, 2019; Rowe et al., 2021), these traits were typically framed as responses to adversity or discrimination, rather than as innate ND strengths. This study is among the first to explicitly explore how special interests function as a professional asset within midwifery and broader healthcare practice—reframing passion not as a coping mechanism, but as a core driver of clinical excellence and identity for ND practitioners

Tuning In: Neuroception, Co-Regulation, and the ND Contribution to Healthcare

A strong theme across the data was how personal adversity shaped participants’ empathy and commitment to affirming care. Many had faced stigma, misdiagnosis, or exclusion—especially in childhood, during the undergraduate degree or early career—which deepened their compassion for others. While existing literature acknowledges that receiving a diagnosis can validate the lived experiences of ND healthcare professionals (Godfrey-Harris & Shaw, 2023; Price et al., 2017) and documents the prevalence of workplace discrimination (e.g., Anderson & Shaw, 2023; Crouch, 2019), this study found that participants felt their experiences of marginalisation also fostered heightened emotional attunement and radical acceptance of others.

Participants described the phenomena of nervous system co-regulation with whānau as central to their practice. Drawing on personal experiences of nervous system dysregulation and mental distress, they describe remaining calm and emotionally present in high-stress situations. This reflects emerging research on biorhythmic attunement (Mordeniz, 2020) and neuroception, the subconscious sensing of safety or danger (Porges, 2022). Some ND individuals experience heightened



neuroception, enabling them to perceive and respond to others' nervous system states, even without interpreting conventional social cues (Letsoalo, 2025; Maričić et al., 2020). Notably, existing healthcare worker literature does not report findings on co-regulation or de-escalation with patients in states of distress, highlighting a significant gap that this study begins to address.

Spiky Skills Profile: An Expectation Versus Reality Gap

Participants in this study managed their professional roles with uneven skill sets, often demonstrating exceptional strengths alongside pronounced challenges in areas like motor coordination, executive functioning, social interaction and sensory integration. A spiky skills profile created a significant gap for participants between expectations and lived realities in the workplace. Their distinctive profiles frequently required additional time, repeated practice, and individualised strategies to master clinical tasks and adapt to workplace demands. While the concept of a Spiky Profile was not named explicitly in the healthcare worker literature, its presence was implied through recurring themes. For instance, healthcare professionals reported difficulties with executive functioning (Shaw, Fossi et al., 2023) especially with multitasking (Crouch, 2019; Price et al., 2017; Rowe et al., 2021; Walker et al., 2021), time management, and documentation (Anderson & Shaw, 2020; Locke et al., 2016). Wider workplace research highlights common challenges among neurominorities, particularly in executive functioning—affecting processing speed, working memory, and attention regulation (Bartlett et al., 2010; Grant, 2009; Howlin et al., 2005; McLoughlin & Leather, 2013; Prevatt & Yelland, 2013). Difficulties with organisation and time management are also well-documented (Adamou et al., 2013; Doyle & McDowall, 2015; Kirby et al., 2018; Todd, 2011; Wehman et al., 2016).

Within the healthcare worker research, challenges in reading social cues, processing verbal information, and distinguishing between implicit and explicit communication were widely reported (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Price et al., 2017; Rowe et al., 2021; Walker et al., 2021). These studies consistently highlighted healthcare workers experiences of the Double Empathy Problem (Milton, 2012), noting that most of their social and communication challenges occurred in interactions with NT colleagues. My own findings echoed this, and also extended current knowledge, revealing that communication challenges between neurotypes were particularly pronounced during clinical debriefings.



Debriefing was frequently described as emotionally and cognitively demanding, often requiring extended periods of reflection—particularly for those experiencing alexithymia, a trait more commonly observed within the ND community (Fox-Muraton, 2024). Wider workplace research also highlights social challenges for ND people, including teamwork, communication and self-regulation with colleagues (Bartlett et al., 2010; Coetze & Gibbison, 2013; Katz et al., 2015; Kirby et al., 2011; de Beer et al., 2014; McLoughlin & Leather, 2017; Prevatt & Yelland, 2013; Todd, 2011).

Notably, none of the healthcare worker literature explicitly addresses motor skill challenges. Although none of the participants in this study disclosed a diagnosis of Developmental Coordination Disorder (DCD), formerly known as dyspraxia, the broader ND literature provides strong evidence that many ND conditions involve differences in fine and gross motor abilities—even when these differences do not meet the threshold for a formal DCD diagnosis (Doyle, 2024). Wider research on ND people also reports persistent motor difficulties within workplace settings (Bartlett et al., 2010).

The Compounding Impact of Sensory Processing Differences

For participants with sensory-avoidant profiles, this study revealed significant workplace environmental challenges—particularly related to auditory input. While issues such as fluorescent lighting, hospital uniforms, and strong smells were noted, sound was by far the most frequently cited source of sensory stress. This aligns with existing research showing that ND healthcare workers often struggle with sensory overload in clinical settings, especially noise, which can be particularly disruptive during tasks like documentation (Anderson & Shaw, 2020; Crouch, 2019; Rowe et al., 2021). These sensory stressors were frequently found to exacerbate executive functioning difficulties and negatively impact mental health (Shaw, Fossi et al., 2023; Walker et al., 2021). In this study, participants described how auditory processing difficulties compounded routine tasks such as documentation and clinical handovers—especially in loud, shared, multi-use office spaces.

These findings align with broader neurodiversity literature, which emphasises that many ND individuals rely on ‘bottom-up processing’—a cognitive style that prioritises sensory input over conceptual frameworks—resulting in heightened sensitivity to unpredictable or chaotic environments (Vonk, 2021). Emerging evidence also



suggests that auditory processing differences in ND people extend beyond hypersensitivity. These include heightened pitch perception (Bonnell et al., 2010), difficulty filtering speech from background noise (Caniato et al., 2022; Ruiz & Boets, 2023), and slower adaptation to changing soundscapes (Millin et al., 2018). Such differences can affect both cognitive and social functioning, including challenges with non-verbal communication and interpreting complex auditory cues (Callejo & Boets, 2023). Additionally, unpredictable auditory environments may reduce cognitive flexibility, making it harder to switch tasks or maintain focus—transforming sensory discomfort into a significant barrier to employment participation and performance in healthcare settings (de Vries, 2021; Poulsen et al., 2024).

Spiky Skills as a Defining Feature of Neurominorities

This study builds upon and extends existing literature by explicitly naming and examining the concept of a spiky skills profile, offering a more nuanced understanding of how ND health professionals experience and navigate clinical environments. A spiky or uneven cognitive profile is a central theme within neurodiversity research, yet it remains frequently misunderstood or overlooked (Doyle, 2020). For instance, verbal autistic individuals are often assumed to possess broad competence, while those with limited verbal communication may be inaccurately perceived as lacking ability or potential (Milton, 2017). The British Psychological Society's Psychology at Work report (McLoughlin & Doyle, 2017) outlines how significant variability across cognitive domains can be clinically meaningful. Such profiles are routinely used in the diagnoses of ND conditions (Grant, 2009; McLoughlin & Leather, 2013; McLoughlin & Doyle, 2017) and in assessing cognitive function after injury or illness (British Society of Rehabilitation Medicine, Jobcentre Plus & Royal College of Physicians, e2004). In contrast, neurotypical individuals tend to have more consistent performance across cognitive domains—typically within one or two standard deviations—regardless of whether those scores are high, average, or low (Doyle, 2020; Grant, 2009).

There is growing recognition that ND traits may serve an evolutionary role, offering specialised thinking that complements more NT generalist cognitive styles (Armstrong, 2010; Doyle, 2020; Logan, 2009; Meilleur et al., 2015; Sedgwick et al., 2019; Todd, 2011; White & Shah, 2005). Some advocates argue that the spiky profile may ultimately become the defining feature of neurominorities, encompassing traits



currently categorised as autism, ADHD, dyslexia, and DCD—a view supported by a growing body of research (Astle et al., 2018; Karmiloff-Smith, 2009). While biological markers of these profiles are measurable (Astle et al., 2018; Kapp et al., 2012), they are not inherently disabling—especially when considered in the context of traditional, community-based human societies (Doyle, 2020).

Intense World Theory: A Unifying Understanding of ND Strengths and Challenges

Participants in this study navigated their professional roles with varied and uneven skill sets, each demonstrating distinct strengths and challenges within their kahu pōkai careers. These findings resonate with the “Intense World Theory” (Markram & Markram, 2010), a growing framework within ND literature. This theory posits that ND individuals may retain hyper-connected neural pathways due to atypical synaptic pruning, resulting in heightened perception, memory, and empathy—traits that participants in this study affirmed and that ND advocates have long emphasised (Hansen, 2019; Maričić et al., 2020; Rizzo & Rock, 2021).

The Intense World Theory offers a compelling lens through which to understand participants’ experiences of navigating kahu pōkai careers with a spiky skill profile. While it highlights neuronal hyper-connectivity, research also points to areas of hypo-connectivity in ND individuals. These less-connected regions may contribute to asynchronous skill development often observed (Maričić et al., 2020; Markram & Markram, 2010; Markram et al., 2007). In this light, participants’ strengths and challenges emerge not as contradictions, but as interdependent expressions of the same neurodevelopmental architecture. For instance, many participants perceived hyperfocus to be a powerful asset in their kahu pōkai practice, enabling deep engagement, precision, and sustained attention during critical tasks. However, the participants also described this trait as coming with trade-offs: difficulty shifting attention, losing track of time, and diminished interoceptive awareness. As a result, participants reported sometimes overlooking their basic bodily needs such as hunger, fatigue, or the need for rest. These dualities underscore the complexity of ND experiences uncovered in this research—where the perception of exceptional capabilities and awareness of significant challenges do not sit in opposition, but are recognised by the ND kāhu pōkai to be intimately linked facets of a richly textured cognitive profile.



The Importance of a Broader Disability Perspective

Participants in this study articulated their experiences through the lens of the social model of disability. They emphasised that the challenges they faced were not inherently due to their neurodivergence, but rather stemmed from inflexible, ableist systems and pervasive misconceptions about ND traits and experiences. This perspective aligns with findings in the broader ND health professional literature, where individuals viewed themselves through disability affirming frameworks (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Locke et al., 2017; Price et al., 2019; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021).

A substantial number of participants in this study disclosed overlapping ND identities, most commonly Autism and ADHD—referred to as AuADHD. Other combinations were also present, including bipolar disorder, dyslexia, epilepsy, and acquired brain injury, each contributing to a distinct neurotype. Despite growing recognition of the prevalence and nuanced experience of overlapping neurodivergence, explicit reporting of this within the ND health professional literature was limited. Notably, Shaw, Fossi et al. (2023) were the only authors to document this phenomenon among Autistic doctors' participants. In contrast, the broader ND workforce literature has begun to address this intersection more comprehensively. Hewlett et al. (2018), in a landmark study commissioned by the British Parliament, investigated neurodivergence across employment contexts. Drawing on a large cohort, the study found that individuals frequently identified with multiple ND labels—17% with three or more. Greater degrees of neurodivergence were associated with increased workplace challenges, with compounded effects observed among ethnic minority groups.

Although this study did not explicitly ask about co-occurring health conditions, some participants voluntarily disclosed living with chronic conditions such as Ehlers-Danlos Syndrome (EDS), Chronic Fatigue Syndrome (CFS), and long COVID. Hormonal fluctuations related to menstruation and menopause were frequently cited as exacerbating both ND traits and chronic health symptoms. These disclosures may reflect the neuro- and disability-affirming methodology employed, which may have fostered a sense of safety and openness among participants. It raises the question: how much more might have been revealed had these topics been directly



addressed? The broader ND literature highlights a disproportionately high prevalence of chronic health conditions among ND women and gender-diverse individuals (Al-Beltagi, 2021; Davies et al., 2023). Studies report elevated rates of fibromyalgia (Asztely et al., 2019), joint hypermobility and EDS (Csecs et al., 2022; Kelly et al., 2022) and CFS (Grant et al., 2025; Ryan et al., 2023). Hormonal transitions—such as menstruation and menopause—frequently exacerbate these conditions and intensify ND traits (Grove et al., 2023). Notably, research indicates that menopause is a period of acute vulnerability for ND people, with increased rates of mental health issues and suicide risk. Some have described this phase of life as “when my autism broke” (Moseley et al., 2020). Brady et al. (2024) further underscore ND menopause as a convergence point for compounded difficulties across employment, physical and mental health, and social isolation. By centering the voices of ND kahu pōkai, this study deepens our understanding of some of the ways neurodivergence can intersect with health disabilities and gendered experiences in the midwifery context.

Identifying Optimal Workplace Settings: A Personalised Process

Participants described a personal process of experimentation as they navigated various work environments, roles and schedules, in search of settings that aligned with their sensory, social, and cognitive needs. While some thrived in fast-paced, high-stimulation hospital settings, others found greater comfort and effectiveness in calmer, more structured environments such as homebirths or community-based teams. This study may be the first to examine how different healthcare settings can be experienced by ND midwives as either affirming or depleting, depending on individual neuroceptive and sensory needs. Some participants preferred novelty, stimulation, and polytropic settings, while others gravitated toward predictability, structure, and monotropic spaces. These preferences were closely linked to whether individuals identified as sensory-seeking or sensory-avoidant. Such findings are both novel and significant within midwifery and broader healthcare research and highlight the wide spectrum of ND experiences. Each participant described a distinct expression of neurodivergence, resulting in unique environmental preferences—underscoring the value of personalised approaches to workplace design. Insights from broader ND literature help contextualise the diverse preferences reported by participants. For instance, the Intense World Theory, which attributes sensory,



cognitive, and social differences to underlying variations in neural connectivity, offers one explanatory framework (Milton, 2017).

Several participants described a preference for, or exclusively worked, night shifts due to the reduced sensory, cognitive, and social demands. This finding, not previously reported in the literature on ND healthcare workers, underscores the adaptability of the participants in tailoring their work environments to suit their needs and their determination to remain in the profession. Others opted for part-time or casual employment as a strategy to manage fluctuating capacity, especially if they experienced co-occurring health conditions. While Shaw et al. (2023) reported that 50% of Autistic doctors in their study worked part-time, they did not explore the underlying motivations. Broader employment data, such as that from the Australian Longitudinal Study of Autism in Adulthood (Harvey et al., 2021), similarly show higher rates of part-time work among autistic individuals—particularly women—highlighting a trend that may reflect necessity, strategic self-care and increased parental care-giving responsibilities.

Valuing Contribution Over Conformity.

Some participants gravitated toward specialist kahu pōkai roles—such as working exclusively in caesarean sections or postnatal wards—to focus on their strengths and avoid tasks or environments that felt less compatible. While several had successfully shaped fulfilling careers, others found themselves at a crossroads: unsure where to seek support or how to identify roles that aligned with their ND profiles, particularly when co-occurring disabilities were involved. These findings align with Baker et al. (2023), whose scoping review of nurses and midwives with disabilities revealed that inadequate workplace support often led to instability, increased absenteeism, and decisions to leave the profession altogether. The urgency of these concerns is underscored by current workforce challenges. In Aotearoa New Zealand, there is an estimated shortfall of 1,050 full-time equivalent midwives—representing a 40% deficit in the current workforce (Te Whatu Ora | Health New Zealand, 2023). As Dixon et al. (2025) argue, retaining the existing workforce is the most cost-effective and immediate strategy for alleviating workforce pressures.

A promising strategy emerging from ND employment research is job crafting—the process of tailoring roles to better fit individual strengths (Praslova, 2023). This approach has been shown to enhance both productivity and self-efficacy (Miraglia et



al., 2017). Participants expressed a desire for more options and support in crafting kahu pōkai careers that suited them, rather than being expected to conform to the full scope of midwifery practice. Many felt their contributions were overlooked when their roles didn't fit neatly into existing categories such as core or LMC kahu pōkai, which they described as restrictive. They were particularly interested in specialised areas like abortion services, extended postnatal care, and whānau-wide STI testing. There was hope that the Te Tatau o te Whare Kahu | The Midwifery Council's recent scope expansion would create more opportunities and allow for greater flexibility in practice (2024). Crucially, participants wanted these roles to be recognised as legitimate expressions of midwifery—not as deviations from it. While research on healthcare workers rarely explored how professionals found roles that suited them, Autistic doctors in Price et al. (2019) reported that mentoring helped them identify work contexts that aligned with their strengths and minimised their challenges. This enabled them to practice in ways that reflected their unique skill profiles. Together, these insights highlight the need for more inclusive, flexible, and responsive workplace role and structures—ones that recognise and accommodate the diverse realities of ND professionals, not only for their wellbeing but also for the sustainability of the kahu pōkai workforce as a whole.

Where Joy Sparks: More Glimmers Less Triggers

Factors that contribute to the psychological wellbeing of ND adults at work remains under-researched (Deakin et al., 2024). What is known suggests that ND individuals may experience wellbeing differently from their NT peers, yet most wellbeing measures are still grounded in normative frameworks (Ayres et al., 2017; Lam et al., 2021). Chapman and Carel (2022) argue that epistemic injustice has historically denied ND individuals the opportunity to flourish, particularly in professional settings. Participants in this study shared professional experiences that evoked a strong sense of professional joy and fulfilment. These moments often occurred when they were able to engage deeply in practice areas that aligned with their special interests. Notably, many participants—regardless of their sensory profile—identified environments that supported hyperfocus as the most energising and fulfilling. This aligns with emerging research identifying hyperfocus-supportive settings as an underexplored yet potentially transformative factor in ND well-being and professional satisfaction (Rollnik-Sadowska & Grabińska, 2024). Interestingly, similar energising



experiences were not reported in broader healthcare worker studies. This discrepancy may be attributed to methodological differences. This study employed an Appreciative Inquiry approach, which intentionally sought out affirming and positive experiences, likely increasing the visibility of such moments.

While the biological mechanisms behind these experiences are still being investigated, a growing body of research indicates that affirming environments can have a profound impact on the wellbeing of ND individuals (Praslova, 2023). Building on polyvagal theory, Dana (2018) introduced the concept of “glimmers”—subtle, uplifting experiences that signal safety and help regulate the nervous system. These moments can foster emotional connection, enhance creativity, and promote a sense of calm. For ND people, who often navigate the world with heightened sensory and emotional awareness, the benefits of such positive cues may be especially significant. This heightened sensitivity, however, presents both challenges and opportunities. On one side, it can lead to intense stress reactions in response to adverse stimuli such as loud sounds or harsh lighting (Kuiper et al., 2019). Yet, this same sensitivity also enables a deep responsiveness to positive stimuli—those glimmers that evoke feelings of joy, safety, and connection. When nurtured appropriately, these experiences can unlock remarkable capacities for innovation, empathy, and problem-solving (Praslova, 2023).

Most current approaches to neuro-inclusion prioritise minimising sensory discomfort—through strategies like reducing noise, adjusting lighting, and offering quiet spaces (Kuiper et al., 2019). These interventions are essential, but they represent only the foundational layer of support. To fully embrace and harness neurodiversity, workplaces must go beyond mitigation and actively cultivate environments that promote joy, creativity, and meaningful connection (Griep et al. 2025). Importantly, glimmers are highly individualised; what brings comfort or inspiration to one person may not resonate with another. Some may thrive in solitude, while others seek social engagement. Therefore, effective strategies should be flexible and voluntary, allowing individuals to opt into experiences that align with their personal preferences and needs (Praslova, 2023)

Balancing Safety and Self

In moments of clinical urgency, participants consistently prioritised whānau safety above all else—even when that meant overriding their own sensory, cognitive, and



social needs until immediate demands had passed. The focus remained firmly on delivering safe and timely care. This unwavering commitment to patient safety was echoed across the ND healthcare worker literature, with all nine reviewed studies highlighting a similar determination to uphold clinical standards (Anderson & Shaw, 2023; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes et al., 2021; Locke et al., 2016; Price et al., 2017; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021).

Self-Management Strategies

Across both this study and the broader healthcare workforce literature, ND participants described a wide range of self-management strategies developed through lived experience and iterative trial and error. These strategies—cognitive, organisational, pharmacological, and physical—were essential for maintaining safety and effectiveness in high-pressure clinical environments. In previous research, fears around clinical safety and resulting hypervigilance often emerged as a key driver behind the development of such strategies, closely associated with mental fatigue and burnout (Anderson & Shaw, 2020; Crouch, 2019; Godfrey-Harris & Shaw, 2023; Hughes et al., 2021; Locke et al., 2016; Rowe et al., 2021; Shaw, Fossi et al., 2023; Walker et al., 2021). In contrast, participants in this study reframed their self-management efforts through the lens of “managing spoons”—a metaphor for energy regulation and conservation. Originating from Christine Miserandino’s ‘spoon theory’, this concept illustrates how individuals with invisible disabilities experience fluctuating and limited energy or capacity, which must be carefully allocated throughout the day (Matheiken et al., 2024; Miserandino, 2003). This strength-based, neuro-affirming perspective may reflect the participant-led methodology of this study and offers valuable insight into how ND midwives sustain safe, effective care while honouring their own ND needs.

A particularly prominent and novel strategy identified in this study was the use of intentional self-regulation breaks. Unlike standard lunch or scheduled breaks, these served as essential resets from sensory, cognitive, and social demands. Participants described these breaks as vital for maintaining emotional equilibrium, mental energy, and clinical safety. However, in the absence of formalised options for such breaks within healthcare workspaces, participants often resorted to using the toilet or retreating to their car. This lack of designated sensory-friendly environments stands



in contrast to broader workplace research, which has shown that access to quiet decompression spaces—equipped with sensory-reducing features—can significantly alleviate stress for ND employees (Pierce, 2018). A compelling example of what is possible, even under crisis conditions, comes from the COVID-19 pandemic, when multisensory, nature-inspired “Recharge Rooms” were rapidly implemented in hospitals to support frontline healthcare workers. These low-cost, immersive environments led to significant short-term reductions in perceived stress and were highly rated by all users, regardless of their neurotype, demonstrating the feasibility and impact of sensory-supportive spaces in high-pressure clinical settings (Putrino et al., 2020). The absence of such accommodations in everyday clinical environments highlights a critical gap in workplace design and inclusion.

Neurodivergence: A Cultural Reclamation

Participants in this study consistently described their neurodivergence as an intrinsic and inseparable part of their identity—deeply interwoven with both their cultural and professional selves. This perspective aligns with the findings from Godfrey-Harris and Shaw (2023) where ADHD doctors described their neurodivergence as not merely a clinical descriptor, but as a cultural identity that shaped their values, communication styles, and relational dynamics. Recognising neurodivergence as a culture invites a shift from deficit-based models toward relational and contextual understandings of difference. Broader ND literature highlights that there are psychological benefits of cultivating a positive ND identity. For example, a strong sense of ND identity has been associated with enhanced self-esteem and mental health (Botha et al., 2024; Cage et al., 2022; Cooper et al., 2017; Ferenc et al., 2022; Maitland et al., 2021). Grove et al. (2023) underscore the role of ND interpersonal, community, and cultural connections in supporting wellbeing among ND women and gender-diverse individuals. Engagement with the ND community—through shared experiences and mutual understanding—was found to foster identity development and resilience. Being ND and disabled was described not as a limitation, but as a core aspect of self (Grove et al., 2023).

The Value of ND Peer Support

Participants described their relationships with other ND colleagues as uniquely affirming, with shared neurocognitive experiences fostering deeper empathy,



smoother collaboration, and enhanced wellbeing. The focus group component of this study further amplified these connections, offering a rare opportunity for mutual recognition and exchange of strategies. These findings support a cultural framing of neurodivergence and extend Milton's (2012) "Double Empathy Problem" by illustrating how communication challenges often stem from cultural mismatches between neurotypes, rather than deficits within ND individuals (Szechy et al., 2024). Consistent with this, previous healthcare worker research has found that interpersonal difficulties were more likely to arise in interactions with NT colleagues (Anderson & Shaw, 2020; Crouch, 2019; Price et al., 2017; Rowe et al., 2021; Walker et al., 2021). Participants expressed a strong desire for formalised channels of peer support—spaces created by ND midwives, for ND midwives. These connections were seen as vital for enhancing professional wellbeing, enabling the sharing of resources, strategies, and lived experiences. Participants envisioned these networks as safe, affirming spaces that could foster both personal and collective resilience.

The importance of ND peer support is echoed in broader healthcare literature. Godfrey-Harris and Shaw (2023) found that ADHD doctors explicitly requested access to ND-specific peer networks. Shaw, Fossi et al. (2023) conducted research with autistic doctors who were recruited through Autistic Doctors International, one of the few formalised international peer support organisations for ND health professionals. Participants in this study reported statistically significant improvements in mental health because of their involvement in an ND peer support group. Autistic Doctors International currently supports over 1,000 autistic doctors through advocacy, education, and community-building initiatives. It offers a range of confidential connection points, including social media groups, Discord servers, private Zoom meetings, and WhatsApp groups (Autistic Doctors International, 2025). For many ND individuals, peer groups can offer a space to navigate the often-invisible challenges of professional life through shared understanding and mutual empowerment (Newcombe et al., 2025).

In light of these findings, it is reasonable to call for a funded, formalised model of ND midwifery support. Existing initiatives in Aotearoa New Zealand demonstrate that structured mentorship models can be highly effective. Te Ara o Hine Tapu Ora, which supports Māori and Pacific midwifery students, provides a successful precedent through its Tuakaka/Teina mentoring framework - a relational approach pairing



experienced students with those newer to the programme. A similar model could be adapted to meet the needs of ND kahu pōkai, offering consistent, culturally informed peer support (Te Ara o Hine Tapu Ora, 2023).

Bridging the Cultural Gap with NT Colleagues

Participants in this study expressed a strong desire to be recognised by their NT colleagues as individuals with valuable, naturally-occurring neurological differences—differences that shape perception, interpretation, and response to stimuli, and should be seen as expressions of ND identity rather than deficits (Botha et al., 2024; den Houting, 2018; Dunne, 2024). Many advocated for neurodivergence to be understood as a distinct cultural identity, where ND kahu pōkai, for example, are valued for their unique approaches to empathy and rapport-building with whānau. Participants called for the kahu pōkai profession to move beyond deficit-based models and embrace a social understanding of neurological diversity (Dunne, 2024). They envisioned a future where, for example, stimming—for focus, self-regulation, or as an expression of joy—is accepted in professional settings and recognised by NT colleagues as a valid expression of ND identity. This call for greater understanding was echoed in the healthcare worker research. Shaw, Fossi et al. (2023) found that ND health professionals wanted their NT peers to abandon pathologised language and to reciprocate in bridging communication gaps. Across the nine literature review studies, participants consistently reported their ND traits were misunderstood and often met with discrimination (e.g., Anderson & Shaw, 2020).

Research shows that without adequate training from a disability-affirming lens, health professionals may unintentionally perpetuate outdated or harmful beliefs rooted in ableist misconceptions (Marks & Sisirak, 2022). While kahu pōkai researchers and advocates have long called for a shift from the cultural competence model to the cultural humility model in caring for marginalised groups—emphasising self-reflection, recognition of systemic power imbalances, and lifelong learning—this shift must also extend to disability as a cultural identity (Allwright et al., 2019; Curtis et al., 2019; Fisher-Borne et al., 2014; Foronda, 2019; Lekas et al., 2020; Ramsden, 2002; Ruud, 2018; Tervalon & Murray-García, 1998). While cultural competence suggests a finite level of expertise in another culture, cultural humility recognises the impossibility of fully knowing another’s lived experience (Marks & Sisirak, 2022; Moreland, 2021). Participants wanted NT colleagues to actively engage in bridging the cultural gap,



rather than expecting ND individuals to conform. Emerging wider workplace research increasingly highlights the importance of addressing the double empathy problem between ND and NT individuals as a key strategy for improving employment outcomes for ND adults (Szechy et al., 2024).

Several participants reported meaningful shifts in workplace culture after management completed neurodiversity training. However, they emphasised that such training must be developed and facilitated by ND individuals and grounded in a disability-affirming perspective. One compelling example shared by participants involved how NT colleagues could adapt to support ND needs for reduced sensory input during documentation tasks. Drawing on Praslova (2023), this can be described as fostering “cultures of quiet”—organisational environments that actively value and promote sensory safety as part of broader inclusion efforts, particularly neuro-inclusion strategies. In practice, this might include ND kahu pōkai wearing noise-reducing headphones as a visual signal to minimise interruptions, with NT colleagues respecting this cue. Importantly, participants noted the need for accommodations to balance sensory safety with essential workplace functions—such as ensuring that emergency alerts, like bells or alarms, remain audible even when using noise-reducing equipment. Praslova (2023) further argues these discussions also touch on deeper cultural dynamics, including comfort with silence and the recognition of uninterrupted time as essential for deep, meaningful work.

Tackling the Triple Empathy Problem

Participants in this study described a profound sense of resonance when working with ND whānau, where shared neurotypes enabled not only intuitive communication and mutual trust, but also a deep understanding of unspoken needs—even in the absence of formal disclosure. Many noted that this relational depth allowed them to anticipate the needs of ND whānau and actively support them in navigating complex health environments and systems. This capacity for attuned, proactive care is largely absent from existing healthcare literature and underscores the transformative potential of ND kahu pōkai in delivering culturally safe and neurodivergence-informed care. Building on the established concept of the Double Empathy Problem (Milton, 2012) —which highlights mutual misunderstandings between ND and NT individuals—the Triple Empathy Problem introduces a more nuanced dynamic specific to healthcare (Shaw et al., 2024). This expanded framework identifies a three-way



communication breakdown: between ND patients, NT healthcare providers, and the broader medical system. These disconnects are intensified by the distinct cultural norms, terminologies, and institutional practices of the medical field, which often marginalise ND individuals and obstruct effective care.

This phenomenon aligns with the work of Godfrey-Harris and Shaw (2023), who argue that ND doctors are uniquely positioned to challenge deficit-based models and foster inclusive, empathetic care. Their Autistic SPACE framework—centered on Sensory needs, Predictability, Acceptance, Communication, and Empathy—offers a practical roadmap for creating ND-affirming clinical environments. As neurodivergence becomes more visible and widely diagnosed, the leadership of ND kahu pōkai will be essential in advancing equitable, responsive, and inclusive perinatal care. However, integrating cultural competency and disability-informed practice remains a significant challenge—particularly in healthcare settings that lack professionals with lived experience of disability (Marks & Sisirak, 2022). Addressing the Triple Empathy Problem requires not only systemic change but also the elevation of ND voices within healthcare leadership and practice.

Coming Out at Work: Navigating Disclosure

Workplace disclosure of neurodivergence was frequently described by participants as akin to “coming out,” motivated either by pride in ND identity or the need to access accommodations. Some engaged in “radical unmasking”—a deliberate choice to be visibly ND at work—a strategy to normalise ND traits, prevent burnout, and drive cultural change. This visibility was framed as a form of ND cultural reclamation, with the intention to contribute to a more inclusive kahu pōkai profession. For some, disclosure led to thriving in supportive teams, echoing findings from Price et al. (2017), where dyspraxic doctors reported improved communication with colleagues’ post-disclosure. However, many participants from this study experienced feeling “othered” in normative workspaces, encountering resistance when requesting accommodations and widespread ableist misconceptions about ND traits, which left them feeling isolated and misunderstood.

Consequently, some chose selective disclosure or avoided it entirely—a pattern reflected in broader healthcare worker literature, where fear of discrimination often deterred ND professionals from seeking accommodations (Godfrey-Harris & Shaw, 2023; Hughes et al., 2021; Walker et al., 2021). In Hughes et al.’s (2021) New



Zealand study, most disabled nurses did not disclose, citing a lack of inclusive policies. Across all nine studies reviewed, disclosure was consistently linked to discrimination, and accommodations—when requested—were often denied or insufficient, with negative impacts on mental health (e.g., Shaw, Fossi et al., 2023). Notably, this study diverges from wider healthcare literature by highlighting acts of intentional visibility, suggesting a shift toward empowerment among some ND professionals. These findings underscore the need for inclusive policy development, including transparent disclosure pathways and formal recognition of neurodivergence as a vital aspect of workforce diversity.

Te ao Māori Spaces are Inclusive Spaces

Both Tangata Whenua and Tangata Tiriti participants described Te ao Māori spaces as inherently more neuro-affirming than mainstream, coloniser-informed environments. These spaces were experienced as offering a deep sense of cultural safety and belonging, regardless of whether individuals chose to disclose their neurodivergence. This aligns with research showing that pre-colonial Māori worldviews recognised the unique gifts of disabled individuals—tāngata whaikaha. Disability was not viewed through a deficit lens, but rather as part of the natural diversity of human experience (Hickey & Wilson, 2017; Ingham, 2024). Colonisation disrupted these inclusive perspectives, introducing Western biomedical models that pathologised difference and imposed institutional structures that marginalised tāngata whaikaha Māori (Ingham, 2024; Simpson, 2021).

In contrast, Te ao Māori advocates offer frameworks such as Te Whare Tapa Whā, that centre collective wellbeing, relationality, and the mana of individuals (Durie, 1994) and support a more holistic understanding of disability (Hickey & Wilson, 2017). Participants in this study described mainstream healthcare and institutional settings as rigid and conditional on conformity—where access to reasonable accommodations typically required formal disclosure of neurodivergence. This need to "out" oneself in order to receive support was experienced as deeply uncomfortable and rooted in colonial systems of categorisation, surveillance, and deficit-based thinking. It placed emotional and professional strain on individuals and reinforced systemic inequities. Although this study included Tangata Whenua participants, the intersection of neurodivergence and Māori identity remains a particularly underexplored area. Understanding this is a vital kaupapa for future research—one



that must be led by Māori and grounded in tikanga, whakapapa, and mana-enhancing methodologies. By recognising te ao Māori spaces as consciously inclusive and affirming, this study points to the potential of Indigenous frameworks to inform more equitable and responsive models of care and workplace design—not only for Māori but for all.

Universal design

Participants in this study emphasised the importance of adopting Universal Design (UD) within kahu pūkai and healthcare settings, to foster equity and reduce the need for ND individuals to disclose diagnoses to access support. Unlike accessible design, which meets minimum standards, UD aims to create environments, services, and systems usable by all from the outset, minimising the need for adaptation (Maisel & Ranahan, 2022). Although UD was not widely reflected in broader healthcare worker literature—likely due to methodological differences—this study’s Appreciative Inquiry approach revealed UD as a key aspiration. Universal Design aligns with the New Zealand Disability Strategy 2016–2026, which advocates for inclusive design across physical spaces, services, curricula, and technologies. Its proactive implementation benefits everyone, not just those with disabilities (Te Tari Mō Ngā Take Haunātanga | Office for Disability Issues, 2016). Participants shared examples of UD in action, such as managers offering multiple communication options to all staff, or team meetings being accessible both in-person and online. These practices reduce stigma, streamline accommodations, and support workforce sustainability—particularly as injuries and disabilities become more common in aging healthcare professionals (Disabled People’s Organisations Coalition, Human Rights Coalition & Ombudsman, 2023; Mark & Sisirak, 2022; Matt et al., 2015). Embedding UD principles early makes healthcare environments more inclusive, cost-effective, and adaptable over time.

Reasonable Accommodations

While UD can reduce the need for individuals to request support by creating inclusive environments from the outset, tailored accommodations may still be necessary to ensure equitable participation—particularly when specific needs fall outside the scope of universal solutions. Participants in this study advocated for reasonable accommodations as essential mechanisms for achieving equitable inclusion within



the kahu pōkai workforce. Their requests—such as minimising background noise during shared office calls or scheduling debriefs to coincide with medication efficacy—were modest, pragmatic, and aimed at enabling full participation in their professional roles. While some colleagues responded with empathy and flexibility, others, particularly those in managerial positions, denied these accommodations. This inconsistency led several participants to withhold disclosure of their neurodivergence, fearing that the risk of discrimination would outweigh any potential support. These mixed experiences reflect broader patterns observed in the healthcare workforce literature. For instance, Rowe et al. (2021) found that ADHD healthcare professionals thrived under leadership that proactively adjusted work schedules and minimised low-stimulation tasks. Conversely, Godfrey-Harris and Shaw (2023) reported that ADHD doctors frequently had their support requests denied, ultimately leading them to stop seeking accommodations altogether.

Legal Frameworks

There are legal frameworks in Aotearoa New Zealand that aim to provide protections for disabled individuals, including those who are ND. The UN Convention on the Rights of Persons with Disabilities (2006)—ratified by New Zealand—defines reasonable accommodation as necessary and appropriate modifications that do not impose a disproportionate burden and that enable equal participation in society. Domestically, the Human Rights Act 1993 prohibits discrimination based on disability and requires employers to provide reasonable accommodations, explicitly including neurological differences (Te Kāwangatanga o Aotearoa | The New Zealand Government, 1993). The Employment Relations Act 2000 reinforces this by requiring good faith consideration of accommodation requests, with refusals permitted only when they impose “undue hardship”, defined as significant financial or operational burden (Te Kāwangatanga o Aotearoa | The New Zealand Government, 1987).

Despite these protections, participants reported that midwifery and the wider healthcare sector often fail to support disabled health professionals. Limited awareness of disability law and the invisible nature of neurodivergence made navigating accommodations particularly difficult. These findings align with Hughes et al. (2021), who reported that New Zealand-based disabled nurses found physical disabilities more readily supported, while cognitive and neurological differences often went unrecognised. Hughes et al. (2021) also identified a broader absence of



organisational disability support structures. Participants from this research described feeling isolated when their requests were dismissed, and when managers refused to engage, leaving them without clear pathways for advocacy or advice. Participants who worked as Lead Maternity Carers (LMCs), as self-employed practitioners, were able to implement some neuro-affirming adjustments, but these were self-funded and did not extend to hospital settings - raising concerns about where LMCs can seek support if their practice partners are uncooperative.

Participants also critiqued midwifery's fitness-to-practice standards as rigid and outdated. Although this issue is underexplored in the ND healthcare worker literature, international pan-disability based research highlights similar concerns across health professions, noting that technical standards often ignore modern assistive technologies and disproportionately exclude disabled individuals (DeLisa & Lindenthal, 2016; Zazove et al., 2016). Te Tatau o te Whare Kahu | The Midwifery Council's (2024) expectation that graduates demonstrate competence across the full scope of practice was perceived by participants as disadvantaging those with disabilities. This expectation is grounded in the Health Practitioners Competence Assurance Act 2003, which provides the legal framework for regulatory bodies like the Midwifery Council to ensure public safety by maintaining practitioner competence (Te Kāwangatanga o Aotearoa | The New Zealand Government, 2003). Participants in this study expressed a strong commitment to patient safety but felt that the current discourse often overlooks the inclusion of disabled practitioners and the health and wellbeing of midwives themselves.

Although general workplace resources for reasonable accommodations exist, healthcare professionals face unique challenges in balancing public safety with receiving affirming support to pursue and sustain their careers. The regulatory emphasis on competence and risk management can unintentionally marginalise practitioners who require accommodations, reinforcing a culture where disclosure is discouraged and support is inconsistently applied. International exemplars, such as the UK's Health and Care Professions Council (2021) and the Royal College of Speech and Language Therapists (2024), have developed profession-specific, lived experience-led resources. Both resources explicitly affirm that having a health condition or disability should not be viewed as a barrier to entering the health professions. These models offer valuable guidance for New Zealand, where similar resources for ND midwives remain absent.



Individualised Accommodations and the Enabling Good Lives Framework

The Enabling Good Lives (EGL) approach was developed in 2011 by members of New Zealand’s disability community—including disabled people, families, and allies—in response to longstanding concerns about the lack of choice and control in disability support systems. EGL aims to transform disability support by centering the person, their strengths, and aspirations. Pilots in Christchurch, Waikato, and MidCentral have demonstrated improved outcomes in autonomy, social connection, and access to education and employment. At the heart of EGL are principles such as self-determination, relationship building, and the person-centred approach—which emphasises that supports should be tailored to the unique strengths, needs, and aspirations of each individual. These principles are especially relevant when considering individualised accommodations for ND individuals, such as kahu pōkai.

A foundational concept in implementing accommodations is the recognition of individual variability—what works for one person may not work for another. As one participant, Anna, aptly stated: “I think staff education needs to stress that generalising traits and needs shouldn’t happen. It’s about curious enquiry, allowing each person to share what they need and what works for them”. This sentiment reflects EGL’s commitment to self-determination and person-centred support. The ND experience is inherently heterogeneous, as supported by a growing body of literature (Chapman, 2020; De Rubeis et al., 2014; Lenroot & Yeung, 2013; Toal et al., 2009). This diversity necessitates a flexible, individualised approach to accommodations—one grounded in cultural humility and supported by workforce-wide education. Such an approach is mana-enhancing, as it respects and uplifts the dignity and contributions of ND individuals. However, both ND kahu pōkai and their employers, managers, and practice partners may face challenges in identifying appropriate accommodations—especially in professions like midwifery, where these conversations are still emerging. These challenges are often compounded in cases of late diagnosis, where individuals may lack the language or frameworks to articulate their needs.

Participants in this study frequently reported uncertainty about what accommodations would be appropriate or beneficial, revealing a significant gap in kahu pōkai-specific knowledge and support structures. They expressed a strong desire for a formal, confidential service led by midwives and individuals with lived experience of



disability. This vision reflects EGL's principle of relationship building, which emphasises the importance of strong, supportive connections between disabled people, their whānau, and their communities. A recent systematic review by Weber et al. (2022) examined workplace adjustments for ND employees, identifying a range of potential accommodations and their perceived benefits. However, the review also highlighted a significant limitation in the current evidence base: the lack of rigorous, high-quality intervention studies. This evidentiary gap reinforces the importance of continued research and the development of context-specific, evidence-informed guidance for professions such as kahu pōkai.

Towards Authentic Neuro-Inclusion

A consistent theme across participant narratives was a desire for the kahu pōkai profession to become more inclusive and actively affirming of its ND workforce. While a few participants had found work environments where they felt safe enough to “radically unmask,” the prevailing aspiration was for a future in which authenticity is the norm rather than the exception. This reflects a broader call within ND literature for cultural transformation—one that moves beyond surface-level diversity initiatives toward environments where all individuals feel genuinely welcome (Griep et al., 2025). According to Shore et al. (2011) workplace inclusion means that employees feel they belong and are appreciated for what makes them unique. Participants echoed this sentiment, expressing a strong desire to see more openly ND individuals in leadership roles within midwifery. Such visibility was seen as both symbolically and structurally significant. Azevedo et al. (2022) argue in favour of the intentional appointment—and incentivisation—of ND individuals in leadership positions, to help ensure that efforts toward equity are both authentic and transformative.

The terms “inclusion” and “diversity” are often used together, leading to the misconception that they are inseparable. However, they are distinct. Diversity refers to the presence of differences within a group, while inclusion is about cultivating a culture where those differences are respected and embraced (Griep et al., 2025). Participants suggested that a more visibly ND kahu pōkai culture could attract greater ND representation in the profession. This vision of increased diversity was often expressed through an intersectional lens, acknowledging the experiences of other minority groups within midwifery. The goal, as Dunne (2024) argues, should be cultural expansion—not cultural fit. Although some participants described moments of



belonging and recognition in their careers, many reported feeling marginalised or peripheral to the profession. As participant Di expressed: “It’s like I’m paddling my own little waka and no one really knows what it is”. What participants sought aligns with Praslova’s (2023) concept of ‘authentic inclusion’—the meaningful integration of diverse individuals and perspectives, underpinned by a genuine commitment to equity and transformation. Crucially, authentic inclusion requires that ND kahu pōkai define for themselves what inclusion looks like in practice. Neurodivergent midwives exist in Aotearoa, yet prior to this research, their presence has been largely invisible and poorly understood. This study represents an initial step toward increasing the visibility of ND kahu pōkai in Aotearoa New Zealand and advocating for a more affirming and equitable professional culture.

Chapter Summary

In this chapter, I returned to the original aims and objectives of the research, outlining the data collection process and the neuro-inclusive methodologies I employed. I summarised the five themes identified through reflexive thematic analysis and explored the lived experiences of ND kahu pōkai, highlighting their vision for a neuro-affirming midwifery practice. I then situated these insights within international literature across healthcare professions and recent scholarship within the neurodiversity paradigm. Through this work, I aimed to increase the visibility of ND kahu pōkai in Aotearoa New Zealand and advocate for a more inclusive, affirming, and equitable professional culture. In the concluding chapter, I reflect on the broader significance of these findings, discuss the strengths and limitations of the study, and offer practical and theoretical recommendations to support ND inclusion in midwifery and beyond.



Chapter Six: Conclusion

Introduction

This concluding chapter brings together the key insights from this thesis, which explored the experiences of ND kahu pōkai in Aotearoa New Zealand. It begins by reflecting on the strengths and limitations of the study, followed by a discussion of the implications of the findings—both within the kahu pōkai Aotearoa context and across the wider health professions, nationally and internationally. The chapter then outlines a series of recommendations informed by the research, including those aimed at the broader midwifery profession. Finally, the chapter concludes with suggestions for future research priorities to continue advancing equity and understanding in this space.

Strengths

A major strength of this study lies in the intentional methodological choices I made from the outset, as outlined in Chapter Three. I employed Appreciative Inquiry, which seeks to disrupt deficit narratives and uncover the positive core of an organisation, group, or phenomenon. In addition to this overarching methodology, I adopted person-oriented research ethics that enabled me to tailor data collection methods to suit the individual needs of each participant. Accessible design choices were embedded throughout the recruitment process and all participant communications. These choices were not only practical but also deeply intentional—I aimed to create a research experience that was affirming for myself, for participants, and for future readers. The study was designed to respect and value neurocognitive diversity in both participation and knowledge creation.

Participant feedback further affirmed the effectiveness of these design choices. Several participants expressed appreciation for the clarity and accessibility of the recruitment materials, participant information sheets, and the overall research process. While I regret not including specific questions during data collection to formally capture participants' experiences of the methodological adaptations, their informal feedback was nonetheless encouraging.



Another strength of this study was the richness of the data generated through the generous and thoughtful contributions of the participants. The participatory nature of the research enabled a dynamic and iterative process, where themes identified during the Phase One interviews were revisited and refined during the Phase Two focus group. This approach added depth to the thematic analysis and gave participants the opportunity to see themselves reflected in the findings. Their engagement in this process strengthened the credibility and resonance of the results.

The recruitment phase also demonstrated strong interest in the study, with an enthusiastic response that exceeded the maximum quota for a Master's-level project. The final sample size of fifteen participants was appropriate for a qualitative study of this scope. While the findings are not intended to be generalisable, the diversity within the sample adds value. Participants were drawn from across Aotearoa, representing both rural and urban settings, a range of ages, varied work contexts, and differing lengths of time in the kahu pōkai profession. Most notably, most participants had received their ND diagnoses in adulthood, which shaped the perspectives shared. It remains an open question whether participants diagnosed in childhood might have articulated different needs or experiences.

It is also worth noting that participants self-selected to be involved in the study, which may mean that those with strong views or particular interest in the topic are overrepresented. While this is a common feature of qualitative research, it is important to acknowledge the potential influence this may have had on the findings.

Limitations

One potential limitation of this study relates to the use of Appreciative Inquiry and its emphasis on positive framing. Critics of this approach have argued that it can obscure the more complex or painful aspects of human experience, potentially leading to a form of toxic positivity where negative phenomena are downplayed or overlooked. To address this concern, I began each interview by clearly explaining the Appreciative Inquiry process and explicitly inviting participants to share negative experiences if they wished. When such experiences were shared, I responded with empathy and followed up by asking how those scenarios could have been improved or made more affirming. This approach was intended to honour the full spectrum of participant experiences while remaining consistent with the overall research design.



However, it is still possible that some participants may have felt hesitant to share more difficult or critical reflections, which could have influenced the depth and balance of the data collected.

This study focused exclusively on qualitative data, which allowed for rich, descriptive insights into participants lived experiences. However, the absence of quantitative data may be seen as a limitation, particularly for readers seeking measurable outcomes or broader statistical trends. Future research could consider incorporating mixed methods to complement qualitative findings with quantitative measures, potentially enhancing the scope and applicability of the results.

While the study did include one participant who had left the kahu pōkai profession, it is likely that others with similar experiences were missed. The perspectives of those who have exited the profession—whether due to burnout, systemic challenges, or personal reasons—may offer valuable insights that differ from those currently practicing. Similarly, the study did not include participants who were still undergraduate students at the time of data collection. While many participants did reflect on their undergraduate experiences, the absence of current students means that real-time perspectives on education, training, and early professional identity formation are not fully captured. Including these groups in future studies could enrich understanding of the broader spectrum of neurodivergent experiences within midwifery.

My own role as a novice researcher also shaped the strengths and limitations of this work. Throughout the research process, my skills and confidence grew, and I engaged in ongoing reflexivity to critically examine my positionality and influence on the study. I bring to this research my own lived experiences, values, and worldview, which inevitably shaped the way I interpreted and presented the data. As a white Tangata Tiriti researcher, I acknowledge that I bring one perspective, and that other cultural, professional, and neurodivergent viewpoints would be equally valid and valuable. While I strived to be transparent and reflective throughout, future research could benefit from collaborative or co-researcher models that include a wider range of voices and experiences.



Implications

Findings from this study contribute to the international literature by offering an ‘insider’ lens into the experiences of ND midwives. This research begins to shift deficit-based narratives and instead reveals what being ND feels like from within the profession. It also introduces ideas for how to enhance the wellbeing of ND kahu pōkai, with implications that may extend beyond midwifery to other health professions where ND individuals work.

For midwifery in Aotearoa New Zealand, this study marks an important first: it is the first known research to explore the experiences of ND kahu pōkai within the profession. In doing so, it directly addresses the primary research objective of increasing visibility for ND kahu pōkai. Currently, midwifery in Aotearoa does not actively consider the inclusion or support of its ND workforce. This research highlights the need for greater awareness, structural inclusion, and affirming practices that recognise neurodiversity as a valuable aspect of professional identity.

Importantly, this study also represents a methodological milestone within the profession. It is among the first to incorporate disability-affirming methodological adaptations as a core part of its design. I hope that this work can serve as a model for future midwifery research—encouraging more inclusive and affirming approaches to knowledge generation that reflect the diversity of those within the profession.

Recommendations

Considering the findings of this study, I offer the following recommendations for the midwifery profession in Aotearoa New Zealand:

1. Elevate and Celebrate our ND Workforce

The profession should proactively celebrate the strengths and contributions of ND kahu pōkai. This includes recognising ND as a cultural identity and optimising visibility through intentional leadership appointments and incentivised inclusion efforts. ND kahu pōkai should be centred in initiatives that promote neuro-affirming care, and their voices elevated in shaping the future of the profession.

2. Support ND Kahu Pōkai to Thrive



ND kahu pōkai should be supported to embrace their strengths and find work roles and environments that align with their neurocognitive profiles. This includes recognising individual factors such as neuroceptive preferences—whether one thrives in novelty and variety or prefers structure and predictability—sensory profiles (e.g., sensory-seeking versus sensory-avoidant), and cognitive styles such as monotropic (focused, single-task) versus polytropic (multi-tasking) processing. Career choices should be guided by special interests and sources of joy—what participants described as “the glimmers”. To enable this, the profession should promote diverse expressions of midwifery through transparent and accessible career pathways, including both clinical and non-clinical options. Strength-based specialisation should be supported from early career stages, with opportunities to work in areas such as early pregnancy loss, postnatal care, sexual health, education, and governance. Rather than expecting all midwives to work across the full scope of practice, the profession should foster a culture that values individual contributions and diverse skill sets. This shift will help ensure that all midwives feel seen, supported, and empowered to thrive in roles that suit them best.

3. Implement Workforce-Wide Education

Training on ND traits should be developed through a neuro- and disability-affirming lens, grounded in principles of cultural humility. Such education could help bridge the “double empathy problem” by fostering mutual understanding and improving communication between neurotypes within the workplace. It should also enhance neuro-affirming clinical support by increasing awareness of spiky skill profiles and the challenges ND kahu pōkai may face in areas such as executive functioning, fine motor coordination, and social communication. This approach will contribute to a more inclusive and responsive professional environment.

4. Establish Disclosure and Anti-discrimination Policies

Disclosure protocols must be developed and actively safeguard ND kahu pōkai from discrimination. These pathways should be designed to support—not penalise—disclosure, and provide clear, accessible guidance for employers, managers, and colleagues on disability law, reasonable accommodations, and inclusive workplace practices. Policies should explicitly address inclusion and anti-discrimination, ensuring that disclosure leads to support and understanding rather than risk or stigma. Creating a culture of safety around disclosure is essential for enabling ND



kahu pōkai to access the adjustments they need and for fostering a more inclusive professional environment.

Additional consideration must be given to LMC Kahu pōkai who work in groups where each midwife is self-employed. These practitioners may not have a traditional employer or HR structure to turn to if they experience discrimination. It is essential to establish clear, independent pathways for support and resolution in such contexts. Disclosure mechanisms must be inclusive of self-employed models of practice, ensuring that all Kahu pōkai—regardless of employment status—have access to safe, supportive, and effective systems for addressing discrimination and accessing accommodations.

5. Review Fitness to Practice Requirements

Being ND and/or disabled need not be a barrier to pursuing a career in midwifery. With the right supports and accommodations, ND kahu pōkai can thrive and contribute meaningfully to the profession. Consideration should also be given to how technological advancements might help bridge skill-based challenges, such as those related to executive functioning, fine motor coordination, or communication differences. The wider kahu pōkai profession must now critically review its fitness-to-practice policies with meaningful input from the disability sector. This is an opportunity for midwifery in Aotearoa to lead the way in creating a profession that is inclusive, affirming, and responsive to the needs of ND and disabled practitioners.

6. Create Neuro and Disability Affirming Support Resources

There is a clear need for formalised, confidential support systems designed by and for ND kahu pōkai. Peer support spaces—led by ND kahu pōkai and grounded in lived experience—should be established to foster connection, mentorship, and mutual support in navigating professional challenges. In addition, participants expressed a strong desire for a centralised, trusted resource tailored specifically to ND and disabled midwives. This service should be led by individuals with lived experience and offer neuro- and pan-disability affirming advocacy, mentoring, and peer support. It could also provide guidance on managing spiky skill profiles, career development assistance, and support in navigating workplace challenges. Crucially, it should offer confidentiality and accountability, especially in situations where kahu pōkai face resistance or lack of support from their workplaces.



Reasonable Accommodations

This study adopts a principled and conceptual approach to the topic of reasonable accommodations, focusing not on an exhaustive list of adjustments but on the underlying values that support an ND-affirming career in midwifery. Before exploring tailored options, it is essential to establish several guiding principles:

- Diagnosis is not a prerequisite for support - Legal and ethical frameworks affirm that individuals are entitled to reasonable accommodations without the need for formal diagnosis. In a context where diagnostic pathways are often inaccessible due to long waitlists and prohibitive costs, the normalisation of self-identification is both necessary and just.
- Universal design should be the starting point - When a specific adjustment is requested by an ND kahu pōkai, consider whether it can be offered universally. Designing environments and systems that accommodate a wide range of needs from the outset reduces stigma and fosters collective wellbeing.
- Neurodivergence is not monolithic - Each ND kahu pōkai brings unique strengths, challenges, and preferences. Assumptions about ability or limitations must be avoided, and recognition given to the dynamic nature of capacity, which may fluctuate over time or in response to context.
- Curious enquiry fosters trust - A stance of open, respectful curiosity—offering a friendly hand and a listening ear—creates space for individuals to articulate what they need and what works for them. This approach affirms autonomy and supports collaborative problem-solving.

Rather than listing all possible accommodations here, readers are referred to the Practice Guidance document (see Appendix Nine), which details specific adjustments identified by participants. These examples are grounded in a framework that prioritises equity, dignity, and inclusion, and offer practical insights into how the guiding principles above can be enacted in real-world settings.

Future Research Priorities

To strengthen inclusion and wellbeing within the kahu pōkai workforce, future research should explore the following areas:



1. Mātauranga Māori and Kaupapa Māori-Based Research

Explore how Māori knowledge systems and methodologies can guide inclusive practices for ND and disabled midwives. Te ao Māori spaces often feel safer and more welcoming for some, and research could examine the cultural values and structures that contribute to this, and how they can be applied more broadly.

2. Contextualised Reasonable Accommodations in Kahu Pōkai Practice

Investigate specific accommodations suited to the kahu pōkai context, especially those that support individuals with spiky skill profiles. Key areas for exploration include motor coordination, executive functioning (EF), and social communication, with a focus on practical strategies that enhance performance and wellbeing.

3. Lived Experiences of Disability in the Workforce

Research could explore the diverse experiences of kahu pōkai living with disabilities, chronic health conditions, or impairments—whether physical, sensory, cognitive, or psychological. A pan-disability lens allows for a broader understanding of how different conditions intersect with kahu pōkai practice, including access to accommodations, workplace culture, and career progression. This research should also consider fluctuating conditions and invisible disabilities, and how these impact clinical work, emotional wellbeing, and professional identity.

4. Impact of Perimenopause and Menopause on the Kahu Pōkai Workforce

Examine how hormonal transitions affect cognitive, emotional, and physical functioning across the kahu pōkai workforce. This includes understanding the unique challenges faced by kahu pōkai during perimenopause and menopause, and identifying supports that promote retention, wellbeing, and career sustainability.

5. Neurodivergent Student Experiences in Undergraduate Kahu Pōkai Education

Explore the experiences of ND students throughout their education, including access to accommodations, clinical placement dynamics, and the impact of academic environments. Findings can inform inclusive curriculum design, support services, and the education of midwifery educators.

6. Whānau Experiences of Receiving Care from ND Kahu Pōkai

Investigate how whānau experience care provided by ND kahu pōkai, with a focus on cultural safety, trust, and relational dynamics. While ND traits were described by



participants as enhancing empathetic connection, only those receiving care can determine whether cultural safety was truly experienced. Including whānau voices is essential to understanding the full impact of ND-informed midwifery practice.

Chapter Summary

In summary, this chapter has drawn together the key findings of the study, highlighting both its strengths and limitations. It has explored the implications of these findings within the Aotearoa kahu pōkai context, across the broader health professions, and in international settings. The chapter has presented a range of recommendations—some directed at the midwifery profession, and others offering practical strategies for ND kahu pōkai and their colleagues. It has also outlined the reasonable accommodations participants identified as essential for fostering inclusive and supportive work environments. Finally, the chapter has proposed future research directions to continue building understanding and equity for neurodivergent and disabled midwives in Aotearoa and beyond.

Researcher Reflection

When people ask me about my master's topic, the initial response is often, "That's very niche." And I agree—it is. Yet, I believe this mahi has a much broader application to midwifery and the wider health professions. This broader relevance is, I hope, evident in the rich narrative themes generated through this research—themes that speak to the complexity of human experience, the need for more inclusive systems, and the importance of recognising neurodivergence within healthcare contexts. As I wrote in the introduction, the neurodiversity movement invites us to expand our understanding of what it means to be human (Yergeau, 2018). Our current systems, I believe, are not fit for purpose—they are not designed to accommodate the wide diversity of human experience. This is why the vital mahi around decolonisation feels so deeply connected. Both movements challenge us to reimagine structures that have long excluded or marginalised, and to build ones that honour complexity, humanity, and justice.

Throughout the process of conducting this master's research, I've also been navigating a personal journey of recovery from autistic burnout. This work has become part of a broader healing process—an effort to rediscover and express my midwifery heart in a way that feels sustainable for both myself and my whānau. It has



been a deeply reflective and transformative time, allowing me to learn more about myself as a neurodivergent person and to better understand what I need from employment moving forward. Writing this thesis has felt like crafting a wee love note to my younger self—the one who was newly diagnosed during their new graduate year and searching for guidance, understanding, and hope. I hope that, in the various ways this work will go out into the world, it offers that same sense of connection and encouragement to others who may be on similar paths.

As both the researcher and a ND person, the process of writing this thesis presented a unique challenge. My mind naturally organises ideas as dynamic, three-dimensional networks—constantly shifting, interwoven, and alive—rather than as linear narratives. Translating that multidimensional experience into the flat structure of academic writing often felt like compressing a living, breathing system into a single plane. I was also deeply aware of you, the reader. Some of you may be well-versed in the emerging work within neurodivergent literature, while for others, this may be entirely new terrain. My goal was to bring everyone along on this journey. To assist that journey—for myself and for you—I have tried to write with clarity, compassion, and care.

References

- Accardo, A. L., Bomgardner, E. M., Rubinstein, M. B., & Woodruff, J. (2024). Valuing neurodiversity on campus: Perspectives and priorities of neurodivergent students, faculty, and professional staff. *Journal of Diversity in Higher Education*. Advance online publication. <https://doi.org/10.1037/dhe0000571>
- Adamou, M., Arif, M., Asherson, P., Aw, T., Bolea, B., Coghill, D., Guðjónsson, G., Halmøy, A., Hodgkins, P., Müller, U., Pitts, M., Trakoli, A., Williams, N., & Young, S. (2013). Occupational issues of adults with ADHD. *BMC Psychiatry*, *13*(1). <https://doi.org/10.1186/1471-244x-13-59>
- Al-Beltagi, M. (2021). Autism medical comorbidities. *World Journal of Clinical Pediatrics*, *10*(3), 15-28. <https://doi.org/10.5409/wjcp.v10.i3.15>
- Albendin-Garcia, L., Suleiman-Martos, N., Canadas-De la Fuente, G., Ramirez-Baena, L., Gomez-Urquiza, J., & De la Fuente-Solana, E. (2021). Prevalence, related factors, and levels of burnout among midwives: A systematic review. *Journal of Midwifery & Women's Health*, *66*(1), 24-44.
- Allwright, K., Goldie, C., Almost, J., & Wilson, R. (2019). Fostering positive spaces in public health using a cultural humility approach. *Public Health Nursing*, *36*(4), 551-556. <https://doi.org/10.1111/phn.12613>
- American Psychiatric Association, DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™* (5th ed.). American Psychiatric Publishing, Inc. <https://doi.org/10.1176/appi.books.9780890425596>
- Anderson, J. L., & Shaw, S. C. K. (2020). The experiences of medical students and junior doctors with dyslexia: a survey study. *International Journal of Social Sciences & Educational Studies*, *7*(1), 62-73. <https://doi.org/10.23918/ijsses.v7i1p62>
- Antonetta S. (2007). *A mind apart: Travels in a neurodiverse world*. Tarcherperigee, New York.
- Anttila, V., Bulik-Sullivan, B., Finucane, H. K., Walters, R. K., Bras, J., Duncan, L., Escott-Price, V., Falcone, G. J., Gormley, P., Malik, R., Patsopoulos, N. A., Ripke, S., Wei, Z., Yu, D., Lee, P. H., Turley, P., Grenier-Boley, B., Chouraki, V., Kamatani, Y., ... Murray, R. (2018). Analysis of shared heritability in

- common disorders of the brain: Brainstorm consortium. *Science*, 360(6395), eaap8757. <https://doi.org/10.1126/science.aap8757>
- Armstrong, T. (2010). *The power of neurodiversity*. Cambridge, MA: De Capo.
- Astle, D. E., Bathelt, J., & Holmes, J. (2018). Remapping the cognitive and neural profiles of children who struggle at school. *Developmental Science*, 22(1). <https://doi.org/10.1111/desc.12747>
- Asztély, K., Kopp, S., Gillberg, C., Waern, M., & Bergman, S. (2019). Chronic pain and health-related quality of life in women with autism and/or ADHD: A prospective longitudinal study. *Journal of Pain Research*, 12, 2925-2932. <https://doi.org/10.2147/JPR.S212422>
- Autistic Doctors International. (2005). *Autistic Doctors International*. <https://autisticdoctorsinternational.com/about-us>
- Ayres, M., Parr, J. R., Rodgers, J., Mason, D., Avery, L., & Flynn, D. (2017). A systematic review of quality of life of adults on the autism spectrum. *Autism*, 22(7), 774-783. <https://doi.org/10.1177/1362361317714988>
- Azevedo, F., Middleton, S., Phan, J. M., Kapp, S., Gourdon-Kanhukamwe, A., Iley, B., Elsherif, M., & Shaw, J. J. (2022). *Navigating academia as neurodivergent researchers: Promoting neurodiversity with open scholarship*. *Association for Psychological Science*. <https://www.psychologicalscience.org/observer/gs-navigating-academia-as-neurodivergent-researchers>
- Bagby, M., Zito, L., Lau, S. L., Mortezaei, A., Procelli, P., & Taylor, G. J. (2025). Alexithymia and impaired mentalization: Evidence from self-, informant-, and meta-perception ratings on the 20-item Toronto alexithymia scale. *Journal of Intelligence*, 13(7), 89. <https://doi.org/10.3390/jintelligence13070089>
- Baker, C., Malik, G., Davis, J., & McKenna, L. (2023). Experiences of nurses and midwives with disabilities: a scoping review. *Journal of Advanced Nursing*, 79(11), 4149-4163. <https://doi.org/10.1111/jan.15802>
- Bartlett, D., Moody, S., Kindersley, K. (2010). *Dyslexia in the workplace: An introductory guide*. London: Wiley. <https://doi.org/10.1002/9780470669341.ch1>
- Bartlett, R., Koncul, A., Lid, I. M., George, E. O., & Haugen, I. (2023). Using walking / go along interviews with people in vulnerable situations: A synthesized review

- of the research literature, *Sage Journals*, 22.
<https://doi.org/10.1177/16094069231164606>
- Benford, P., & Standen, P. (2009). The internet: A comfortable communication medium for people with Asperger syndrome (AS) and high functioning autism (HFA)? *Journal of Assistive Technologies*, 3(2), 44-53.
<https://doi.org/10.1108/17549450200900015>
- Bennie, M. (2025). *What is autistic info dumping?* Autism Awareness Centre.
<https://autismawarenesscentre.com/what-is-autistic-info-dumping/>
- Bevan-Brown, J. (2013). Including people with disabilities: an indigenous perspective. *International Journal of Inclusive Education*, 17(6), 571-583.
<https://doi.org/10.1080/13603116.2012.694483>
- Bonnel, A., McAdams, S., Smith, B., Berthiaume, C., Bertone, A., Ciocca, V., Burack, J. A., & Mottron, L. (2010). Enhanced pure-tone pitch discrimination among persons with autism but not Asperger syndrome. *Neuropsychologia*, 48(9), 2465-2475. <https://doi.org/10.1016/j.neuropsychologia.2010.04.020>
- Botha, M. (2021). Academic, activist, or advocate? Angry, entangled, and emerging: A critical reflection on autism knowledge production. *Frontiers in Psychology*, 12, 727542. <https://doi.org/10.3389/fpsyg.2021.727542>
- Botha, M., & Cage, E. (2022). "Autism research is in crisis": A mixed method study of researcher's constructions of autistic people and autism research. *Frontiers in Psychology*, 13, Article 1050897. <https://doi.org/10.3389/FPSYG.2022.1050897>
- Botha, M., Dibb, B., & Frost, D. M. (2022). 'It's being a part of a grand tradition, a grand counterculture which involves communities': A qualitative investigation of autistic community connectedness. *Autism*, 26(8), 2151-2164.
<https://doi.org/10.1177/13623613221080248>
- Botha, M., Dibb, B., & Frost, D. M. (2024). Autistic community connectedness, disability identity, and well-being. *Autism*, 28(1), 45-60.
<https://doi.org/10.1177/13623613221080248>
- Bottema-Beutel, K., Kapp, S. K., Lester, J. N., Sasson, N. J., & Hand, B. N. (2021). Avoiding ableist language: suggestions for autism researchers. *Autism in Adulthood*, 3(1), 18-29. <https://doi.org/10.1089/AUT.2020.0014>

- Brady, M. J., Jenkins, C. A., Gamble-Turner, J. M., Moseley, R. L., Van Rensburg, M. J., & Matthews, R. J. (2024). "A perfect storm": Autistic experiences of menopause and midlife. *Autism, 28*(6), 1405-1418.
<https://doi.org/10.1177/13623613241244548>
- Brailas, A. (2025). The Appreciative Qualitative Interview: A research method for empowering people. *Methodology, 21*(1), 74-90.
<https://doi.org/10.5964/meth.15421>
- Brainstorm Consortium, Anttila, V., Bulik-Sullivan, B., Finucane, H., Walters, R., Bras, J., Duncan, L., ... Neale, B. M. (2018). Analysis of shared heritability in common disorders of the brain. *Science, 360*(6395), eaap8757.
<https://doi.org/10.1126/science.aap8757>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.
<https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597.
<https://doi.org/10.1080/2159676X.2019.1628806>
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE Publications.
- British Society of Rehabilitation Medicine, Jobcentre Plus & Royal College of Physicians. (2004). *Vocational assessment and rehabilitation after acquired brain injury: inter-agency guidelines*. Clinical effectiveness and evaluation unit.
<https://abil.co.uk/wp-content/uploads/2023/11/Reference-2.pdf>
- Brooks, J. L. (2017). *An appreciative inquiry into the social skills an individual with disabilities uses to maintain employment* [PhD dissertation]. Southwestern College. Proquest, 10599241. <https://www.proquest.com/dissertations-theses/appreciative-inquiry-into-social-skills/docview/1964256553/se-2>
- Bury, S. M., Flower, R. L., Zulla, R., Nicholas, D. B., & Hedley, D. (2021). Workplace social challenges experienced by employees on the autism spectrum: an international exploratory study examining employee and supervisor perspectives. *Journal of Autism and Developmental Disorders, 51*(5), 1614-1627. <https://doi.org/10.1007/s10803-020-04662-6>

- Bushe, G. R. (2011). Appreciative inquiry: Theory and critique. In D. Boje, B. Burnes, & J. Hassard (Eds.), *The Routledge Companion to Organizational Change* (pp. 87-103). Oxford, UK: Routledge.
- Cabana-Domínguez, J., Torrico, B., Reif, A., Fernández-Castillo, N., & Cormand, B. (2022). Comprehensive exploration of the genetic contribution of the dopaminergic and serotonergic pathways to psychiatric disorders. *Translational psychiatry*, *12*(1), 11. <https://doi.org/10.1038/s41398-021-01771-3>
- Cage, E., Cranney, R., & Botha, M. (2022). Brief report: Does autistic community connectedness moderate the relationship between masking and wellbeing? *Autism in Adulthood*, *4*(3), 247-253. <https://doi.org/10.1089/aut.2021.0096>
- Came, H. A. (2013). Doing research in Aotearoa: A Pākehā exemplar of applying Te Ara Tika ethical framework. *Kōtuitui: New Zealand Journal of Social Sciences Online*, *8*(2), 64-73. <https://doi.org/10.1080/1177083X.2013.841265>
- Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2020). The Waitangi Tribunal's WAI, 2575 report: Implications for decolonising health systems. *Health and Human Rights*, *22*(1), 209-220.
- Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2023). Critical Tiriti Analysis: A prospective policy-making tool from Aotearoa New Zealand. *Ethnicities*. Advance online publication. <https://doi.org/10.1177/14687968231171651>
- Caniato, M., Zaniboni, L., Marzi, A., & Gasparella, A. (2022). Evaluation of the main sensitivity drivers in relation to indoor comfort for individuals with autism spectrum disorder Part 1: Investigation methodology and general results. *Energy Reports*, *8*, 1907-1920. <https://doi.org/10.1016/j.egy.2022.01.009>
- Cascella, P. W. (2009). Standardised speech-language tests and students with intellectual disability: A review of normative data. *Journal of Intellectual & Developmental Disability*, *31*(2), 120-124. <https://doi.org/10.1080/13668250600681503>
- Cascio, M. A., Weiss, J. A., & Racine, E. (2020). Making autism research inclusive by attending to intersectionality: A review of the research ethics literature. *Review Journal of Autism and Developmental Disorders*, *8*, 22-36. <https://doi.org/10.1007/s40489-020-00204-z>

- Cascio, M. A., Weiss, J. A., & Racine, E. (2021). Making autism research inclusive by attending to intersectionality: A review of the research ethics literature. *Review Journal of Autism and Developmental Disorders, 8*, 22-36.
<https://doi.org/10.1007/s40489-020-00204-z>/Published
- CASP UK (n.d.). *CASP checklists*. <https://casp-uk.net/casp-tools-checklists>
- Cassidy, S., Bradley, L., Shaw, R., & Baron-Cohen, S. (2018). Risk markers for suicidality in autistic adults. *Molecular Autism, 9*, Article 42.
<https://doi.org/10.1186/S13229-018-0226-4>
- Chapman, R. (2020). The reality of autism: On the metaphysics of disorder and diversity. *Philosophical Psychology, 33*(6), 799-819.
<https://doi.org/10.1080/09515089.2020.1751103>
- Chapman, R., & Carel, H. (2022). Neurodiversity, epistemic injustice, and the good human life. *Journal of Social Philosophy, 53*(4), 614-631.
<https://doi.org/10.1111/josp.12456>
- Co-Liberate. (n.d.). *Mental health first aid training*. Co-Liberate. <https://www.co-liberate.ac.nz/mental-health-first-aid>
- Coetze, G., & Gibbison, G. (2013). Mediating influence of time management on the relationship between adult attention deficit disorder and the operational effectiveness of project managers. *J Manag Dev, 35*, 970-84.
<https://doi.org/10.1108/JMD-06-2015-0090>
- Cooper, K., Smith, L. G. E., & Russell, A. (2017). Social identity, self-esteem, and mental health in autism. *European Journal of Social Psychology, 47*(7), 844-854. <https://doi.org/10.1002/ejsp.2297>
- Cooper, R., Cooper, K., Russell, A. J., & Smith, L. G. E. (2020). "I'm proud to be a little bit different": The effects of Autistic individuals' perceptions of Autism and Autism social identity on their collective self-esteem. *Journal of Autism and Developmental Disorders, 51*(2), 704-714. <https://doi.org/10.1007/s10803-020-04575-4>
- Cooperrider, D. L., & McQuaid, M. (2012). The positive arc of systemic inquiry: A new turn in action research. In H. Bradbury (Ed.), *The SAGE Handbook of Action Research* (pp. 101-117). SAGE Publications

- Cooperrider, D. L., & Whitney, D. (2005). *Appreciative inquiry: A positive revolution in change*. Berrett-Koehler Publishers.
- Crasta, J. E., et al. (2020). Sensory processing and attention profiles among children with sensory processing disorders and Autism Spectrum Disorders. *Frontiers in Integrative Neuroscience, 14*, 22. <https://doi.org/10.3389/fnint.2020.00022>
- Cross-Disorder Group of the Psychiatric Genomics Consortium (2013). Identification of risk loci with shared effects on five major psychiatric disorders: a genome-wide analysis. *Lancet, 381*(9875), 1371-1379. [https://doi.org/10.1016/S0140-6736\(12\)62129-1](https://doi.org/10.1016/S0140-6736(12)62129-1)
- Crouch, A. T. (2019). Perceptions of the possible impact of dyslexia on nursing and midwifery students and of the coping strategies they develop and/or use to help them cope in clinical practice. *Nurse Education in Practice, 35*, 90-97. <https://doi.org/10.1016/j.nepr.2018.12.008>
- Csecs, J. L. L., Iodice, V., Rae, C. L., Brooke, A., Simmons, R., Quadt, L., Savage, G. K., Dowell, N. G., Prowse, F., Themelis, K., Mathias, C. J., Critchley, H. D., & Eccles, J. A. (2022). Joint hypermobility links neurodivergence to dysautonomia and pain. *Frontiers in Psychiatry, 12*. <https://doi.org/10.3389/fpsy.2021.786916>
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health, 18*(1). <https://doi.org/10.1186/s12939-019-1082-3>
- Dana, D. (2018). *The polyvagal theory in therapy: Engaging the rhythm of regulation*. W. W. Norton & Company.
- Davies, C., Moosa, M., McKenna, K., Mittal, J., Memis, I., Mittal, R., & Eshraghi, A. A. (2023). Quality of life, neurosensory disorders and co-occurring medical conditions in individuals on the spectrum, with a special focus on females diagnosed with Autism: A systematic review. *Journal of Clinical Medicine, 12*(3), 927. <https://doi.org/10.3390/jcm12030927>
- De Beer, J., Engels, J., Heerkens, Y., & Van Der Klink, J. (2014). Factors influencing work participation of adults with developmental dyslexia: a systematic review. *BMC Public Health, 14*(1). <https://doi.org/10.1186/1471-2458-14-77>

- De Rubeis, S., He, X., Goldberg, A. P., Poultney, C. S., Samocha, K., Cicek, A. E., Kou, Y., Liu, L., Fromer, M., Walker, S., Singh, T., Klei, L., Kosmicki, J., Fu, S., Aleksic, B., Biscaldi, M., Bolton, P. F., Brownfeld, J. M., Cai, J., . . . Buxbaum, J. D. (2014). Synaptic, transcriptional and chromatin genes disrupted in autism. *Nature*, *515*(7526), 209-215. <https://doi.org/10.1038/nature13772>
- DeStefano, D., & LeFevre, J.-A. (2007). Cognitive load in hypertext reading: A review. *Computers in Human Behavior*, *23*(3), 1616-1641. <https://doi.org/10.1016/j.chb.2005.08.012>
- de Vries, B. (2021). Autism and the right to a hypersensitivity-friendly workspace. *Public Health Ethics*, *14*(3), 281-287. <https://doi.org/10.1093/phe/phab021>
- Deakin, M., Petty, S., Heasman, B., & Hamilton, L. G. (2024). A critical reflection on definitions of autistic well-being. *Brain and Behavior*, *14*(7). <https://doi.org/10.1002/brb3.3572>
- DeLisa, J. A., & Lindenthal, J. J. (2016). Learning from physicians with disabilities and their patients. *AMA Journal of Ethics*, *18*(10), 1003-1009. <https://doi.org/10.1001/journalofethics.2016.18.10.stas1-1610>
- den Houting, J. D. (2018). Neurodiversity: An insider's perspective. *Autism*, *23*(2), 271-273. <https://doi.org/10.1177/1362361318820762>
- Denzin, N., & Lincoln Y. (2005). Introduction: The discipline and practice of qualitative research. In Denzin N., Lincoln Y. (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 1-32). Thousand Oaks, CA: Sage
- Dewar, B. (2012). Caring about caring: Developing a model to implement compassionate relationship-centred care in an older people care setting. *International Journal of Nursing Studies*, *49*(11), 1247-1257. <https://doi.org/10.1016/j.ijnurstu.2012.04.012>
- Dewar, B., Stulz, V., Buliak, A., Connelly, L., McLaughlin, K., Newport, K., Rebolledo, S., Stephenson, L., MacBride, T., Lennon, K., & Drayton, N. (2020). Exploring and developing student midwives' experiences (ESME): An appreciative inquiry study. *University of the West of Scotland Academic Portal*. <https://research-portal.uws.ac.uk/en/publications/exploring-and-developing-student-midwives-experiences-esme-an-app>

- Disabled People's Organisations Coalition., Human Rights Commission., & Ombudsman. (2023). *Removing barriers: A guide for reasonable accommodation of disabled people in Aotearoa*.
<https://www.ombudsman.parliament.nz/sites/default/files/2023-02/Reasonable%20Accommodation%20Guide%202023.pdf>
- Discord Inc. (2024). *Privacy policy*. Discord. <https://discord.com/privacy>
- Dixon, L., Clemons, J. H., & Mharapara, T. (2025). Exploring the midwifery workplace environment in Aotearoa New Zealand over the three years from 2019-2021. *New Zealand College of Midwives Journal*, 61, 256104.
<https://doi.org/10.12784/nzcomjnl.256104>
- Dixon, L., Guilliland, K., Pallant, J., Sidebotham, M., Fenwick, J., McAra-Couper, J., & Gilkison, A. (2017). The emotional wellbeing of New Zealand midwives: Comparing responses for midwives in caseloading and shift work settings. *New Zealand College of Midwives Journal*, 53, 5-14.
- Doyle, N. (2017). Neurodiversity at work: Improving wellbeing and productivity in the workplace. Leicester: *British Psychological Society*, 44-62.
https://www.researchgate.net/publication/325487123_Neurodiversity_at_Work
- Doyle, N. (2020). Neurodiversity at work: A biopsychosocial model and the impact on working adults. *British Medical Bulletin*, 135(1), 108-125.
<https://doi.org/10.1093/bmb/ldaa021>
- Doyle, N. (2024). Defining neurodiversity and identifying neurominorities. In E. Patton & A. M. Santuzzi (Eds.), *Neurodiversity and work: Employment, identity, and support networks for neurominorities* (1st ed., pp. 13-38). Palgrave Macmillan.
https://doi.org/10.1007/978-3-031-55072-0_2
- Doyle, N., & McDowall, A. (2015). Is coaching an effective adjustment for dyslexic adults? *Coaching an International Journal of Theory Research and Practice*, 8(2), 154-168. <https://doi.org/10.1080/17521882.2015.1065894>
- Dryden, D. (2024). *Monotropism & polytropism: Understanding Autism, ADHD & AuDHD*. <https://www.theasc-adhdcoach.com/post/monotropism-vs-polytropism-understanding-autism-adhd-audhd-and-their-overlapping-challenges-and>

- Drysdale, H., & van der Meer, L. (2020). Rates of autism spectrum disorder diagnoses for children and adolescents in the Hutt Valley Region of New Zealand between 2012 and 2016. *Research in Autism Spectrum Disorders*, 73(ss-6), 101547. <https://doi.org/10.1016/j.rasd.2020.101547>
- Dudas, R. B., Lovejoy, C., Cassidy, S., Allison, C., Smith, P., & Baron-Cohen, S. (2017). The overlap between autistic spectrum conditions and borderline personality disorder. *PloS one*, 12(9), e0184447.
- Dunne, M. (2024). *The neurodiversity edge: The essential guide to embracing Autism, ADHD, Dyslexia and other neurological differences for any organization* (1st ed.). John Wiley & Sons. <https://doi.org/10.1177/19394225251325667>
- Durie, M. (1994). *Whaiora: Māori health development*. Oxford University Press.
- Dwyer, P., Williams, Z. J., Lawson, W. B., & Rivera, S. M. (2024). A trans-diagnostic investigation of attention, hyper-focus, and monotropism in autism. *Neurodiversity*, 2, 1-27. <https://doi.org/10.1177/27546330241237883>
- East, L., Jackson, D., O'Brien, L., & Peters, K. (2010). Storytelling: An approach that can help to develop resilience. *Nurse Researcher*, 17(3), 17-25. <https://doi.org/10.7748/nr2010.04.17.3.17.c7742>
- Eide, B., & Eide, F. (2011). *The Dyslexic advantage*. Plume: New York, NY.
- Elam, G., & Fenton, K. A. (2003). Researching sensitive issues and ethnicity: lessons from sexual health. *Ethnicity & Health*, 8(1), 15-27. <https://doi.org/10.1080/13557850303557>
- Elsherif, M. M., Middleton, S. L., Phan, J. M., Azevedo, F., Iley, B. J., Grose-Hodge, M., Tyler, S., Kapp, S. K., Gourdon-Kanhukamwe, A., Grafton-Clarke, D., Yeung, S. K., Shaw, J. J., Hartmann, H., & Dokovova, M. (2022). Bridging neurodiversity and open scholarship: How shared values can guide best practices for research integrity, social justice, and principled education. *MetaArXiv*. <https://doi.org/10.31222/osf.io/k7a9p>
- Ferenc, K., Płatos, M., Byrka, K., & Król, M. E. (2022). Looking through rainbow-rimmed glasses: Taking neurodiversity perspective is related to subjective well-being of autistic adults. *Autism*, 27(5), 1348-1361. <https://doi.org/10.1177/13623613221135818>

- Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2014). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165-181. <https://doi.org/10.1080/02615479.2014.977244>
- Fitzgerald, S. P., Oliver, C., & Hoxsey, J. C. (2010). Appreciative Inquiry as a shadow process. *Journal of Management Inquiry, 19*(3), 220-233. <https://doi.org/10.1177/1056492609349349>
- Fletcher, T. V., & Navarrete, L. A. (2003). Learning disabilities or difference: A critical look at issues associated with the misidentification and placement of hispanic students in special education programs. *Rural Special Education Quarterly, 22*(4), 37-46. <https://doi.org/10.1177/875687050302200406>
- Foronda, C. (2019). A theory of cultural humility. *Journal of Transcultural Nursing, 31*(1), 7-12. <https://doi.org/10.1177/1043659619875184>
- Fox-Muraton, M. (2024). *Alexithymia and neurodivergence: A wittgensteinian deconstruction*. In Facets of Reality - Contemporary Debates, Austrian Ludwig Wittgenstein Society, Kirchberg am Wechsel, Austria, 234-42. <https://hal.science/hal-04734508v1/document>
- Frisch, B., Peters, B., & Vertanen, K. (2025). Examining the social communication and community engagement of autistic adults through an asynchronous focus group. *arXiv*. <https://arxiv.org/abs/2507.00202>
- Galea, K. (2021). *What to know about untreated ADHD in adults*. Medical News Today. <https://www.medicalnewstoday.com/articles/323667#whatis-adhd>
- General Medical Council. (2024). *The importance of inclusion in medicine*. <https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/welcomed-and-valued/health-and-disability-in-medicine/theimportance-of-inclusion-in-medicine>
- Gergen, K. J. (1978). Toward generative theory. *Journal of Personality and Social Psychology, 36*(11), 1344-1360. <https://doi.org/10.1037/0022-3514.36.11.1344>
- Gilkison, A., Pairman, S., McAra-Couper, J., Kensington, M., & James, L. (2016). Midwifery education in New Zealand: Education, practice and autonomy. *Midwifery, 33*, 31-33. <https://doi.org/10.1016/j.midw.2015.12.001>

- Godfrey-Harris, M., & Shaw, S. C. K. (2023). The experiences of medical students with ADHD: a phenomenological study. *PLoS ONE*, *18*(8), e0290513. <https://doi.org/10.1371/JOURNAL.PONE.0290513>
- Grant, D. (2009). The psychological assessment of neurodiversity. In D. Pollak (Ed.), *Neurodiversity in higher education: Positive responses to specific learning differences* (1st ed., pp. 33-62). John Wiley & Sons. <https://doi.org/10.1002/9780470742259.ch3>
- Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information and Libraries Journal*, *26*(2), 91-108. <https://onlinelibrary.wiley.com/doi/10.1111/j.1471-1842.2009.00848.x>
- Grant, S., Norton, S., & Hoekstra, R. A. (2025). Central sensitivity symptoms and autistic traits in autistic and non-autistic adults. *Autism Research*, *18*(3), 660-674. <https://doi.org/10.1002/aur.3297>
- Griep, Y., Cruz, K. S., Haggard, D. L., & Haggard, K. S. (2025). The inclusive leadership paradox: When inclusion efforts lead to the exclusion of neurodivergent people. *Group & Organization Management*, *0*(0). <https://doi.org/10.1177/10596011251330687>
- Grove, R., Clapham, H., Moodie, T., Gurrin, S., Hall, G. (2023) 'Living in a world that's not about us': The impact of everyday life on the health and wellbeing of autistic women and gender diverse people. *Women's Health*, *19*. <https://doi.org/10.1177/17455057231189542>
- Hammond, D. (2022). *Neurodiversity: Untapped Talent - a guide for public sector recruitment*. Quality of Policy Advice, Ministry for the Environment. https://www.idc.govt.nz/assets/Fellowships/Neurodiversity_Untapped-Talent.pdf
- Hansen, Q. (2019). *The intense world theory of autism: What we've been saying all along! Speaking of autism. An autistic speaks about living with autism*. <https://speakingofautismcom.wordpress.com/2019/02/07/the-intense-world-theory-of-autism-what-weve-been-saying-all-along/>;
- Hansson, M., Dencker, A., Lundgren, I., Carlsson, I.-M., Eriksson, M., & Hensing, G. (2022). Job satisfaction in midwives and its association with organisational and

- psychosocial factors at work: A nation-wide, cross-sectional study. *BMC Health Services Research*, 22, 436. <https://doi.org/10.1186/s12913-022-07852-3>
- Harden, K. P. (2021). *The genetic lottery: why DNA matters for social equality*. Princeton University Press.
- Harvery, M., Froude, E. H., Foley, K.-R., Trollor, J. N., & Arnold, S. R. (2021). Employment profiles of autistic adults in Australia. *Autism Research*, 14(10), 2061-2077. <https://doi.org/10.1002/aur.2588>
- Hayward, S. M., McVilly, K. R., & Stokes, D. (2019). Inclusive research design: Enhancing participation of people with intellectual disability in qualitative research. *Journal of Applied Research in Intellectual Disabilities*, 32(6), 1400-1410. <https://doi.org/10.1111/jar.12612>
- Health and Care Professions Council. (2021). *New guidance on health and character declarations: What you need to know*. <https://www.hcpc-uk.org/news-and-events/blog/2021/health-and-character-guidance/>
- Health New Zealand | Te Whatu Ora. (2024). *Report on maternity web tool*. *Health New Zealand | Te Whatu Ora*. <https://tewhatuora.shinyapps.io/report-on-maternityweb-tool/>
- Health Research Council of New Zealand. (2019). *The New Zealand health research prioritisation framework: Maximising the benefits of health research for New Zealanders*. <https://www.hrc.govt.nz/resources/new-zealand-health-researchprioritisation-framework>
- Hedlund, A. (2023). Autistic nurses: do they exist? *British Journal of Nursing*, 32(4), 210-214.
- Hewlett, K., Cooper, R., & Jameson, M. (2018). *Neurodiverse voices: Opening doors to employment*. The Westminster AchieveAbility Commission for Dyslexia and Neurodivergence. https://www.achieveability.org.uk/files/1518955206/wac-report_2017_interactive-2.pdf
- Hickey, H., & Wilson, D. (2017). Whānau hauā: Reframing disability from an Indigenous perspective. *MAI Journal*, 6(1), 82-94. <https://www.journal.mai.ac.nz/content/whānau-hauā-reframing-disability-indigenous-perspective>

- Hirtle, S. C. (2018). Wayfinding and orientation: Cognitive aspects of human navigation. In D. R. Montello (Ed.), *Handbook of behavioral and cognitive geography* (pp. 141-153). Edward Elgar Publishing.
<https://doi.org/10.4337/9781784717544.00015>
- Howard, P. L., & Sedgewick, F. (2021). "Anything but the phone!": Communication mode preferences in the autism community. *Autism, 25*(8), 2265-2278.
<https://doi.org/10.1177/13623613211014995>
- Howlin, P., Alcock, J., & Burkin, C. (2005). An 8-year follow-up of a specialist supported employment service for high-ability adults with autism or Asperger syndrome. *Autism, 9*, 533-49. <https://doi.org/10.1177/1362361305057871>
- Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika: Guidelines for Māori research ethics - A framework for researchers and ethics committee members*. Health Research Council of New Zealand.
<https://www.hrc.govt.nz/resources/te-ara-tika-guidelines-maori-research-ethics-0>
- Hughes, M. E., Rose, G. M., & Trip, H. (2021). Registered nurses' experiences and perceptions of practising with a disability. *Kai Tiaki Nursing Research, 12*(1), 7-15.
- Hull, L., Levy, L., Lai, M.-C., Petrides, K. V., Baron-Cohen, S., Allison, C., Smith, P., & Mandy, W. (2021). Is social camouflaging associated with anxiety and depression in autistic adults? *Molecular Autism, 12*(1), Article 13.
<https://doi.org/10.1186/s13229-021-00421-1>
- Hunter, B., Fenwick, J., Sidebotham, M., & Henley, J. (2019). Midwives in the United Kingdom: Levels of burnout, depression, anxiety and stress and associated predictors. *Midwifery, 79*, 102526. <https://doi.org/10.1016/j.midw.2019.08.008>
- Ingham, T. (2024). Decolonizing disability: Indigenous Māori perspectives of disability research in the modern era. In M. H. Rioux, A. Buettgen, E. Zubrow, & J. Zubrow (Eds.), *Handbook of Disability*. Springer. https://doi.org/10.1007/978-981-19-6056-7_68
- Jacobson, D., & Mustafa, N. (2019). Social identity map: A reflexivity tool for practicing explicit positionality in critical qualitative research. *International*

Journal of Qualitative Methods, 18, 1-12.

<https://doi.org/10.1177/1609406919870075>

Jaleniauskiene, E. & Kasperuniene, J., (2023). Infographics in higher education: A scoping review. *E-Learning and Digital Media*, 20(2), 191-206

Johnson, P. C. (2013). Transcending the polarity of light and shadow in appreciative inquiry: An appreciative exploration of practice. *Advances in Appreciative Inquiry*, 4, 189-207. [https://doi.org/10.1108/S1475-9152\(2013\)0000004007](https://doi.org/10.1108/S1475-9152(2013)0000004007)

Joyful Soul Psychology. (2025). *Visual supports: Helping neurodivergent & special-needs individuals communicate, learn and function efficiently.*

<https://joyfulsoulpsychology.com/blog/visual-supports-helping-neurodivergent-special-needs-individuals-communicate-learn-and-function-efficiently/>

Kapp, S. K. (2025). Sensory-movement underpinnings of lifelong neurodivergence: getting a grip on autism. *Frontiers in Integrative Neuroscience*, 19.

<https://doi.org/10.3389/fnint.2025.1489322>

Kapp, S. K., Gillespie-Lynch, K., Sherman, L. E., & Hutman, T. (2013). Deficit, difference, or both? Autism and neurodiversity. *Developmental Psychology*, 49(1), 59-71. <https://doi.org/10.1037/a0028353>

Karmiloff-Smith, A. (2009). Nativism versus neuroconstructivism: rethinking the study of developmental disorders. *Dev Psychol*, 45, 56-63.

<https://doi.org/10.1037/a0014506>

Katz, N., Dejak, I., & Ga, I E. (2015). Work performance evaluation and QoL of adults with high functioning autism spectrum disorders (HFASD). *Work J Prev Assess Rehabil*, 51, 887-92. <https://doi.org/doi:10.3233/WOR-152001>

Katz, V. S., Moran, M. B., & Gonzalez, C. (2015). Connecting with technology in lower-income U.S. families: Variations by race and ethnicity. *Information, Communication & Society*, 18(1), 98-115.

<https://doi.org/10.1080/1369118X.2014.934235>

Kelly, C., Martin, R., & Saravanan, V. (2022). The links between fibromyalgia, hypermobility and neurodivergence. *touchREVIEWS in RMD*, 1(1), 3-4.

<https://doi.org/doi.org/10.17925/RMD.2022.1.1.3>

- Kirby A. (2004). *The adolescent with developmental coordination disorder (DCD)*. Jessica Kingsley Publishers.
- Kirby, A. (2022, March 2nd). *Neurodiversity: not a norma or normman in sight?* LinkedIn. <https://www.linkedin.com/pulse/neurodiversity-norma-normman-sight-prof-amanda-kirby>
- Kirby, A., Edwards, L., & Sugden, D. (2018). Emerging adulthood and developmental co-ordination disorder. *J Adult Dev*, 18, 107-13. <https://doi.org/10.1007/s10804-011-9123-1>
- Kivunja, C., & Kuyini, A. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*, 6(5), 26-41. <https://doi.org/10.5430/ijhe.v6n5p26>
- Kourti, M. (2021). A critical realist approach on autism: ontological and epistemological implications for knowledge production in autism research. *Frontiers in Psychology*, 12, 713423. <https://doi.org/10.3389/fpsyg.2021.713423>
- Kudelski Communications Krzysztof Kudelski. (2024). *Privacy policy*. Transkryptor. <https://transkryptor.com/privacy-policy/>
- Kuiper, M. W. M., Verhoeven, E. W. M., & Geurts, H. M. (2019). Stop making noise! Auditory sensitivity in adults with an autism spectrum disorder diagnosis: Physiological habituation and subjective detection thresholds. *J Autism Dev Disord*, 49(5), 2116-2128. <https://doi.org/10.1007/s10803-019-03890-9>
- Lam, G. Y. H., Sabnis, S., Migueliz Valcarlos, M., & Wolgemuth, J. R. (2021). A critical review of academic literature constructing well-being in autistic adults. *Autism Adulthood*, 3(1), 61-71. <https://doi.org/10.1089/aut.2020.0053>
- Leather, C., Hogh, H., Seiss, E., & Everatt, J. (2011). Cognitive Functioning and Work Success in Adults with Dyslexia. *Dyslexia*, 17(4), 327-338. <https://doi.org/10.1002/dys.441>
- Lekas, H. M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights*, 13, 1-4. <https://doi.org/10.1177/1178632920970580>

- Lenroot, R. K., & Yeung, P. K. (2013). Heterogeneity within autism spectrum disorders: what have we learned from neuroimaging studies? *Front Hum Neurosci*, 7, 733. <https://doi.org/10.3389/fnhum.2013.00733>
- Letsoalo, M. (2025). Neurodivergent attachment theory. *SSRN*. <http://dx.doi.org/10.2139/ssrn.5264844>
- Levers, M. (2013). Philosophical paradigms, grounded theory and perspectives on emergence. *Sage Open*. <https://doi.org/10.1177/2158244013517243>
- Lewis, T. A. (2022). *Working definition of ableism: January 2022 update*. Talila A. Lewis. <https://www.talilalewis.com/blog/working-definition-ofableism-january-2022-update>
- Locke, R., Alexander, G., Mann, R., Kibble, S., & Scallan, S. (2016). Doctors with dyslexia: strategies and support. *The Clinical Teacher*, 14(5), 355-359.
- Logan, J. (2009). Dyslexic entrepreneurs: the incidence; their coping strategies and their business skills. *Dyslexia*, 15, 328-46. <https://doi.org/10.1002/dys.388>
- MacCoy, D. J. (2014). Appreciative Inquiry and evaluation: Getting to what works. *Canadian Journal of Program Evaluation*, 29(2), 104-127. <https://doi.org/10.3138/cjpe.29.2.104>
- Maisel, J. L., & Ranahan, M. (2022). *Beyond accessibility to universal design*. *Whole Building Design Guide*. <https://www.wbdg.org/design-objectives/accessible/beyond-accessibility-universal-design>
- Maitland, C. A., Rhodes, S., O'Hare, A., Stewart, M. (2021). Social identities and mental wellbeing in autistic adults. *Autism*, 25(6), 1771-1783. <https://doi.org/10.1177/13623613211004328>
- Manatū Hauora | Ministry of Health. (2021). *Primary Maternity Services Notice Section 88 of the New Zealand Public Health and Disability Act 2000: Section 88*. <https://www.health.govt.nz/publication/primary-maternity-services-notice-2021>
- Maričić, L. M., Walter, H., Rosenthal, A., Ripke, S., Quinlan, E. B., Banaschewski, T., Barker, G. J., Bokde, A. L. W., Bromberg, U., Büchel, C., Desrivières, S., Flor, H., Frouin, V., Garavan, H., Itterman, B., Martinot, J., Martinot, M. P., Nees, F., Orfanos, D. P., . . . Tahmasebi, A. (2020). The IMAGEN study: a decade of

- imaging genetics in adolescents. *Molecular Psychiatry*, 25(11), 2648-2671.
<https://doi.org/10.1038/s41380-020-0822-5>
- Markram, H., Rinaldi, T., & Markram, K. (2007). The intense world syndrome: an alternative hypothesis for autism. *Frontiers in neuroscience*, 1(1), 77-96.
<https://doi.org/10.3389/neuro.01.1.1.006.2007>
- Markram, K., & Markram, H. (2010). The intense world theory: a unifying theory of the neurobiology of autism. *Frontiers in human neuroscience*, 4, 224.
<https://doi.org/10.3389/fnhum.2010.00224>
- Marks, B., & Sisirak, J. (2022). Nurses with disability: Transforming Healthcare for All. *The Online Journal of Issues in Nursing*, 27(3), 4.
<https://www.doi.org/10.3912/OJIN.Vol27No03Man04>
- Matheiken, S., Erden, M., Krishnadas, R., & Pinto da Costa, M. (2024). Adult attention-deficit hyperactivity disorder: Time for a rethink? *BJPsych Advances*, 30(5), 298-302. <https://doi.org/10.1192/bja.2023.54>
- Matt, S. B., Fleming, S. E., & Maheady, D. C. (2015). Creating disability inclusive work environments for our aging nursing workforce. *Journal of Nursing Administration*, 45(6), 325-30. <https://doi.org/10.1097/NNA.0000000000000208>
- McDonald, T. A. M. (2020). Autism identity and the “lost generation”: structural validation of the autism spectrum identity scale and comparison of diagnosed and self-diagnosed adults on the autism spectrum. *Autism in Adulthood*, 2(1), 13-23. <https://doi.org/10.1089/AUT.2019.0069>
- McLoughlin, D., & Doyle, N. (2017). The psychological assessment of adults with specific performance difficulties at work. *British Psychological Society*, 1-40.
<https://cms.bps.org.uk/sites/default/files/2022-06/DOP%20Psychological%20Assessment%20of%20Adults%20with%20Specific%20Difficulties%20WEB.pdf>
- McLoughlin, D., & Leather, C. (2013). *The dyslexic adult*. John Wiley and Sons, Chichester. <https://doi.org/10.1002/9781118323373>
- Mead, S. M., & Grove, N. (2003). *Ngā pēpeha a ngā tīpuna: The sayings of the ancestors*. Victoria University Press.

- Meilleur, A. A. S., Jelenic, P., & Mottron, L. (2015). Prevalence of clinically and empirically defined talents and strengths in autism. *J Autism Dev Disord*, *45*, 1354-67. <https://doi.org/10.1007/s10803-014-2296-2>.
- Mharapara, T., Ravenswood, K., Clemons, J., Kirton, G., & Greenslade-Yeats, J. (2024). Enhancing midwives' occupational wellbeing: Lessons from New Zealand's COVID-19 experience. *Health Care Management Review*, *49*(3), 210-219. <https://doi.org/10.1097/>
- Millin, R., Kolodny, T., Flevaris, V. A., Kale, M. A., Schallmo, M., Gerdts, J., Bernier, A. R., & Murray, S. (2018). Reduced auditory cortical adaptation in autism spectrum disorder. *Elife*, *7*, e36493. <https://doi.org/10.7554/eLife.36493>
- Milton, D. (2012). On the ontological status of autism: The 'double empathy problem'. *Disability & Society*, *27*(6), 883-887. <https://doi.org/10.1080/09687599.2012.710008>
- Milton, D. (2017). A mismatch of salience: Explorations of the nature of autism from theory to practice. *Disability & Society*, *33*(10), 1-2. <https://doi.org/10.1080/09687599.2018.1541617>
- Milton, D. (n.d). *So what exactly is autism*. Autism Education Trust. <https://capacity-resource.middletownautism.com/wp-content/uploads/sites/6/2017/03/damian-milton.pdf>
- Miraglia, M., Cenciotti, R., Alessandri, G., & Borgogni, L. (2017). Translating self-efficacy in job performance over time: The role of job crafting. *Human Performance*, *30*(5), 254-271. <http://dx.doi.org/10.1080/08959285.2017.1373115>
- Miserandino, C. (2003). *The spoon theory: But you don't look sick*. <https://www.butyoudontlooksick.com/articles/written-by-christine/the-spoon-theory/>
- Monteiro, M. J. (2025). *A clinician's guide to delivering neuro-informed care: Revealing the autism story* (1st ed.). Routledge. <https://www.routledge.com/A-Clinicians-Guide-to-Delivering-Neuro-Informed-Care-Revealing-the-Autism-Story/Monteiro/p/book/9781032858395>

- Moon, K. & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, 28(5), 1167-1177. <https://doi.org/10.1111/cobi.12326>
- Moore, A. (2021). Diversity in nursing: why it's time to think neurodiversity. *Nursing Standard*, 36(1), 67-69. <https://doi.org/10.7748/ns.36.1.67.s23>
- Mordeniz, C. (2020). The heart and the brain quantic interaction. *Neurol Neurosci Rep*, 3. <http://dx.doi.org/10.15761/NNR.1000120>
- Moreland, C. L. (2021). *Fostering cultural humility in disability services. Fostering Cultural Humility Workshop*. Fisa Foundation. <https://fisafoundation.org/wp-content/uploads/2021/04/Fostering-Cultural-Humility-Workshop-04-07-2021.pdf>
- Morrison, K. E., DeBrabander, K. M., Jones, D. R., Faso, D. J., Ackerman, R. A., & Sasson, N. J. (2019). Outcomes of real-world social interaction for autistic adults paired with autistic compared to typically developing partners. *Autism*, 24(5), 1067-1080. <https://doi.org/10.1177/1362361319892701>
- Moseley, R. L., Druce, T., & Turner-Cobb, J. M. (2020). 'When my autism broke': a qualitative study spotlighting autistic voices on menopause. *Autism*, 24(6), 1423-1437. <https://doi.org/10.1177/1362361319901184>
- Murray, D., Lesser, M., & Lawson, W. (2005). Attention, monotropism and the diagnostic criteria for autism. *Autism*, 9(2), 139-156. <https://doi.org/10.1177/1362361305051398>
- Murray, F. (2018). *Me and monotropism: A unified theory of autism*. The Psychologist. <https://www.bps.org.uk/psychologist/me-and-monotropism-unified-theory-autism>
- National Ethics Advisory Committee. (2019). *National ethical standards for health and disability research and quality improvement*. Ministry of Health. <https://neac.health.govt.nz/assets/Uploads/NEAC/publications/national-ethical-standards-health-disability-research-quality-improvement-2019.pdf>
- Neff, M. A. (2022). *Spoon theory for Autism and ADHD: The neurodivergent spoon drawer*. Neurodivergent Insights. <https://neurodivergentinsights.com/the-neurodivergent-spoon-drawer-spoon-theory-for-adhders-and-autists/>

- Newcombe, N., Cox, W., Hoefhamer, S., & Sacra, A. (2025). Peer groups: Building a connected autistic community in Aotearoa. *Altogether Autism Journal, Autistic and Making the Invisible Visible*, 10-13.
<https://www.altogetherautism.org.nz/wp-content/uploads/2025/05/AA25-Journal-Digital-FINAL.pdf>
- Nicolaidis, C., Raymaker, D. M., McDonald, K. E., Lund, E. M., Leotti, S., Kapp, S. K., ... & Boisclair, W. C. (2015). Comparison of healthcare experiences in autistic and non-autistic adults: A cross-sectional online survey facilitated by an academic-community partnership. *Journal of General Internal Medicine*, 30(10), 1441-1447. <https://doi.org/10.1007/s11606-015-3247-9>
- Nicolson, R. I., & Fawcett, A. J. (2008). *Dyslexia, learning, and the brain*. MIT Press.
- Nowell, K. P., Bernardin, C. J., Brown, C., & Kanne, S. (2021). Characterization of special interests in Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders*, 51, 2711-2724. <https://doi.org/10.1007/s10803-020-04743-6>
- Nussbaum, N. L. (2012). ADHD and female specific concerns: a review of the literature and clinical implications. *Journal of Attention Disorders*, 16(2), 87-100. <https://doi.org/10.1177/1087054711416909>
- Olssen, M. (1995). The epistemology of constructivism. *Contemporary issues in education*, 13(2), 82-94. https://pesaagora.com/access-archive-files/ACCESSAV13N2_082.pdf
- Opai, K. (2020). *Te Reo Hapai*. <https://www.tereohapai.nz/Browse/Terms/mi-NZ>
- Orange, C. (2023). *'Te Tiriti o Waitangi - the Treaty of Waitangi'*. Te Ara - the encyclopedia of New Zealand. <http://www.TeAra.govt.nz/en/te-tiriti-o-waitangi-the-treaty-of-waitangi/print>
- Otago Polytechnic. (n.d.). *Using AI tools*. Otago Polytechnic.
<https://studentsupport.op.ac.nz/learning-support/using-ai-tools>
- Patterson, M. E., & Williams, D. R. (1998). Paradigms and problems: The practice of social science in natural resource management. *Society & Natural Resources*, 11(3), 279-295. <https://doi.org/10.1080/08941929809381080>

- Pearce, W. M., & Williams, C. (2013). The cultural appropriateness and diagnostic usefulness of standardized language assessments for Indigenous Australian children. *International Journal of Speech-Language Pathology*, *15*(4), 429-440. <https://doi.org/10.3109/17549507.2012.762043>
- Pearson, A., & Rose, K. (2021). A conceptual analysis of Autistic masking: Understanding the narrative of stigma and the illusion of choice. *Autism in Adulthood*, *3*(1). <https://doi.org/10.1089/aut.2020.0043>
- [*Picture of Neurodiversity Rainbow Infinity Symbol*]. (n.d.). <https://www.altogetherautism.org.nz/autism-no-puzzle-nothing-wrong-with-us/>
- Pierce, J. (2018). *Leaders' strategies to support and accommodate employees with high-functioning autism* [PhD dissertation]. Walden University, 4751. <https://scholarworks.waldenu.edu/dissertations/4751>
- Porges, S. W. (2022). Polyvagal theory: A science of safety. *Frontiers in Integrative Neuroscience*, *16*, 871227. <https://doi.org/10.3389/fnint.2022.871227>
- Poulsen, R., Williams, Z., Dwyer, P., Pellicano, L., Sowman, P. F. & McAlpine, D. (2024). How auditory processing influences the Autistic profile: A review. *Autism Res*, *17*(12), 2452-2470. <https://doi.org/10.1002/aur.3259>
- Praslova, L. (2021). *Autism doesn't hold people back at work. Discrimination does*. Harvard Business Review. <https://hbr.org/2021/07/autism-doesnt-hold-people-back-at-work-discrimination-does>
- Praslova, L. (2023). Job crafting for neurodivergent professionals: Aligning strengths and roles. *Journal of Management Development*, *42*(2), 123-138.
- Preece, D. A., & Gross, J. J. (2023). Conceptualizing alexithymia. *Personality and Individual Differences*, *215*. <https://doi.org/10.1016/j.paid.2023.112375>
- Prevatt, F., & Yelland, S. (2013). An empirical evaluation of ADHD coaching in college students. *J Atten Disord*, *1*, 12. <https://doi.org/10.1177/1087054713480036>
- Price, S., Luszkat, R., Mann, R., & Locke, R. (2017). Doctors with Asperger's: The impact of a diagnosis. *The Clinical Teacher*, *16*(1), 19-22.

- Proff, I., Williams, G. L., Quadt, L., & Garfinkel, S. N. (2021). Sensory processing in Autism across exteroceptive and interoceptive domains. *Psychology & Neuroscience, 15*(2), 105-130. <https://doi.org/10.1037/pne0000262>
- Putrino, D., Ripp, J., Herrera, J. E., Cortes, M., Kellner, C., Rizk, D., & Dams-O'Connor, K. (2020). Multisensory, nature-inspired recharge rooms yield short-term reductions in perceived stress among frontline healthcare workers. *Front Psychol, 19*(11), 560833. <https://doi.org/10.3389/fpsyg.2020.560833>
- Radulski, E. (2022). Conceptualising autistic masking, camouflaging, and neurotypical privilege: towards a minority group model of neurodiversity. *Human Development, 66*(2), 113-127. <https://doi.org/10.1159/000524122>
- Rakime, E., Greasley, P., & Waterhouse, J. (2011). Appreciative Inquiry: A way of reframing the student experience of learning. *Nurse Education Today, 31*(4), 439-443. <https://doi.org/10.1016/j.nedt.2010.08.004>
- Ramsden, I. M. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* [PhD dissertation]. Te Herenga Waka | Victoria University of Wellington.
https://www.nzno.org.nz/Portals/0/Files/Documents/Services/Library/2002%20RAMSDEN%20I%20Cultural%20Safety_Full.pdf
- Raper, S. (2019). Turning points. Pearson and the parameter. *Significance, 16*(3), 22-25. <https://doi.org/10.1111/j.1740-9713.2019.01276.x>
- Raymaker, D. M., Teo, A. R., Steckler, N. A., Lentz, B., Scharer, M., Delos Santos, A., Kapp, S. K., Hunter, M., Joyce, A., & Nicolaidis, C. (2020). Having all of your internal resources exhausted beyond measure and being left with no clean-up crew: Defining autistic burnout. *Autism in Adulthood, 2*(2), 132-143. <https://doi.org/10.1089/aut.2019.0079>
- Riwai-Couch, M. (2021). *Poipoiā ngā ākongā kanorau ā-roro: a literature review prepared for the Ministry of Education*. Ministry of Education.
<https://inclusive.tki.org.nz/assets/inclusive-education/resources/files/Akongā-Kanorau-a-roro-Final-Draft-of-Literature-Review-MRC-1.pdf>
- Rizzo, E. A., & Röck, T. (2021). Autistics as empathic subjects: Phenomenology and intense world theory. *Phenomenology and Mind, 21*, 34-47. <https://doi.org/10.17454/pam-2103>

- Roberts, S. O., & Mortenson, E. (2022). Challenging the White = neutral framework in psychology. *Perspectives on Psychological Science*, *18*(3).
<https://doi.org/10.1177/17456916221077117>
- Roddy, E., MacBride, T., McBride, A., Douglas-Smith, N., McCaig, M., Orr, J., & Dewar, B. (2019). Visual inquiry: A method for exploring the emotional, cognitive and experiential worlds in practice development, research and education. *International Practice Development Journal*, *9*(1), Article 6.
<https://doi.org/10.19043/ipdj.91.006>
- Rollnik-Sadowska, E., & Grabińska, V. (2024). Managing neurodiversity in workplaces: A review and future research agenda for sustainable human resource management. *Sustainability*, *16*(15), 6594.
<https://doi.org/10.3390/su16156594>
- Rosqvist, H., Chown, N., & Stenning, A. (2020). *Neurodiversity studies: a new critical paradigm*. Routledge Press.
- Rowe, K. J., Bailey, S., Teague, B., Mattless, K., & Notley, C. (2021). A phenomenological inquiry into the lived experience of adults diagnosed with attention deficit hyperactivity disorder (ADHD) employed by the NHS. *Mental Health and Social Inclusion*, *25*(2), 159-170. <https://doi.org/10.1108/MHSI-11-2020-0075>
- Rowney-Smith, A., Sutton, B., Quadt, L., & Eccles, J. A. (2024). The lived experience of rejection sensitivity in ADHD - A qualitative exploration. *medRxiv*.
<https://doi.org/10.1101/2024.11.16.24317418>
- Royal College of Speech and Language Therapists. (2024). *Support for neurodivergent SLTs*. Royal College of Speech and Language Therapists.
<https://www.rcslt.org/learning/equity-diversity-and-belonging/neurodivergence-in-the-workplace/support-for-neurodivergent-slts/>
- Ruiz Callejo, D. & Boets, B. (2023). A systematic review on speech-in-noise perception in autism. *Neurosci Biobehav Rev*, *154*, 105406.
<https://doi.org/10.1016/j.neubiorev.2023.105406>
- Ruud, M. (2018). Cultural humility in the care of individuals who are lesbian, gay, bisexual, transgender, or queer. *Nursing for Women's Health*, *22*(3), 255-263.
<https://doi.org/10.1016/j.nwh.2018.03.009>

- Ryan, L., Beer, H., Thomson, E., Philcox, E., & Kelly, C. (2023). Autistic traits correlate with chronic musculoskeletal pain: A self-selected population-based survey. *OBM Neurobiology*, *7*(1), 1-21.
<https://doi.org/10.21926/obm.neurobiol.2301155>
- Sainsbury, C. (2000). *Martian in the playground: Understanding the school experiences of children with Asperger Syndrome*. London: Sage Publications.
- Sánchez-Morán, M., Hernández, J. A., Duñabeitia, J. A., Estévez, A., Bárcena, L., González-Lahera, A., Bajo, M. T., Fuentes, L. J., Aransay, A. M., & Carreiras, M. (2018). Genetic association study of dyslexia and ADHD candidate genes in a Spanish cohort: Implications of comorbid samples. *PloS one*, *13*(10), e0206431. <https://doi.org/10.1371/journal.pone.0206431>
- Secules, S., McCall, C., Mejia, J.A., Beebe, C., Masters, A.S., Sánchez-Peña, M.L., & Svyantec, M. (2021). Positionality practices and dimensions of impact on equity research: A collaborative inquiry and call to the community. *Journal of Engineering Education*, *110*, 19-43. <https://doi.org/10.1002/jee.20377>
- Sedgwick, J. A., Merwood, A., & Asherson, P. (2019). The positive aspects of attention deficit hyperactivity disorder: a qualitative investigation of successful adults with ADHD. *Atten Defic Hyperact Disord*, *11*(3), 241-253.
<https://doi.org/10.1007/s12402-018-0277-6>
- Segal, O., Bronshtein, K., & Weinbach, N. (2025). The benefits of radical acceptance of reality as a standalone strategy for emotion regulation. *Current Psychology*, *44*, 1780-1792. <https://doi.org/10.1007/s12144-025-07286-0>
- Shaw, S. C. K., Carravallah, L., Johnson, M., O'Sullivan, J., Chown, N., Neilson, S., & Doherty, M. (2024). Barriers to healthcare and a 'triple empathy problem' may lead to adverse outcomes for autistic adults: A qualitative study. *Autism*, *28*(7), 1746-1757. <https://doi.org/10.1177/13623613231205629>
- Shaw, S. C. K., Doherty, M., & Anderson, J. L. (2023). The experiences of autistic medical students: a phenomenological study. *Medical Education*, *57*(10), 971-979. <https://doi.org/10.1111/MEDU.15119>
- Shaw, S. C. K., Fossi, A., Carravallah, L. A., Rabenstein, K., Ross, W., & Doherty, M. (2023). The experiences of autistic doctors: a cross-sectional study. *Frontiers in Psychiatry*, *14*. <https://doi.org/10.3389/fpsy.2023.1160994>

- Shore L. M., Randel A. E., Chung B. G., Dean M. A., Holcombe Ehrhart K., Singh G. (2011). Inclusion and diversity in work groups: A review and model for future research. *Journal of Management*, 37(4), 1262-1289. <https://doi.org/10.1177/0149206310385943>
- Shore, S. (2018, March 23). *Interview with Dr. Stephen Shore: Autism advocate & on the spectrum*. IBCCES. [https://ibcces.org/blog/2018/03/23/12748/\[1\]\(https://ibcces.org/blog/2018/03/23/12748/\)](https://ibcces.org/blog/2018/03/23/12748/[1](https://ibcces.org/blog/2018/03/23/12748/))
- Sidhu, R., Su, B., Shapiro, K., & Stoll, K. (2020). Prevalence of and factors associated with burnout in midwifery: A scoping review. *European Journal of Midwifery*, 4, 4. <https://doi.org/10.18332/ejm/115983>
- Silberman, C. (2015). Review of the book *NeuroTribes: the legacy of autism and the future of neurodiversity*, by Steve Silberman. *Anthropological Quarterly*, 88(4), 1111-1121. <https://doi.org/10.1353/anq.2015.0057>
- Simpson, H. (2021). Forming strong cultural identities in an intersecting space of indigeneity and autism in Canada, the United States, Australia, and New Zealand. *AlterNative*, 17(3), 416-424. <https://doi.org/10.1177/11771801211039274>
- Singer, J. (2002). 'Why can't you be normal for once in your life?' From a 'problem with no name' to the emergence of a new category of difference. In M. Corker & S. French (Eds.), *Disability discourse*, (pp. 59-67). Open University Press.
- Stajduhar, K., Balneaves, L., & Thorne, S. (2001). A case for the "middle ground": Exploring the tensions of postmodern thought in nursing. *Nursing Philosophy*, 2, 72-82.
- Szechy, K. A., Turk, P. D., & O'Donnell, L. A. (2024). Autism and employment challenges: The double empathy problem and perceptions of an autistic employee in the workplace. *Autism in Adulthood*, 6(2), 205-217. <https://doi.org/10.1089/aut.2023.0046>
- Taylor, J. (2021). Working memory and academic writing challenges in neurodivergent students. In A. J. Wallbank (Ed.), *Academic writing and neurodiversity: Pedagogies for inclusion* [PowerPoint slides]. University College London. https://mediacentral.ucl.ac.uk/assoc_files/C8H0iF24.pdf

- Taylor, A. R., Miller, S., & Davies, L. (2024). Neurodivergence among healthcare professionals and implications for midwifery: A literature review. *New Zealand College of Midwives Journal*, 6. <https://www.midwife.org.nz/wp-content/uploads/2024/08/2024-Article-6-neurodivergence-246006.pdf>
- Te Ara o Hine Tapu Ora. (2023). *Programme overview and support framework*. [Organisation publication]
- Te Kāhui Tika Tangata | Human Rights Commission. (n.d.). *Human rights and Te Tiriti o Waitangi*. <https://www.tikatangata.org.nz/humanrights-in-aotearoa/human-rights-and-te-tiriti-o-waitangi>
- Te kāreti o ngā kaiwhakawhanau ki Aotearoa | New Zealand College of Midwives. (2018). *Midwives' handbook for practice* (6th Ed). New Zealand College of Midwives.
- Te Kāwangatanga o Aotearoa | New Zealand Government. (1987). *Employment Relations Act 2000*. <https://www.legislation.govt.nz/act/public/2000/0024/latest/DLM58317.html>
- Te Kāwangatanga o Aotearoa | New Zealand Government. (1993). *Human Rights Act 1993*. <https://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html>
- Te Kāwangatanga o Aotearoa | New Zealand Government. (2003). *Health Practitioners Competence Assurance Act 2003*. <https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>[1](
<https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>)
- Te Kāwangatanga o Aotearoa | New Zealand Government. (2024). *Midwifery scope of practice and qualifications notice 2024*. <https://www.gazette.govt.nz/notice/id/2024-gs1575>
- Te Manatū Whakahiato Ora | Ministry of Social Development. (n.d.). *Accessible document formats*. <https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/accessibility/accessibility-guide/document-formats.html>
- Te Tari Mō Ngā Take Haunātanga | Office for Disability Issues. (2016). *New Zealand disability strategy 2016-2026*. Whaikaha - Ministry of Disabled People.

<https://www.whaikaha.govt.nz/assets/About-us/Disability-Strategy/pdf-nz-disability-strategy-2016.pdf>

Te Tatau o te Whare Kahu | Midwifery Council of New Zealand. (2022). *2022 Midwifery Workforce Survey and Non-Practising Survey*.

<https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Workforce%20surveys/Midwifery%20Workforce%20Survey%202022.pdf>

Te Tatau o te Whare Kahu | Midwifery Council of New Zealand. (2023). *2023*

Midwifery workforce survey and non-practising survey. <https://midwiferycouncil.health.nz/>

Te Tatau o te Whare Kahu | Midwifery Council of New Zealand. (2024). *Scope of Practice*.

<https://www.midwiferycouncil.health.nz/common/Uploaded%20files/SCOPE%201%20March%202024.pdf>

Te Tatau o te Whare Kahu | Midwifery Council of New Zealand. (n.d.) *Ngā Paerewa mātau ā-haumanu, ā-ahurea me ngā whanonga | Standards of clinical & cultural competence & conduct*.

<https://midwiferycouncil.health.nz/Public/Public/06.-I-am-a-registered-midwife/1.-Standards-of-Clinical---Cultural%20Competence---Conduct.aspx>

Te Tatau o te Whare Kahu | Midwifery Council of New Zealand. (n.d.) *Ngā Paerewa mātau ā-haumanu, ā-ahurea me ngā whanonga | Standards of clinical & cultural competence & conduct*.

<https://midwiferycouncil.health.nz/Public/Public/06.-I-am-a-registered-midwife/1.-Standards-of-Clinical---Cultural%20Competence---Conduct.aspx>

Te Whatu Ora | Health New Zealand. (2023). *Health Workforce Plan 2023/24*.

<https://www.tewhatauora.govt.nz/publications/health-workforceplan-202324>

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117-125. <https://doi.org/10.1353/hpu.2010.0233>

The Neurobirth Podcast. (2023). <https://neurobirthpodcast.wordpress.com/>

The Noun Project. (n.d.). *The Noun Project*. <https://thenounproject.com/>

- Toal, F., Daly, E. M., Page, L., Deeley, Q., Hallahan, B., Bloemen, O., Cutter, W. J., Brammer, M. J., Curran, S., Robertson, D., Murphy, C., Murphy, K. C., & Murphy, D. G. M. (2009). Clinical and anatomical heterogeneity in autistic spectrum disorder: a structural MRI study. *Psychological Medicine*, *40*(7), 1171-1181. <https://doi.org/10.1017/s0033291709991541>
- Todd, R. (2011). *Working with dyspraxia: A hidden asset dyspraxia foundation guide for employers*. Dyspraxia Foundation.
https://ascpractice.camden.gov.uk/media/2949/employer_guide_to_dyspraxia_10.pdf
- Tupara, H., & Tahere, M. (2020). *Rapua te aronga-a-hine: The Māori midwifery workforce in Aotearoa, A literature review*. Wellington, NZ: Te Rau Ora.
- Twenty To Nine, LLC. (2020). *Delve's privacy policy*. Delve.
<https://delvetool.com/privacy-policy-2020>
- UMass Office of the President. (n.d.). *Neurodivergence*.
<https://www.umassp.edu/inclusive-by-design/who-before-how/understanding-disabilities/neurodivergence>
- United Nations Convention on the Rights of Persons with Disabilities. (2006). *Convention on the Rights of Persons with Disabilities*.
<https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>
- United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf
- Urbanowicz, A., Nicolaidis, C., den Houting, J., Shore, S. M., Gaudion, K., Girdler, S., & Savarese, R. J. (2019). An expert discussion on strengths-based approaches in autism. *Autism in Adulthood*, *1*(2), 82-89.
<https://doi.org/10.1089/AUT.2019.29002.AJU>
- van der Harr, D., & Hosking, D. (2004). Evaluating appreciative inquiry: a relational constructionist perspective. *Human Relations*, *57*(8), 1017-1036.
- Vonk, J. (2021). Bottom-up processing. In *Encyclopedia of Animal Cognition and Behavior*, (pp. 1-5). Springer International Publishing.
https://doi.org/10.1007/978-3-319-47829-6_1279-1

- Walker, E., Shaw, S. C. K., Reed, M., & Anderson, J. L. (2021). The experiences of foundation doctors with dyspraxia: a phenomenological study. *Advances in Health Sciences Education, 26*(3), 959-974. <https://doi.org/10.1007/s10459-021-10029-y>
- Walker, N. (2021). *Neuroqueer heresies: Notes on the neurodiversity paradigm, autistic empowerment, and postnormal possibilities*. Autonomous Press.
- Weber, C., Krieger, B., Häne, E., Yarker, J., & McDowall, A. (2022). Physical workplace adjustments to support neurodivergent workers: *A systematic review*. *Applied Psychology, 73*(3), 910-962. <https://doi.org/10.1111/apps.12431>
- Wehman, P., Brooke, V., Brooke, A. M., Ham, W., Schall, C., McDonough, J., Lau, S., Seward, H., & Avellone. (2016). Employment for adults with autism spectrum disorders: a retrospective review of a customized employment approach. *Research in Developmental Disabilities, 53-54*, 61-72. <https://doi.org/10.1016/j.ridd.2016.01.015>
- White, H. A., & Shah, P. (2005). Uninhibited imaginations: creativity in adults with attention-deficit/hyperactivity disorder. *Personality and Individual Differences, 40*(6), 1121-31. <https://doi.org/10.1016/j.paid.2005.11.007>.
- Williams, E. L., & Casanova, M. F. (2010). Autism and dyslexia: a spectrum of cognitive styles as defined by minicolumnar morphometry. *Medical hypotheses, 74*(1), 59-62. <https://doi.org/10.1016/j.mehy.2009.08.003>
- Windsong, E. A. (2018). Incorporating intersectionality into research design: An example using qualitative interviews. *International Journal of Social Research Methodology, 21*(2), 135-147. <https://doi.org/10.1080/13645579.2016.1268361>
- Yergeau, L. (2018). *Authoring autism: on rhetoric and neurological queerness*. Duke University Press.
- Young, S., Adamo, N., Asgeirsdottir, B., Branney, P., Beckett, M., Colley, W., Cubbin, S., Deeley, Q., Farrag, E., Gudjonsson, G., Hill, P., Hollingdale, J., Kilic, O., Lloyd, T., Mason, P., Paliokosta, E., Perecherla, S., Sedgwick, J., Skirrow, C., ... Woodhouse, E. (2020). Females with ADHD: an expert consensus statement taking a lifespan approach providing guidance for the

identification and treatment of attention-deficit/hyperactivity disorder in girls and women. *BMC Psychiatry*, *20*, 404.

Zazove, P., Case, B., Moreland, C., Plegue, M. A., Hoekstra, A., Ouellette, A., Sen, A., & Fetters, M. D. (2016). US medical schools' compliance with the Americans with disabilities act: Findings from a national study. *Academic Medicine*, *91*(7), 979-986. <https://doi.org/10.1097/ACM.0000000000001087>

Zelazo, P. D., & Carlson, S. M. (2020). The neurodevelopment of executive function skills: Implications for academic achievement gaps. *Psychology & Neuroscience*, *13*(3), 273-298. <https://doi.org/10.1037/pne0000208>

Zhu, X., Need, A. C., Petrovski, S., & Goldstein, D. B. (2014). One gene, many neuropsychiatric disorders: lessons from Mendelian diseases. *Nature neuroscience*, *17*(6), 773-781. <https://doi.org/10.1038/nn.3713>

Zigon, J., & Throop, C. J. (2021). Ethics as grammar: Changing ethical perspectives in the anthropological study of morality. In R. D. Fassin (Ed.), *A Companion to Moral Anthropology* (pp. 45-62). Wiley-Blackwell.

Appendices

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Appendix Two: Ethics Approval Letter



Category B Ethics Approval Letter

Date: 15 August 2024

Address: Private Bag 1901, Dunedin 9054

Kia ora Amy Taylor

Re: Application for Ethics Consent

Reference Number: 011

Title of Application: The experiences of neurodivergent midwives in Aotearoa, New Zealand: An appreciative inquiry

Thank you for your application for ethics approval for this project.

The review panel has considered your revised application including response to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm ethical approval for the project.

Many thanks for your careful responses to our recommendations.

We wish you well with your work and remind you that at the conclusion of your research you should send a brief report with findings and /or conclusions to the Midwifery Research and Ethics Committee.

All correspondence regarding this application should include the reference number assigned.

Best wishes with your research, we know it will make an important contribution to your community.

Ngā mihi nui,

Annabel Farry,

Chair Ethics Committee

School of Midwifery

School of Midwifery

Private Bag 1910
Dunedin 9054

Freephone 0800 762 786
Phone +64 3 477 3014
Fax +64 3 474 8486

info@otago.ac.nz
www.otagonpolytechnic.ac.nz

Appendix Three: Kaitohutohu Office Approval

Thursday, June 20, 2024 at 14:30:10 New Zealand Standard Time

Subject: RE: KTO Consultation - Amy Taylor
Date: Wednesday, 19 June 2024 at 4:50:55 PM New Zealand Standard Time
From: [Redacted]
To: Amy Taylor

Perfect, thank you.


Please take this e-mail as confirmation that your submission has been reviewed and consultation is now complete.
If you do want to discuss anything further or would like any additional support, please do feel free to reach out again.

You can contact me directly via e-mail and include the [Redacted] email address.

Best wishes with your research!

Ngā Mihi,
[Redacted]

Otago Polytechnic | Te Pukenga



Kaiāwhina Rakāhau
Office of Kaitohutohu | Otago Polytechnic
Otago Polytechnic | Te Kura Matatini ki Otago
Forth Street, Private Bag 1910, Dunedin 9054, New Zealand
P +64 0800 762 786 | Email
www.op.ac.nz

From: I
Sent: Wednesday, June 19, 2024 4:30:52 PM
To: Amy Taylor
Subject: RE: KTO Consultation - Amy Taylor

Kia ora Amy,

Thank you for getting back to me promptly.
Not yet, are you please able to advise if there are any additional points that you believe might

1 of

methodological adaption.

- You will approach several organisations using e-mails initially and a will organise a hui with Ngā Maia to engage in an open dialogue. This is to ensure whakawhanaungatanga.
- 4 day online asynchronous text-based focus groups will also be utilised (Online discord forum)
- Social media will also be used to recruit potential participants.

Participants will also have the ability to review and ammend transcripts.


The only suggestion that I would have is that if the research should move to include any demographic data that the option to include lwi or hapū might be considered.

Findings will be analysed using Thematic Analysis and shared with participants on the discord forum.
Kupu Māori will be woven throughout the material to actively include Māori participants.

I hope I have captured the main points from this discussion.

Ngā Mihi,
[Redacted]

Otago Polytechnic | Te Pukenga



Kaiāwhina Rakāhau
Office of Kaitohutohu | Otago Polytechnic

Appendix Four: Recruitment Poster

Are you a neurodivergent (ND) midwife practising in Aotearoa, NZ?

Would you like to participate in new research looking into the experiences of ND midwives?

Kia ora Koutou



My name is Amy Taylor (they/them; tangata tiriti). I am AuADHD and dyslexic. I worked as an LMC midwife for four years in Te Awakairangi, Lower Hutt. This research is being conducted as part of my Master of Midwifery at Otago Polytechnic.

Contact



Have pātai/questions?

Keen to participate?

Want to request a Participant Information Sheet?

Contact Amy directly at:

This Research Aims to:



1. Increase visibility and highlight the strengths of ND midwives.
2. Co-create a guidance document to help ND midwives thrive in their workplace environments.

What does participation involve:



- A one-to-one interview, and
- A structured online focus group.

A Neuro-affirming approach to research:

Created by disabled academics, this research will utilise Person-Orientated Research Ethics; each participants' access needs, including communication, executive functioning and sensory accommodations will be woven throughout the study design.


Easy to Read Formats:




Participant Information Sheet and Consent Forms have been created in an easy to read, accessible format with supporting visuals.

Appendix Five: Participant Information Sheet

Participant Information Sheet

 **Research Title:**
The experiences of neurodivergent (ND) midwives in Aotearoa New Zealand: An appreciative inquiry.

 **Kia ora,**
My name is Amy Taylor (they/them) and I am an AuADHD, dyslexic midwife recruiting participants for Master of Midwifery research.

 **Research Objective:**

- To increase the visibility of ND midwives in Aotearoa New Zealand and highlight what strengths they bring to the profession.
- To co-create a guidance document containing strategies for workplaces that can optimise workplace experiences for ND midwives.

1

If you...


- Identify as neurodivergent*, whether clinically diagnosed or self-identified.
- Are practicing midwifery in Aotearoa New Zealand.
- Are available to participate in both Phase 1 and 2 of the data collection (more information below) and are interested in participating, I would love to hear from you.

★ Neurodivergence is an umbrella term; this includes (but is not exclusive to) autism, ADHD, Dyslexia, Dyspraxia, Tourette's, chronic mental health conditions such as bipolar disorder, obsessive-compulsive disorder, and acquired brain conditions such as multiple sclerosis and traumatic brain injuries.

2

What would be required of me if I take part in this research?

Phase 1: semi-structured, one-to-one interview



Created by Shutterstock
from Adobe Photoshop


Affirmative questioning will invite you to describe what you value about being an ND midwife and what strengths you feel you bring to our profession.

Accessibility Considerations:

- You can choose whether you'd like an online interview, or to be in-person with me, although this might depend on where you are located.
- You have the option to sit and chat, or be on the move for your interview, depending on whether it is kōwhiri ki te kōwhiri (face to face) or online.
- The interview length will depend on your specific access needs and chosen communication method, but will likely take around an hour of your time.
- The interview questions will be sent to you in advance of our scheduled conversation.
- Visual tools will be available to assist you as necessary to identify and describe your emotions.

3

Phase 1: semi-structured, one-to-one interview continued...



Created by Shutterstock
from Adobe Photoshop

Accessibility considerations:

- Your stimming/fidget items are welcome and encouraged.
- You are welcome to have/bring a support person with you.
- You will be invited to communicate any additional after thoughts via email, text or phone call after the interview has taken place.

4

What would be required of me if I take part in this research?

Phase 2: online focus group



Copyright © 2020
New North Project

An online focus group that doesn't happen in real-time, which means you can engage in writing online posts when you are available to respond to the questions posed. Presenting the identified themes from the interview phase, the focus group will explore strategies to enhance the experiences of ND midwives.

Accessibility Considerations:

- The online event will take place over 4 consecutive 24-hour days; enabling you to engage at times that best suit you.
- You will be offered individual assistance from the researcher on getting set-up and familiar with focus-group platform; visual tools will be provided to also assist with this.
- 1 week in advance of the focus-group, you will be sent a list of the topic discussions, the expected focus group size and a sample screenshot of the central discussion board.

5

Phase 2: online focus group continued...



Copyright © 2020
New North Project

Accessibility considerations:

- To reduce your executive functioning load: a daily email will be sent out containing the access link, a summary of recent discussions and a question to prompt further thinking.
- Once the four-day event has finished, you will be invited to communicate any additional after thoughts via email, text or phone call.

6

Your Data, Your Mana

Participants in this research are co-creators of the research findings. You get to decide how visible you want to be!



- You can opt to use your real name or choose a pseudonym.
- Your interview will be audio-recorded and transcribed word-for-word; the transcript will be sent to you to ensure you agree it reflects the conversation we had. If you want to make changes to the transcript to clarify anything you said, or remove anything you said, you may do so, and return the transcript to me. If I do not hear from you after two weeks from when I send it to you, I will assume that you are happy for your transcript (as sent) to be included in the data analysis.
- Your data will be securely stored so that only the researcher and research supervisors can access it. Audio-recordings will be deleted once the final thesis is submitted. The digital data (transcripts) will be password protected and any hard copy information (e.g. signed consent forms) will be stored in a locked cupboard. At the end of the project any personal information or any raw data on which the results are based will be destroyed.

7

What if I change my mind?




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New North Project

You can decline to participate without any disadvantage to yourself.

- If you choose to participate, you can stop participating in the project at any time, without having to give a reason.
- You can also withdraw any information already supplied until the stage agreed on the consent form.
- You can decline to answer any question and ask for the recorder/audio to be turned off at any stage.

8

How to contact me...



Content by Accessibility
with Screen Readers

Ngā mihi nui for considering participating in this research.
If you have an pātai/questions please contact me at

Your communication access needs are important and I can accommodate your preferences.
Please let me know what they are, for example: phone, email, instant messaging, video-call.

The primary supervisor for this research is Dr Suzanne Miller who may be contacted at

9

This project has been reviewed and approved by:

Otago Polytechnic
Research Ethics Committee




10

Appendix Six: Phase 1 Participant Consent Form

Consent to Participate in a Research Project

Title of Project:
The experiences of neurodivergent midwives:
An appreciative inquiry.




Created by Mutuallam
from Noun Project

Phase 1: One-to-one Interview

1

Declaration




Created by Vior
from Noun Project

- I have read the Participant Information Sheet concerning this project and understand what it is about.
- All my questions have been answered to my satisfaction.
- I understand that I am free to request further information at any stage.
- I agree to take part in a one-to-one interview

2

I Understand that...




Created by Daisy
from Noun Project

- My participation is voluntary.
- I am free to decline to answer any questions.
- I am free to stop participating at any time.
- I agree that the interview will be audio-recorded.
- I can choose to withdraw information without giving reasons and without any disadvantage.
- I will be able to review my interview transcript and make changes.
- I cannot withdraw any information I have supplied once data analysis commences.
- The audio-recording will be deleted when the final thesis is submitted.
- Any raw data on which the results of the project depend will be retained in secure storage for seven years after which it will be destroyed.

3

Tell me what you would like...



Created by Haroon
from Noun Project

Place a tick in the boxes that match your preferences:

I prefer to use my own first name.

I prefer to use this pseudonym (write here): _____

I would prefer my one-to-one interview:

- In person
- Video-call
- Phone-call
- Instant-messaging
- Email

Would you like any of the following:

- A walking/go-along interview
- A support person

Do you need any additional sensory, communication or cognitive accommodations?
Please write anything else you can think of here:

4

Tell me about yourself....

There is no obligation for you to fill-in this demographic information; if you choose not too, you can still participate in this study.

Ethnicity: _____ Iwi/hapū affiliations: _____

Pronouns: _____ Years in midwifery practice: _____

ND identity/diagnosis: _____ Age at ND identification/diagnosis: _____

Years since ND identification/diagnosis: _____ What is your current midwifery role: _____

Please tick if you would like to receive a copy of the research findings.

5

I agree to take part in the one-to-one interview under the conditions set out in this consent form



Created by corpus delicti from Noun Project

Your name and signature:

Date: _____

Researcher name and signature: _____


Date: _____

6

Appendix Seven: Phase 2 Participant Consent Form

Consent to Participate in a Research Project

Title of Project:
The experiences of neurodivergent midwives:
An appreciative inquiry.




Created by Daisy from Neuron Project

Phase 2: Asynchronous Online Focus Group

1

Declaration




Created by Vitor from Neuron Project

- I have read the Participant Information Sheet concerning this project and understand what it is about.
- All my questions have been answered to my satisfaction.
- I understand that I am free to request further information at any stage.
- I agree to take part in the online focus group.

2

I Understand that...




Created by Daisy from Neuron Project

- My participation is voluntary.
- I am free to decline to answer any questions.
- I can choose to withdraw from the focus group at any time without needing to explain why. Information I have already provided will not be able to be withdrawn as it will be part of the discussion with other participants.
- The focus group discussions will be transcribed word-for-word.
- After the focus group timeline is complete, the online forum will be deleted.
- Any raw data on which the results of the project depend will be retained in secure storage for seven years after which it will be destroyed.

3

Confidentiality



- I will carry out the tasks assigned to me in this project mindful of the confidential nature of the research
- I will keep confidential all information provided to me and will not disclose it to any third party except people involved in this research project
- I will not make or retain any copies and/or records of the data other than what is required for the research

4


Is there anything else you need to fully participate?

Do you need any additional executive function,ing communication or cognitive accomodations?

Please write anything you can think of below:

5

I agree to take part in the focus group under the conditions set out in this consent form



Created by iStockphoto
From Newer Project

Your name and signature:

Date: _____


Researcher & moderator name and signature:


Amy Taylor

Date: 06/02/2023 _____

6

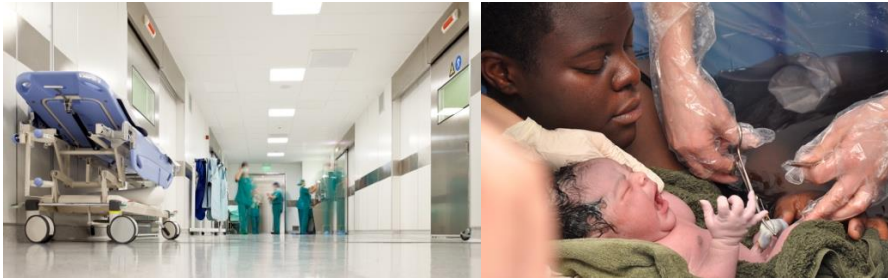
This project has been reviewed and approved by:

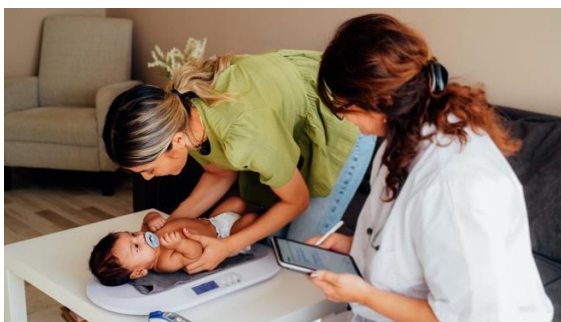




7

Appendix Eight: Photo Elicitation Resources





All images licensed from [www. https://istockphoto.com](https://istockphoto.com)

Appendix Nine: Interview Questions

Interview Questions

Topic 1 - Neurodivergence & You

1. What does being neurodivergent (ND) mean to you?
2. What does being a ND midwife mean to you?
3. Without being modest, what do you value most about yourself as an ND midwife? What strengths do you feel you bring to the profession as an ND midwife?
4. What is it you do now and what most attracted you to your present midwifery work that you find meaningful, valuable, challenging, or exciting?

Topic 2 - Discovering what is.....

Think back over your midwifery career, and all the mahi (work) you have done:

1. Can you describe a high-point experience from your perspective as a ND midwife? A time when you felt professionally alive, and engaged; when you experienced yourself as successful, satisfied, engaged, and excited about your ND midwifery self?
2. Can you describe a conversation with colleagues that has felt neuro-affirming? An experience where colleagues have supported you and accommodated your communication needs?
3. Can you describe a working environment that has most supported your sensory needs?

★ If you can't think of real life examples, we can explore your hypothetical ideal!

1

Interview questions

Topic 3 - Imagining what could be.....

1. Imagine you have awakened from a long, deep sleep. It is the year 2030. You resume working. Midwifery in Aotearoa New Zealand has become an international exemplar of neuro-inclusion.
2. In 2030 you are more successful and satisfied as an ND midwife than you have ever been. Your ideal has become a reality.
3. If you were in charge, what changes or improvements would you make to foster workplace equity and inclusion for ND midwives? What big or small changes would you implement and why?

Pātai (Question) Prompts

I may use these prompts to explore the pātai (questions) from topics 1, 2, and 3:

- What is happening? Where are you? What do you feel/see/hear?
- What makes the experience or change so positive and ND affirming?
- What are you doing? What did you do to contribute?
- What are your colleagues doing? What are others doing to contribute?
- What is the wider midwifery profession doing to contribute?
- What is different? What has changed?
- What did it take to achieve this change? What types of supports have enabled this experience or change?
- Were there any other conditions that contributed to this experience or change?

2

What is Appreciative Inquiry?



To 'Appreciate', means "...to value or admire highly; to judge with heightened understanding to recognise with gratitude."


To 'inquire', means "...to search into, investigate, to seek for information by questioning."

I have chosen the research methodology of Appreciative Inquiry as an intentional way to generate positive, strengths-based data about ND midwives in Aotearoa; data that can be used to challenge pervasive stereotypes, neuro-normative assumptions and deficit discourses. Appreciative Inquiry aims to evoke systemic and structural change and has been successfully adapted for use in research, business and public services. If you want to know more about Appreciative Inquiry, check out this video.

Many times, in interviews, researchers ask questions about things that aren't working well, the problems, so that we can fix them. During our time together we are going to approach things from a different angle. Through what is known as an 'Appreciative Interview', we are going to explore your experiences of success, satisfaction, and celebration as a neurodivergent midwife. Our aim is to discover the positive core of these affirming experiences so that we can then find ways to create more of them, for you and for ND midwives in the future.

3

Taking Care of Yourself



Support Options & Actions

As the interviewer for this research, I have recently completed a mental health first aid course through Colubrate. Whilst the intention of affirmative questioning is to create mana-enhancing data that celebrates your strengths as an ND midwife, we do not ignore any negative experiences you may have had. During our interview you may end up describing challenging or even distressing workplace situations.

Please consider the following before and/or after your interview:

- Identify your personal support options; what does this look like for you; what do you do to fill your cup?
- Consider a debrief with your support people, colleagues and/or whānau.
- Seek support from your GP, counsellor, therapist or psychologist.
- Need to talk to someone? Free call or text 1737. Open 24/7.
- You may be eligible for free counselling through an Employee Assistance Program (EAP). EAP is available to employees of Te Whānau Ora; self-employed midwives can apply for EAP through NZCOM in limited circumstances.
- See attached PDF for more national helplines and local mental health services near you.

4

Appendix Ten: Participant Instructions for Discord App Set-Up

Focus Group Preparation



The asynchronous online focus group will start from: **07:00 hours on Thursday the 6th of March and finish at 19:00 hours on Sunday the 9th of March.**

You can contribute to the focus group at times that suit you; I encourage you to access and engage with the group conversations multiple times and across the 4-day period. I will send a daily email with a summary of the conversations in the last 24-hours and some prompts to invite further discussion.

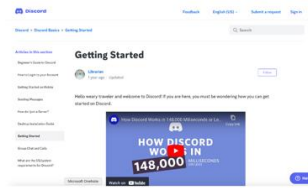


I will need your focus group consent form signed prior to you gaining access to the server.

Here are some written instructions (with supporting visuals) on how to get set-up and ready. If you would prefer to have real-time support from me via a phone or video call, then please let me know. If I don't hear from you then I will assume that you don't need help!



Step 1
We will be using an online platform known as Discord. You will need to create your own Discord account. This is all free and your account can be deleted afterwards if you wish. Click on this [link](#). It will take you to a webpage that looks like this:



Scroll down the webpage until you see the heading 'Create Your Account' and select the link 'the Discord registration page':

Create Your Account

You can create your account on the Discord registration page, or in the app.



Follow the instructions to register, remembering to verify your account via email or phone. When generating a username please consider if you want to be anonymous to the group and choose accordingly. It is encouraged that you choose a thumbnail image to be associated with your account; this is a useful visual for the other participants. You can

1

2

upload a photograph of your face, or a non-identifying image/avatar that you like.



Step 2
Next choose how you want to access Discord. You can use a web browser and/or download the app onto your computer, tablet or phone (note: you can choose multiple options). If you are using a web browser then just save the webpage link, plus your username/password. You can download the Discord app for free on [desktop](#), [here](#), or through the [Google Play store](#) or [Apple App Store](#) on mobile and tablets.



Step 3
One week prior to the start date I will send out an email containing the following information:

- An invitation link to the focus group server on Discord. This link will remain active until the focus group is finished.
- Five candidate themes created from the one-to-one interviews.
- The focus group discussion prompts and questions I have for you regarding potential workplace accommodations.

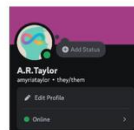
You will have access to the focus group server upon selecting and accepting the invitation link. The server will be locked from receiving contributions until the focus group begins.

Discord User Tips

The name of our focus group server is 'Neurodivergent Midwifery Aotearoa' and the thumbnail looks like this:



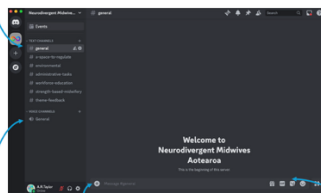
The server is private. I will be your moderator, and this is my Discord username and thumbnail:



3

This is what the focus group server page looks like:

- On the left of the above screenshot below, you will see a **number of 'text channels'**.
- The 'general' channel will be for you to ask general troubleshooting questions. As the group moderator, I will also post updates here and if you wish, you can also introduce yourself.
- The remaining text channels will be devoted to discussing some key accommodation areas identified from the one-to-one interviews.



Press this + symbol to contribute to a channel. You can type a message or even upload a file or image if you want to. Feel free to also add in GIFs, Stickers or Emojis.

At 11:00 - 12:00 hours and 19:00 - 20:00 hours each day I will have the voice channel enabled. This is a great option if you would prefer to speak your thoughts to myself and whomever else wants to join. These sessions will not be recorded, but I will make written notes.

All screen shoots above were sourced from "Computer Hope, Getting into Windows Safe Mode. September 28, 2024, from <https://www.computerhope.com/issues/chsafe.htm>

Appendix Eleven: Guidance for Creating Neuro-affirming Midwifery Workplaces.

Background

As societal awareness of neurodivergence increases, and diagnostic pathways become more accurate, health professionals, including kahu pōkai (midwives) are among those who are seeking and receiving diagnoses. Taylor et al. (2024) highlighted the need for neuro-affirming workplace accommodations and inclusive social conditions to enable neurodivergent (ND) health care workers to thrive in their work contexts. This Guidance Document has been created to assist workplaces to provide neuro-affirming environments to support midwifery practice sustainability objectives. This Guidance was developed collaboratively by neurodivergent midwives and researchers and is underpinned by established scholarship within the neurodiversity movement.

The Neurodiversity Movement

Neurodiversity Studies is a critical field that challenges norms around cognitive functioning and embraces neurodivergence as part of human diversity (Yergeau, 2018). Rooted in the human rights model of disability, it reframes disability as a product of societal barriers rather than individual deficits (Rosqvist et al., 2020), prioritising autonomy, inclusion, and self-identification—regardless of formal diagnosis (Kapp et al., 2013; Elsherif et al., 2022; Walker, 2021).

In Aotearoa New Zealand, neurodivergent conditions are legally recognised as disabilities under the Human Rights Act (Te Kāwangatanga o Aotearoa | New Zealand Government, 1993), though identifying as disabled remains a personal choice (Accardo et al., 2024). This document adopts a broad neurodiversity framework, accepting overlapping neurodevelopmental traits rather than focusing on single diagnoses, which reflects the complexity and intersectionality of lived experience (Doyle, 2020).

Reasonable Accommodations

Enabling Good Lives Principles

Building an ND-affirming career in midwifery and the health professions begins with a foundation of disability-affirming values. The Enabling Good Lives (EGL) principles, developed in 2011 by New Zealand's disability community, offer a values-based framework to guide how the midwifery profession can approach requests for reasonable accommodations. EGL centres the person—their strengths, aspirations, and needs—and promotes principles such as tino rangatiratanga | self-determination and whanaungatanga | relationship building.

By embedding EGL principles into everyday practice, organisations can foster environments that are inclusive, empowering, and responsive to the diverse realities of neurodivergent (ND) individuals, including kahu pōkai. For more information on EGL and its application, visit www.enablinggoodlives.co.nz.

Key Values:

In addition to EGL, the following principles are essential:

1. **Diagnosis is not required for support**
Neurodivergent individuals are legally entitled to accommodations regardless of formal diagnosis. Given the barriers to accessing diagnostic services, self-identification must be recognised as both valid and equitable.
2. **Start with universal design**
When an ND kahu pōkai requests an adjustment, consider whether it could benefit others. Universal design reduces stigma and enhances collective wellbeing.
3. **Neurodivergence is not monolithic**
Neurodivergent individuals bring diverse strengths, challenges, and preferences. Avoid assumptions and acknowledge that capacity is dynamic, shifting with time and context.
4. **Curious enquiry builds trust**
A stance of open, respectful curiosity creates space for individuals to express what works for them. This affirms autonomy and supports collaborative problem-solving.

The following sections offer illustrative—but not exhaustive—examples of reasonable accommodations that are relevant to ND kahu pūkai and healthcare workplace settings.

Sensory Adjustments

To support comfort, focus, and wellbeing in diverse sensory environments, the following adjustments should be considered:

- Sound - Designate quiet zones for focused working, consulting, and debriefing; use noise reducing ear buds; promote a ‘culture of quiet’ (e.g. comfort with silence; recognition of uninterrupted time as essential for deep, meaningful work).
- Visual - Minimise visual clutter through clear organisation and labelling; centralise notices on designated boards; use adjustable LED lighting and side lamps to accommodate light sensitivity.
- Olfactory - Implement a fragrance-free policy.
- Tactile - Offer alternative uniform or clothing options to meet individual sensory needs; ensure physical contact (e.g. hugs) occur with prior consent; embrace less tactile greeting options (e.g. waves, nods, verbal greetings) to respect personal boundaries.
- Multi-sensory - provide ergonomic, adjustable workstations and varied seating options; use screen filters on computer monitors, ensure access to outdoor spaces.

Social Adjustments

The following social adjustments should be considered to accommodate diverse communication styles, emotional needs, and participation preferences:

- Communication Modes: Offer flexible communication options tailored to context; stationary or mobile, face-to-face or side-by-side; remote via video-call, voice notes, email or phone-call; timing can be asynchronous or synchronous.
- Meetings: Provide online access options; share agendas and pre-reading materials at least one week in advance.

- Debriefing and Feedback: Foster awareness of rejection sensitivity and emotional regulation needs; allow time to process and follow-up contributions; support self-regulation through fidgeting or stimming; encourage diverse communication formats.
- Social Events: Participation is always optional; offer structured and predictable engagement options; communicate event format, schedule and expectations clearly in advance; include structured activities (like games, guided discussions, themed stations) to reduce ambiguity; provide optional roles (e.g. helping with setup or managing music) to offer a sense of purpose and comfort; support self-regulation through fidgeting or stimming.

Executive Functioning Adjustments

Tailoring environments and workflows to support executive functioning can significantly improve focus, productivity, and wellbeing. Consider the following strategies:

- Support for High Focus Tasks - Provide no distraction, quiet work zones and collaborative work zones; use visual cues (e.g. “please don’t distract me” signs); allow noise-reducing headphones; normalise fidgeting and stimming as focus aids.
- Workspace Consistence - Offer exemptions from flexi/hot-desking for those that need a predictable administrative setup.
- Cognitive-Friendly Templates - Co-design document and shift-planning templates with ND input; include non-clinical wellbeing check-ins and clear breakdowns of clinical tasks (e.g. medication schedules).
- Accessible Written Communication - Use negative space, visuals, sub-headings and bullet points to improve readability.
- Low Motivation Task Support - Encourage ‘body-doubling’ (e.g. co-working with a buddy) or appoint an accountability partner.
- Verbal Processing Support- Follow up verbal instructions with written summaries where possible.
- Technology Considerations - Recognise that tech can be enabling or disabling depending on neurotype; consider voice to text tools; AI assistance and additional support with adapting to new technology.

Time/Space to Regulate

To support ND individuals needing time and space to regulate and recover, consider the following approaches:

- Respectful Protocols and Tikanga - Establish clear guidelines such as no eating, no perfumes/fragrances, inclusive access for all staff and no blood products.
- Multi-Sensory Considerations - Ensure the environment accommodates diverse sensory needs, including lighting, sound, texture and scent.
- Flexible Break Options - Where acuity allows, enable self-determination around breaks (e.g. some individuals may benefit from shorter, more frequent breaks rather than longer, scheduled ones).

Consider a continuum from minimal to maximal interventions:

1. Noise Reducing Headphones - Minimal intervention; allows focus with limited interruptions.
2. Access to Outdoors - Provides natural sensory regulation opportunities.
3. Flexible Spaces - Includes quiet/loud rooms and use of car between LMC visits.
4. Low-Tech Recharge Rooms: Separate space with adjustable lighting and personal tools.
5. High-Tech Recharge Rooms - Advanced multi-sensory environments inspired by global best practices.

Handover and Multi-Disciplinary Consulting Options

Handover and consults can be cognitively, socially, and sensorily overwhelming. To support individuals who may find these environments challenging, consider the following strategies:

- Create Dedicated Spaces - Provide allocated or flexible-use areas with minimal background noise and activity to help maintain focus and reduce sensory overload.
- Introduce Structured Tools - Use paper or digital templates to guide discussions and documentation, helping to streamline communication and reduce cognitive load.

- Allocate Extra Time - Where clinical acuity permits, allocate additional time for handovers and consults to accommodate processing needs.
- Support Verbal Processing - Recognise that verbal communication may be difficult for some individuals; consider alternative methods of information exchange, such as written summaries or visual aids.

Fine & Gross Motor Skills Support

Currently, there is limited understanding and guidance on how best to support practitioners facing challenges with fine and gross motor skills. This gap highlights the need for more thoughtful, inclusive, and evidence-informed approaches to skill development. In the meantime:

- Recognise the need for repetition: Provide frequent opportunities to practice motor skills in varied contexts to reinforce learning and build confidence.
- Embrace adaptive methods: Support alternative approaches to conducting clinical skills, provided they meet all safety and competency requirements.
- Collaborate with specialists: Seek input and support from disability-informed occupational therapists to tailor strategies that address individual needs.

Strength-Based Rostering & Schedules

Designing rosters that align with individual strengths and neurodiverse needs can enhance wellbeing and performance. Consider the following:

- Circadian Rhythm Alignment - ND individuals may have unique circadian rhythms—some thrive on consistent night shifts, while others may need to opt out entirely.
- Permanent Shift Options - Offer stable, predictable rosters for those who benefit from routine and structure.
- Rest and Recovery for LMCs - Support LMCs in building in recovery time from on-call demands, with backing from practice partners.
- Inclusive Practices for Part-Time and Casual Staff - Improve visibility, protections, and team integration for non-full-time staff; explore ways to foster belonging and connection across all employment types.

Recommended Resources

Removing Barriers: A Guide for Reasonable Accommodation of Disabled People in Aotearoa offers practical guidance on implementing reasonable accommodations within workplace settings. Co-created by the Disabled People's Organisations Coalition, the Human Rights Commission, and the Office of the Ombudsman (2023), it is a valuable resource for those seeking detailed, real-world examples of how to support disabled people effectively in employment contexts.

The Monotropism Questionnaire (MQ) helps individuals understand their tendency to focus deeply on a limited number of interests—a trait common in ND cognition. For ND kahu pūkai, the MQ can offer insight into attention patterns and sensory needs, supporting strategies to reduce burnout and enhance wellbeing in clinical practice.

References:

- Accardo, A. L., Bomgardner, E. M., Rubinstein, M. B., & Woodruff, J. (2024). Valuing neurodiversity on campus: Perspectives and priorities of neurodivergent students, faculty, and professional staff. *Journal of Diversity in Higher Education*. Advance online publication. <https://doi.org/10.1037/dhe0000571>
- Disabled People's Organisations Coalition., Human Rights Commission., & Ombudsman. (2023). *Removing barriers: A guide for reasonable accommodation of disabled people in Aotearoa*. <https://www.ombudsman.parliament.nz/sites/default/files/2023-02/Reasonable%20Accomodation%20Guide%202023.pdf>
- Doyle, N. (2020). Neurodiversity at work: A biopsychosocial model and the impact on working adults. *British Medical Bulletin*, 135(1), 108-125. <https://doi.org/10.1093/bmb/ldaa021>
- Elsherif, M. M., Middleton, S. L., Phan, J. M., Azevedo, F., Iley, B. J., Grose-Hodge, M., Tyler, S., Kapp, S. K., Gourdon-Kanhukamwe, A., Grafton-Clarke, D., Yeung, S. K., Shaw, J. J., Hartmann, H., & Dokovova, M. (2022). Bridging neurodiversity and open scholarship: How shared values can guide best practices for research integrity, social justice, and principled education. *MetaArXiv*. <https://doi.org/10.31222/osf.io/k7a9p>

- Garau, V., Woods, R., Chown, N., Hallett, S., Murray, F., Wood, R., Murray, A., & Fletcher-Watson, S. (2023). The Monotropism Questionnaire. *Open Science Framework*. <https://doi.org/10.17605/OSF.IO/G2NM7>
- Kapp, S. K., Gillespie-Lynch, K., Sherman, L. E., & Hutman, T. (2013). Deficit, difference, or both? Autism and neurodiversity. *Developmental Psychology*, *49*(1), 59-71. <https://doi.org/10.1037/a0028353>
- Rosqvist, H., Chown, N., & Stenning, A. (2020). *Neurodiversity studies: a new critical paradigm*. Routledge Press.
- Taylor, A. R., Miller, S., & Davies, L. (2024). Neurodivergence among healthcare professionals and implications for midwifery: A literature review. *New Zealand College of Midwives Journal*, *60*, Article 246006. <https://doi.org/10.12784/nzcomjnl.246006>
- Te Kāwanatanga o Aotearoa | New Zealand Government. (1993). *Human Rights Act 1993*. <https://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html>
- Walker, N. (2021). *Neuroqueer heresies: Notes on the neurodiversity paradigm, autistic empowerment, and postnormal possibilities*. Autonomous Press.
- Yergeau, L. (2018). *Authoring autism: on rhetoric and neurological queerness*. Duke University Press.