



AOTEAROA NEW ZEALAND RESEARCH

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

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ABSTRACT

Background: As societal awareness of neurodivergence increases and diagnostic pathways become more accurate, health professionals are among those who are seeking and receiving diagnoses. Previous research has highlighted the need for neuro-affirming workplace accommodations and inclusive social conditions to enable neurodivergent (ND) healthcare professionals to thrive in their work contexts. To date, little is known about the experiences of ND midwives (kahu pōkai) within the Aotearoa New Zealand (Aotearoa) workforce, including what accommodations would assist them to thrive.

Aims: To explore the experiences of ND kahu pōkai in Aotearoa, identify the strengths they feel they bring to the profession and explore ideas for neuro-affirming accommodations in healthcare settings.

Method: Appreciative inquiry methodology was utilised to generate strengths-based data. Person-orientated research ethics minimised barriers to engagement for the ND participants. Semi-structured interviews with 15 ND kahu pōkai were followed by a four-day, online, asynchronous focus group. Reflexive thematic analysis was undertaken to recognise patterns within the data.

Findings: Five themes were identified: 1. ND traits facilitate strong therapeutic relationships with whānau; 2. Spiky skill profiles; 3. A journey: finding a workplace; 4. Fostering ND midwifery culture and leadership; and 5. Expanding our idea of what a midwife can be. Participants experienced their neurodivergence as an asset to their clinical practice, particularly in building meaningful connections with whānau. They also highlighted challenges stemming from their spiky skill profiles – areas of both high and low ability – which often clashed with workplace expectations. This mismatch created a gap between expectations and reality, largely driven by ableist barriers embedded in healthcare workplace cultures and systems. To address these challenges, participants explored workplace accommodations tailored specifically to the needs of kahu pōkai.

Conclusion: This research provided novel insights into the experiences and strengths of one group of ND kahu pōkai working in Aotearoa. It is by increasing ND visibility that constructive challenge to neuro-normative assumptions within midwifery workplace settings is enabled.

Keywords: neurodiversity, midwifery, workplace inclusion, healthcare professionals, disability

INTRODUCTION

Societal understanding of neurodiversity, as a natural aspect of human variation, is increasing, with cognitive, sensory and social differences framed as variations rather than deficits (Rosqvist et al., 2020). This contrasts with diagnostic frameworks such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM5)*, which contains definitions of neurodevelopmental conditions according to deviations from statistical norms (American Psychiatric Association, 2022). These criteria have been shaped by research disproportionately sampling white, cisgender, heterosexual, nondisabled and neurotypical (NT) participants, narrowing conceptions of typical cognition and contributing to the pathologisation of neurodivergent (ND) people (Roberts & Mortenson, 2022). Standardised psychological assessments similarly privilege observable behaviour, whereas neurodiversity-aligned scholarship emphasises internal lived experience and the strengths ND people bring (Pearce & Williams, 2013). Neurodiversity scholarship also aligns with the human rights model

of disability, which situates inequity in ableist societal barriers rather than individual impairment (Rosqvist et al., 2020), allowing ND people to choose whether they identify their neurodivergence as a disability.

Building on this shift, a broader, interconnected view of neurodivergence is increasingly supported, with research demonstrating overlaps between autism, attention deficit hyperactivity disorder (ADHD), dyslexia and borderline personality disorder (Sánchez-Morán et al., 2018; Williams & Casanova, 2010). Genetic studies similarly reveal shared risk factors across many ND presentations, suggesting fluid boundaries between diagnostic categories (Brainstorm Consortium et al., 2018; Cabana-Domínguez et al., 2022). This holistic perspective is increasingly relevant for employment research, where scholars advocate using a broader ND umbrella to better capture workers' diverse lived experiences (Vargas-Salas et al., 2025). Many individuals experience co-occurring neurodivergences, with cognitive, sensory

Published online October 2026

Taylor, A. R., Miller, S., & Fakhri, A. (2026). The experiences of neurodivergent midwives in Aotearoa New Zealand: An appreciative inquiry. *New Zealand College of Midwives Journal*, 62, Article 266202. <https://doi.org/10.12784/nzcomjnl.266202> © 2026 New Zealand College of Midwives | Te Kāreti o ngā Kaiwhakawhānau ki Aotearoa. ISSN 1178-3893

and social profiles spanning multiple diagnostic categories and characterised by overlapping traits across conditions (Michellini et al., 2024). Recognising these intersecting traits enables a more accurate understanding of ND employees and supports workplace practices that reflect the complexity of real-world neurodiversity (Vargas-Salas et al., 2025).

A recent literature review by Taylor et al. (2024) identified a substantial gap in understanding the experiences of ND health professionals, particularly kahu pōkai, in Aotearoa. Meanwhile, identification and diagnosis of ND conditions such as autism and ADHD have risen markedly over the past five years, including among health professionals themselves (Johnson & Ahluwalia, 2024).

To improve flow and readability of this paper a glossary is supplied for terms used that readers may be unfamiliar with.

AIM

To explore the experiences and strengths of ND kahu pōkai in Aotearoa and identify the neuro-affirming changes they would like to see within the profession.

METHOD

This study upheld neurocognitive diversity in participation and knowledge creation. Appreciative inquiry was used as a strengths-based methodology to counter deficit narratives by identifying a group's "positive core" (MacCoy, 2014) and guiding change through the 4D cycle: Discover, Dream, Design and Destiny (Cooperrider & Whitney, 2005).

The 4D cycle informed the structure and framing of data collection rather than acting as discrete analytic categories. Questions aligned with Discover (strengths), Dream (envisioning neuro-affirming futures) and Design (strategies for change). Consistent with appreciative inquiry, these stages were iterative and co-occurring rather than linear (Brooks, 2017). The Destiny phase also informed development of a guideline resource, beyond this paper's scope.

Ethics approval was granted by the Otago Polytechnic Ethics Committee (011). As Tangata Tiriti researchers, we worked with cultural humility, guided by Te Ara Tika principles of whakapapa, tika, manaakitanga and mana (Hudson et al., 2010). Ongoing consultation with the Kaitohutohu Office at Otago Polytechnic supported culturally appropriate interpretation of Māori data.

The lead author (AT) is an autistic, ADHD and dyslexic kahu pōkai. Inclusion of ND scholars in ND-focused research reduces ableist framing and enhances research quality (Botha & Cage, 2022). Supervising co-authors (SM, AF) are Tangata Tiriti and neurotypical midwifery academics.

Participants were purposively recruited from the Aotearoa midwifery community through midwifery and ND networks. Inclusion criteria included self-identified or clinically diagnosed neurodivergence, midwifery experience and availability for both phases of the study. Neurodivergence was broadly defined, including autism, ADHD, dyslexia, dyspraxia, Tourette's, chronic mental health conditions and acquired brain-based conditions. Recognising that communication modes can either enable or disable ND people (Howard & Sedgewick, 2021), the design prioritised accessibility through advance preparation, sensory consideration and multiple communication options (Cascio et al., 2021), such as walk-along interviews and asynchronous participation. Appreciative inquiry's flexibility enabled responsiveness to participants' needs (Bushe, 2011).

Fifteen ND kahu pōkai participated in semi-structured interviews after providing informed consent. Participant confidentiality was protected through de-identification of data. Participants described their strengths, envisioned neuro-affirming midwifery practice, and proposed strategies for enabling such futures. Audio recordings were transcribed and returned to participants for checking.

Reflexive thematic analysis was used to identify patterned meaning (Braun & Clarke, 2006). Familiarisation, coding and initial theme generation were followed by the use of Delve software to organise and refine codes. Seven initial themes were developed and refined into five candidate themes (Braun & Clarke, 2022).

Phase two involved a four-day asynchronous, text-based focus group hosted on Discord™, chosen to minimise barriers associated with social anxiety and information processing differences (Frisch et al., 2025). Thirteen phase one participants contributed. This phase aligned with Design and Destiny, focusing on refining strategies for neuro-affirming practice and developing guidance for the wider midwifery community.

Theme reviewing, defining and naming were discussed collaboratively within the focus group, strengthening credibility and ensuring resonance. The focus group transcript was also analysed alongside interview data, and cross-dataset checking informed theme refinement. The lead author conducted the analysis, with supervising co-authors (SM and AF) contributing through regular review of coding, and interpretation theme development. Final integration of both phases into a coherent thematic narrative was completed by the lead author.

Artificial intelligence (AI) use was limited to assistive functions within Delve for data organisation, code grouping, and navigating of large datasets to enhance accessibility for the ND researcher. The researcher retained full control of analysis and writing. No generative AI created, modified or transcribed participant data.

FINDINGS

Participants

Participants disclosed diverse ND conditions, often including multiple diagnoses: ADHD ($n = 11$), autism ($n = 8$), dyslexia ($n = 3$), bipolar disorder ($n = 1$), epilepsy ($n = 1$) and acquired brain injury ($n = 1$). Most participants were diagnosed in adulthood with the time since diagnosis ranging from 1 to 40 years. Their midwifery experience varied from 1 to 35 years, including roles as lead maternity carers ($n = 5$), core midwives ($n = 4$), in community teams ($n = 2$), as clinical coaches ($n = 1$), and within academia ($n = 1$). One participant was a return-to-practice midwife and one had made a career change away from midwifery.

Four participants used pseudonyms (three self-selected, one assigned), while 11 used their real name. Most participants used she/her pronouns, with one using they/them. They lived across Aotearoa, in both Te Ika-a-Māui (North Island) and Te Waipounamu (South Island), spanning urban and rural areas. Two were Tangata Whenua, with the remainder Tangata Tiriti, representing NZ European, African and Canadian ethnicities.

Thematic findings

The thematic findings are presented using a narrative, participant-centred approach, with participant quotations closely woven throughout the analytic narrative. The presentation reflects the iterative appreciative inquiry process, encompassing participants' strengths, their visions for neuro-affirming midwifery and strategies for enabling these futures. An overview of the themes and subthemes is presented visually in Figure 1.

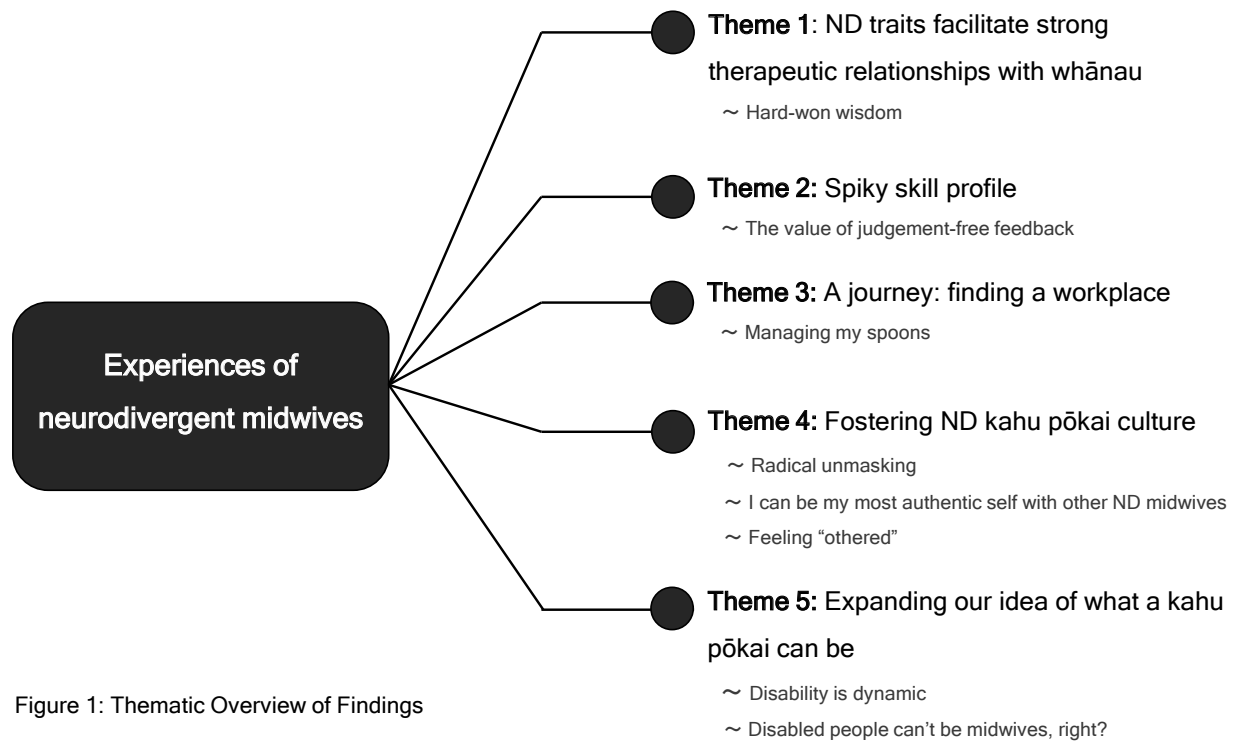


Figure 1: Thematic Overview of Findings

ND traits facilitate strong therapeutic relationships with whānau

Participants described how their ND traits supported their practice and contributed to therapeutic relationships. Many highlighted divergent communication styles that supported meaningful connection. Associative storytelling was described as a natural ND communication pattern that helped to build rapport and trust: *We'll tell a story when they've told a story to, like, connect* (Michelle). Others valued their preference for honesty and directness, feeling it contributed to more authentic relationships with whānau: *What I thought was a negative... whānau respect it* (Lizz). Participants also described strengths in health communication, noting their ability to translate clinical information in accessible ways: *Because of my brain... I'm translating it for myself, which helps translate it to whānau even better* (Nirvana). Passion-driven learning and info dumping were described as supporting whānau education: *My mind just works that way... I'm intellectually curious* (Tamsin).

Participants also described cognitive traits as supporting clinical care. Many identified that hyperfocus enabled deep presence: *You are in the zone... I focus on what is in front of me* (Lizz). Some participants felt that hyperfocus also sharpened their pattern recognition: *I'm the radar of trouble* (Anna). Participants believed this vigilance contributed to safety and trust, including early recognition of deterioration: *Knowing when to act... I'm very, very good at noticing a deteriorating baby* (Tamsin). Hannah similarly described a sense of strong objectivity: *Being able to look at it objectively with the whole picture... so many people had missed it*.

Hard-won wisdom

Participants' empathy was deeply shaped by adversity. Many felt that growing up misunderstood or stigmatised, fostered compassion: *Being undiagnosed during your childhood... makes you more compassionate* (Amber). Experiences of not being understood motivated affirming, non judgemental care: *It makes me feel like not wanting to do that to someone else* (Kate). For many, this contributed to a practice grounded in radical acceptance: *If someone doesn't show up... there's probably a reason* (Kate).

Masking, though exhausting, produced adaptive interpersonal

skills. Participants described that it could strengthen relational flexibility: *Each woman is different and you have to adapt... we make very good midwives because we already know how to do that* (Karien). Many participants attributed their ability to appear calm under pressure to this masking: *I look really calm even if I'm shitting myself inside* (Michelle).

Participants spoke of creating safe, judgement-free spaces where whānau felt comfortable asking questions. Emotional coregulation emerged as a key strength: *I can be people's calm in the storm* (Hannah). Many were frequently assigned complex cases, including whānau experiencing distress: *I'm often put in with tricky people... and I don't find them really difficult* (Leila). Participants especially valued working with ND whānau, drawing on shared experience: *We can talk about some of the big sensory inputs... because for me, I have also done that* (Lizz).

Spiky skill profile

Participants described navigating their work with a "spiky skill profile" — marked by exceptional strengths alongside areas requiring significant support. For many, fine and gross motor coordination differences affected clinical tasks: *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). Participants commonly broke tasks into smaller steps and needed neuro-affirming coaching during training, though such support was often unavailable. Kirsty shared: *I definitely didn't ask for more help during the degree because the time I did... there wasn't actually much available... academic services couldn't help with clinical skills*. Building confidence required time, repetition and diverse explanations: *I need repetition, so much repetition, and a variety of methods of explanation so I can work out what works for me* (Hannah).

Social navigation also posed challenges. Difficulties interpreting tone or body language created uncertainty: *If you're giving off a vibe or you're a little bit huffy... I can't quite read that* (Ana). This ambiguity often led to 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* (Neve). Participants attributed this to alexithymia and slower processing,

which appeared to amplify the impact of interactions. Many described needing to revisit conversations long after others had moved on: *They might have had a short moment... but I've thought about it and thought about it... and got advice and then thought about it* (Neve).

Executive functioning differences affected time management, prioritisation and attention in overstimulating environments. Distractibility made documentation difficult: *I'd always be the last to leave because I couldn't do my work till the office was clear* (Leila). Interruptions disrupted focus: *It takes so long to get back into the train of thought... it derails you for ages* (Hannah). Clinical handover was particularly stressful: *I find it hard to focus on the clinical handover... I don't feel like I could say, 'Hey, this is a lot for me'* (Lizz).

The value of judgement-free feedback

Participants emphasised that factual, nonjudgemental feedback was essential for safe and effective practice. As Anna explained: *Staff education needs to stress that generalising traits and needs shouldn't happen. It's about curious enquiry*. While participants welcomed constructive feedback, pathologising language or comments framed as personality flaws were destabilising. As Nirvana noted: *'Weird' is not a fact... you could talk about traits*. Amber added: *I want feedback about my work and not my personality*. When specific and respectful, feedback supported growth and emotional regulation, particularly when offered by trusted colleagues: *To be able to go to someone I trust... actually does help me* (Neve).

Feeling safe to ask clarifying questions was equally important. Participants described anxiety about appearing incompetent when questions were misinterpreted as lack of knowledge. Supportive colleagues fostered psychological safety by offering help without judgement. As Di described: *It feels like I'm asking a really dumb question... but it's the people who say... would you like some help? And they don't do it in a patronising way*.

Participants also noted that strengths in one area often led colleagues to assume competence across all domains, leaving them feeling misunderstood: *Maybe she was expecting something else... that I didn't do* (Michelle). They emphasised that genuine inclusion required mutual adjustment rather than one-sided adaptation: *If I try to adapt to them... why can't they do the same?* (Karien).

A journey: finding a workplace

Each participant navigated a personal journey to find workplaces aligned with their sensory, social and cognitive profiles — often through trial and error.

Some described a neuroceptive need for novelty, stimulation and polytropic environments. Karien thrived with a busy LMC caseload: *... the lack of structure and not being boring... every day you think, 'oh, what's going to happen today'*. Secondary and tertiary settings appealed to those drawn to complexity: *I get to see more interesting medical conditions... I find different interesting* (Hannah). Amber agreed: *The uncertainty, the level of crisis... I don't like things being super quiet*. Hospital environments suited participants with a sensory-seeking profile: *... an epidural pump, the SYNT, the CTG, the beeping... in terms of the sensory, I love it* (Ana).

Others had a neuroceptive need for predictability, structure and monotropic environments. Small LMC caseloads offered autonomy and sensory control: *I work in a space that is sensory friendly for me. And that is calming* (Lizz). Bec described her clinic as: *like stepping into a home*. For some, the routine of shift work in primary units or community teams was more sustainable: *It feels a lot safer than a bigger and busier and more clinical space* (Di). Smaller teams and

fewer simultaneous clients also supported executive functioning: *Four women and four babies... that level of executive function is incredibly hard for me* (Leila).

Hospital settings were challenging for participants with sensory-avoidant profiles: *I can't do lights and loud noises... the beeping of the IV pumps* (Leila). Those who stayed often preferred nights for reduced sensory load: *Because of the lower kind of sensory and peopling input* (Hannah). Nirvana noted: *... you can turn off the lights and have just a lamp on*. Tamsin worked nights exclusively: *Less people, less noise, less interruptions*.

For many, primary birth — especially homebirth — was described as deeply neuro-affirming: *The ideal birthing space... dark, quiet, warm... very low stimuli environment and for me, that is a very, very safe place* (Lizz).

Managing my spoons

Clinical urgency consistently overrode sensory and cognitive needs, driven by monotropic hyperfocus, until the demands subsided: *You may have to ring the emergency bell... You just do it* (Lizz). Participants developed strategies to conserve energy and prioritise clinical safety — collectively called “managing spoons”. For example, to reduce cognitive strain, participants created systems for efficiency. Anna structured workflows to optimise focus; Ana used digital prompts: *That is something I need within my practice to thrive*. Amber shared: *I have so many strategies to not miss things*. Karien found AI-assisted documentation transformative: *It's been a game changer*.

Intentional self-regulation breaks were essential but hard to access, pushing some to retreat to cars or toilets. Anna explained: *It's a social break, but also a noise break*. Participants imagined multi-sensory spaces: *One loud room... and then a quiet room... a space to rest or work quietly* (Kate) — with significant benefits: *I could do twelve-hour shifts, but I can't... I'm so exhausted and dysregulated* (Hannah). Kate added, *I may have stayed in the profession longer if I was able to work in a way that worked with the needs of my brain*.

Fostering ND kahu pōkai culture

Radical unmasking

Neurodivergence was integral to participants' identities rather than something to conceal; they aligned with the neurodiversity paradigm: *It weaves through every part of me... it's literally woven through my entire existence* (Hannah). Radical unmasking — dropping neurotypical façades — was described as liberating, protective and key to sustainability. For many, authenticity was essential for safe and effective practice: *I can be better at my job if I'm not having to pretend* (Bec).

Unmasking was also framed as leadership and advocacy: *It's my way of making space for others... education by demonstration* (Hannah). Nirvana shared: *I'm very vocal about the fact that I've got ADHD... because then people feel more comfortable not masking with me*. Participants envisioned workplaces where such openness was normalised. For Kirsty, this was already true: *We just understand each other... turn off the radio when the phone rings, go outside on breaks, sit in a different room when we need to concentrate*.

I can be my most authentic self with other ND colleagues

Working alongside other ND kahu pōkai created a sense of ease, safety and belonging. *Shifts with my ND colleagues are the best! I feel so at home* (Kirsty). Shared communication styles supported efficient teamwork, particularly in high acuity environments: *I felt very safe and seen... it's helpful in terms of communicating things quickly* (Hannah).

The focus group itself was described as a rare, affirming space: *It*

feels like a thought connection with ND midwives across the motu (Bec). Many wanted formalised peer support to strengthen this sense of community: *Peer to peer support and education is our best chance at changing the culture* (Bec). Ana imagined the value of simply: *Meeting up with someone once a month to be like, 'oh, my God, you get it'.* Seeing ND kahu pōkai in leadership roles was similarly validating: *It gives you faith that you can get there* (Kate). Both Māori and non-Māori participants also noted that te ao Māori environments often felt more neuro-affirming: *I say this as Tangata Tiriti, that te ao Māori spaces are often more inclusive and safe* (Di).

Feeling “othered”

Despite the value of authenticity, disclosure carried risk: *Outing myself... is an avenue for asking for reasonable accommodations, but risks being shamed or rejected for being 'needy' or othered* (Anna). Ableist responses were common; one participant recalled her manager dismissing her request with “everyone’s got something” and “toughen up”. She concluded: *We need an advocacy role to turn to in situations like this* (Hannah).

Universal design emerged as a key solution to reducing experiences of othering. Lizz described feeling affirmed when communication options were offered to everyone: *It was a level of safety that I didn't have to explain... it wasn't because I was neurodivergent. It was just an option.*

Participants also called for ND leadership to drive this change: *Not as a token hire... when those people get into that place, they can start influencing this stuff to change* (Lizz). As Kirsty summarised: *Many things that accommodate our neurodiversity are beneficial to everyone.*

Expanding our idea of what a kahu pōkai can be

Many participants sought roles aligned with their strengths rather than full scope expectations. Anna thrived in elective theatres: *I'm really good at this, so why can't I just do this all the time?* Tamsin moved into academia: *I can just stay at home... I am a little bit burnt out from the clinical stuff.* They envisioned a profession that recognised diverse contributions: *We all have different strengths... but in our current environment, we recognise just a few things* (Neve). Di echoed this sense of misalignment: *It's like I'm paddling my own little waka and no one really knows what it is.* Participants challenged rigid scope expectations: *The rules are you have to do the gamut, and actually what if the gamut doesn't work for you?* (Neve).

Alternative career pathways — sexual health, abortion care, lactation, governance, research — were seen as essential for retention: *I so badly want expansion of my scope... when I can't do shift work anymore* (Kirsty).

Disability is dynamic

Participants understood their experiences through the social model of disability, emphasising that barriers arose from rigid systems and attitudes: *It's only disability for them because they don't understand and they don't know what to do with it* (Karien). Many lived with co-occurring conditions — Ehlers Danlos Syndrome, chronic fatigue, long COVID — and noted that hormonal shifts could amplify ND traits. Capacity fluctuated with health and environmental demands: *We get flares... and have to really put myself on the line to accommodate my employment* (Neve).

To navigate these fluctuations, some participants chose part-time or casual work, even when this meant reduced connection with colleagues: *Part of being casual is that horrible thing that you're not really relationally connected to the team* (Di). Others relied on the predictability of core midwifery roles: *Having a set number of hours... is really important for managing my illness* (Kirsty). As Kirsty explained: *Consistent hours... are made out like some sort of*

luxury... but realistically they are necessary.

LMC participants highlighted the importance of reciprocity within teams: *So where you lack, I'm going to help you* (Karien). Ana described working 12-hour, on-call blocks that aligned with her cognitive needs: *It gives my brain the space to put all the energy into what it needs to do and then crash.* In contrast, the autonomy of LMC work allowed tailoring of schedules around fluctuating capacity: *I can fit my timetable to what I need and still allow me to have decent rest time* (Lizz).

Disabled people can't be midwives, right?

Participants feared diminishing options as disability progressed: *Sometimes I feel like a caged bird... I feel I still have so much to give but worry my profession won't want me* (Kirsty). Dominant “fitness to practise” discourse limited their ability to seek support: *I don't think there's always... a feeling that you can share certain things* (Kate). Some questioned their future in the profession: *I kind of feel like the wheels are coming off... there's nowhere to go and get advice* (Leila).

They called for pan-disability, neuro-affirming support and advocacy. As Neve put it, ... *discovery of what us midwives can do other than being on the floor.* Bec suggested it may be a professional responsibility to ask: *How can we keep you around? What are your other interests in midwifery?*

DISCUSSION

Findings from this study show that ND traits were central to how participants felt they built trusting, empathetic relationships with whānau. Participants described using associative storytelling, honesty and directness, hyperfocus, info dumping, pattern recognition, and attention to detail to support clear communication, informed consent and rapport. Prior research recognises hyperfocus and pattern recognition as ND clinician strengths but seldom links them to midwives’ perceptions of enhanced client relationships — a contribution of this work (Godfrey-Harris & Shaw, 2023; Rowe et al., 2021; Shaw et al., 2023).

Participants’ reflections also aligned with monotropic cognition, describing highly focused attentional styles when work holds personal significance (Murray et al., 2005). Midwifery was characterised as a lifelong passion akin to ND “special interests”, experienced as energising, meaningful and prosocial. Several participants also felt that their monotropic focus enhanced client safety during clinical emergencies by supporting sustained concentration and calm, deliberate decision-making under pressure. This mirrors wider ND literature that reframes special interests as identity-affirming motivators (Doyle, 2020), despite their historical pathologisation in diagnostic frameworks (American Psychiatric Association, 2022).

Experiences of adversity further shaped empathy. Participants described stigma, misdiagnosis and exclusion — especially in childhood or undergraduate education — as fostering care grounded in compassion and radical acceptance. They also reported skills in nervous system co-regulation and the ability to remain calm in high stress situations. These strengths suggest that ND kahu pōkai may be an under-recognised resource for improving care for people experiencing perinatal mental distress. Such accounts align with research on neuroception and biorhythmic attunement (Porges, 2022), and echo findings that many ND people experience heightened neuroception that supports emotional attunement without relying solely on conventional social cues (Letsoalo, 2025).

A recurring theme in the data was the presence of spiky skills profiles — uneven distributions of strengths and challenges.

Participants described exceptional performance in some domains alongside difficulties in others, such as executive functioning, communication, sensory processing and motor skills, which often required time, repeated practice and personalised strategies to overcome. This pattern reflects the British Psychological Society's *Psychology at Work* report on clinically meaningful variability among neurominorities (McLoughlin & Doyle, 2017). In contrast, neurotypical profiles tend to show more even skill distribution — typically within one to two standard deviations across domains (Doyle, 2020; Grant, 2009). Recognising these differences helps distinguish contextual barriers from intrinsic limitations and supports strength-based adjustments.

Communication across neurotypes was frequently described as effortful. Participants reported that most difficulties arose with NT colleagues, and clinical debriefings were particularly demanding — especially for those experiencing alexithymia. This aligns with the double empathy problem (Milton, 2012) and with research showing that alexithymia can extend reflection processes (Fox-Muraton, 2024). Sensory stressors, particularly noise, also intensified documentation and handover challenges, consistent with previous studies (Anderson & Shaw, 2020; Rowe et al., 2021; Shaw et al., 2023).

Although none of the participants reported a formal developmental coordination disorder (DCD) diagnosis, several described motor coordination challenges, such as tasks requiring fine motor precision. This reflects broader ND literature showing that motor differences are common across neurominorities even without meeting DCD thresholds (Doyle, 2024).

Across the dataset, participants located their difficulties not in their neurodivergence itself but in inflexible, ableist systems and expectations. A disability-affirming approach, that recognises ND relational and attentional strengths, optimises sensory environments (particularly acoustics) and adapts communication and debriefing practices, could reduce avoidable cognitive load and amplify ND contributions.

Workplace flexibility emerged as a major enabler of sustainable practice. Participants described experimenting with different settings, with some thriving in polytropic, fast-paced hospitals and others preferring monotropic, calmer community or homebirth environments. Flexible rostering (e.g., night shifts), part-time or casual work, and specialist roles (e.g., caesarean lists, extended postnatal care) supported retention. These preferences align with job crafting literature linking task/context fit to productivity and self-efficacy (Miraglia et al., 2017; Praslova, 2023). Given workforce shortages in Aotearoa, such flexibility is increasingly important (Dixon et al., 2025).

Participants also emphasised the need for sensory-safe, cognition supportive work cultures. Reducing noise, optimising lighting, and providing quiet spaces were viewed as foundational (Kuiper et al., 2019). Short, intentional self-regulation breaks were described as essential for emotional stability and clinical safety. The success of multisensory “recharge rooms” during COVID-19 illustrates the feasibility of such supports (Putrino et al., 2020). Creating “cultures of quiet”, such as normalising noise reducing headphones while ensuring emergency bell audibility, was seen as a practical team-level change (Praslova, 2023).

Universal design (UD) was widely endorsed to reduce the need for disclosure. Participants wanted systems, spaces, communication and meetings to be accessible by default, consistent with national and international guidance (Maisel & Ranahan, 2022; Te Tari Mō Ngā Take Hauātanga, 2016). Where UD was not possible, they

sought consistent, policy-backed, reasonable accommodations in line with legal obligations (Te Kāwanatanga o Aotearoa, 1993, 2000; United Nations, 2006) and timely transparent processes consistent with wider healthcare findings (Hughes et al., 2021; Rowe et al., 2021).

Participants also framed neurodivergence as a cultural identity. They advocated for ND-led education grounded in disability-affirming practice to address the double empathy problem and shift norms around common ND traits such as associative storytelling, stimming and energy regulation (Milton, 2012). Neurodivergent peer support was described as uniquely protective, echoing evidence that such networks enhance wellbeing and practice sustainability (Godfrey Harris & Shaw, 2023; Shaw et al., 2023). Formalised ND-for-ND spaces — such as mentoring and communities of practice — were seen as essential infrastructure.

Te ao Māori spaces were consistently described as more mana enhancing and neuro-affirming. These accounts resonate with frameworks such as *Te Whare Tapa Whā* (Durie, 1998) and with precolonial recognition of tāngata whaikaha (Hickey & Wilson, 2017). In contrast, mainstream environments were experienced as conditional on disclosure and conformity, reflecting critiques of deficit-based colonial structures (Ingham et al., 2024).

Participants argued that current regulatory approaches to fitness-to-practise, including expectations regarding competence across the full scope of practice, are rigid and outdated. They sought regulatory and scope flexibility that legitimises diverse, strengths-based expressions of midwifery practice, supported by mentoring to identify best-fit contexts (Price et al., 2019; Te Tatau o te Whare Kahu, 2024). Pan-disability research notes technical standards often overlook assistive technologies and exclude disabled health practitioners (DeLisa & Lindenthal, 2016; Zazove et al., 2016). Te Tatau o te Whare Kahu's full scope competence expectation (2024), rooted in the Health Practitioners Competence Assurance Act 2003, was viewed by participants as disadvantaging disabled kahu pūkai, despite their strong personal commitments to safe practice. International exemplars — the UK's Health and Care Professions Council (2021) and the Royal College of Speech and Language Therapists (2024) — provide lived experience-led guidance, affirming disability is not a barrier. Such affirming, strength-based guidance from professional and regulatory bodies is currently lacking in Aotearoa.

STRENGTHS AND LIMITATIONS

A key strength of this study was the use of appreciative inquiry alongside disability-affirming, person-centred methods that enhanced flexibility, accessibility and psychological safety, aligning with the aim of honouring neurocognitive diversity. Insider research was also advantageous; the ND lead researcher's positionality supported deeper rapport and more nuanced data interpretation. However, purposive sampling may have contributed to over-representation of participants with strong vested interests. Appreciative inquiry has been criticised for idealising experiences and minimising hardship (Fitzgerald et al., 2010), though its founders argue this reflects misapplication, emphasising its focus on identifying what participants want more of (Cooperrider & McQuaid, 2012). In this study, participants articulated difficult experiences before considering what would have made them more neuro-affirming. Whānau perspectives were not included; future research should address this gap and further examine the experiences of ND students and the broader experience of disability within the workforce.

CONCLUSION

This study highlights the need for a midwifery profession that moves beyond diversity rhetoric toward genuinely valuing the strengths ND kahu pōkai bring. While a few participants found spaces to “radically unmask”, most described a profession yet to fully embrace meaningful ND inclusion. Their spiky skill profiles often created tension when expectations mismatched realities, yet they also offered unique capacities that enrich midwifery practice. By foregrounding insider perspectives, this research begins to address the historical invisibility of ND kahu pōkai and shifts discourse away from deficit-based narratives. The findings have

wider relevance, offering insights for health professions seeking to better support ND practitioners. For midwifery in Aotearoa, this marks an important first step toward structural inclusion, affirming practices, and a profession responsive to diverse neurocognitive identities.

DECLARATION OF INTEREST

The authors declare that the lead author is the co-presenter and researcher of *the Neurobirth Podcast* which is funded by Te Whatu Ora.

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 about 'normalcy, productivity, desirability, intelligence and fitness' (Lewis, 2022, para 3).
Accommodation	Strategies and tools utilised to create an equitable environment for a disabled person (Cooper et al., 2017).
ADHD/ADHDe	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, 2022).
Alexithymia	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, 2022).
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., 2017).
Dyspraxia	A neurodevelopmental condition that affects gross and fine motor skills, coordination and cognitive function (Walker, 2021).
Emotional co-regulation	The process by which people help each other regulate emotions through connection and interaction, supporting a sense of calm, safety and emotional balance (Butler & Randall, 2013).
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).
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).
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, 2022).
Neurodivergent	An umbrella term that describes individuals with a brain that diverges from what is typical; this may include those with autism, ADHD, dyslexia and dyspraxia among other atypical brain configurations (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, and who exhibit 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 (Silverman, 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 judgement or resistance. It is used to reduce emotional suffering by fostering nonjudgemental 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 (Rowney-Smith et al., 2024).
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 (Consedine & Consedine, 2012).
Tangata Whenua	People of the Treaty – Māori (Consedine & Consedine, 2012).
Te Ika-a-Māui	North Island of Aotearoa.
Te Waipounamu	South Island of Aotearoa
Universal design	An approach to design that aims to create environments, products and systems that are inclusive, accessible and usable for all people, regardless of age, ability or life stage, without the need for adaptation or specialised design (Kāinga Ora – Homes and Communities, 2024).
Whānau	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.

KEY POINTS

- Neurodivergent participant midwives described hyperfocus, pattern recognition, associative communication and emotional co-regulation as strengths, in that they supported relationships, risk awareness and emergency responsiveness.
- Spiky cognitive, sensory and motor profiles revealed strengths alongside support needs, highlighting systemic barriers and the need for neuro-affirming accommodations.
- Flexibility, sensory-safe environments and ND peer support enabled sustainable practice, while participants called for ND-led advocacy and policy change.

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