Portfolio Volume 1: Major Research Project

Navigating Neurodivergence on the Doctorate in Clinical Psychology: Experiences of Neurodivergent Trainee Clinical Psychologists

Rachel Ison

A thesis submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology

August 2025

Word count: 28,885

(Excluding: title page, acknowledgements, contents page, abstract, tables, figures, references and appendices)

Acknowledgements

To **Mum, Dad and Sarah** – the 'et al.' to everything I've ever done. From my whole heart, thank you for not only supporting me, but accepting me, unconditionally. After all these years, we finally made it.

To **Alexis** – le soleil de ma vie, even in the hardest moments of this doctorate. Your love, strength and humour have kept me going when it felt impossible.

To my supervisors, **Dr Scott Steen and Dr Barbara Rishworth** – thank you for your unwavering encouragement and commitment to this research, and for supporting me to go at my own pace throughout the process.

To **my friends** – thank you for walking beside me through the mess and the milestones, and for ensuring there was joy along the way. And to **Yoni** (also my SLR co-pilot) – I truly could not have crossed the finish line without you, nor would I have wanted to.

To my course tutor, **Dr Rachel McKail** – thank you for helping me navigate my neurodivergence on training, and for continuously reminding me that it is the system that needs to change, not me.

To **Andrew Sandor** – for being the first to recognise my neurodivergence. Your insight changed my life, and shaped the heart of this thesis.

And most importantly, to the **70 neurodivergent Trainee Clinical Psychologists** who took part in this research – thank you for sharing your stories so they could be heard for the first time. I hope I have done them justice. And to the **Consultants** – thank you for your valuable time and expertise in shaping the research materials. I hope that all together we can take steps towards change.

Table of Contents

List of Tables

List of Figures

Abstract

Rationale and Aims: In the clinical psychology profession, despite a key focus on understanding neurodivergence and working towards neuro-affirmative clinical practice, there remains a paucity of research exploring the experiences of its own neurodivergent professionals. A Systematic Literature Review further highlighted this gap through a synthesis and appraisal of existing literature about the experiences of neurodivergent students in healthcare professions training. This research therefore aimed to explore and give voice to the experiences of neurodivergent Trainee Clinical Psychologists completing Doctorate in Clinical Psychology (DClinPsy) programmes in the United Kingdom (UK), and to develop recommendations to improve support.

Method: A qualitative online questionnaire was completed by 70 neurodivergent Trainee Clinical Psychologists across 17 DClinPsy programmes in the UK. Data were analysed using reflexive thematic analysis, and the research was conducted from a critical realist epistemological stance.

Results: Four themes with accompanying sub-themes were constructed: '*This System's Not Built for Us'*, '*The Ever-Present Burnout'*, '*Do I Fit/Belong Here?'*, and '*Reclaiming Identity, Belonging and Hope'*. Together, these themes highlight the complex experiences of neurodivergent trainees across personal, relational and systemic domains – marked by structural barriers and systemic ableism, heightened emotional and cognitive strain, and ongoing negotiations of identity, belonging, and connection.

Implications: This research has implications for programme design, relational practice, and the wider professional culture and structures of clinical psychology. It calls for a shift from reactive individualised adjustments to proactive systemic change that meaningfully includes and improves the experiences of neurodivergent Trainee Clinical Psychologists. Recommendations for future research are also discussed.

Chapter 1: Introduction

1.1 Chapter Overview

This chapter begins by outlining the researcher's positioning and epistemological stance, before defining neurodivergence and outlining several theoretical frameworks that support the understanding of the experiences of neurodivergent individuals. It situates neurodivergence within broader historical, social and political contexts, and then explores existing literature about the experiences of neurodivergent individuals in educational contexts, with particular attention to higher education settings. The chapter then narrows the focus to healthcare training contexts, and lastly establishes the rationale for the Systematic Literature Review (SLR) (Chapter 2).

1.2 Personal Positioning and Reflexivity

Personal Connection: Growing up, if I was asked what superpower I would like to have, my answer was always "to be able to pause time". I did not fully understand this until I started the Doctorate in Clinical Psychology (DClinPsy) and hit my 'ceiling'; a ceiling I did not know I had. The long-held stories about myself were no longer a good enough fit for my experiences on the course, and part way through I was assessed and diagnosed as neurodivergent. Naturally it resulted in reflections on identity that needed a lot of time to be processed, and although I am still not able to pause time (unfortunately), it led me to choose this thesis topic. My personal experiences and challenges on the DClinPsy, and those I observed of fellow neurodivergent Trainee Clinical Psychologists, informed my thinking when developing this research and my commitment to amplifying voices in the hope of improving experiences.

Insider Researcher: As a neurodivergent Trainee Clinical Psychologist in the DClinPsy training context, I occupy an insider researcher position, as I share characteristics

and lived experiences with the population I am researching (Greene, 2014). Within this, there are complex dynamics that require attending to. Literature highlights the benefits of being an insider researcher in qualitative research; such as shaping the research design in contextually meaningful ways (its relevance, question framing and accessibility) (Callander, n.d.), being more attuned to the nuances of the lived realities and language of participants (Greene, 2014; Ross, 2017), and being able to provide a richer, more authentic and accurate interpretation of participants' accounts (Dwyer & Buckle, 2009). However, the dual role of a researcher and member of the researched community can introduce challenges. Literature notes that insider status may lead to assumptions being made, alternative perspectives being overlooked, or personal experiences overly shaping the research process (Dwyer & Buckle, 2009; Greene, 2014; Ross, 2017). There is also an emotional labour involved, particularly when working with narratives that resonate with personal experiences (Ross, 2017). I also acknowledge the fluidity of insider/outsider positioning (Dwyer & Buckle, 2009), and as I am a cis-gendered female from a middle-class family and religious minority, there are aspects of my identity which will impact where my experiences converge and diverge with those of participants. Therefore, throughout the research process, I have been consciously aware of the potential impact of my positioning, engaging in reflexive practices such as journaling and supervision (Berger, 2015; Olmos-Vega et al., 2022). Extracts from my journal have been included in the appendices (see Appendix A) to support the reader to consider my position alongside the research process.

1.3 Epistemology and Ontology

This research is grounded in a critical realist epistemology and ontology, which was developed by Bhaskar in the 1970s/1980s (Bhaskar, 1975; Fletcher, 2017). Critical realism proposes that an objective reality exists independent of our perceptions (ontological realism),

but our knowledge of that reality is filtered through social, cultural and individual interpretative frameworks (epistemic relativism) (Bhaskar, 1975; Maxwell, 2012). Therefore, in the context of this thesis, a critical realist stance involves acknowledging that neurodivergence has material, biological realities (for example, cognitive differences that can be observed or measured; Doyle, 2020), while also recognising that the meaning and experience of neurodivergence is socially, culturally and historically situated. This perspective bridges the gap between a purely positivist approach (which might treat neurodivergent conditions as fixed, measurable deficits) and a purely social constructionist approach (which might treat neurodivergence as solely a social label).

Critical realist epistemology and ontology are aligned with qualitative research and thematic analysis (Lawani, 2021), and require researcher reflexivity, as knowledge is understood to be shaped by the researcher's conceptual frameworks, making it essential to examine how assumptions and positioning influence the process (Fletcher, 2017). In addition, as critical realism is suited to the development of recommendations, due to its focus on uncovering causal mechanisms of social issues (Fletcher, 2017; Lawani, 2021), it is particularly relevant given the aims of this research. Therefore, applying critical realism to this research provides a framework to understand the experiences of neurodivergent Trainee Clinical Psychologists and to identify recommendations.

Within this section, it is important to highlight the epistemic injustice faced by neurodivergent individuals; defined as "injustice on matters epistemic, namely, concerning the generation of knowledge and understanding within social practices, relationships, and systems" (Russell & Wilkinson, 2023, p. 2). Shaw et al. (2025) write about the lack of neurodivergent voices for years in academia, and consequently the importance of research being centred on neurodivergent individuals' perspectives. This is core to the present

research; exploring the experiences of neurodivergent individuals, led by a neurodivergent researcher.

1.4 Defining Neurodivergence and Language

Clarity in definition and terminology is key for research on neurodivergence. The term *neurodiversity*, originally coined by sociologist Judy Singer in the late 1990s, refers to the natural diversity of all human brains – how they take in, process and act in response to information – and the consequential diversity of experiences of the world (Singer, 1999). It is an idea rooted in the disability rights movement, suggesting that variations in neurocognitive functioning are part of natural human diversity rather than pathologies to be cured (Baron-Cohen, 2017; Kapp et al., 2013). Developed from this, *neurodivergence*, and the related adjective *neurodivergent*, were coined by Kassiane Asasumasu to describe individuals whose brains diverge from what is considered typical or the 'norm' (Farrant et al., 2022); known as *neurotypical* individuals, who comprise the larger societal group with "common forms of cognitive functioning" (Manalili et al., 2023, p. 2).

Neurodivergent is an umbrella term, and the following conditions are often included under it: autism/autism spectrum condition (ASC), attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, dyscalculia, specific learning difficulties, developmental language disorder (DLD) and Tourette's Syndrome (Clouder et al., 2020). This is the definition of neurodivergence that the present research has adopted to align with existing literature; using neurodivergent as a collective term to reflect shared experiences of navigating neurotypical systems, whilst acknowledging heterogeneous identities and experiences within this. Given that this is, to the author's knowledge, the first empirical research exploring the experiences of neurodivergent Trainee Clinical Psychologists, it was deemed valuable to focus on the umbrella term of neurodivergence to identify shared

experiences and patterns, with future research then able to examine condition-specific experiences in more depth. Other definitions of neurodivergence can include neurodivergence produced through experience, such as trauma or acquired brain injury (Walker, 2021), however these differ from innate neurodivergence and are not part of this research's focus.

This research uses neurodivergent affirming language; for example, *identity-first language* (e.g., 'neurodivergent trainee' or 'autistic student') to align with community preferences (Walker, 2021; Zajic & Gudknecht, 2024).

1.5 Theoretical Frameworks

This research is informed by several theoretical frameworks outlined below. They provide lenses to support understanding about the experiences of neurodivergent individuals and interactions with environments and broader society.

***The Social Model of Disability (Oliver, 1990)*:** This model posits that individuals are not disabled by their 'impairments' but by societal and environmental barriers (Oliver, 2013). It is in response to the traditional medical model of disability which views an individual's 'impairments' as the root cause of any experienced disadvantages (Goering, 2015). Applied to neurodivergence, neurodivergent individuals are not disabled by their neurocognitive differences ('impairments'), rather, by their surrounding environments – neuronormative, ableist systems, expectations and lack of adjustments to different needs (The Brain Charity, 2021). Therefore, it is the environment that needs to change, not the individual. This model underpins key discussions around policy, adjustments and inclusive practice, prioritising inclusion and acceptance over 'treatment' (Whelpley et al., 2023). However, it is important to note that the current classification of neurodivergence as a disability under UK law and policy, for example the Equality Act 2010 (GOV.UK, n.d.-a), legally protects against discrimination and mandates access to adjustments and support.

The Neurodiversity Paradigm and Identity (Singer, 1999; Walker, 2021): The neurodiversity paradigm, closely related to the social model of disability, frames neurocognitive differences – strengths and difficulties – as natural variations in the human condition that enrich human experiences (Peters, 2023). The paradigm consequently redefines neurodivergence as an identity, not a deficit. Social Identity Theory (Tajfel & Turner, 1979) can be considered within this to understand how neurodivergent individuals may develop their sense of self through identifying with the neurodivergent community; their 'in-group' amongst the neurotypical 'out-group'. As the paradigm frames the group positively, this can lead to an enhanced sense of belonging and positive self-image (Islam, 2014). The neurodiversity paradigm also highlights how neurodivergent individuals should be the centre of knowledge creation around neurodivergence to rebalance the epistemic injustice (Shaw et al., 2025), including in research, which this study has focused on.

***Minority Stress Theory (Meyer, 2003)*:** The minority stress theory proposes that individuals belonging to minority groups experience chronic stress due to marginalisation, stigmatisation, discrimination and prejudice (Botha & Gillespie-Lynch, 2022). The model identifies two types of stressors: distal stressors, such as discrimination, and proximal stressors, which are internal processes such as concealment of minority identity. This theory first focused on sexual minorities but has been extended to neurominorities, considering how the ongoing pressures to conform to neurotypical norms/expectations can lead to significant stress, masking and mental health challenges for neurodivergent individuals (Botha & Frost, 2020). The model also focuses on the different coping strategies employed, both individual and collective, which links to Social Identity Theory and the forming of an in-group to enhance self-esteem and protection (Tajfel & Turner, 1979).

Person-Environment Fit (P-E Fit) (Edwards et al., 1998): The P-E Fit theory suggests that it is the mismatch between personal characteristics and environmental demands

that leads to poor outcomes, such as decreased wellbeing and performance (Caplan & Harrison, 1993; Edwards & Shipp, 2007). When applied to neurodivergent individuals, it can provide a valuable and practical lens to understand difficulties – for example, when there is a misalignment of an individual's cognitive, sensory and communication needs with their work or education environment. Much like the social model of disability, P-E Fit theory has implications for environment changes to improve fit, however it also considers individual differences, acknowledging heterogeneity in the neurodivergent community.

***Ecological Systems Theory (Bronfenbrenner, 1979)*:** Bronfenbrenner's ecological systems theory explains that human development is shaped by five interrelated layers of the environment. When applied to the systems of neurodivergent individuals, examples could be: microsystem (e.g., school teacher, colleagues), mesosystem (e.g., communication between university tutor and placement supervisor), exosystem (e.g., National Health Service (NHS), university policies), macrosystem (e.g., societal attitudes towards neurodivergence) and chronosystem (e.g., late diagnoses, updated legislative changes). This framework highlights how different environmental systems impact upon the experiences and development of neurodivergent individuals (Butcher & Lane, 2024).

1.6 Contextualising the Research

To understand neurodivergence in the context of this research requires a grounding in its historical evolution, shaped by shifts in social attitudes and political policies.

Early Understandings and Historical Stigma: Historically, neurodivergent conditions such as autism and dyslexia were poorly understood, heavily stigmatised, and perceived predominantly through a medical or deficit-oriented lens (Bagatell, 2010; Odegard & Dye, 2024). Traits of neurodivergent individuals were pathologised, and consequently neurodivergent individuals were segregated in special schools (Hornby & Kauffman, 2024)

or deemed unfit for higher education or skilled employment due to misconceptions about their abilities (Ker & Van Gorp, 2023). Under this traditional medical model, the focus was on the individual's 'impairments', with minimal consideration of how the environment might disable the person (den Houting, 2019).

Emergence of the Neurodiversity Movement: Societal views began shifting from the 1970s, heavily influenced by the broader disability rights movement and the emergence of the neurodiversity movement (Scotch & Sutton, 2021). The introduction of the social model of disability was pivotal, as it offered an alternative view that it is society's barriers (such as inaccessible environments, prejudiced attitudes and policies) that disable people more than their impairments do (den Houting, 2019; Oliver, 1990). Judy Singer then coined the term neurodiversity in the late 1990s, advocating for recognition that neurological variations are part of human diversity, rather than disorders that need a cure (Singer, 1999). The neurodiversity movement, supported by autistic self-advocates, altered perceptions and promoted acceptance and inclusion of neurodivergent people (Leadbitter et al., 2021).

Legislative Advances: Legislative advancements mirrored these social shifts. For example, in the UK, the Disability Discrimination Act 1995 (UK Government, 1995) and the Equality Act 2010 (GOV.UK, n.d.-a) prohibited the discrimination of neurodivergent individuals (classifying neurodivergent conditions as disabilities), and mandated reasonable adjustments in education and employment (Ralph, 2013). Simultaneously, diagnostic awareness increased, for example autism diagnoses in the UK rose by approximately 787% between 1998 and 2018 (Russell et al., 2021). This growth can be seen to reflect greater awareness, broader diagnostic criteria and reduced stigma, however there are also ongoing debates about over-diagnosis (Fagundes & Gouhie, 2025; Poletti et al., 2025). As a result, many more neurodivergent individuals are accessing higher education and professional opportunities (Clouder et al., 2020).

Ongoing Social Challenges: Despite advancements in inclusion, awareness and visibility, neurodivergent individuals continue to experience social and systemic challenges (Cottingham & Spear, 2025). Stereotypes, such as autistic students being considered unsuitable for academic environments, are still prevalent and reflect historical biases (Tan et al., 2024). In addition, many challenges faced are social in nature, for example being targets of bullying or exclusion, or feeling pressure to 'mask' differences to fit in (Hull et al., 2017). Intersectionality also plays a role in the social experience of neurodivergence, for example research highlights that women and non-binary people are underdiagnosed or often diagnosed later, delaying support (Krazinski, 2023). Likewise, cultural differences can affect the understanding, disclosure and stigma around neurodivergence (Gillespie-Lynch et al., 2019).

Policy Implementation Gaps and Systemic Barriers: Politically, despite legislative frameworks, implementation of policies like the Disabled Students' Allowance (DSA; GOV.UK, n.d.-b), which funds specialist support for neurodivergent students, remains inconsistent (Taylor et al., 2016). Research does support the value of the DSA (Hayhoe et al., 2015), however uptake is low by those eligible (Johnson et al., 2019). Neurodivergent students are hindered by bureaucratic barriers and lack of awareness (Johnson et al., 2019), and notably delayed diagnoses due to extensive NHS waiting lists for assessments (Lang, 2024).

Beyond academia, support into employment for neurodivergent individuals remains inconsistent. Schemes such as Access to Work provide funding for adjustments in the workplace or vocational placements, yet awareness and uptake are limited, and eligibility can vary (Department for Work and Pensions, 2018). Consequently, neurodivergent individuals continue to face poorer employment outcomes relative to their neurotypical peers (Branicki et al., 2024).

1.7 Neurodivergence in Education

To further situate the present research, an examination of the literature about the experiences of neurodivergent individuals in educational settings is required.

1.7.1 Neurodivergence in School Systems

School systems have long operated on the problematic myth of the 'normal child' in relation to learning, communication and behaviour (Cook, 2024). Consequently, mainstream classrooms are often ill-equipped to meet the needs of neurodivergent students (Fielding et al., 2025). Research shows that neurodivergent students frequently experience difficulties in school, such as poorer educational outcomes (Alcorn et al., 2024), formal and informal exclusion (Paget et al., 2015), bullying and victimisation (Connolly et al., 2023), and emotional distress (Fielding et al., 2025).

Policy developments such as the Equality Act 2010 (GOV.UK, n.d.-a) and the Special Educational Needs and Disability (SEND) Code of Practice (Department for Education & Department of Health and Social Care, 2014) have sought to embed inclusion by mandating reasonable adjustments to support neurodivergent students. Implementation is reportedly inconsistent, however these frameworks have increased the visibility of neurodivergence and responsibility of schools (Cameron et al., 2019). In addition, Education, Health and Care Plans (EHCPs) can provide tailored support for students, but research indicates that families often encounter systemic barriers in accessing them (Connolly et al., 2023).

1.7.2 Neurodivergence in Higher Education

There are increasing numbers of neurodivergent students in higher education, in the UK and internationally, due to widening access (Hamilton & Petty, 2023). With this, there has also been an increase in literature exploring how neurodivergent students experience

higher education and support strategies (Clouder et al., 2020). Key themes in the literature are summarised below.

Academic Experiences and Performance: Neurodivergent students in higher education report varied academic experiences, often marked by systemic barriers and challenges (Pigato, 2024). For example, traditional teaching methods, such as lecture-based learning and group discussions, can be difficult for neurodivergent students to engage with (Durgungoz & Durgungoz, 2025). Clouder et al.'s (2020) narrative synthesis noted specificities, for example dyslexic students struggled with aspects such as writing and reading, and autistic students struggled with aspects such as information processing and prioritisation, impacting academic performance. These challenges are compounded by neuro-normative ('typical') expectations around learning, which can marginalise students who think and learn differently (Spaeth & Pearson, 2023). However, when teaching methods align with strengths, such as flexible assessment strategies, clear instructions and resources in different formats, neurodivergent students can excel and bring many strengths (Clouder et al., 2020; Durgungoz & Durgungoz, 2025; Elsherif et al., 2022). To manage academic challenges, literature highlights that many neurodivergent students develop self-directed strategies, such as intensive planning, assistive technology or not taking time off work (Alexander, 2024). Whilst they can be effective, they require significant additional labour on the part of the student (Durgungoz & Durgungoz, 2025).

Social Experiences and Wellbeing: Literature highlights how navigating the social aspects of higher education can present distinct challenges for neurodivergent students, often with implications for their wellbeing. For example, difficulties forming and sustaining peer relationships (Wang et al., 2024), a lack of sense of belonging (Syharat et al., 2023) and feelings of exclusion (Clouder et al., 2020) are common themes. The concept of the *hidden curriculum*, defined as the unwritten social rules and expectations in educational

environments, can also marginalise neurodivergent individuals who do not intuit them (Sulaimani & Gut, 2019). Research consistently notes the emotional toll of these social challenges, with higher levels of stress, anxiety and depression (Clouder et al., 2020; Griffin & Pollak, 2009; Syharat et al., 2023; Wang et al., 2024). As a response, some individuals engage in masking or camouflaging their neurodivergence to reduce potential negative responses/judgements from neurotypical peers, however this often leads to exhaustion, burnout and poor wellbeing (Lewis & Arday, 2023; Syharat et al., 2023). However, neurodivergent peer-led spaces in higher education settings, such as peer mentoring and networks, have been found to be of value to foster community, inclusivity and wellbeing, and reduce isolation (Back et al., 2025; Clouder et al., 2020).

Access to Support and Accommodations: A key factor in the literature that impacts the experiences of neurodivergent students in higher education is whether they receive necessary and adequate support. Strategies such as staff training, adopting inclusive and strengths-based pedagogies, providing tailored coaching/mentorship, additional time and technology-based interventions have been shown to have value (Bolourian et al., 2024; Gibbs et al., 2025; Hamilton & Petty, 2023; Wang et al., 2024). There are, however, many barriers to accessing support, such as lack of a formal diagnosis, fear of disclosure, limited staff awareness and uncertainty around eligibility (Gibbs et al., 2025; McDowall & Kiseleva, 2024). McDowall and Kiseleva's (2024) rapid review of support for neurodivergent students identified that current accommodations are majority focused on specific learning/academic needs, as opposed to inclusive systems-level design. *Universal Design for Learning* (UDL), which embeds accessibility into teaching and assessment design from the outset (Bolourian et al., 2024; Hamilton & Petty, 2023), is recommended as a framework with growing evidence to change the landscape of inclusive support for neurodivergent students (Clouder et al., 2020; McDowall & Kiseleva, 2024; Syharat et al., 2023). However, adoption is currently

limited (Durgungoz & Durgungoz, 2025), as is consistent support for neurodivergent students, leading to disparities in outcomes versus neurotypical peers, often extending into employment (Clouder et al., 2020).

Gaps in the Literature: Despite a growing evidence-base, research relating to the experiences of neurodivergent students in higher education remains limited. First, much of the literature is condition-specific (notably dyslexia, autism and ADHD), overlooking certain neurodivergent identities and shared experiences across neurodivergent groups (Butcher & Lane, 2024; Clouder et al., 2020). Second, the involvement of those with lived experiences in research and inclusive practice design is minimal (Durgungoz & Durgungoz, 2025; McDowall & Kiseleva, 2024). Third, intersectionality within neurodivergence is rarely considered, neglecting to explore the impact of layers of minoritisation (Lewis & Arday, 2023). Lastly, existing studies are mainly qualitative with small sample sizes, with reviews focusing on English-speaking, Western countries, reducing generalisability and breadth of findings (Clouder et al., 2020; McDowall & Kiseleva, 2024).

1.8 Neurodivergence in Healthcare Training

Following on from the literature about the experiences of neurodivergent students in higher education, there is limited but growing research about experiences in healthcare training programmes specifically. These programmes present a distinctive dual demand, requiring neurodivergent students to engage with both academic work and clinical practice (Gray et al., 2025).

The evidence-base is predominantly condition-specific, for example focusing on the experiences of dyslexic medical students (Shaw & Anderson, 2018), dyslexic nursing students (Child & Langford, 2011), and autistic medical students (Shaw et al., 2023). The literature therefore highlights condition-specific challenges encountered by neurodivergent

students in healthcare training. For example, dyslexic and dyspraxic students expressed anxiety around clinical competence and errors, particularly in high-risk tasks such as drug calculations (Morris & Turnbull, 2007; Murphy, 2011); ADHD students reported difficulties with sustained attention, timekeeping, and navigating unstructured clinical tasks (Godfrey-Harris & Shaw, 2023); and autistic medical students described difficulties with sensory overload, unwritten social rules, and the emotional cost of masking (Dabbs et al., 2024; Shaw et al., 2023). Across the literature, there are themes such as stigma, the challenges of disclosure, the emotional and social impact, the barriers to accessing adjustments, and the additional academic pressures faced – which align with the broader literature about neurodivergent students' experiences in higher education (e.g., Clouder et al., 2020; Syharat et al., 2023). The hidden labour of navigating these challenges, whilst maintaining professional identity under pressure, is noted as leading to high emotional strain (Cornwell & Shaw, 2023; Dabbs et al., 2024). Nonetheless, the literature additionally highlights how neurodivergent students in healthcare training demonstrate resilience, develop personal coping strategies and derive strength from community, mentorship and advocacy (Gray et al., 2025; Shaw & Anderson, 2018).

1.9 Rationale for the Systematic Literature Review

With increasing numbers of neurodivergent students in healthcare training (e.g., Shaw et al., 2023), it is imperative to understand experiences and consequently improve support and practice. The evidence-base is fragmented but growing, and is predominantly condition- and discipline-specific. To the author's knowledge, only one scoping review to date has been completed by Gray et al. (2025), focusing on the evolving narratives around neurodivergence in healthcare education literature, incorporating the perspectives of students and staff, with the aim to guide educators. In contrast, the SLR presented in Chapter 2 aims to synthesise

and appraise existing literature that focuses specifically on the experiences of neurodivergent students in healthcare professions training, to amplify their perspectives, across conditions and disciplines. It is hoped that this will provide further valuable insights about experiences and where they converge and diverge, and have implications for practice, policy and research.

Chapter 2: Systematic Literature Review

2.1 Chapter Overview

This chapter presents a SLR about the experiences of neurodivergent students in healthcare professions training. SLRs provide a rigorous and structured approach to synthesising existing research, allowing for a comprehensive evaluation of patterns, gaps, and methodological quality within a field (Paul & Barari, 2022). By systematically identifying and appraising relevant studies, they can enhance clarity in the evidence base and support the development of informed conclusions about a topic (Newman & Gough, 2020).

This chapter begins by outlining the methodology employed in the SLR, including initial scoping and question development, search strategy, study selection, and the data extraction process. The chapter then goes on to present the quality appraisal and findings of a thematic synthesis (Thomas & Harden, 2008), before concluding with a discussion that highlights the implications for practice, policy and research. The chapter closes with the rationale for the present research.

2.2 Initial Scoping

As outlined in Chapter 1, there is a need to better understand the experiences of neurodivergent students in healthcare professions training, across disciplines and neurodivergent conditions. An initial scoping review was conducted between October and November 2024 using Google Scholar, The Cochrane Library and PROSPERO**,** revealing no existing reviews addressing this specific topic. Therefore, this review sought to answer the question: *What are the experiences of neurodivergent students in healthcare professions training?*

This review defines *neurodivergent* consistently with Chapter 1 (p. 6) and *healthcare professions training* as students enrolled in medicine, nursing (including midwifery),

dentistry and allied health professions (e.g., occupational therapy, radiography, art therapy). This grouping aligns with established classifications in healthcare education and reflects core clinical training pathways (UNESCO Institute for Statistics, 2014). It is important to note that the terms ‘student’ and ‘trainee’ are used interchangeably throughout. A PROSPERO protocol was created and published, protocol number: CRD420250639727.

2.3 Search Strategy

The search strategy was informed by the SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) (Cooke et al., 2012), which provides a structured framework to define key components. The SPIDER tool**,** an adaptation of the PICO framework (Cooke et al., 2012), was used in this systematic literature review as it is more suited to qualitative research, focusing on the exploration of experiences and perceptions**,** whereas PICO is primarily designed for quantitative studies with an emphasis on interventions and outcomes (Cooke et al., 2012). The search terms were developed based on the SPIDER tool, related reviews (e.g., Clouder et al., 2020), and pilot searches. Terms related to neurodivergence (e.g., neurodivergent, neurodiversity, autism, dyslexia, dyspraxia, ADHD), students (e.g., student, trainee), healthcare (e.g., healthcare profession, medical, nursing, allied health) and experiences e.g., experiences, perceptions, perspectives). Boolean operators (‘AND’/’OR’) were used to combine search terms, asterisks (*) were applied as truncation symbols to capture word variations, and quotation marks were used to search exact phrases. Specific search strategies were adapted to the different databases as appropriate (see Appendix B). The SPIDER search strategy can be found in Table 1.

Table 1: *SPIDER Criteria*

Acronym	Criteria
Sample	Neurodivergent healthcare professions students/trainees
Phenomenon of **I**nterest	Experiences of neurodivergent students/trainees in healthcare professions training
Design	Interviews; focus groups; questionnaires; surveys
Evaluation Type	Experiences; views; perspectives; challenges; impact; perceptions
Research Type	Qualitative; mixed methods

Searches were conducted across four research databases: Scopus, PubMed, CINAHL Plus, and Education Research Complete. These databases were selected for their broad coverage of healthcare, education, and social sciences research, providing access to key literature from medical, nursing, allied health and education fields to support a comprehensive understanding of the topic.

Eligibility criteria were developed from the SPIDER criteria – see Table 2. Only papers published in the English language were considered due to the project's resource and language constraints. No restrictions were placed on the country of publication, as research on the experiences of neurodivergent students in healthcare professions training is limited, so a global search was deemed valuable to capture all available perspectives. Grey literature, which refers to research outside of traditional academic or commercial publishing (such as theses, government reports and unpublished academic papers) (Paez, 2017), was included to minimise publication bias and to ensure that relevant insights were not overlooked. This review was chosen to be qualitative in focus, as this aligns with exploring experiences, perspectives and meaning (Braun & Clarke, 2013). Therefore, qualitative and mixed-methods studies were included; however, for mixed-methods papers, only the qualitative components were analysed to align with the review's aims. Single case studies were excluded due to

limited generalisability. In studies where there were neurotypical comparison samples (e.g., non-dyslexic students), only the experiences of neurodivergent students were analysed. Studies reporting on the perspectives of qualified healthcare professionals, including in a mentorship or supervisory capacity, were excluded because this review specifically aimed to focus on and amplify the experiences of neurodivergent students.

Table 2: *Eligibility Criteria*

Inclusion Criteria	Exclusion Criteria
Studies about the experiences of neurodivergent students/trainees in healthcare professions training	Studies about the experiences of qualified healthcare professionals, including mentors and supervisors
Qualitative or mixed-methods studies	Quantitative studies
Peer reviewed primary research and grey literature	Systematic reviews, meta-analyses, and single case studies
Adults	Under 18 years old
Published in the English language	Published in a language other than English
Any time period	
Published in any country	

2.4 Study Screening and Selection

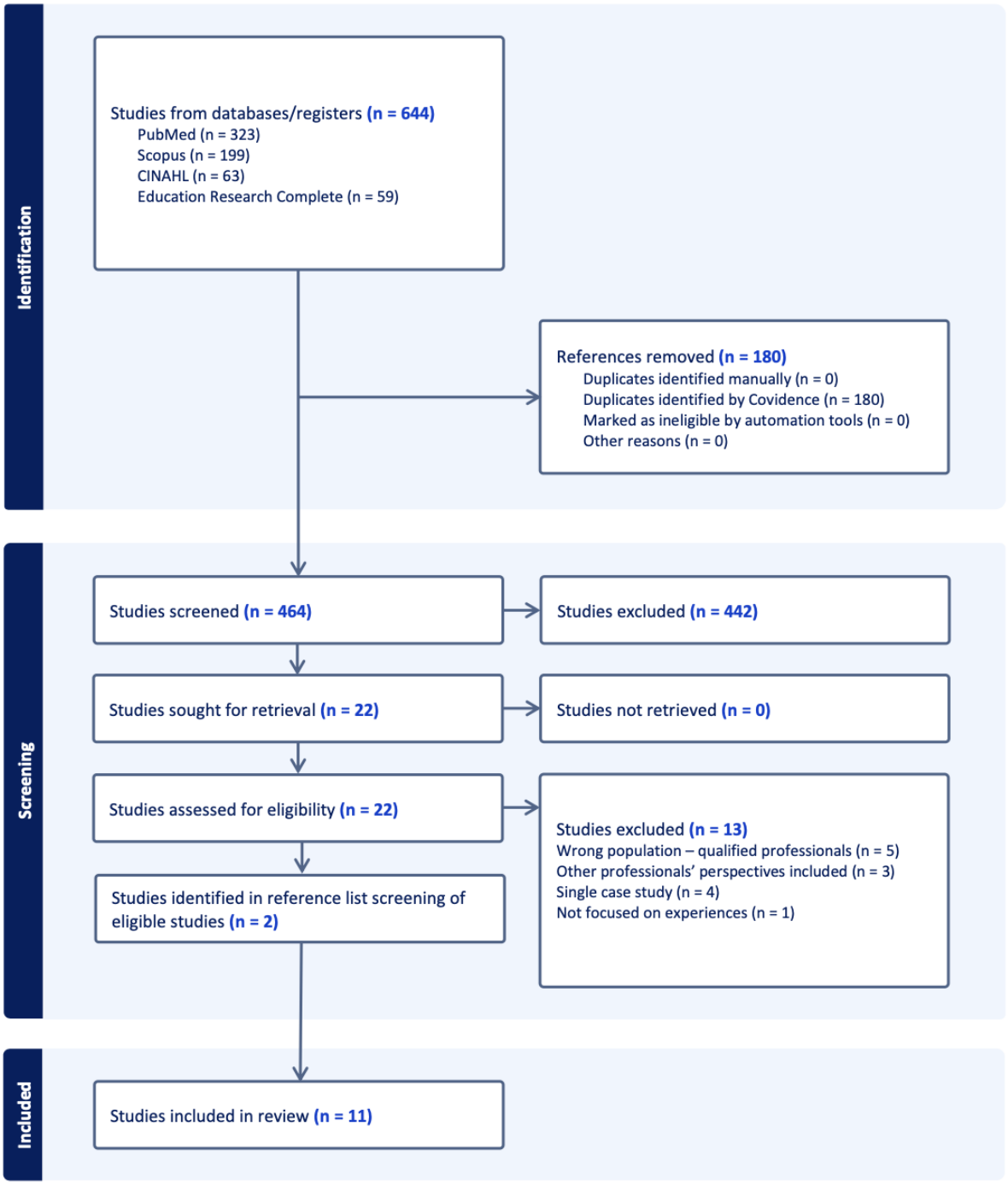
The final literature search was conducted in December 2024. The PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) diagram (Page et al., 2021) in Figure 1 visually represents the study selection process of this review, ensuring clarity and reproducibility.

Search results from the four databases were combined, totalling 644 studies, and 180 duplicate records were removed using Covidence software (Covidence Systematic Review Software, Veritas Health Innovation, 2025). After the removal of duplicates, 464 studies

remained and were screened based on titles and abstracts. Following this, 22 studies underwent full-text review to assess eligibility. Of these, 13 were excluded, leaving a total of 9 studies that met the eligibility criteria. Lastly, a reference list search identified two additional studies for inclusion. Therefore, a total of 11 studies were included in the systematic literature review.

To strengthen the rigour and reliability of this review, a fellow Trainee Clinical Psychologist joined the research team as a second reviewer for the title/abstract screening and full text review stages. To assess inter-rater reliability, Cohen's kappa scores were calculated (Gisev et al., 2013). For the title/abstract screening stage, the Cohen's kappa was 0.90; and for the full-text review stage, the Cohen's kappa was 0.81. Both scores indicate 'almost perfect agreement' among reviewers (Gisev et al., 2013). Any disagreements were resolved through discussion, with reviewers presenting their rationale until full agreement was reached.

Figure 1: *PRISMA Diagram*



2.5 Data Extraction

Table 3: *Data Extraction Table*

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
Ali et al. (2020) How does dyslexia impact on the educational experiences of healthcare students? A qualitative study UK	To explore the impact of dyslexia on the educational experiences of healthcare students across multiple disciplines (medicine, dentistry, dental therapy and biomedical sciences).	Dyslexia	15 healthcare undergraduate students from one UK university studying medicine (5), dentistry (4), dental therapy (3) and biomedical sciences (3) Formal diagnoses of dyslexia Gender: female (8), male (7) Age range: 19-24 years old	Qualitative study Purposive sampling Semi-structured interviews Thematic analysis	• Most participants felt comfortable disclosing dyslexia and valued diagnosis, though some feared admission bias. • Transition to university was challenging, but accessing support services helped. • Academic difficulties included slow reading, spelling errors, note-taking challenges, and fatigue. • PBL was preferred over lectures for its interactive format. • Clinical skills and communication were unaffected; clinical note writing remained a key challenge. • Participants used coping strategies including assistive tech, peer support, and advance preparation.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
			Ethnicity: White (12), Asian Pakistani (1), Asian Indian (1), Asian other (1)		• Staff and peer interactions were overall positive, though some lacked awareness or questioned accommodations. • The format of some assessments was deemed challenging, and strategies were required to manage written assignments. • Participants recommended better staff training, peer awareness sessions, accessible resources, and dedicated support tutors. • Concerns post-graduation included time pressures, documentation demands, and potential employer bias.
Allen (2013) The journey to becoming-authentic from the voices of nursing students living with Attention Deficit	To develop a deep understanding of the lived experience of having ADHD as a nursing student.	ADHD	6 nursing students from one US university Formal diagnoses of ADHD Gender: not stated	Qualitative study Convenience sampling Interviews	• Participants with ADHD became aware of their differences in comparison to their peers, particularly in filtering distractions. • This awareness often led to ontological anxiety, described as an unsettling feeling about being different, and a strong desire to be like others.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
Hyperactivity Disorder US			Age range: not stated Ethnicity: not stated	Integrative phenomenological analysis	• Participants described the stigma associated with ADHD**,** and many feared being misunderstood or judged by peers and staff. • In response, they developed personalised strategies to manage their difficulties and meet academic demands in nursing school. • Through this process, participants engaged in what the author terms “becoming-authentic” – gradually accepting their differences, finding their own way of being, and recognising their unique identity.
Child & Langford (2011) Exploring the learning experiences of nursing students with dyslexia UK	To explore the learning experiences of dyslexic nursing students on clinical placements to enhance understanding and support in practice.	Dyslexia	12 nursing students from one UK university 6 had formal diagnoses of dyslexia and 6 had no known disability Gender: not stated	Qualitative study Purposive sampling Semi-structured interviews Thematic analysis	• Participants with dyslexia faced challenges in clinical placements, including memory, spelling, writing, and time management. • Work-based learning days were valued for peer support and interactive learning. • Mentorship quality varied; some mentors lacked understanding of dyslexia but a good mentor greatly improved learning experiences.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
			Age range: not stated Ethnicity: not stated		• Disclosure was difficult due to fear of judgement; many preferred university-led disclosure (advocacy on their behalf). • Participants used personal strategies (e.g., notebooks, spelling aids, diaries) to cope. • Participants recommended placement info packs, pre-placement visits, action plans, and clearer communication between university and practice settings.
Godfrey-Harris & Shaw (2023) The experiences of medical students with ADHD: A phenomenological study UK	To explore the lived experiences of medical students with ADHD, to promote inclusive approaches.	ADHD	6 medical students from one UK university Formal diagnoses of ADHD Gender: cis-female (4), cis-male (1), non-binary (1)	Qualitative study Purposive sampling Loosely structured interviews	• Participants had a mixed relationship with their ADHD identity. • The process of obtaining a diagnosis was challenging, however it also provided validation. • Participants identified ADHD-related strengths such as empathy, creativity, and high energy. • They also experienced challenges, such as with communication, attention, mental health and managing their own emotional responses.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
			Age range: 20-25 years old Ethnicity: not stated	Interpretive phenomenological analysis	• Disclosure decisions were shaped by fears of being perceived as less capable. • Participants felt disabled by the training system with additional hurdles than neurotypical peers, and a lack of adequate, personalised support. • Participants experienced direct and indirect discrimination and challenging social interactions with peers and staff. • They adopted survival strategies, such as masking. • Recommendations were made to improve training experiences, such as funding support tools, creating a community for neurodivergent students, and identifying role models.
Morris & Turnbull (2006)	To explore the clinical experiences of nursing students with dyslexia and	Dyslexia	18 nursing students from one UK university	Qualitative study Convenience sampling	• Disclosure decisions were challenging for all participants, mostly due to fears of discrimination and judgement. Some felt disclosure was beneficial to access support.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
Clinical experiences of students with dyslexia UK	the impact on their practice.		Formal diagnoses of dyslexia Gender: not stated Age range: not stated Ethnicity: not stated	Semi-structured interviews Thematic Analysis	• Participants adopted a range of personal coping strategies, such as using voice-recorders and additional practice. • Many required more time than peers to complete tasks to ensure patient safety. • Participants viewed their diagnosis negatively, sharing the resulting emotional aspects. • Participants' dyslexia informed their choice of future practice area, with most preferring slower-paced environments.
Morris & Turnbull (2007) The disclosure of dyslexia in clinical practice: Experiences of student nurses in the United Kingdom	To examine the clinical experiences of nursing students with dyslexia, with a particular focus on decisions and experiences around disclosing dyslexia.	Dyslexia	18 nursing students from one UK university Formal diagnoses of dyslexia Gender: not stated Age range: not stated	Qualitative study Convenience sampling Semi-structured interviews Thematic analysis	• Disclosure decisions were challenging for participants, with some choosing not to disclose. • Stigma and negative attitudes towards dyslexia were commonly reported and shaped decisions to conceal. • Participants' perceptions of their mentors' support and attitude greatly impacted disclosure decisions, in addition to those of other healthcare professionals.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
UK			Ethnicity: not stated		• Concerns for patient safety also influenced disclosure decisions. • Expectations of confidentiality were not always met; breaches caused distress and reduced willingness to disclose. • Recommendations made for placements to be tailored to individual needs and for disability awareness training.
Murphy (2011) On being dyslexic: Student radiographers' perspectives UK	To understand how dyslexia affects radiography students' clinical training and what support or adjustments are needed.	Dyslexia	Radiography students from different UK universities Questionnaire component: 37 participants (14 dyslexic, 23 non-dyslexic) Interview component: 10 participants (8	Mixed-methods study Volunteer sampling Self-report questionnaire and semi-structure interviews Thematic analysis	• Participants had early negative experiences related to their dyslexia, leading to negative self-perceptions. • They developed coping strategies to manage their difficulties, such as using alternative vocabulary, rote learning medical terms, checking and double-checking forms and avoiding challenging situations and tasks. • Some highlighted positive strengths associated with dyslexia, such as organisational skills and resilience.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
			dyslexic, 2 non-dyslexic) Formal diagnoses of dyslexia Gender: female (30), male (7) Age range: not stated Ethnicity: not stated		• Participants required more time to complete tasks than peers, but often this adjustment was not met on placement. • Participants struggled with the label/ "badge" of disability. • Reasonable adjustments were a challenge for all participants, either because they did not have access and/or they were unaware of what was available. • Support involving technology, mentors, role models and peer support spaces were deemed helpful.
Price & Gale (2006) How do dyslexic nursing students cope with clinical practice placements? The	To assess the impact of dyslexia on nursing students' clinical practice and to identify pedagogical	Dyslexia	20 nursing students from one UK university 10 had formal diagnoses of dyslexia, 10 were non-dyslexic	Qualitative study Convenience sampling Focus group interviews	• Participants reported challenges with literacy, including spelling, word recognition, medical terminology, and speed of written documentation. • Organisational difficulties were described, particularly in adapting to differing ward

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
impact of the dyslexic profile on the clinical practice of dyslexic nursing students: pedagogical issues and considerations UK	considerations for better support.		Gender: female (20) Age range: not stated Ethnicity: not stated	(separate groups for dyslexic and non-dyslexic students) Thematic analysis	systems, understanding and completing charts, and managing shift handovers. • Telephone communication posed difficulties for dyslexic participants due to background noise, unfamiliar accents, lack of visual cues, and difficulty taking notes or remembering instructions. • Disclosure of dyslexia was generally seen as helpful by participants but was also associated with low self-esteem and anxiety about being judged or mistrusted by mentors. • Some participants reported negative or unhelpful responses from mentors, including a lack of understanding. • Participants expressed strong concerns about patient safety and described strategies to minimise risk, such as repeated checking and seeking confirmation from colleagues.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
					• Participants used compensatory strategies, including pre-reading, colour-coding, memory prompts, and task chunking.
Ridley (2011) The experiences of nursing students with dyslexia UK	To explore the experiences of pre-registration nurses with dyslexia.	Dyslexia	7 nursing students from one UK university Formal diagnoses of dyslexia Gender: not stated Age range: not stated Ethnicity: not stated	Qualitative study Purposive sampling Semi-structured interviews Thematic analysis	• Delays in the identification and testing for dyslexia negatively affected learning experiences. • Emotional responses to diagnosis varied, such as appreciating clarity and concerns about labelling. • Participants felt a professional duty to disclose their dyslexia to safeguard patient care, though there was confusion around how disclosure was managed by the university. • Disclosure was anxiety-provoking due to concerns around judgement. • Participants were self-aware and reflective, focusing on personal development and strategies. • Support from mentors, tutors, and peers was variable; positive relationships improved

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
					confidence, while dismissive attitudes reduced help-seeking. Participants often had to advocate for themselves. • A strong preference was expressed for personalised, continuous academic support.
Shaw et al. (2022) The learning experiences of dyslexic medical students during the COVID-19 pandemic: a phenomenological study UK	To explore the educational experiences of dyslexic medical students during the COVID-19 pandemic.	Dyslexia	5 medical students from one UK university Formal diagnoses of dyslexia Gender: female (3), male (2) Age range: not stated Ethnicity: not stated	Qualitative study Purposive sampling Semi-structured interviews Interpretive phenomenological analysis	• Participants valued increased control, flexibility, and enjoyment in self-directed learning during remote education. • Technology-enhanced tools, personalised routines, ability to revisit materials, and reduced pressure were reported as beneficial to their learning and wellbeing. • Participants appreciated inclusive adjustments such as captions and customisable exam interfaces, though acknowledged no solution suited everyone. • Traditional lectures were viewed as ineffective, and participants expressed a strong preference for

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
					continuation of blended and flexible approaches post-pandemic. • Participants described increased kindness, unity, and acceptance among peers and staff. However, some also reported negative social dynamics such as online hostility and challenges from reduced peer interaction. • Concerns were raised about the lack of clinical exposure and uncertainty about future preparedness. • Participants were worried about disadvantages in assessment due to reliance on written exams, potential cheating by peers, and technical issues affecting accessibility.
Shaw et al. (2023) The experiences of autistic medical students: A	To explore and understand the lived experiences of autistic medical students in the UK.	Autism	5 medical students from 5 different medical schools in the UK	Qualitative study Purposive sampling	• Participants described a mix of strengths and challenges associated with being autistic, including empathy, perseverance, and communication differences.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
phenomenological study UK			Formal diagnoses of autism Gender: female (3), male (2) Age range: 22-27 years old Ethnicity: not stated	Semi-structured interviews Interpretive phenomenological analysis	• They experienced stigma and stereotyping from peers and staff, including disbelief about their diagnosis. • Participants reported sensory sensitivities that interfered with learning. • A lack of structure and predictability contributed to emotional and cognitive exhaustion. • Receiving a diagnosis prompted personal journeys of self-understanding and identity development. • Participants described masking their autistic traits to appear 'normal', especially in professional contexts, which was experienced as exhausting and anxiety-inducing. • Group work and social interactions were experienced as difficult. • Participants described feelings of isolation, peer competitiveness, and experiences of bullying.

Author (Year), Title and Location	Study Aim(s)	Neurodivergent Condition(s)	Sample Characteristics	Study Design	Key Findings
					• Peer support from other autistic individuals and role models was experienced as validating and supportive. • Participants disclosed their diagnosis to medical schools and requested reasonable adjustments, but described receiving standardised or inappropriate support. • Requests for personalised adjustments were often rejected, leaving participants felt dismissed. • Participants were sometimes advised or pressured to take time out rather than receiving support to continue.

2.6 Study Characteristics

Country of Origin: Of the 11 studies included, 10 were conducted in the UK and one in the US (Allen, 2013). This indicates a focus in UK healthcare education research on neurodivergent students, and a noticeable gap in international research.

Aims: All studies aimed to explore and understand the experiences of neurodivergent students in healthcare education and/or clinical placements. The specific focus varied depending on neurodivergent condition, healthcare profession and clinical practice versus academic context, however they predominantly explored experiences, challenges, coping strategies and institutional support. Collectively, these studies aimed to inform educational practices and policies to improve support and inclusion for neurodivergent students in healthcare training programmes.

Study Design and Methodology: All 11 studies employed qualitative methodologies, predominantly using semi-structured interviews to explore student experiences in depth, however one study used focus group interviews (Price & Gale, 2006). One study (Murphy, 2011) utilised a mixed-methods approach, combining questionnaire data with semi-structured interviews. Interpretive Phenomenological Analysis (IPA) was used by studies focusing on medical students (Godfrey-Harris & Shaw, 2023; Shaw et al., 2022; Shaw et al., 2023) to explore lived experiences. Across seven studies, thematic analysis was used to identify recurring patterns and themes in the qualitative datasets.

Participants: Sample sizes ranged from five to 18 participants. Nursing students were most frequently studied (n=6), followed by medical students (n=4), and radiography students (n=1). The majority of studies focused specifically on dyslexic students (n=8), with fewer studies exploring ADHD (n=2), and only one study examining autistic students' experiences (n=1). No studies included other neurodivergent conditions such as dyspraxia or dyscalculia.

Participant demographics typically reflected a higher proportion of female students, particularly within nursing samples. Across all studies, demographic factors such as ethnicity and age were consistently under-reported.

2.7 Quality Assessment

A key component of a systematic literature review is conducting a quality appraisal, as it critically evaluates the methodological rigour and credibility of the selected studies, underpinning the validity of the overall synthesis. All included studies in this review were quality appraised using the Critical Appraisal Skills Programme (CASP, 2024) tool, designed for qualitative research. The CASP tool is widely recognised and recommended by organisations such as the Cochrane Qualitative and Implementation Methods Group as a reliable framework for evaluating qualitative research within health and social care contexts (Long et al., 2020). It comprises of ten questions that assess key aspects of methodological rigour, with response options of ‘Yes’, ‘No’ or ‘Can’t Tell’. To aid transparency and comparability, a cumulative rating score out of ten was generated for each study (‘Yes’ = 1, ‘Can’t Tell’ = 0, ‘No’ = 0), consistent with previous qualitative syntheses (e.g., Boeije et al., 2011). A summary of how each paper met the CASP criteria is presented in Table 4, and following this there is a narrative provided with more detail.

Table 4: *CASP Scoring*

Author (Year)	Q1: Was there a clear statement of the aims of the research?	Q2: Is a qualitative methodology appropriate?	Q3: Was the research design appropriate to address the aims of the research?	Q4: Was the recruitment strategy appropriate to the aims of the research?	Q5: Was the data collected in a way that addressed the research issue?	Q6: Has the relationship between researcher and participants been adequately considered?	Q7: Have ethical issues been taken into consideration?	Q8: Was the data analysis sufficiently rigorous?	Q9: Is there a clear statement of findings?	Q10: How valuable is the research?	Rating
Ali et al. (2020)	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	Yes	9/10
Allen (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
Child & Langford (2011)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	9/10
Godfrey-Harris & Shaw (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
Morris & Turnbull (2006)	Yes	Yes	Can't Tell	Yes	Yes	Can't Tell	Yes	Yes	Yes	Yes	8/10

Author (Year)	Q1: Was there a clear statement of the aims of the research?	Q2: Is a qualitative methodology appropriate?	Q3: Was the research design appropriate to address the aims of the research?	Q4: Was the recruitment strategy appropriate to the aims of the research?	Q5: Was the data collected in a way that addressed the research issue?	Q6: Has the relationship between researcher and participants been adequately considered?	Q7: Have ethical issues been taken into consideration?	Q8: Was the data analysis sufficiently rigorous?	Q9: Is there a clear statement of findings?	Q10: How valuable is the research?	Rating
Morris & Turnbull (2007)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	9/10
Murphy (2011)	Yes	Yes	Can't Tell	Yes	Yes	No	Yes	Yes	Yes	Yes	8/10
Price & Gale (2006)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	9/10
Ridley (2011)	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	Yes	9/10
Shaw et al. (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
Shaw et al. (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10

The overall methodological quality of the studies included in this review is good, with all papers meeting the majority of the criteria set out in the CASP checklist. All 11 studies provided a clear statement of their research aims, and employed appropriate qualitative methodologies for exploring the lived experiences of neurodivergent students in healthcare education. Most studies used well-justified research designs – most commonly semi-structured interviews – which were suitably aligned with their exploratory aims (e.g., Allen, 2013; Shaw et al., 2023), however two studies did not provide sufficient detail about their choice of design (Morris & Turnbull, 2006; Murphy, 2011). Data collection methods were appropriately matched to the research objectives in all cases, allowing participants to describe their experiences in rich detail. In addition, data analysis methods appeared rigorous and transparently described, and were most commonly thematic analysis and interpretative phenomenological analysis.

Recruitment strategies were appropriate and clearly described. Ethical considerations were consistently addressed, such as informed consent, with procedures and formal ethical approval outlined across all studies. However, risk of harm to participants due to the sensitivity of the topics was not covered unanimously.

The most common limitation related to the discussion of the relationship between the researcher and participants (CASP Q6). Whilst several studies explicitly addressed researcher reflexivity and positionality (Allen, 2013; Godfrey-Harris & Shaw, 2023; Shaw et al., 2022; Shaw et al., 2023), the remainder did not discuss this aspect in detail making it difficult to assess (Morris & Turnbull, 2006; Ridley, 2011), or at all (Child & Langford, 2011; Morris & Turnbull, 2007; Murphy, 2011; Price & Gale, 2006).

Findings were clearly presented across all studies, supported by illustrative participant quotations and structured around themes that related back to the research aims. All studies were judged to be of value, contributing meaningfully to an under-researched area;

supporting the understanding of the experiences of neurodivergent healthcare students and offering practical insights for educators, policymakers, employers and support services. Several studies stood out for their originality, particularly those focusing on under-researched groups such as neurodivergent healthcare professions students with ADHD (Allen, 2013; Godfrey-Harris & Shaw, 2023), and autism (Shaw et al., 2023).

No studies were excluded based on quality; the body of evidence as a whole was deemed of sufficient quality to support a robust synthesis of the experiences of neurodivergent students in healthcare professions training.

2.8 Synthesis

Synthesis Strategy: The chosen method of data synthesis for this SLR was thematic synthesis (Thomas & Harden, 2008). Other methods were considered, for example narrative synthesis and meta-ethnography, however thematic synthesis was deemed most suitable given the qualitative and thematic findings of the included papers, the focus on experiences, and the aim of meaning-making beyond descriptive accounts (Kastner et al., 2012). Following the framework outlined by Thomas and Harden (2008), the thematic synthesis involved a three-stage process: line-by-line coding of each paper's findings, including both participant quotes and author-generated interpretations; grouping these codes into broader descriptive themes that reflected recurring patterns; and developing higher-level analytical themes to generate insights beyond the original data.

***Findings*:** As a result of this thematic synthesis, four main themes with relevant sub-themes (Table 5) emerged that encapsulate the experiences of neurodivergent students in healthcare professions training.

Table 5: *SLR Themes and Sub-Themes*

Themes	Sub-Themes
1: Academic and Clinical Challenges	• Academic Learning Challenges • Clinical Practice Challenges • Social Communication Barriers • Barriers to Accessing Support
2: Disclosure and Identity Management	• Fear of Stigma and Discrimination • Disclosure as a Dynamic, Selective Process
3: Coping Strategies and Support Systems	• Adaptive Strategies • Masking and Self-Protection Behaviours • Self-Advocacy • Supportive Relationships
4: Growth and Self-Acceptance	

2.8.1 Theme 1: Academic and Clinical Challenges

All 11 studies detailed a range of difficulties that neurodivergent students encounter during healthcare professions training. Challenges were often described as rooted in their neurodivergence, however they were compounded by the demanding environments and inconsistent support structures.

Academic Learning Challenges: Across nine studies, participants described academic learning challenges including difficulties with reading, writing, concentration, memory and information processing (Ali et al., 2020; Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006; Murphy, 2011; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022). For example, one student shared: *"if any lectures aren't recorded, that's a nightmare, because you even if you're trying. . . if you're paying attention as much as you can throughout the lecture you'll never like, it just doesn't pick up as well."* (Godfrey-Harris & Shaw, 2023, p. 8). Dyslexic students commonly reported struggling with

intensive reading and note-taking, lacking automaticity in tasks such as spelling medical terminology or calculating drug dosages that peers seemed to perform with ease (Morris & Turnbull, 2006; Price & Gale, 2006). These difficulties were described as often undermining students' confidence in classroom and exam settings (Murphy, 2011; Price & Gale, 2006; Ridley, 2011). Students with ADHD reported challenges sustaining attention in lectures, organising their time, and meeting coursework deadlines, which contributed to stress and feelings of overwhelm (Allen, 2013; Godfrey-Harris & Shaw, 2023). Frequently, participants across neurodivergent conditions emphasised the difficulty of trying to 'keep up', often due to misaligned cognitive and processing challenges. Students commonly described the pace and volume of work as overwhelming (Allen, 2013; Godfrey-Harris & Shaw, 2023; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022; Shaw et al., 2023), which often led to high levels of stress, anxiety and self-doubt, particularly during assessments (Allen, 2013; Godfrey-Harris & Shaw, 2023; Ridley, 2011; Shaw et al., 2023).

Clinical Practice Challenges: In clinical settings, academic challenges were reportedly intensified as students entered fast-paced, high-pressure healthcare environments. Clinical practice challenges emerged in eight studies, particularly among dyslexic and autistic students (Ali et al., 2020; Child & Langford, 2011; Morris & Turnbull, 2006; Murphy, 2011; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022; Shaw et al., 2023). Many neurodivergent students described struggling with multitasking, rapid decision-making, and information processing required on clinical placements. For instance, dyslexic nursing students shared finding documentation, drug rounds and reading patient charts particularly stressful under time constraints, and experienced overwhelming cognitive load when combined with patient interactions (Morris & Turnbull, 2006; Price & Gale, 2006; Ridley, 2011). As one expressed, "*A drug round will take me a long time because I'll check and re-check the drug card and dosage...I may read the same drug about 20 to 30 times"* (Morris &

Turnbull, 2006, p. 242). These challenges were compounded by the need to simultaneously interact with patients and integrate complex information quickly. One study noted that students would sometimes avoid tasks like answering telephones on wards due to fear of quickly processing spoken information or accurately transcribing messages (Morris & Turnbull, 2006). Across studies, clinical environments were described as cognitively and emotionally exhausting for many neurodivergent students.

Social Communication Barriers: The intricate social demands of healthcare training programmes were also experienced as challenging by neurodivergent students (Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Shaw et al., 2023). Difficulties included following rapid conversations during handovers, hesitancy in group discussions, and misinterpreting social cues from patients, peers, or supervisors (Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Shaw et al., 2023). Autistic students expressed greater comfort in one-to-one patient interactions than informal conversations with colleagues, where unwritten social rules were expressed as harder to navigate (Shaw et al., 2023). Group work was also described as challenging due to the dual academic and social demand, for example one student said: *"You can't focus on learning something and focus on ... passing ... socially at the same time ..."* (Shaw et al., 2023, p.974). In Shaw et al.'s (2022) study of experiences during the COVID-19 pandemic, some students felt as if kindness and unity were enhanced amongst peers and staff, however they still reported experiences of online hostility in peer interactions. Across numerous studies, social communication barriers were noted as contributing to feelings of anxiety, isolation, and disconnection in healthcare environments and teams.

Barriers to Accessing Support: Many studies highlighted how delayed or inconsistent institutional support exacerbated students' academic and clinical challenges. While learning support plans, assistive technology, and adjustments such as extra time were described as

helpful when available (Ali et al., 2020; Godfrey-Harris & Shaw, 2023; Ridley, 2011; Shaw et al., 2022), access to such provisions was not guaranteed. Students often described long delays in receiving support, particularly if awaiting formal diagnoses (Godfrey-Harris & Shaw, 2023; Shaw et al., 2022). Bureaucratic requirements – such as the need for detailed assessments, repeated documentation, and navigating fragmented disability services – further compounded these difficulties. In Godfrey-Harris and Shaw's (2023) paper, accessing support was described as *"financially and emotionally expensive"* (p.12), highlighting how financial barriers also prevented equitable access. In addition, Morris and Turnbull (2006) reported instances where students were unclear about what support they were entitled to, or found themselves unsupported due to lack of awareness or responsiveness from staff. Some were reluctant to pursue adjustments altogether, anticipating stigma or feeling unsure how to engage with institutional processes. The cumulative effect of these obstacles left many students feeling without the tools or understanding needed to effectively manage academic demands and clinical placements. Consequently, many studies provided recommendations to improve support options and structures for neurodivergent students (Ali et al., 2020; Child & Langford, 2011; Morris & Turnbull, 2007; Murphy, 2011; Ridley, 2011; Shaw et al., 2023).

2.8.2 Theme 2: Disclosure and Identity Management

Negotiating whether, when, and how to disclose neurodivergent identity emerged as a pervasive issue in all of the studies (Ali et al., 2020; Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006, 2007; Murphy, 2011; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022; Shaw et al., 2023).

Fear of Stigma and Discrimination: In 10 of the 11 studies, participants described hesitancy to disclose their neurodivergent identity, particularly within clinical environments, due to fears of being judged, misunderstood, or perceived as less competent (Allen, 2013;

Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006, 2007; Murphy, 2011; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022; Shaw et al., 2023). In one study, a student expressed worries that disclosure would lead to patronising behaviour rather than meaningful support: *"I didn't say anything, I didn't want her to pat me on my head and make special allowances. I want help not pity"* (Morris & Turnbull, 2007, p. 38). Similarly, students in Murphy's (2011) study described disclosure as a *"badge"* they were unsure about wearing, fearing it would invite judgement or limit opportunities.

Numerous studies highlighted how these concerns were reinforced by prior experiences of stigma or a lack of understanding from staff and supervisors. Students described encountering mentors who minimised or dismissed their neurodivergence, or made insensitive remarks after disclosure (Allen, 2013; Godfrey-Harris & Shaw, 2023; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022). For example, in some cases clinical mistakes were attributed to laziness or incompetence, rather than understood within the context of learning differences (Price & Gale, 2006). Several students also shared experiences of insensitive comments from mentors who failed to adjust performance expectations despite awareness of their dyslexia (Price & Gale, 2006; Ridley, 2011). This reportedly impacted students' willingness to disclose their neurodivergence and seek support.

Disclosure as a Dynamic, Selective Process: Disclosure was rarely a single or straightforward act for the participants in the studies. In nine of the 11 studies, participants described disclosure as a selective and evolving process shaped by personal confidence, relational trust, and perceptions of risk (Ali et al., 2020; Allen, 2013; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2007; Murphy, 2011; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022; Shaw et al., 2023). Students often made calculated decisions about if, when, and to whom to disclose, weighing potential support against fears of judgement. One student nurse only disclosed on longer placements: *"I've always told my core placement*

mentor as I'm there for longer (15 weeks+) but for inter-semester placements (3–4 weeks) I don't tell" (Morris & Turnbull, 2007, p. 38). Others described increased openness over time, often linked to maturity or self-acceptance: *"I am quite happy to disclose it but only because I'm older now"* (Morris & Turnbull, 2007, p. 38).

Yet some shared that they chose to conceal their neurodivergence to avoid being treated differently (Allen, 2013; Morris & Turnbull, 2007; Price & Gale, 2006). Even when disclosure occurred, it was often described as being accompanied by ambivalence or anxiety (Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006; Shaw et al., 2022). A minority expressed comfort with disclosure, particularly in Ali et al.'s (2020) study, such as one student who shared, *"I'm quite open about it and do not feel there is any need to hide a disability from staff or students"* (Ali et al., 2020, p. 157). Overall, disclosure was a careful, ongoing negotiation of identity and safety within healthcare training contexts.

2.8.3 Theme 3: Coping Strategies and Support Systems

Despite encountering academic, clinical and relational challenges, participants across 10 of the 11 studies demonstrated resilience and adaptability by developing a range of coping strategies and drawing on informal and formal support systems (Ali et al., 2020; Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006, 2007; Murphy, 2011; Price & Gale, 2006; Shaw et al., 2022; Shaw et al., 2023). These strategies ranged from practical and cognitive adaptations to relational forms of self-protection, advocacy, and peer connection. Collectively, they suggest how neurodivergent students worked resourcefully, and often invisibly, to survive and succeed within healthcare professions training.

Adaptive Strategies: Across eight studies, participants described developing adaptive strategies to help them manage the demands of academic and clinical training (Ali et al.,

2020; Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006; Murphy, 2011; Price & Gale, 2006; Ridley, 2011). These strategies were typically developed through trial and error and carefully tailored to students' individual cognitive and sensory needs. For example, dyslexic students described using assistive technologies such as voice recorders, colour-coded notes, mind maps, and extra practice with documentation to support literacy and memory difficulties (Ali et al., 2020; Child & Langford, 2011; Murphy, 2011; Price & Gale, 2006). Some described spending extra hours practising documentation or drug calculations to compensate for slower processing speed or spelling difficulties (Morris & Turnbull, 2006; Shaw et al., 2023). One student noted *"She worked twice as hard as the others."* (Price & Gale, 2006, p. 230). Students with ADHD discussed structuring their environment to reduce distractions, such as using quiet study spaces, noise-cancelling headphones, or blocking apps, and relied on planners, alarms, and phone reminders to manage competing academic demands (Allen, 2013; Godfrey-Harris & Shaw, 2023). While these adaptations were often invisible to others, they arguably reflect a high level of resourcefulness, determination, and a deep commitment to maintaining safe and competent practice.

Masking and Self-Protection Behaviours: A subset of coping strategies involved masking and self-protection. In nine of the 11 studies, participants described strategies aimed at hiding difficulties, avoiding risk, or minimising the likelihood of being perceived as different (Allen, 2013; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006, 2007; Murphy, 2011; Price & Gale, 2006; Ridley, 2011; Shaw et al., 2022; Shaw et al., 2023). Examples given included pretending to take notes while actually drawing diagrams (Price & Gale, 2006), avoiding tasks like answering telephones or calculating drug dosages in high-pressure situations (Morris & Turnbull, 2006; Ridley, 2011), or subtly relying on peers to help interpret complex written information. These behaviours were suggested to protect

against embarrassment or negative judgement. Murphy (2011) described "self-protection" as a key theme among student radiographers who intentionally shielded themselves from exposing situations, even if this meant missing learning opportunities.

Masking was also used to navigate social and sensory environments. Students described masking neurodivergent characteristics, such as mimicking peer behaviour, concealing discomfort, and carefully managing their outward presentation to appear neurotypical (Allen, 2013; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2007; Shaw et al., 2023). Whilst this was sometimes felt to be effective in avoiding unwanted attention, the constant monitoring was reported to be emotionally exhausting and unsustainable: "*that extra worry of. . . making sure that you're not seeming distracted*, *and you're seeming engaged*, *and you're making the patient feel safe and comfortable and able to talk to you. . . that's a lot of things to have to do all at once"* (Godfrey-Harris & Shaw, 2023, p.10). Some shared that the ongoing effort to fit in ultimately led to withdrawal, detachment from peers, and further stress and masking (Allen, 2013; Morris & Turnbull, 2007). These accounts highlight how masking and self-protection were active responses to environments that were experienced as unsafe, invalidating, or unaccommodating.

Self-advocacy: Alongside private coping methods, many neurodivergent students developed self-advocacy as a means of navigating academic and clinical challenges. This was highlighted in six studies (Ali et al., 2020; Allen, 2013; Child & Langford, 2011; Godfrey-Harris & Shaw, 2023; Shaw et al., 2022; Shaw et al., 2023). Participants described learning to articulate their needs clearly to staff to actively seek help. Some shared having to "fight" for accommodations or repeatedly explain their difficulties in order to be taken seriously, particularly when their needs were invisible or not well understood by educators (Godfrey-Harris & Shaw, 2023). One student with ADHD explained the emotional toll of this effort: "…*Every day you're having to say*, *if not twice a day*, *you're having to go up to someone and*

explain why you are the way you are. . . And then you also have that extra like emotional burden of having to take on the fact that probably 80% of people aren't going to listen to you, or fully take on what you're saying" (Godfrey-Harris & Shaw, 2023, p.9). Students also expressed frustration at having to educate their educators, or that their educators did not advocate for them across settings (Child & Langford, 2011) suggesting that neurodivergent students were advocating not only for personal needs but also systemic change.

Supportive Relationships: Supportive relationships were described as playing a crucial role in helping neurodivergent students navigate the demands of healthcare training. In seven studies, participants described how encouragement, understanding, and practical support from mentors, supervisors, and peers helped them feel more secure, confident, and able to cope with the pressures (Ali et al., 2020; Child & Langford, 2011; Morris & Turnbull, 2007; Murphy, 2011; Price & Gale, 2006; Shaw et al., 2022; Shaw et al., 2023). Trusted staff were seen as those who took time to listen, adapted their feedback styles, or helped students find workarounds when challenges arose. One student reflected: *"She was really understanding. I struggled with care plans and she spent a lot of time with me. I trusted her, but she's the only one I've been able to tell"* (Morris & Turnbull, 2007, p. 38). As this quote suggests, staff support could also foster psychological safety and an environment for disclosure.

Peers were also described as vital sources of informal support. Across several studies, students shared examples of peers offering academic help, such as sharing notes or proofreading work, or quietly stepping in to support them in clinical placements (Ali et al., 2020; Price & Gale, 2006; Shaw et al., 2023). These gestures appeared to reduce feelings of isolation and helped students manage the invisible labour of training. Overall, the accounts in these studies propose that connection could buffer against marginalisation and strengthen students' ability to cope.

2.8.4 Theme 4: Growth and Self-Acceptance

Despite the academic, relational and systemic challenges described across the studies, there was also a theme of personal growth and increased self-acceptance. In seven studies, neurodivergent healthcare professions students described a process of identity transformation, often involving reframing their neurodivergence as valid and valuable (Allen, 2013; Ali et al., 2020; Godfrey-Harris & Shaw, 2023; Morris & Turnbull, 2006; Murphy, 2011; Shaw et al., 2022; Shaw et al., 2023). Allen (2013) documented the *"becoming-authentic"* for nursing students with ADHD, noting that initial insecurity and awareness of difference shifted to embracing ADHD and authenticity over time. Diagnoses were part of the self-acceptance process for some, for example Murphy's (2011) study of radiography students noted that receiving a diagnosis helped some to make sense of their learning difficulties and begin to understand their needs more compassionately. Similarly, Ali et al. (2020) discussed the "relief" that some felt to have a name to their difficulties. Additionally, Morris and Turnbull (2006) reported increased confidence among some nursing students who had come to view their dyslexia as part of what made them compassionate and diligent practitioners.

Across five studies, participants also recognised and celebrated personal strengths linked to their neurodivergence (Ali et al., 2020; Allen, 2013; Murphy, 2011; Shaw et al., 2022; Shaw et al., 2023). Students described pride in their empathy, creativity, problem-solving, perseverance, and unique perspectives (Allen, 2013; Murphy, 2011; Shaw et al., 2023). In Godfrey-Harris and Shaw (2023), students noted how being neurodivergent enabled them to connect with marginalised patients and advocate for more inclusive care. A student in Shaw et al. (2023) captured the dual process of personal and professional growth: *"So, medicine's hard. But I'm also studying myself and I'm figuring myself out and that degree is harder"* (p. 974). This theme suggests how some neurodivergent healthcare students

increased their understanding of themselves and their strengths, and led to greater self-acceptance.

2.9 Discussion

This SLR explored the experiences of neurodivergent students across healthcare professions training. Four themes were identified in the thematic synthesis: '*Academic and Clinical Challenges'*, '*Disclosure and Identity Management'*, '*Coping Strategies and Support Systems'*, and '*Growth and Self-Acceptance'*.

In summary, this review found that neurodivergent students in healthcare professions training face a complex interplay of academic, clinical, structural and relational challenges. These findings corroborate many of the difficulties previously identified in condition-specific studies, such as those with literacy, attention, processing, and the complications of disclosure (e.g., Crouch, 2019; Shaw & Anderson, 2018). However, by synthesising across neurodivergent conditions and healthcare disciplines, this review offers a broader and more integrated understanding of the shared and systemic pressures. It highlights how the additional cognitive and emotional strain, inaccessible support structures, labour of disclosure decisions, lack of understanding about neurodivergence, and the need for strategies and self-advocacy, are recurring themes in healthcare training contexts regardless of diagnosis or profession. Consequently, it foregrounds the need for structural, rather than solely individual or condition-specific adaptations, suggesting that neurodivergent students are disadvantaged by healthcare training norms (British Medical Association, 2020). Importantly, this review also contributes to the growing body of literature that challenges deficit-focused narratives in healthcare education, by including accounts of resilience, growth and pride – reinforcing the value of neurodivergent-affirmative approaches (Gray et al., 2025).

Strengths of the Review: This systematic review has several notable strengths, including its scope and methodology. To the author's knowledge, this is the first review to synthesise research solely examining neurodivergent students' experiences across healthcare professions, addressing a gap in existing literature. The exploration of the literature was thorough, using multiple databases that address different aspects of the research area, and both peer-reviewed research and grey literature. As rated by the CASP tool (CASP, 2024), the included studies were deemed to be of good quality, supporting the overall strength of the review. The review process was rigorous and selection bias was minimised by using two reviewers for both the title/abstract screening and full text review of the studies, with a high Cohen's Kappa (Gisev et al., 2013) suggesting clearly defined inclusion/exclusion criteria. As the included studies were qualitative and mixed-methods (with a focus only on the qualitative findings), the use of thematic synthesis allowed for deeper, analytic insights that went beyond narrative summarisation. This enabled the development of coherent, transferable themes that span different neurodivergent conditions and healthcare disciplines.

Limitations of the Review: This review also has several limitations that warrant consideration for interpreting the findings and identifying areas for future research. Firstly, the evidence base was relatively small and geographically concentrated, with all bar one study originating from the UK despite aiming to offer a wider perspective. This restricts the generalisability of findings to other international contexts where education systems, disability legislation, and cultural attitudes may differ. The review also faced potential selection biases given that the studies were limited to the English language, possibly missing relevant articles in other languages; as well as voluntary participant samples, thereby excluding students who chose not to disclose their neurodivergence. Additionally, the predominance of studies focusing on students with dyslexia led to less representation of conditions such as autism and ADHD, potentially limiting the depth and specificity of certain themes. While grouping

various neurodivergent conditions importantly facilitated the identification of common experiences, this broad approach may inadvertently mask nuanced differences unique to each condition. Methodologically, although steps were taken to enhance rigour, the qualitative nature of thematic synthesis introduces unavoidable subjectivity in theme development. As part of this, the positioning of the lead researcher – a neurodivergent healthcare professions student – may have impacted interpretation, despite reflexive discussions with the research team to reduce this.

Implications of the Review: This review highlights implications for practice, policy and research. Given the shared experience of difficulties in academic settings across neurodivergent conditions, rather than relying on reactive or condition-specific adjustments, programmes should implement inclusive design principles such as UDL (Hamilton & Petty, 2023) which would promote flexibility in teaching, assessment and placement practices. Another key implication is the need for staff and placement supervisors to receive targeted training in neurodivergence to address the lack of understanding and stigma highlighted across studies, aligning with existing recommendations for building neurodivergent-inclusive campuses (Dwyer et al., 2023). This may also support students' willingness to disclose and experiences of disclosure (Kennedy et al., 2025) and reduce the need to mask their neurodivergence, which were key challenges across studies in this review. At a policy level, within universities and regulatory bodies, greater clarity is needed around entitlement and access to adjustments, as inconsistencies in awareness and securing support contributes to increased stress and inequity (Dwyer et al., 2023). Lastly, embedding neurodivergent-affirmative approaches in healthcare professions training will have value for neurodivergent students and their professions, irrespective of condition(s) (Gray et al., 2025).

Following on from this review, it would be valuable for future research to focus on underrepresented neurodivergent populations, for example autistic, ADHD, dyspraxic and

dyscalculic students across healthcare professions, to ensure tailored understanding and support. On the other hand, it would also be valuable for future research to continue exploring the experiences, challenges and strengths of neurodivergent students across conditions/identities to develop the evidence-base (Gray et al., 2025), as in the current SLR. Additionally, it would be valuable for future research to explore the experiences of neurodivergent students in a wider range of healthcare professions. This review also highlighted a need to move beyond exploratory studies into intervention research – identifying and testing what works to improve neurodivergent students' experiences in healthcare professions training.

Conclusion: This SLR has enhanced understanding about the experiences of neurodivergent students in healthcare professions training; drawing together condition-specific and profession-specific research and identifying shared themes. While the journey towards inclusive healthcare training is ongoing (Gray et al., 2025), this review amplifies the voices of neurodivergent students and provides an evidence-based impetus to support and accelerate that work.

2.10 Rationale for the Current Research

In the field of clinical psychology, despite a key focus on understanding neurodivergence and working towards neuroaffirmative clinical practice (Sisulu et al., 2024), there remains a paucity of research exploring the experiences of its own neurodivergent professionals. As stated in an article by a group of autistic psychologists, "Neurodiversity is not just for those we work with" (Hawker et al., 2022), underscoring the importance of looking within the profession. The preceding SLR highlighted this gap, as no studies were found that specifically focused on the experiences of neurodivergent Trainee Clinical Psychologists. To the author's knowledge, there are several personal, reflective articles

written by neurodivergent Trainee Clinical Psychologists on their experiences (e.g., Khan & Shepherdson, 2024; Muggleton & Johnston, 2016), alongside contributions to articles with qualified psychologists (e.g., Hawker et al., 2022), however their experiences do not appear to be researched formally.

Trainee Clinical Psychologists on DClinPsy programmes in the UK are uniquely positioned as both National Health Service (NHS) employees and postgraduate university students, balancing clinical, research and academic duties (The British Psychological Society (BPS), 2024). Given the identified complexities and challenges for neurodivergent students in higher education, and notably in healthcare professions training (Clouder et al., 2020; Gray et al., 2025), this topic was deemed an important focus to increase understanding, support and inclusive practices. It additionally aligns with calls from the BPS for universities to take collective action to strive for inclusivity and celebrate neurodivergence (Farrant et al., 2022), and the need to amplify the voices of neurodivergent students (Peters, 2023). Lastly, the current research is also informed by the author's position as an insider researcher. The rationale is therefore not only academic, but personal – rooted in lived experience, a recognition of how rarely these stories are heard, and the hope to contribute to meaningful change within the profession.

Aims and Research Questions: The current study aimed to give voice to and understand the experiences of neurodivergent Trainee Clinical Psychologists completing a DClinPsy programme in the UK, and to develop recommendations for programmes to improve support. Within this, the specific research question was: *What are the experiences of neurodivergent Trainee Clinical Psychologists completing a DClinPsy programme in the UK?*

Chapter 3: Methodology

3.1 Chapter Overview

This research aims to explore the experiences of neurodivergent Trainee Clinical Psychologists on DClinPsy programmes in the UK. This chapter outlines the research's epistemology and methodology, including the processes of consultation, participant recruitment, data collection and analysis, ethical considerations, researcher reflexivity, and lastly a quality appraisal.

3.2 Positioning and Epistemology

As discussed in Chapter 1, this research was conducted from a critical realist epistemological stance; acknowledging the existence of objective (ontological) realities, but recognising that these realities are situated within and shaped by socio-cultural and historical contexts (Bhaskar, 2008; Fletcher, 2017). In line with this, data in this research are not treated as revealing an absolute truth, but rather as constructed accounts shaped by participants' perspectives and interpreted through the researcher's lens. Interpretations reflect not only the content of the data but also the researcher's own positioning, including the identity of an insider researcher (a neurodivergent Trainee Clinical Psychologist). Reflexivity was therefore integral throughout the research process to enhance transparency and improve methodological rigour (Bukamal, 2022; Finlay, 2002; Olmos-Vega et al., 2022), utilising strategies such as a reflective journal (Olmos-Vega et al., 2022) and supervisory discussions (Berger, 2015). A reflective journal was maintained throughout the research process, with entries written at every stage – from initial idea conception through consultation, recruitment and data collection, each analysis session, and the write-up – as well as after supervision meetings. Entries captured emotional responses, emerging interpretations, analytic decisions, and reflections on assumptions, uncertainties, and the influence of positionality – guided by

questions such as ‘What assumptions am I making?’ and ‘What alternative interpretations could there be?’.

3.3 Design

3.3.1 Rationale for Qualitative Design

A qualitative approach was deemed most suitable as it prioritises the depth, complexity, and subjective realities of human experiences, allowing participants to express personal meanings, perceptions, and understandings (Braun & Clarke, 2014). Given that the experiences of neurodivergent individuals within clinical psychology training remain under-explored, qualitative methods are particularly valuable as they enable the researcher to generate in-depth understanding which can inform future practice and policy (McAleese & Kilty, 2019). Additionally, qualitative approaches align with the research’s critical realist epistemological stance, recognising multiple subjective interpretations of lived realities shaped by broader socio-cultural and historical contexts (Bhaskar, 2008).

3.3.2 Rationale for Qualitative Questionnaire

A qualitative questionnaire was chosen as the method for data collection. Although less traditionally employed in qualitative research compared to interviews or focus groups, qualitative questionnaires are becoming recognised as valuable tools for eliciting detailed narratives, particularly where anonymity, accessibility, and participant flexibility are priorities (Braun et al., 2021). This method was deemed valuable for several reasons. Firstly, qualitative questionnaires can capture the perspectives and experiences of a larger sample, which is particularly important given the under-explored research area (Braun et al., 2021). Secondly, they allow participants the time and reflective space necessary to articulate thoughtful, detailed responses without the immediacy or social pressures inherent in face-to-face interactions (Terry & Braun, 2017), thus accommodating a range of neurodivergent

communication preferences. Thirdly, the online delivery of the questionnaire facilitated the inclusion of participants geographically dispersed across the UK, increasing the diversity and representativeness of neurodivergent trainee voices. Finally, the anonymity offered by this approach has been found to support deeper disclosure and reduce social desirability bias, encouraging openness in sharing potentially sensitive experiences (Braun et al., 2021). Whilst alternative methods were considered – for example, interviews could have afforded interactional depth and complexity that may not be captured through written responses (Braun & Clarke, 2013), and a quantitative survey could have enabled measurement and comparison across training or neurodivergent-related variables (Taherdoost, 2022) – a qualitative, open-ended questionnaire was deemed to provide the most appropriate balance: a practical, inclusive, and ethically sensitive means of capturing rich, authentic accounts of participants' lived experiences.

3.3.3 Rationale for Reflexive Thematic Analysis

Reflexive thematic analysis (RTA), developed by Braun and Clarke (2006, 2019), was chosen as the qualitative analytic method. RTA is a theoretically flexible approach that enables the identification of patterns and themes within qualitative data (Braun & Clarke, 2006). It acknowledges that themes are actively constructed by the researcher – they do not emerge passively – through a process of deep engagement and reflexivity (Braun & Clarke, 2019). Given the researcher's position as an insider researcher, and the research's critical realist epistemological stance, RTA provides a framework that values and incorporates subjectivity as a resource, facilitating a richer analysis of participants' responses (Clarke & Braun, 2017). In addition, RTA is an accessible and systematic approach to qualitative data analysis (Clarke & Braun, 2017). Braun and Clarke's (2006) six-phase process provides a framework that guides researchers through the analytical journey of codes to themes, and

when the process is clearly detailed, it enhances transparency and consequently credibility of findings (Campbell et al., 2021). RTA can also be used to analyse qualitative datasets of different sizes and nature, and is often used in the analysis of qualitative survey data (Braun & Clarke, 2013; Braun et al., 2021; Terry & Braun, 2017).

However, RTA presents several challenges that researchers must navigate to ensure methodological rigour. A common issue cited in the literature is methodological incoherence, where RTA is inadvertently combined with other incompatible versions of thematic analysis, such as coding reliability, leading to inconsistencies in epistemological underpinnings (Campbell et al., 2021; Finlay, 2021). Another challenge is that whilst the flexibility of RTA is considered a strength, it has been misinterpreted to be atheoretical where researchers do not make explicit their theoretical assumptions and position, or clearly articulate their methodological decisions (Braun & Clarke, 2020). Additionally, whilst reflexivity is highly valued, maintaining this throughout the research process can be demanding and requires ongoing self-awareness and reflection which researchers may not fully attend to (Olmos-Vega et al., 2022). Lastly, another commonly noted pitfall is the development of superficial, descriptive themes that are merely topic-based summaries of the data rather than identified patterns of shared meaning (Braun & Clarke, 2006; Braun & Clarke, 2019; Finlay, 2021). Thoughtful engagement with these challenges is necessary to preserve the richness and credibility of RTA.

Alternative qualitative analytic methods were considered before selecting RTA, including Interpretative Phenomenological Analysis (IPA), Grounded Theory, and Narrative Analysis. IPA focuses on the detailed exploration of how individuals make sense of their lived experiences and is best suited to small, homogeneous samples using in-depth interviews (Smith, Flowers & Larkin, 2009). While IPA offers valuable depth, its idiographic focus on individual cases was less compatible with this study's aim to identify shared patterns across a

diverse group of trainees. Grounded Theory, which seeks to generate theory through iterative data collection, coding, and constant comparison (Charmaz, 2014), was also explored. However, this study did not aim to produce new theoretical models but instead sought to develop a rich, interpretative understanding of participants' experiences. Narrative Analysis, which examines how individuals construct meaning through storytelling by analysing the structure, content, and context of narratives (Riessman, 2008), was similarly set aside. Although well-suited to in-depth individual accounts, it was less appropriate for analysing common themes across multiple responses. RTA was therefore selected as the most appropriate approach, as it supports the identification of patterns across the dataset while preserving the complexity and nuance of participants' accounts.

3.4 Ethical Considerations

Ethical Approval: Ethical approval was granted by the University of Hertfordshire's Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The research's protocol number is: aLMS/PGR/UH05636(2) (Appendix C).

Informed Consent and Right to Withdraw: Before being able to take part, participants were required to read an Information Sheet (Appendix D) which outlined the research aims, procedure, inclusion and exclusion criteria, and ethical considerations, such as the right to withdraw, data confidentiality and storage, and potential risks. Participants were informed that their involvement was entirely voluntary and they had the right to withdraw at any time before the electronic submission of the questionnaire – due to the anonymisation process, after submission it would not be possible to identify responses. Consent was obtained electronically via a Consent Form (Appendix E), which participants had to complete prior to accessing the questionnaire.

Confidentiality, Anonymity and Data Protection: Participants were not asked to share their name or address, and they were offered the opportunity to choose their own pseudonym or one was allocated for them for write-up of the research.

Participants were given the opportunity to enter an optional prize draw for a £50 Love2Shop voucher upon completion of the questionnaire by providing their email address. They were informed that this data would be kept entirely separately and was not a requirement of participation. Any email addresses provided by participants for the optional prize draw were stored separately to their questionnaire data and in a password-protected file, and were deleted following the prize draw.

Participants were informed via the Information Sheet that the data collected in this study will be processed and kept in accordance with the Data Protection Act 2018 (GOV.UK, n.d.-c) and the BPS's ethical guidelines for internet mediated research (BPS, 2021). Data was collected via a questionnaire hosted on the platform Qualtrics (2025) via a secure University of Hertfordshire login. The data was downloaded and stored securely in a password-protected file on a University of Hertfordshire One Drive account. There are no direct identifiers in the data set. The anonymised data will be stored for five years after completion of the study in accordance with the University of Hertfordshire's policies, and destroyed thereafter.

Potential Distress: Given the possibility that participants may feel emotional reflecting on and writing about their experiences (Richards & Schwartz, 2002), they were encouraged in the Information Sheet to take care of themselves as needed, for example taking a break from completing the questionnaire and returning to it when feeling able to. Upon submission of the questionnaire, participants were given a Debrief Sheet (Appendix F) which signposted where to access support if required, including: their course/personal tutor on the DClinPsy, university wellbeing service or GP, and to contact 999 or the Samaritans if more urgent support is needed.

3.5 Consultation

Consultation, a key model in inclusive research (Fletcher-Watson et al., 2021), was sought from the community this research relates to: neurodivergent Trainee Clinical Psychologists currently completing a DClinPsy programme. Consultation has been defined as "inviting community members to provide targeted, expert advice on a project at key intervals or in specified areas of responsibility", and is of particular importance when working with minorities, such as neurodivergent individuals (Fletcher-Watson et al., 2021, p. 88). In this research, consultation was essential to ensure the relevance, sensitivity, and accessibility of the research materials. Therefore, three Experts by Experience (EbE) – current neurodivergent Trainee Clinical Psychologists at the University of Hertfordshire – were recruited as Consultants through the University of Hertfordshire's *DClinPsy Neurodivergent Working Group*, following an email from the researcher which detailed the study's aims and a request for participation. Consultants reviewed and piloted the qualitative questionnaire, offering feedback on aspects including language use, clarity of content, design considerations, and accessibility for neurodivergent participants. Changes were made in response, such as editing question phrasing, adjusting the order of questions, ensuring clarity and readability of the visual layout, and incorporating a progress bar. While this approach ensured that consultation came directly from the community whose experiences were being explored, it is acknowledged that the perspectives gathered were limited to those of neurodivergent Trainee Clinical Psychologists at a single university and working group. Although not EbE Consultants, the research supervisors were DClinPsy course staff members and provided academic and methodological consultation throughout. Consultants were compensated with a Love2Shop voucher, valuing their expertise by lived experience and promoting empowerment within the research process (Black et al., 2013; Fletcher-Watson et al., 2021).

3.6 Participants

3.6.1 Recruitment and Sample Size

A purposive, self-selecting sampling strategy was utilised to recruit participants for this research, chosen to ensure the sample comprised of individuals with direct experience of the phenomenon of interest (Palinkas et al., 2015). Recruitment was conducted by emailing all DClinPsy courses in the UK with a request to distribute the research poster (Appendix G) to their current cohorts of Trainee Clinical Psychologists. The poster contained a link to the online questionnaire, where potential participants could access the Information Sheet to understand the study's purpose and assess their eligibility based on the inclusion criteria. Individuals who met the criteria and wished to participate were able to provide their consent and complete the questionnaire.

The initial aim of this research was to recruit 25-30 participants, in line with literature that suggests "10-50 for participant generated text" for small projects using thematic analysis (Fugard & Potts, 2015, p. 671; Braun & Clarke, 2013). It was hoped that this sample size would provide enough data to ensure richness and depth of exploration of this novel topic. However, this sample size was almost reached within three days of commencement of recruitment, so the research team reviewed the depth of the data collected, in addition to the registered interest to participate. Following this, it was decided to amend the methodology to have a maximum of 70 participants. This was to align with the lower of the "mid-range of 60-99" recommended participant numbers (Braun et al., 2021, p. 649), to account for any data quality issues, ensure manageability of analysis, and improve the data's variability and impact. No reminders were needed and recruitment closed after 26 days, with a total sample of 70 participants.

3.6.2 Participant Criteria

Participants for this research were Trainee Clinical Psychologists who identify as neurodivergent. The criteria are inclusive of those who self-identify as neurodivergent as well as those who have diagnoses. This was for several reasons, including: understanding the inaccessibility and barriers to assessments for diagnosis (e.g., Smith et al., 2023); the biases of diagnoses, for example the diagnostic bias against girls and women (Cook et al., 2024); and the different relationships with and value ascribed to neurodivergent diagnoses for different individuals (e.g., Cameron, 2023). The inclusion and exclusion criteria are detailed in Table 6 below.

Table 6: *Participant Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Trainee Clinical Psychologists currently enrolled on a DClinPsy course in the UK	Those who are not currently enrolled on a DClinPsy course in the UK
Trainee Clinical Psychologists who identify as neurodivergent – either diagnosed or self-identified – based on a definition that included the following conditions: • Autism Spectrum Condition (ASC) • Attention Deficit Hyperactivity Disorder (ADHD) • Dyslexia • Dyspraxia • Dyscalculia • Developmental Language Disorder • Other specific learning difficulties • Tourette's Syndrome	Trainee Clinical Psychologists who identify as neurodivergent solely on the basis of mental health difficulties (for example, anxiety or Obsessive Compulsive Disorder) or acquired brain injury
Adults (18+ years old)	Those who are under 18 years old

3.6.3 Participant Characteristics

In total, 70 neurodivergent Trainee Clinical Psychologists from 17 of the DClinPsy programmes across the UK completed the questionnaire. Information about participants' demographics and neurodivergence was collected. Participants represented a diverse neurodivergent sample, including a range of conditions under the umbrella term 'neurodivergent', both formally diagnosed and/or self-identified, and variation in when individuals' neurodivergence was identified. To protect the anonymity and confidentiality of participants, this information is not presented per participant but as an overview per category/question, detailed in Table 7. In addition, participants were able to choose their own pseudonym for the write-up of the research if they wished (see Appendix H for the full list of pseudonyms).

Table 7: *Participant Characteristics*

Category	Question Asked	Participants' Responses (n)
Gender	How do you define your gender identity? [Open text box]	• Female: 51 • Cisgender female: 5 • Male: 8 • Transgender male: 1 • Non-binary: 4 • Gender non-conforming: 1
Age	What is your age? [Open text box]	• 22-26 years old: 12 • 27-31 years old: 39 • 32-36 years old: 16 • 37-43 years old: 3

Category	Question Asked	Participants' Responses (n)
Ethnicity	How do you define your ethnicity? [Open text box]	• Asian British: 1 • Bangladeshi: 1 • Black British African: 1 • Cornish: 1 • Irish: 1 • White Irish: 2 • Mixed – Asian: 1 • Mixed – White and Asian: 2 • Mixed – Black and White: 2 • Mixed – North African and European: 1 • Mixed – White and Black Caribbean: 1 • White: 13 • White British: 38 • White European: 2 • White Other: 2
Diagnosed and/or self-identified neurodivergence	Has your neurodivergence been formally diagnosed and/or is it self-identified? [Closed response options]	• Formally diagnosed: 27 • Self-identified: 21 • A mix of formally diagnosed and self-identified: 22
Neurodivergent conditions identified with	Under the umbrella term 'neurodivergent', which of the following do you identify with? [Closed response options – participants could select all those that applied]	• Autism Spectrum Condition: 39 • Attention Deficit Hyperactivity Disorder: 35 • Dyslexia: 16 • Dyspraxia: 14 • Dyscalculia: 6 • Other specific learning difficulties: 5
Formal neurodivergent diagnoses	If you have received formal diagnoses, please specify which: [Closed response options – participants could select all those that applied]	• Autism Spectrum Condition: 17 • Attention Deficit Hyperactivity Disorder: 18 • Dyslexia: 13 • Dyspraxia: 8 • Dyscalculia: 4 • Other specific learning difficulties: 5

Category	Question Asked	Participants' Responses (n)
When neurodivergence was identified	When was your neurodivergence identified? [Closed response options – participants could select all those that applied]	• Prior to school years (approximately 0-5 years old): 2 • During school years (approximately 5-18 years old): 14 • During a previous undergraduate or postgraduate degree: 17 • In adulthood whilst not in education (18+ years old): 28 • During the DClinPsy: 22

3.7 Data Collection

Questionnaire Development: A qualitative questionnaire was developed to explore and capture the experiences of neurodivergent Trainee Clinical Psychologists, informed by the research aims, relevant existing literature, and guidance on qualitative questionnaire design. Example open-ended questions included "What has been your overall experience of the DClinPsy as a neurodivergent trainee?", "We often develop stories based on our experiences – what stories do you hold about yourself as a neurodivergent trainee?", and stream-specific questions such as "What challenges have you experienced in relation to academic work as a neurodivergent trainee?" (see Appendix I for the full questionnaire). Particular attention was given to the clarity, accessibility, sequencing and sensitivity of the questions, as well as the length to minimise fatigue (Braun & Clarke, 2013; Braun et al., 2021). The questionnaire was designed to elicit rich, detailed responses through open-ended questions that explored participants' experiences, challenges, strengths, sources of support, adjustments, and recommendations in relation to their training programmes. It began with a few closed questions about participants' neurodivergence, such as whether they self-identify and/or are diagnosed, then moved to the open-ended questions about experiences, and ended

with a few demographic questions, such as their age, and the opportunity to enter an optional prize draw. There were reminders embedded in the questionnaire that the research was not looking at aspects such as spelling and grammar so energy/time was not required to be spent on this, and also that participants can take breaks when they need to and return to the questionnaire at a later point.

The development of the questionnaire was an iterative and consultative process. Initial drafts were reviewed by the research supervisors, and refinements were made to strengthen the structure, clarity and tone of the questions. The questionnaire was then reviewed and piloted by the three Consultants, who provided detailed feedback on both the design (question wording and order, and visual aspects) and the experience of completing it, which led to the final changes. The questionnaire was hosted on Qualtrics, a GDPR compliant online platform. This method facilitated wide geographical reach and removed barriers commonly associated with synchronous or in-person data collection, also aligning with literature that supports the value of qualitative questionnaire for exploring sensitive and under-researched experiences (Braun et al., 2021).

Procedure: Participants interested in taking part in the research accessed the questionnaire on Qualtrics via a URL or QR code on the recruitment poster. The Information Sheet appeared first so potential participants could understand the research aims and assess their eligibility to participate. Following this, those who wished to participate completed a consent form, which was designed as a mandatory step before being able to proceed to the questionnaire. Participants then completed the questionnaire anonymously, at their own convenience, pace and in their chosen environment. Whilst the questions were set as mandatory for completion, participants could choose to write as much or as little as they wished in the text boxes. At the end of the questionnaire, participants were able to choose their own pseudonym for the write-up of the research if they wished, and they were given the

option to enter a prize draw to win a £50 Love2Shop voucher. Upon submission of the questionnaire, a Debrief Form appeared for participants to read. A total sample of 70 participants completed the questionnaire within 26 days, and then it was closed to responses.

3.8 Data Analysis

Data were analysed using RTA, in accordance with the six-phase process outlined by Braun and Clarke (2006, 2013, 2019) – see Table 8 for a summary of the process. It is important to note that this process was non-linear; it involved movement back and forth between phases as insights evolved, and reflexivity was prioritised throughout as an active, continuous practice. During coding and theme development, reflexivity was enacted through sustained attention to how assumptions, insider positioning, values and emotional responses shaped analytic decisions, including what was coded, how codes were clustered and prioritised, and how themes were defined and refined. A reflective diary (detailed in section 3.2), reflexive questioning and supervisory discussions were used to critically examine these influences and to support analytic grounding in participants' accounts, whilst recognising themes as interpretive constructions rather than passively emerging patterns. The software NVivo 14 (Lumivero, 2023) was used to assist with the organisation and analysis of data (Dhakal, 2022).

Table 8: *Six-Phase Process of RTA (Braun & Clarke, 2006, 2013, 2019)*

RTA Phase	Researcher's Process
1. Data familiarisation	The researcher immersed themselves thoroughly in the qualitative questionnaire data, which was downloaded securely from Qualtrics, by reading participants' responses multiple times and noting down initial thoughts and ideas. Given that the data collection method did not involve direct interaction with the researcher, an in-depth familiarisation phase was particularly crucial as it was the first time the researcher was privy to participants' responses.

RTA Phase	Researcher's Process
2. Generating initial codes	Each of the participants' responses was systematically coded by the researcher using NVivo 14 software (see Appendix J), identifying and labelling meaningful and interesting segments relevant to the research question. Throughout this phase, coding was iterative and reflective, influenced by ongoing engagement with the data.
3. Generating initial themes	Once all the data had been coded, the code names were transferred by the researcher onto post-it notes that were colour-coded based on initial patterns. Codes were then grouped and re-grouped iteratively to identify potential overarching themes and sub-themes, and an initial thematic map was created (see Appendix K). This was shared with the research supervisors for discussion and further exploration.
4. Reviewing themes	The potential themes were rigorously reviewed; each critically evaluated to ensure they represented the meaning of participants' responses and their coherence in relation to the research question. The potential themes were reviewed at two levels: first, in relation to coded extracts, and second, in relation to the entire dataset. Where necessary, themes were reorganised, merged or discarded until distinct themes were constructed.
5. Defining and naming themes	In this phase, themes were refined and defined, with explicit focus on capturing their core meaning and story, within the wider story of the whole dataset. As part of the refinement, sub-themes were also developed and defined where relevant. Themes and sub-themes were given clear and concise names. These were then presented to the research supervisors for review and finalisation. (See Appendix K).
6. Producing the report	Finally, themes were integrated into an analytic narrative; a story about the data, answering the research question. Participant quotations were carefully selected to illustrate, substantiate and add richness to each theme. Reflexivity continued to be integral throughout the write-up, considering the researcher's own assumptions, positionality and influence over the analytic narrative.

3.9 Quality Appraisal and Self-Reflexivity

***Quality Appraisal*:** To evaluate the quality and rigour of this qualitative research, Tracy's (2010) Eight "Big-Tent" Criteria for Excellent Qualitative Research were used as a

guiding framework. These criteria provide a means of assessing qualitative studies across a range of paradigms and methodologies, emphasising aspects such as ethical integrity, resonance, and meaningful coherence (Tracy, 2010). Given the reflexive and interpretive nature of this research, Tracy's framework offers a valuable lens through which to reflect on its methodological integrity and contribution. The quality assessment of each of the criteria are outlined in Table 9. The strengths and limitations of this research are discussed further in Chapter 5.

Table 9: *Quality Appraisal of This Research (Tracy, 2010)*

Criteria for Quality	Criteria Definition	Application to Current Research
Worthy topic	The topic of the research is: • Relevant • Timely • Significant • Interesting	This research addresses an under-researched, socially, politically, professionally and personally relevant area with implications for practice and policy.
Rich rigour	The study uses sufficient, abundant, appropriate, and complex: • Theoretical constructs • Data and time in the field • Sample(s) • Context(s) • Data collection and analysis processes	The research has a sample of 70 neurodivergent Trainee Clinical Psychologists from 17 different universities, offering rich variation in neurodivergent identities, training contexts and lived experiences. The qualitative questionnaire was carefully designed to elicit detailed, reflective responses through open-ended questions, and to accommodate a range of neurodivergent communication preferences. Data analysis followed the phases outlined by Braun and Clarke (2006), and was a clearly documented iterative and reflexive process. The research was grounded in theory and critical realist epistemology.

Criteria for Quality	Criteria Definition	Application to Current Research
Sincerity	The study is characterised by: • Self-reflexivity about subjective values, biases, and inclinations of the researcher(s) • Transparency about the methods and challenges	There is a clear emphasis on researcher reflexivity (e.g., use of reflective journal and supervisory team discussions), with reflections on insider researcher positionality and what this means for the conceptualisation, design and analysis processes.
Credibility	The research is marked by: • Thick description, concrete detail, explication of tacit (nontextual) knowledge, and showing rather than telling • Triangulation or crystallization • Multivocality • Member reflections	The researcher was deeply immersed in the data, understanding tacit meaning in participants' responses by doing so, in addition to the added layer of being an insider researcher. The themes express a reality that aligns with previous literature, including the SLR, enhancing its credibility (Richardson, 2000), and complexity is shown by detail and illustrative participant quotes.
Resonance	The research influences, affects, or moves particular readers or a variety of audiences through: • Aesthetic, evocative representation • Naturalistic generalizations • Transferable findings	Participants' narratives are presented through carefully selected quotes that vividly illustrate lived experience, aiming to evoke emotional insight from readers. There is added emotional authenticity due to the researcher's insider status. The language aims to be accessible and engaging for academic and non-academic readers. The inclusion of a substantial and diverse neurodivergent sample increases the potential for transferability across training programmes and neurodivergent identities.
Significant contribution	The research provides a significant contribution: • Conceptually/theoretically • Practically • Morally	This research offers novel insights into the experiences of neurodivergent Trainee Clinical Psychologists completing DClinPsy Programmes in the UK – an area with very limited previous exploration. It has generated

Criteria for Quality	Criteria Definition	Application to Current Research
	• Methodologically • Heuristically	clear implications for DClinPsy programmes and placement supervisors to improve experiences and support. The research is grounded in relevant theory and a critical realist epistemological stance. It demonstrates the use and value of qualitative surveys (Braun et al., 2021; Terry & Braun, 2017), which are an under-utilised yet accessible and inclusive method, particularly for neurodivergent populations. Lastly, it sparks new areas for inquiry, for universities on a practical level and for future research.
Ethical	The research considers: • Procedural ethics (such as human subjects) • Situational and culturally specific ethics • Relational ethics • Exiting ethics (leaving the scene and sharing the research)	This research gained full ethical approval (see Appendix C), and the ethical considerations and procedures are clearly detailed. Consultants were recruited to review and pilot the questionnaire to ensure its sensitivity and accessibility for participants.
Meaningful coherence	The study: • Achieves what it purports to be about • Uses methods and procedures that fit its stated goals • Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other	All elements of this research reflect the aims and research question. The methodological approach, notably RTA, aligns with the research's critical realist epistemological stance. The findings and implications are grounded in the data and situated within the broader literature and academic/professional contexts. Suggestions are also made for future research.

***Self-Reflexivity*:** Reflexivity has been a continuous and intentional part of this research journey, from topic choice to write-up, shaped by my positionality. My insider status brought both depth and complexity; it fostered deeper understanding, and also required ongoing reflection to ensure that my interpretations remained grounded in participants' accounts and were not solely shaped by my assumptions (Greene et al., 2014). To support reflexive practice, I maintained a reflective journal and engaged in regular supervisory discussions, which provided space to consider how my personal experiences, values and positionality influenced data collection and analysis, including where perspectives diverged from my own (Le Gallais, 2008). One example is that during coding, I noticed how strongly the theme of questioning belonging in the profession emerged in participants' narratives. This differed from my own experience, so journaling helped to ensure that I did not unintentionally minimise its significance and I stayed close to participants' stories (see Appendix A). I approached this research with curiosity, critical self-awareness, and a commitment to representing participants' voices and the neurodivergent community with integrity.

Chapter 4: Results

4.1 Chapter Overview

This chapter presents the qualitative analysis of the 70 participant responses, using RTA (Braun & Clarke, 2006, 2019). Four themes and twelve sub-themes were constructed from the data, which are shown in Figure 2. Each theme is explored in depth, with participant quotations woven throughout to illuminate meaning, convey nuance, and centre their voices. It is important to note that these themes reflect one interpretation, shaped through reflexive engagement with the data and informed by my positioning as an insider researcher.

Pseudonyms have been used throughout to protect the anonymity and confidentiality of participants. All quotes have been taken directly from participants' written responses, and spelling, grammar and abbreviations (including Clinical Psychologist to "CP" and neurodivergent to "ND") have not been altered in order to preserve authenticity. Where necessary, square brackets '[ ]' have been used to clarify meaning, and ellipses '…' indicate where text has been omitted for brevity or focus.

Figure 2: *Thematic Map of Themes and Sub-Themes*

4.2 Theme 1: This System's Not Built for Us

This theme captures participants' descriptions of a clinical psychology training system shaped by ableism; where the educational and professional structures were seemingly not designed with neurodivergent individuals in mind. This mismatch led to widespread experiences of exclusion, disempowerment and disillusionment. Consequently, progressing through training was often referred to with the metaphor of a *"fight"* or *"battle"* – a constant negotiation for legitimacy, inclusion and survival. The four sub-themes speak to different aspects of this.

Sub-Theme: Pervasive Ableism

Weaved throughout the data, participants shared their views that the training courses are fundamentally shaped by neurotypical norms, expectations and values. These unspoken

standards governed everything, often marginalising those who did not, and/or could not, conform. Multiple participants wrote about feeling (mis)judged for their style of communication and interaction, with the assumption that these differences reflected disinterest or poor professionalism. These expectations created a narrow mould of the 'ideal trainee' that positioned neurodivergent ways of being as deficient rather than different.

> *"Even in presentation assignments, eye contact and the way in which you hold your notes are key grading criteria, which feels discriminatory."* (Riley)

> *"I worry that I sometimes come across as uninterested… I'm definitely not uninterested but I just express my passion and interest in different ways."* (Rosie)

> *"[I got feedback] saying we need to make better eye contact or make our face look interested."* (Bethany)

The absence of Universal Design for Learning (UDL) was particularly striking for participants. While training content often acknowledged diversity in theory, participants wrote about how it failed to embed flexibility into its pedagogical model. Participants described inaccessible teaching formats and resources, a lack of timely materials, limited breaks in lectures, and rigid expectations around participation. Learning environments were posited to be shaped by neurotypical assumptions about how information should be delivered, processed and responded to. Key examples provided were fast-paced didactic teaching, forced reflective discussions, big group tasks and role-plays – all requiring a specific cognitive and social processing style that excludes those who learn differently.

"Teaching however has been impossible to engage in and I think it is pedagogically unsound as a model to teach all trainees as if we have the same brains." (Addie)

"I also feel that the way we are taught and the assumption of how we learn is based on neurotypical assumptions. For example, role plays… There are countless examples like this that basically come down to being told 'this is the way you learn it' - but it might not be the way I learn!" (Kelly)

"Reflective practice groups have been very difficult for me as I feel compelled to reflect on my feelings on the spot, in front of a group of people, when this is not something I am able to do due to slow processing speed." (Joyce)

"Being randomly asked to move around the room during systemic teaching because the lecturer insisted this was best for how they work (despite pointing out the specific difficulties for me)." (Kelly)

These rigid teaching models did not simply make learning harder, but they positioned neurodivergent needs as personal limitations requiring workarounds, rather than signalling structural design failures. As Charlotte shared: *"Until now I have never considered myself disabled but the way DClinPsy courses are structured and their lack of flexibility for neurodiverse trainees has been disabling for me."* This speaks to the social model of disability; highlighting the disabling effects of surrounding environments as opposed to neurodivergence itself.

Participants also described high levels of emotional and cognitive labour required to navigate the hidden curriculum and unclear or inconsistent expectations. Processes around

research, placements and assignments were often deemed poorly communicated, ambiguous, or embedded in implicit norms that required decoding.

> *"I've got into a tailspin at times because of requirements feeling very specific but not clear or explicit."* (Rebecca)

> *"And, as someone who values clear, direct instructions I have found that some of the guidance on the course has been vague and anxiety provoking."* (Sadie)

> *"It's like everyone… is playing games I don't understand the rules of"* (Rebecca)

Despite growing awareness of neurodivergence in clinical practice, participants noted its limited presence within teaching and course staff. This brought up the question of 'Where are we represented?'; spotlighting perceptions of epistemic injustice and marginalisation.

> *"I was interested in speaking to a qualified psychologist with adhd about their experience… unfortunately noone in the course team came forwards (perhaps no ND staff employed which would say a lot...)."* (Isla)

Within these descriptions, participants expressed the cumulative emotional toll of navigating a course not built with them in mind. Poppy captured the impact succinctly: *"It feels impossible - this course was not designed for people like me."* However, amongst the struggle, there were moving quotes of advice and reassurance that participants wanted to share with other neurodivergent trainees, for example: *"It is not you failing, it is the system around you failing to disrupt ableism. Try to not lose who you are too much."* (Ebony).

Sub-Theme: UNreasonable Adjustments

While the principle of reasonable adjustments is embedded within equality legislation, this sub-theme captures participants' experiences of navigating systems of support that, while nominally in place, were often inaccessible, inconsistent or laden with administrative and emotional labour – experienced as anything but 'reasonable'.

The very systems designed to facilitate inclusion were described by participants as burdensome, a "*battle"*/*"fight"* to access, and an increased demand in an already demanding training environment.

> *"it is a battle to get any reasonable adjustments agreed."* (Bethany)

> *"The adaptations are helpful but to get them in place requires things that are particularly difficult for the neurodiverse so that just puts another barrier to it."* (Poppy)

> *"the course regularly need prompting to consider reasonable adjustments, and without prompting these may not be incorporated."* (Sophie)

This *"fight"* extended not only to having needs recognised, but to the very legitimacy of having needs at all. Numerous participants expressed the emotional impact of having to justify, explain and evidence their neurodivergence – often more than once, and sometimes with little result.

> *"That I have to justify or evidence my additional needs."* (McCa)

"After I got my diagnosis I was put in a position of having to repeatedly ask for very minor accommodations (e.g., having access to slides DURING lectures ((even though we should have these at least 24 hours before)))." (Daphne)

"having to constantly assert your needs, explain the difficulties and for things to still not change." (Lina)

"and I'm still fighting for accommodations that would allow me to work in a way that lets me succeed." (Stevie)

Even when adjustments were formally agreed, their usefulness and appropriateness were not guaranteed. Some participants described generic or tokenistic supports that failed to address their actual needs, reflecting a one-size-fits-all model that reduced neurodivergence to spelling and grammar difficulties:

"My SpLD relates to working memory and processing speed, so I don't even benefit from this reasonable adjustment because my grammar and spelling aren't an issue." (Callie)

"I get sympathetic marking on my assignments (I didn't ask for this and find it patronising because my spelling and grammar is an area I actually don't struggle with)." (Daphne)

Others wrote about how adjustments were poorly implemented or not transferred into placement contexts, creating further barriers in environments where support was most needed.

> *"I have a support plan with a list of reasonable adjustments, and only one of them has been implemented."* (Callie)

> *"Reasonable adjustments tend not to be transferred to placement and pressures within the services make this more difficult."* (Maddie)

Beyond structural and implementation challenges, participants shared how the process of requesting and receiving adjustments triggered internalised shame, self-doubt, and beliefs of being a burden. Instead of feeling supported, many described being positioned, or coming to see themselves, as the 'problem'.

> *"The lack of flexibility in the system perpetuates feelings of shame and like I am the problem."* (Isla)

> *"and I am the problem for needing things to be different."* (Sadie)

> *"That my neurodivergent needs make me fallible and problematic."* (Riley)

Participants also reflected on the consequential broader message they received from their training environments – that their needs were unreasonable, inconvenient or less deserving. In some cases, this led to questioning the profession's commitment to inclusion.

> *"I think there's a lot of talk about widening access to CP but then once your non-standard trainee gets into the programme the experience they're given (in my experience) is punitive where the general vibe is "you're asking for us to change, and that's challenging and inconvenient, so shame on you".”* (Daphne)

> *"You deserve reasonable adjustments, do not be made to feel "unreasonable" for asking.”* (Amy)

For some, the experience of advocating for adjustments felt so depleting that they chose to stop asking altogether – sacrificing support for self-protection.

> *"In the end, advocating for myself and for reasonable adjustments made life harder than not having them at all, so I had to go 'underground' with my needs and just do things like teaching slightly leave early, hoping to not get punished.”* (Addie)

Amidst these difficult experiences, numerous participants reflected on what meaningful support could look like. They highlighted person-centred, flexible and proactively offered adjustments, rather than those positioned as a favour to be earned.

> *"I think the course needs to just listen to each individual Trainee, and ask how they can help get the best of them.”* (Laurie)

> *"Have suggestions for adaptations! I dont know what I need and I dont know how im supposed to know what adaptations can be made for the course.”* (Monica)

Overall, in this context for participants, the very notion of 'reasonable' became ironic – obscuring the structural barriers and emotional costs involved in accessing support.

Sub-Theme: Lack of Understanding

Participants described a persistent and often painful sense of not being understood, by course staff, lecturers and placement supervisors. This lack of understanding was not experienced as a passive absence, but as an active source of harm, that shaped how participants were perceived, appraised and supported.

> *"There is a theme of - if they could understand us better these years wouldn't have been so awful."* (Charlotte)

Many participants wrote about the reductive and stigmatising assumptions and stereotypes about neurodivergence that they encountered on training, often reflecting superficial awareness or outdated views. This contributed to the sense of being misunderstood and misjudged:

> *"There have been comments made that show a complete lack of understanding of nd (e.g., how can you be autistic when you're disorganised)"* (Bethany)

> *"I get told that I'm not autistic/neurodivergent because 'I read the NHS (quick guide) and you don't scream those symptoms to me', which feels kind of awful and invalidating."* (Leon)

As part of this, a recurring frustration mentioned was the burden of having to educate others about neurodivergence, including that neurodivergent people are not a homogenous group and therefore their minds and experiences vary widely.

> *"People using phrases such as 'everyone is a bit autistic' 'we are all on the spectrum' and 'very autistic/not very autistic' makes me feel like it is my job to educate and correct people."* (Louise)

> *"Supervisors being educated in the impact of dyslexia and how it impacts people differently"* (Matilda)

This lack of understanding has concrete consequences. When supervisors and course staff failed to grasp how learning and communication needs manifested, participants described being left without the proper scaffolding they required.

> *"They did not quite gather that I needed time and practical ways to demonstrate concepts or knowledge (i.e., visuals/ role playing)."* (Amal)

Beyond the logistical impact, there was a deeper emotional toll expressed of feeling judged or perceived as deficient. For some participants, this likely fed into harmful internalised narratives.

> *"Assumptions about not being good socially - as a profession with foundations in connecting to others, this is a wearing and draining narrative that is simply not true and equates differences with deficits."* (Addie)

Many participants identified education, training and reflection for course staff and supervisors as essential for systemic change. The tones of these responses varied between hopeful, demanding, and desperate.

> *"Understanding the needs better and stop making excuses as to why you can't change things to help neurodivergent trainees."* (Loren)

> *"let go of any ableism they may hold and make an effort to learn, and challenge outdated views within themselves and others."* (Callie)

Whilst some participants did note positive experiences of supervisors who 'got it', they were the exception to the rule. For many others, they were left holding stories about themselves such as *"I am not understood by most."* (Gabrielle), feeding into feelings of systemic marginalisation.

Sub-Theme: Professional Disillusionment

There was a profound sense of disillusionment, both implicit and explicit, in participants' responses. It appeared that many had started training with expectations that on a clinical psychology doctorate – a profession rooted in empathy and inclusion – they would be understood and provided with adjustments and support. However, the gap between expectations and the lived reality described by many participants gave rise to complex feelings of disappointment, sadness and anger.

> *"I'm bitter, disillusioned, let down and broken."* (Callie)

"It's really sad, this is not what I signed up for." (Gerald)

Numerous participants shared the difficulty of encountering course staff and supervisors who, despite working in the profession, did not recognise or respond to their needs in the ways they wished.

"Although most of the course team are clinical psychologists, they failed to understand my needs and make appropriate adjustments even though I was so clear with them." (Loren)

"…like me assuming they have good intentions and putting them on a pedestal, then getting hurt when I realise they do not have the understanding I'd hoped." (Kallie)

This absence of understanding felt particularly jarring given participants' views of how neurodivergence is conceptualised in relation to clients – worthy of empathy, adjustment and respect – versus how it is treated in professionals.

"It all just gets a bit overwhelming, especially when lectures and material constantly discuss compassion and empathy for those we support and provide care for, but this isn't mirrored in the same way for the trainees on the courses" (Leon)

Consequently, some were left with the feeling that neurodivergence may only be (acceptable) for clients: *"[Lecturers] don't seem to acknowledge that some people in the room have these differences and needs (and so don't accommodate them, or talk about ND as just a theoretical other thing that only clients have/are)"* (Ria). Similarly, Billy shared: *"Very*

much 'us and them' mindset so neurodiversity is spoken about in the context of patients and not staff".

This perceived irony, and even hypocrisy, led some participants to question the integrity of the profession itself. They noted that while clinical psychology *"publicly boasts inclusivity, reflexivity and anti-discriminatory practices"* (Riley), these are not being consistently practised within the structures or culture of training. The depth of this contradiction gave rise to broader concerns for some: *"I am worried for the dclin profession."* (Gerald). Overall, these accounts reflect more than personal disappointment; they speak to a loss of trust in the systems and values underpinning clinical psychology itself.

4.3 Theme 2: The Ever-Present Burnout

This theme examines how burnout functioned as a pervasive and cumulative threat, akin to an enduring presence that permeated training and shaped engagement. Most participants described existing in a state of exhaustion – either on the brink of burnout or deep within it – with little space to pause, recover, or be meaningfully supported. As Kallie reflected, *"I feel like I'm constantly balancing the line between burnout which feels frightening - like I will keep pushing myself to qualify, but at what cost?"*. Others wrote of having *"repeatedly cycled through autistic burnout"* (Avery), and shutdown as a recurring feature: *"Multiple episodes of shutdown (physical, verbal, relationship, personal/'core')"* (Eden). This was often described as unavoidable given the demands: *"I have no choice but to burn myself out to reach the same standard as everyone else."* (Samantha). The sub-themes that follow capture how these experiences of burnout were shaped by the relentless demands of masking, hidden labour, and the absence of recovery time; spilling from professional into personal lives.

Sub-Theme: Masking and the Cost of Invisibility

This sub-theme speaks to the emotional, cognitive and physical toll of masking experienced by neurodivergent trainees. For many participants, they found that the training environment – particularly on frequently changing placements – demanded self-monitoring, suppression of traits, and performance of neurotypical norms.

Participants described feeling under constant scrutiny, and therefore masking was often employed as a strategy of survival – a way to 'fit in', avoid judgement, and meet the implicit standards of what a 'competent' and 'professional' trainee looks like.

> *"I need to hide my neurodivergence to survive the course."* (Samantha)

> *"I'm trying to 'fit in' and not be discovered."* (Sarah)

> *"The urge and need to mask more as I am under constant assessment and do not want to come across as this "disinterested or lazy" person."* (Barbara)

> *"Given that there a huge power imbalance between the trainee and the supervisor… the trainee might appease the supervisor and mask their needs in order to 'fit' in like all other seemingly 'competent' trainees."* (Amal)

The pressure to fit a neurotypical ideal led multiple participants to share an internalised belief that being themselves was not 'good enough', contributing to hypervigilance, exhaustion, and more masking.

> *"This stems from the stigma and societal perspectives on neurodivergent individuals as the minority as "atypical". This feeds my chronic masking and means that I spend most of my time not feeling able to be myself as I don't feel this will be "good enough"."* (Anya)

> *"Being made to feel like I cannot be myself on placement meaning I have to mask all day which is exhausting"* (Louise)

Some participants described the dissonance between how they must appear to others when masking, versus how they feel internally:

> *"Although I receive good feed back from placement, I feel this doesn't match up with how I feel inside - it is probably that I heavily mask"* (Rosie)

> *"So to others I look super organised but I think I still internally feel very chaotic."* (Ruby)

Given this performative appearance of coping, a common thread in participants' responses was how masking rendered needs invisible. Paradoxically, the more effectively participants masked, the less likely they were to have their struggles recognised. Some reflected on how being perceived as competent undermined their ability to access support – a double bind in which 'success' came at the cost of recognition and care.

> *"I feel like my masking has made asserting my needs further because they are 'hidden'."* (Lina)

"I feel that because I seem to be functioning and masking well that my difficulties are not always seen." (Freya)

"They are aware of my ADHD but i feel i mask a lot and thats exhausting but it means people forget." (Monica)

Masking was described as fundamentally incompatible with sustaining themselves on the DClinPsy; and a direct contributor to burnout. Though it enabled temporary survival in rigid systems, the longer-term impact on participants' wellbeing was described as significant. Many participants wrote about becoming unwell and burnt out due to the pressure to hide or suppress their neurodivergence.

"I struggle a lot due to masking to fit in better (which still doesn't work), which then leads to me feeling incredibly burnt out." (Leon)

"I have masked so many of my ADHD traits to be more accepted during training, at the detriment of my own wellbeing." (Stevie)

Therefore, whilst masking may offer temporary acceptance, it seemingly comes at a steep cost. For many neurodivergent trainees, the cost of invisibility was not only exhaustion, but a slow erosion of self, which fuelled the ever-present burnout woven through their training experience.

Sub-Theme: Hidden Labour

Whilst it is widely acknowledged that clinical psychology training is challenging across the board, this sub-theme captures the distinctive *additional*, often invisible labour that neurodivergent trainees described undertaking to simply 'keep up'. This hidden labour – the additional effort, time and energy required to navigate training – emerged as a significant contributor to burnout.

"It just requires more of me" stated Soumya, highlighting a core feeling in participants' responses. Many reflected on how tasks that appear relatively straightforward for others, or even challenging, required disproportionate effort for them. There was an underlying sense of frustration and arguably resentment in participants' expressions:

> *"I have to work harder than everyone else in order to achieve the same things."* (George)

> *"It is also difficult due to being surrounded by lots of very capable people in my cohort who do not seem to struggle as much with these demands and just experience the 'normal' stress and demand of training."* (Emma)

This effort related not just to the volume of work, but to how long it took to complete. Time, or more specifically the lack of, was a central feature. Many participants described needing to work significantly longer hours than their neurotypical peers to meet the same academic and clinical demands. This was not attributed to a lack of hard work or capability, but rather the structure and pace of the course failed to account for different cognitive styles:

> *"Because I can't do things as quickly as others, it feels like the course is extra relentless. Where as non-neurodivergent people have down times (in terms of academic work) it feels like I'm always playing catch up and there are no breaks."* (Mango)

> *"It takes me way longer to learn and I do not feel the amount of study days offered are enough."* (Noah)

Similarly, the courses' unrelenting pace and heavy workload were described by participants as incompatible with their processing needs. It appeared that slower processing was not accommodated by deadlines, teaching styles or supervision. As Poppy shared, *"I'm worried I take too long to complete everything. It's hard sometimes too because I need longer to process things and then we're asked questions on the spot and it's like I've not had time to think"* – highlighting the challenges and pressure of working against processing difficulties. Additionally, Amal's response captures the lack of understanding that could accompany these experiences: *"I also noticed that it takes me longer to pick up new information and learn on placement and sometimes my supervisor does not understand that I just need time".*

In addition, the cognitive labour of training – including focus, attention, task-switching and executive functioning – further added to participants' exhaustion. Participants wrote about their struggles across these areas, and how they were left feeling scattered, overextended, and needing to work even harder.

> *"I struggle with attention and feel i have to work 10x more hours than someone without ADHD to keep on top of things."* (Monica)

"I struggle a lot with executive function, planning tasks and motivation" (Louise)

"Switching tasks constantly is mentally exhausting" (Soumya)

"Not being able to juggle all of the "expected workload" so having to do clinical work in the 9-5 and all of my notes at home as I am not able to have time to do these on placement or the right environment." (Ebony)

The hidden labour described by participants extended beyond academic and clinical tasks. The social dimensions of training, from navigating large cohorts to adapting to new teams every six months, demanded significant effort which also contributed to burnout:

"It connected to the way I often feel about often feeling like I have to work extremely hard to fit into situations and around other people" (Toby)

"…but the hardest part has been how socially overwhelming it can feel." (Becky)

"Burn out - particularly around social side of getting to know a large group of people whilst also having a big change in job etc." (Lauren)

Crucially, the emotional cost of overworking was compounded by the invisibility of the effort. Participants expressed fears of being judged as less committed and competent, and often unable to share their struggles as a result:

> *"Working extra hard (e.g., out of hours) because admin tasks, like writing clinical notes, takes so long. Struggling to be open about these with clinical supervisors for fear of sounding lazy or incompetent."* (Fiona)

> *"ADMIN is my worst nightmare… I fell far behind way more that I could admit. I fell into a shame cycle and wasn't really able to solve this or speak to anyone about it."* (Isla)

These dynamics seem to be underpinned by a broader narrative of needing to prove their legitimacy. Participants described how competence appeared to be assumed in their neurotypical peers, but doubted in them, placing further pressure to over-perform:

> *"I think most trainees are assumed competent until shown otherwise. In my experiance nd trainees are assumed incompetent so have to work 10x harder just to be seen as OK."* (Bethany)

Overall, participants' responses suggest that the layers of hidden labour – to catch up, fit in and stay afloat – were not incidental, but woven into a training system that does not accommodate neurodivergent ways of working, learning and being. This led to chronic feelings of inadequacy, exhaustion and burnout.

> *"All of the stress that has built up during training, working long hours just to achieve the same (or less) than my peers can do in less time, navigating the different systems, admin, assessments, exams, and learning in a way that doesn't fit with my needs… all*

eventually led to burnout and me taking an extended period of time off" (Stevie)

Sub-Theme: Spillover into Personal Life

This sub-theme explores how the effects of burnout, for many neurodivergent trainees, extended well beyond the bounds of the course, seeping into their personal lives, relationships and sense of self. Unlike a stressor that can be left at the office door, the cumulative demands of the course followed participants home – mentally, emotionally and physically.

A core thread running through participants' responses was the collapse of a meaningful boundary between training and their personal lives. Participants described how evenings, weekends and annual leave were increasingly absorbed by work to keep up with the course demands, consequently eroding space for recovery. As Fiona explained: *"I am usually working on assignments last minute over the weekend, which eats into my social and personal life."* Similarly, Monica shared: *"i have used all my annual leave to do uni work, work every saturday just to keep on top of things because i get so distracted and struggle to just sit and do work."* The picture painted by participants was training as all-consuming – a course that took, rather than shared, space in their lives.

This erosion of boundaries came at the expense of basic self-care and wellbeing for some participants. They described how the persistent strain left them depleted, struggling to maintain daily activities and routines:

"…frequently either letting my course work slip or my self care (eating meals, showering) slip" (Louise)

"Not being able to keep up with Dclin demands as well as aspects at home such as eating, cleaning, and basic self-care." (Ebony)

"I then become extra stressed due to my standards of living slipping - e.g., washing piling up, washing up not done for multiple days (in a house of 3 adults), nothing tidied away, etc." (Leon)

The consequences of this depletion extended beyond exhaustion – numerous participants shared a deterioration in both their physical and mental health.

"Poor mental health - requiring long term sick, review of past medication, therapy and ND coaching." (Eden)

"I *have become unwell, I am burnt out, I have lost my belief in myself."* (Charlotte)

"My health has suffered, as has my ability to function socially outside of work, and this is disproportionate to other trainees." (Addie)

Even rest was often accompanied by guilt and unease. Multiple participants spoke to the internal conflict of the pressure to over-work versus self-care, needing to use the weekends to recover but feeling as if they were falling behind by doing so:

"Needing to use my weekends to 'recover' from the exhausting week whilst also guilt for not doing more work on the weekends." (Samantha)

For some participants, this minimisation of life outside of the course also led to feelings of isolation. They described the sadness of watching others thrive socially, while they needed to lay in recovery: "*It is very sad seeing others socialising all weekend on social media while I lie in a dark room to recuperate from the week"* (Addie). This speaks to the disconnection created by burnout, from rest, joy and others.

Despite these experiences, many participants offered reflections and advice for future trainees that urged them to *"be as boundaried as you possibly can"* (Tom), *"prioritise your personal wellbeing over the course"* (Fiona), and *"allow yourself time to recover from burnout"* (Barbara).

The metaphor used by Barbara of *"surviving not thriving"* conveyed the ethos of many participants' responses related to experiences of burnout: a constant state of depletion due to demands, with little space to recover.

4.4 Theme 3: Do I Fit/Belong Here?

This theme captures participants' emotional struggles with identity, acceptance and belonging, within a profession perceived as shaped by neurotypical norms. As Callie reflected, *"I wonder if there's supposed to be a world of clinical psychology with me in it or if I don't fit at all."* The two sub-themes explore the impact of this uncertainty, including internalised ableism, self-doubt and the complex relational dilemmas involved in disclosing one's neurodivergent identity.

Sub-Theme: Not the "Cookie-Cutter" Psychologist

This sub-theme explores how many neurodivergent trainees grappled with feeling fundamentally misaligned with the implicit mould of what makes a 'proper' (Trainee) Clinical Psychologist. As it was felt that training, and therefore the profession, privileged

neurotypical ways of thinking, relating and communicating, it left little space for alternative ways of being. Gerald highlighted this by expressing *"uni seems threatened by neuro divergence, wanting a cookie cutter psychologist"*, and Bethany described being told that they *"don't sound like or act like a psychologist"*, implying there is a set way to be.

Therefore, this was not merely about difference, but about being positioned as fundamentally 'other'. As Elodie powerfully articulated, they *"feel like an alien trying to hide among "normal" people."* This sense of otherness ran through participants' responses:

> *"I think this comes from the idea that neurodivergence is 'other' and 'different' way of being a human that is somehow separate from psychologists"* (Alice)

> *"being a polar bear in a rainforest… I have to work extremely hard to fit into situations and around other people, and even when it feels like it's going well, I don't think I've ever shrugged that feeling of being an outsider"* (Toby)

This was also not about lacking confidence – albeit this was present in some of participants' responses – but a relational, structural and embodied sense of exclusion. These experiences cultivated a painful sense not just of not fitting in for participants, but of not being wanted or welcome in the profession. As Riley illustrated: *"I feel entirely othered and unwelcome in the profession and on the course."* Other participants shared being exposed to harmful narratives whilst on training which reinforced these feelings, for example:

> *"I have also heard stories from other trainees about being explicitly told they shouldn't be in psychology as they must have too little empathy or social difficulties to work well in this field"* (Elodie)

The stories participants hold about themselves were often related to this dominant thread, where they questioned their belonging:

> *"I am different and I don't know if the profession wants me."* (Charlotte)

> *"that I am unwelcome in the field"* (Riley)

> *"Maybe my mind doesn't fit here."* (Eden)

This suggests that these external narratives often became internalised, likely intertwining with longstanding personal stories of inadequacy and difference. Many trainees wrote about feeling *"less than"*, *"not good enough and beating yourself up"* (Casey), *"not as good as my peers"* (Montgomery) or *"not as put together"* (Emma). There was a spectrum of how this was conveyed, with Jago emotively exclaiming: *"I see myself as fundamentally 'less' or 'broken' in many ways."*

This self-doubt often intersected with experiences of imposter syndrome, where numerous participants described feeling as if they scammed their way onto the course:

> *"I've spent a lot of training where I haven't been able to disclose being autistic feeling like Cinderella at the ball, about to be revealed for a fraud at midnight, and running out of time as my spoons run out"* (Addie)

> *"I do have a narrative around waiting to be caught out or for my time to be up. As though you can't be an autistic psychologist, and the fact I've gotten this far is a fluke or a ticking time bomb."* (Kallie)

> *"I definitely fall into the imposter syndrome category where I often feel I'm not working as hard as my peers or that I'm not as knowledgeable/as good as them and don't deserve my place as much"* (Faye)

Within participants' narratives of doubt, a quieter yet potent question was foregrounded: not simply *Do I belong here?* but *Do I want to belong here?,* given what/who the profession appears to value. For some, it appeared this questioning was a crucial reframe. While the dominant culture suggested they were not enough, numerous participants offered reminders to future neurodivergent trainees that their difference may in fact be their biggest asset:

> *"Remember that you are an asset to clinical psychology. You bring something valuable, different and needed."* (Callie)

> *"Remember that you deserved and earnt your place on the course. You have a unique perspective to bring that many others don't."* (Kelly)

> *"I refuse to be anything but myself - I don't want to slide into the mould of straight-white-cis-female-NT-middle class-psychologist; I am me, I will dress like me, and talk like me, and that does not make me less effective as a psychologist."* (Ria)

These can be viewed not as uncritical affirmations, but as acts of survival; reminders of self-worth in a context where it was easily eroded, even for participants who had experienced painful events. This speaks to the complexity of identity navigation and survival in a profession seemingly still learning how to welcome those who do not fit the cookie-cutter mould.

Sub-Theme: Disclosure Dilemmas

To disclose or not to disclose was a big question on participants' minds. For most, disclosure was not a one-off decision, but a repeated relational calculation throughout training. Participants described a cautious balancing act: weighing up the perceived risks of stigma, misjudgement or changed dynamics, against the potential benefits of being open, authentic and accessing support.

A strong thread across responses was the fear of being perceived as less competent. Several participants shared that they did not view their neurodivergence as a 'problem', but they were worried that others would:

> *"I've never doubted that I can do this job or felt autism is a problem for being a psychologist, but I think other people would if I was open."* (Rebecca)

> *"I feel that I need to keep it a secret as I am otherwise treated differently."* (Olivia)

> *"People might unfairly consider me less capable as an autistic person."* (Kelly)

These fears were not unfounded. Numerous participants recalled past experiences of prejudice and misinformed assumptions about neurodivergence, both on placement and from

course staff. Some described supervisors making *"untrue and unkind comments"* about neurodivergence (Bethany), holding *"quite stigmatising beliefs regarding ND"* (Barbara), or questioning their empathy and saying they *"would struggle more than others (on my first day!) and would need to take sick leave frequently"* (Addie). These experiences therefore made the act of disclosure feel exposing and risky, particularly in new supervisory relationships where participants were still *"trying to gauge whether they'll be understanding of you and your needs. Some are great and others aren't."* (Jenna).

As a result, some participants chose not to disclose at all during training, or were highly selective, disclosing only when they deemed it necessary or safe:

> *"It's up to you where and who you share being neurodivergent with. Unfortunately stigma does exist among nhs staff and we are only there for 6 months on some placements so think carefully about who you share it with."* (Taylor)

> *"Spend time thinking about who and how you might want to share your neurodivergence which and what you hope to achieve by doing so (e.g., adaptions on placement)."* (Lily)

> *"think carefully about who you want to reveal the diagnosis to, how they will receive it and how it may change how they view you."* (Tom)

For others, disclosure appeared to be positive, freeing and beneficial, particularly when met with understanding and adjustments. Some participants encouraged disclosure proactively, seeing it as a pathway to clarity, support and more authentic relationships.

"I have been open about my diagnosis with staff and my cohort and have generally felt quite accepted." (Sadie)

"my clinical supervisor is aware of my diagnosis and is knowledgeable about ADHD. I feel comfortable speaking to her about potential problems and we are proactive in tackling them before they become actual problems." (Evelyn)

"Be open and talk about it pre-emptively. Plan ahead if you suspect you might have difficulty." (Ryan)

Whether or not disclosure brought benefits, it was often described as involving emotional and relational labour for participants. Therefore, this needed to be factored into the decision-making about if, or when, to disclose.

"Disclosing to supervisors has been really helpful in being able to express my needs more succinctly without having to explain a lot whilst feeling like I'm hiding this big secret. But it has also been difficult in some elements, like the trust and vulnerability I have to put into them when disclosing and the impact this can then have on our supervisory relationship." (Kallie)

"Having conversations with lots of new staff about my needs is always a double edged sword becuase it is important but also tiring. I also struggle with the fact that this can often feel deficit led, and doesn't always present the positives." (Lina)

An additional complexity lay in the experiences of those without a formal diagnosis. Self-identifying participants shared feeling uncertain about whether they were 'entitled' to disclose or access support, highlighting the continued power of formal diagnoses.

> *"Feeling unable to name I am autistic (due to a combination of internalised stigma and also not feeling like I can "justify" disclosing this without a formal diagnosis)"* (Elodie)

> *"haven't told anyone as I'm not sure I am neurodivergent, currently a suspicion"* (Georgia)

> *"I believe that its harder being undiagnosed as I do not feel that I have the right to ask for any additional support"* (Louisa)

> *"Since being in training I've referred myself for an ASC assessment. I always thought being around psychologists I would have that understanding and didn't need 'a diagnosis'. I've changed my mind."* (Tayla)

Ultimately, this sub-theme reveals that decisions about disclosure were rarely just personal – they were shaped by structural and relational dynamics across training. The need to carefully assess when, where and how to reveal one's neurodivergent identity speaks to the broader lack of safety and cultural acceptance discussed by participants. Beneath these dilemmas arguably sits a deeper question that many trainees appeared to carry throughout training: *Can I show my true self here, and still be accepted for it?*

4.5 Theme 4: Reclaiming Identity, Belonging and Hope

This final theme explores how amidst the challenges of training, neurodivergent trainees find meaning and resilience through connection – with themselves, others, and the value of their neurodivergence. It captures moments of resistance to deficit-based narratives, and a reorientation towards pride, self-acceptance and community. Rather than solely asking whether they fit, participants shared how they also carved out spaces of belonging – through celebration of neurodivergent strengths, connection with others, and reimagining what the profession could be. The three sub-themes explore these elements.

Sub-Theme: The Value in Difference

While parts of training left participants feeling pathologised or marginalised, many also described the unique value their neurodivergence brings, particularly to clinical work. This sub-theme explores how neurodivergent trainees recognise and reclaim their strengths, developing a sense of professional identity grounded in difference rather than in spite of it.

Connecting with the strengths of neurodivergence was not always straightforward for some participants. Some found it difficult to reflect on their neurodivergence in positive terms, often as a consequence of training experiences, that left them feeling diminished.

> *"At the moment, I feel it has only hindered the process."* (Emma)

> *"This is still part of my learning and my growth and I really struggle to feel connected to the idea of strengths and my neurodivergence as it feels like it has only brought me unhappiness so far."* (Jago)

> *"In practice I'm good at spinning different plates and cope well when I'm busy. But training feels like a bottleneck that's unintentionally designed to be harder for people like me."* (Ryan)

These reflections can be seen to highlight how systemic and relational contexts can obscure one's sense of value, especially when difference is framed through a deficit lens. Even where participants embraced their neurodivergence, several noted that the training environment had failed to recognise or celebrate the value they brought. For example:

> *"I know I have strengths, and I know some of them come from the different perspectives I hold and the different ways that I think but I haven't felt that that has been celebrated since I started training."* (Daphne)

Despite this, a powerful theme of resistance was embedded in participants' accounts. Many asserted that their neurodivergence shaped who they were professionally and was integral to their work. A wide range of consistent strengths were shared by participants – including empathy, creativity, analytical thinking, problem-solving, resilience, and being justice-orientated – that they linked directly to their neurodivergence. These qualities were not merely compensatory but framed as distinctive assets. As Callie reflected:

> *"There are abilities and skills that are directly related to my neurodivergence that make me a good trainee, such as the ability to compensate for weaknesses and problem solve, my work ethic, clinical psychology being a special interest, a different way of thinking and bringing a different perspective and an analytical mind."*

Others highlighted the "resilience" and strengths that were forged from having to navigate personal challenges, often related to their own neurodivergence. These strengths were therefore not incidental but cultivated through necessity.

> *"I think it's my analytical thinking, the natural curiosity driven by not understanding other people straight away that helps me to not make assumptions and understand client's struggles from their own perspective."* (Green)

> *"My experiences have meant I am an incredibly resilient person."* (Lina)

> *"I recognise the challenge of dyscalculia - my experience as a child and young person not understanding why I struggled so much means I can relate to young people having similar experiences. It's probably made me more resilient, and I've been forced to develop skills in other areas."* (Mary)

The value of bringing an 'insider' lens was an integral part of this, particularly when working with neurodivergent clients. This is likely because participants are bringing this into systems where such perspectives are rare:

> *"An 'insider's' perspective on navigating the world as a neurodivergent person! I have been able to point out when certain approaches or assumptions do not hold for many ND people."* (Ria)

> *"Better understanding and compassion for neurodiverse individuals"* (Tamsin)

"Being able to understand how difficulties might impact… not taking things on 'face value'." (Hannah)

"Being able to empathise with clients who identify as neurodivergent. Always having neurodivergence in mind when working with clients and thinking about how to bring this into formulation if relevant." (Rosie)

Many also shared that their neurodivergence fostered a heightened sense of empathy and attunement to the needs of clients, enriching their clinical work, alongside their ability to think critically, work creatively, and connect authentically.

"my neurodivergence definitely helps me deliver person-centred care and creative working." (Amy)

"I have a different way of thinking and that means that translates into creative and engaging ways of sharing psychology with colleagues and service users." (Daphne)

"I have built strong, therapeutic relationships with clients and my heightened social awareness and sensitivity to nuance, difference, strengths, patterns, and connection, have only ever been a strength clinically." (Addie)

Accompanying this empathy was a strong sense of justice. Across responses, participants described themselves as *"natural advocates"* (Charlotte) and *"driven by strong ideas around justice and equity"* (Kelly). These appeared to not only be personal values but professional commitments:

> *"I believe that I can offer a different perspective and that I can advocate for accessibility not only on the training but in my clinical work as well."* (Sadie)

Together, these accounts form a narrative of reclamation – where neurodivergent trainees not only resist deficit framings, but reassert their worth, insight and place in the profession. As Jenna put it simply: *"I think being ND really shapes me as a psy."*

Sub-Theme: The Power of Finding Your People

Being neurodivergent on training was described as a lonely experience for many participants, marked by a sense of being on a different path and being misunderstood. Jago shared a powerful metaphor to encapsulate this, referencing the increased vulnerability to difficulty and isolation:

> *"I feel like I have taken a different route to everyone else - they have caught the train, which has broken down a few times and had difficulties of its own, but they have been together in that. I've been on a pedal bike traversing rocky terrain on my own, much more prone to the elements and vulnerable in loneliness and a lack of people cycling alongside me. I've got to the same destination, but had a vastly different journey."*

Finding 'your people' – whether neurodivergent peers, supervisors, tutors or allies – emerged as a powerful antidote to isolation. These connections appeared to provide far more than emotional support; they offered a mirror, a sense of belonging, and a reframing of struggle. Across accounts, connection was described as essential to surviving the course and not losing oneself.

For some, the absence of these connections deepened a sense of otherness, whereas for others, their presence transformed their ability to cope and feel understood. Several participants described how meeting other neurodivergent trainees was a turning point, allowing them to drop their mask, feel seen, and realise they were not alone in their experiences. As Elodie expressed *"Without them, I think I would find the course extremely lonely.",* and similarly Leanne shared *"Find people who are also neurodivergent and get support from each other, knowing you are not alone makes a huge difference."* This can be argued as not merely social, but epistemic: peers helped validate what had previously felt like personal failings, and shifted the lens from an internal deficit to a systemic difficulty:

> *"My fellow neurodivergent trainees also remind me that I have every right to be here. I never look at them and wonder if they deserve their place (they 100% do!!), and so maybe I deserve mine too?"* (Callie)

> *"Peer support - I don't think I could do this without having had discussions with other trainees (both on my cohort and across cohorts) naming the challenges that neurodivergence can bring on training, and validating the sense of "oh good! I'm not a crap trainee, I'm just neurodivergent"."* (Elodie)

These relationships, which were often referred to as *"tribes", "networks"* and *"people who get it",* helped participants re-ground in shared experience. They enabled participants to speak openly about burnout, overwhelm, masking and identity, in ways that were not always possible in bigger, likely neurotypical-dominated spaces.

"Find your fellow NDs, they'll understand things easier, and are less likely to judge you!" (Leon)

Many highlighted the importance of neurodivergent affinity spaces. For those that had access, they wrote about them as hugely beneficial and normalising; and for those who did not have access, they expressed a wish for them across programmes.

"The university has a reflective and working group for ND trainees which I have found very beneficial and supportive. This gives me hope moving forwards that changes will be made." (Anya)

"I'd have loved more discussion or a space to help think about things like demand, overwhelm and procrastination, burnout etc. Maybe a space for ND people to get some real supportive and advice around this." (Jenna)

Participants also wrote about the critical importance of who was 'in their corner'. Some felt exceptionally fortunate to have had supervisors, tutors or mentors who understood neurodivergence, occasionally because they identified as neurodivergent themselves. These relationships were described as transformative, enabling participants to feel safer, advocate for their needs, and engage more authentically in training. However, this support was not guaranteed and was described as likely to be a random allocation.

"I have a really amazing personal and professional development tutor. She has held space for me in my darkest times and I am beyond grateful for that." (Callie)

"Placements so far have been encouraging, and I have a neurodivergent supervisor which really helped." (Lina)

"Overall, my tutor has been supportive but they don't represent the entire wider teams views on adjustments." (McCa)

These accounts reveal both the value of supportive relationships and the inequity of their distribution. Multiple participants argued for a more proactive approach, calling for better supervisor matching, dedicated neurodivergent staff contacts, and visibility of neurodivergent professionals within training contexts. Within this, it is interesting to consider that these participants will themselves be those professionals in time.

"Allocated staff members to go to for support who understand ND well. Employ more ND staff members." (Isla)

"Also maybe highlighting the supervisors who are neuro-divergent (with their permission) so we know who we might work well with." (Sadie)

In this way, finding your people was not only about survival, but about imagining what a more inclusive training environment could look like. Participants did not only seek support, but they began creating it, by building informal communities of shared experience, advocating for neurodivergent groups, and supporting others. These acts of connection can be seen to represent not only individual coping strategies, but collective forms of resistance.

In the face of systemic misunderstanding, relationships offered grounding, affirmation and hope – reminding participants that they were not the problem, and that belonging was possible.

Sub-Theme: Holding on to Hope

As the previous themes and sub-themes explored, for many participants, navigating the training experience was mixed at best, and often marked by great difficulty. Yet amongst this, and while re-grounding in shared neurodivergent experiences and the value of their neurodivergence, some voiced a powerful determination to make the path easier for those who follow. This did not appear to be a naïve or passive hope, but an active, politicised wish to transform the profession – ensuring future neurodivergent trainees would not face the same barriers, and instead be recognised, supported and celebrated.

> *"Hope I can help contribute to better training experiences in the future and hope that I can be a force for change within the workforce."* (Charlotte)

> *"I feel a duty of responsibility to fight the fight on behalf of other neurodivergent students and trainees to come"* (Lina)

> *"I put a lot of pressure on myself to get through and make it as a clinical psychologist because some of us have to, to fight the systemic barriers from within the system and make change, so I'm determined to not let those systemic barriers stop me."* (Kallie)

This sense of purpose appears to be closely tied with participants' recognition of their strengths, and crucially the belief that these strengths offer vital contributions to the profession.

> *"Not to forget how incredibly valuable you are to the psychology profession BECAUSE of your neurodivergence."* (Rebecca)

> *"That being said, I also feel that neurodivergent representation in mental healthcare is hugely important, and if you can do it, you will bring unique strengths that will be valued by your clients and service users, and colleagues… I do think we bring uniquely valuable contributions to the profession."* (Avery)

Hope also emerged in reflections on what could be different. For example, some envisioned more flexible training structures, more inclusive pedagogies, and more neurodivergent psychologists shaping the field.

> *"Having neurodivergent psychologists in the workforce is so important and something I hope we can see more of in the future."* (Lauren)

> *"I hope that future trainees are able to have a more flexible learning experience."* (Charlotte)

These participants chose to imagine a better future – one where neurodivergent trainees are not expected to fit the mould, but are valued precisely because they do not.

Chapter 5: Discussion

5.1 Chapter Overview

This chapter provides an integrative discussion of the research findings, exploring each theme in turn in relation to theoretical frameworks and existing literature. It then considers the strengths and limitations of the research, before outlining the implications across programme, relational, and professional culture and structural levels. The chapter then offers suggestions for future research, and closes with reflections and conclusions.

5.2 Summary of Findings

This research aimed to answer the question: *What are the experiences of neurodivergent Trainee Clinical Psychologists completing a DClinPsy programme in the UK?* Using RTA (Braun & Clarke, 2006, 2019), four themes with accompanying sub-themes were constructed: '*This System's Not Built for Us'*, '*The Ever-Present Burnout'*, '*Do I Fit/Belong Here?'*, and '*Reclaiming Identity, Belonging and Hope'*. The findings both resonate with existing literature in higher education and healthcare professions training, and add novel insights, providing the first (to the author's knowledge) in-depth research specific to neurodivergent DClinPsy trainees in the UK.

5.3 Relating Findings to Existing Literature and Theoretical Frameworks

5.3.1 Theme 1: This System's Not Built for Us

This theme describes participants' experiences of navigating a clinical psychology training system that felt exclusionary due to being shaped by systemic ableism. These experiences can be powerfully understood through the lens of the Social Model of Disability (Oliver, 1990), which posits that disability arises primarily from barriers in the environment and society as opposed to inherent deficits in individuals. In participants' responses, the 'barriers' were the neuronormative expectations and practices embedded in their courses –

from inaccessible and inflexible teaching methods to unwritten rules of professional behaviour – which effectively *disabled* them by creating disadvantage and distress. Charlotte's reflection that the course structure had been *"disabling"* speaks directly to this model in action. These findings support existing literature in higher education that proposes that many challenges faced by neurodivergent students stem from neurotypical norms in pedagogical approaches, for example, traditional didactic and group-based teaching methods (Durgungoz & Durgungoz, 2025; Spaeth & Pearson, 2023). However, when teaching methods incorporate flexibility (such as UDL), neurodivergent students are more able to thrive (Clouder et al., 2020) – aligning with the view shared by participants.

The P-E Fit theory (Edwards et al., 1998) provides a complementary lens for understanding these experiences. The theory holds that stress and poor outcomes emerge when there is a misalignment between individuals' characteristics and the demands of their environment. In this context, neurodivergent trainees were arguably attempting to perform in an environment misaligned with their neurology, which is likely why training was referred to as a *"fight"* or *"battle"*. A key part of the *"fight"* described by participants was related to securing and implementing reasonable adjustments, which when combined with internalised ableism left some feeling 'unreasonable', both in their requests and in how they saw themselves. This illustrates how support systems that appear fair in principle may falter in practice, and resonates with broader literature about how institutional support often involves significant administrative burden and gatekeeping (e.g., McDowall & Kiseleva, 2024). The lack of a formal diagnosis, and its implications for disclosure and accessing support, was something some of the participants struggled with, similar to the SLR's findings (e.g., Godfrey-Harris & Shaw, 2023; Shaw et al., 2023). Whilst there are systemic, financial and emotional reasons why trainees may not be able to or wish to get a diagnosis, it is also important to hold in mind that requiring diagnoses is one way to protect resources for those

who need them, and therefore there are complexities for institutions managing this (Riddell & Weedon, 2014). Specific to healthcare professions training, participants also shared how adjustments were often not carried over to clinical placements, echoing findings from the SLR that structural disconnects between academic and clinical components of training can leave students feeling unsupported (e.g., Murphy, 2011).

Within the systemic and procedural challenges was a deeper relational harm described by participants – the experience of not being understood. This sub-theme is mirrored in the SLR, suggesting it is a shared experience with other healthcare professions students. Milton's (2012) *double empathy problem* offers a sociological view, proposing that the communication gap between autistic (or otherwise neurodivergent) and neurotypical people is mutual, arising from a mismatch in perspectives and not specifically an autistic deficit. If we consider participants' experiences with this view, many instances where they felt unheard, misjudged or received ignorant comments by neurotypical staff could be seen as a reciprocal empathy breakdown.

The sub-theme '*Professional Disillusionment'* explores the paradoxical sense of disappointment by a profession that champions compassion and inclusion, and therefore adds to the evidence base as it is specific to clinical psychology. As summarised by Loren, *"Although most of the course team are clinical psychologists, they failed to understand my needs and make appropriate adjustments…".* These feelings perhaps echo the idiom *'The cobbler's children have no shoes',* highlighting the irony that those who are skilled at providing something for others can fail to provide it for themselves or their own professional communities. This irony is reflected in existing literature that finds, for example, that there are high rates of burnout among psychological therapists (Vivolo et al., 2024), despite their work centring on supporting the wellbeing of others. Participants' accounts reflected a

consequential loss of trust in the profession due to the perceived gap between expectation and reality.

Overall, the experienced pervasiveness of neurotypical norms highlighted in this theme can also be viewed through Ecological Systems Theory (Bronfenbrenner, 1979). This theory reminds us that trainees are operating within nested systems; from immediate relationships (microsystem, e.g., supervisors and cohort interactions), to institutional structures (meso/exosystem, e.g., university and NHS policies), to broader societal structures and ideologies (macrosystem, e.g., capitalism and societal ableism). Therefore, the findings suggest that participants' feelings of exclusion were influenced at all of these levels.

5.3.2 Theme 2: The Ever-Present Burnout

Theme 2 revealed that for many neurodivergent trainees, the experience of training was characterised by the chronic and cumulative threat of burnout. Participants described living in a state of near-burnout, actively experiencing burnout and attempting to recover from it – in an endless loop. This eroded boundaries, health and wellbeing for participants. Two major contributors to this ever-present burnout, as identified in the sub-themes, were masking and hidden labour.

In *'Masking and the Cost of Invisibility'*, participants' efforts to mask/camouflage their neurodivergence was described as both a survival strategy and a source of exhaustion. The use of masking by neurodivergent students and its emotional cost strongly aligns with findings across higher education (e.g., Lewis & Arday, 2023; Syharat et al., 2023) and healthcare training contexts (e.g., Dabbs et al., 2024; Shaw et al., 2023). For example, Syharat et al.'s (2023) study presented a model for understanding the experiences of neurodivergent students in Science, Technology, Engineering and Mathematics (STEM) graduate progammes, and a key component is "Neurodivergent Burnout Due to Overwork &

Masking" (p. 6). It discusses how the dual pressure of intensified academic demands and the need to mask neurodivergence led to emotional exhaustion, anxiety and burnout – similar to participants in the present research. Hull et al. (2017) conceptualise camouflaging as a three-stage model: beginning with motivation to fit in, followed by active masking and compensatory strategies, and resulting in unpleasant long-term consequences such as exhaustion and identity loss. This process resonates with participants' accounts, many of whom described masking to avoid judgement and meet neurotypical expectations of a 'competent' trainee, often at the expense of authenticity, energy and their health.

Participants' experiences and reflections on masking can also be considered from the perspective of Minority Stress Theory (Meyer, 2003). Masking acts as a concealment of their minority identity, which is regarded as a proximal stressor – an internal process in response to distal stressors, such as marginalisation and stigma, which participants described facing. The ongoing, cumulative pressure to perform neurotypically, as the theory predicts, seemingly contributed to the emotional exhaustion at the core of burnout (Botha & Frost, 2020; Meyer, 2003). As Stevie shared: *"I have masked so many of my ADHD traits to be more accepted during training, at the detriment of my own wellbeing."* This speaks to the emotional labour of appearing acceptable in a neurotypical environment. Similarly, the sub-theme *'Hidden Labour'* also focuses on this. The sense of needing to prove oneself was heightened by a perception of bias: some felt that unlike their neurotypical peers who were *"assumed competent until shown otherwise"* (Bethany), it was perhaps the opposite for them and thus they had to work significantly harder. This insight may be further understood by considering its alignment with literature around *stereotype threat* – the idea that when individuals are aware of negative stereotypes about their identity group, there is increased pressure to disprove them (Steele, 1997). Crucially, Steele (1997) found that this effect does not require belief in the stereotype, simply the awareness that others might believe it is

enough to trigger stress. For neurodivergent participants, the awareness that others might question their professional competence or interpersonal skills due to their neurodivergence may lead to heightened self-monitoring and overcompensation. The burden of needing to disprove assumptions – to appear 'professional enough', 'organised enough' or even 'neurotypical enough' – adds another layer of stress and a drain on trainees' cognitive resources. This may also support understanding of similar findings in existing literature, across higher education and healthcare professions training.

The sub-theme *'Spillover into Personal Life'* explores how the cumulative toll of professional training infiltrated and affected participants' personal lives. Many participants described having no energy left for recovery, social connection or basic self-care due to feeling depleted. Spoon Theory (Miserandino, 2003), a widely embraced metaphor in neurodivergent and disabled communities, provides a useful lens here. It conceptualises energy as a finite resource – spoons – that must be carefully rationed throughout the day. Participants' accounts reflected the reality of having to use most, if not all, of their spoons on surviving the demands of training. As a result, little or no energy remained for their personal lives or restorative activities. From a structural perspective, the fact that participants described consistently operating with so few spoons can suggest a wider systemic issue around not meeting the needs of neurodivergent trainees. Within this sub-theme, an interesting, novel nuance is how many participants offered reflective advice for future trainees to protect their wellbeing and boundaries and give space to recover from burnout. At face value, this guidance seems compassionate and wise. However, read in the context of their own narratives, it carried a quiet sadness as many were unable to take their own advice. In this sense, it was a poignant dissonance – trainees as both helpers and sufferers, aspiring to model self-care while often being unable to practise it. It evokes the ancient proverb *'Physician, heal thyself'*, highlighting the importance of self-care within a caring profession.

Encouragingly, throughout their responses participants identified ways in which cycles of burnout could be broken and navigating their neurodivergence on training could feel lighter, often through increased support, understanding and adjustments. This therefore identifies a critical point: burnout does not need to be inevitable for neurodivergent trainees.

5.3.3 Theme 3: Do I Fit/Belong Here?

This theme focused on the internal struggles of neurodivergent trainees grappling with uncertainty around fit and acceptance within the clinical psychology profession, and the complexities around whether to disclose their neurodivergent identity as part of this.

A prominent aspect was the sense of 'otherness'. Many participants described feeling fundamentally different from the implicit mould of the *"cookie-cutter psychologist"*, and internalised messages that therefore they perhaps did not belong in the profession. Social Identity Theory (Tajfel & Turner, 1979), as further explored by Rivera and Bennetto (2023), offers a valuable lens here: trainees arguably experienced being repeatedly cast into the 'out-group' through a mix of overt and subtle exclusion, undermining both their personal and professional self-concept. In this framing, the social categorisation of neurodivergent trainees as 'other' threatens their ability to positively identify with the wider group of clinical psychologists, particularly when that identity is implicitly defined in neurotypical terms. This identity threat – defined as the concern out-group members experience when their in-group is devalued, stigmatised or negatively stereotyped by others (Rivera & Bennetto, 2023) – appeared to be internalised by multiple participants. Some described imposter syndrome beliefs, such as feeling as if they had gained a place on training by accident or were *"about to be revealed for a fraud"*. Others used despairing language such as *"fundamentally 'less' or 'broken'"*. These reflections of diminished self-worth and persistent self-doubt align with research by Clouder et al. (2020) and Syharat et al. (2023), who similarly found that

neurodivergent students in higher education report self-criticism and lower feelings of belonging, particularly when their differences are framed as deficits.

A critical sub-theme was '*Disclosure Dilemmas*' – if and/or when to reveal one's neurodivergent identity to others on training. Participants weighed potential benefits (such as accessing adjustments and being authentic), against potential risks (such as stigmatisation and being seen as less competent). These considerations closely mirror the SLR findings that disclosure among neurodivergent healthcare students is highly context-dependent, often delayed or withheld unless a sufficient level of trust or necessity is present (e.g., Ali et al., 2020; Morris & Turnbull, 2007; Shaw et al., 2023). This calculation maps onto Minority Stress Theory's (Meyer, 2003) discussion of *concealment* as a central internal stress process for minority individuals.

To enhance our understanding beyond this, it is valuable to consider the lens of Concealable Stigmatized Identities (CSIs) (Quinn & Earnshaw, 2013). Neurodivergence, for many participants, functioned as a CSI: an identity that could often be masked or hidden, yet was perceived by participants to be socially devalued within the dominant culture of clinical psychology. Participants described the emotional burden of navigating when and how to disclose their neurodivergence. The fear of being judged, disbelieved or pathologised aligns closely with Quinn and Earnshaw's (2013) term *anticipated stigma* – the expectation of rejection or devaluation should their identity become known. This was not merely hypothetical, as several participants shared experiences of real or imagined negative consequences of disclosure, leading to it feeling unsafe for some. The decision to remain concealed, however, came with its own psychological toll. Quinn and Earnshaw's (2013) framework helps explain how both *internalised stigma* (e.g., stories of being not good enough, less than, or inherently deficient), and *identity magnitude* (how central and salient neurodivergence is to one's sense of self) interact to shape wellbeing. It suggests that for

those who feel their neurodivergence is core to their identity, but lack validation or visibility, the dissonance exacerbates distress – which could explain the gravity of emotional difficulty described by some of the participants. The framework also suggests the role of *positive disclosure* experiences in buffering psychological harm (Beals et al., 2009; Quinn & Earnshaw, 2013). When disclosure was met with understanding and acceptance, often from other neurodivergent peers, participants described a sense of relief, acceptance and helpfulness. This highlights the importance of cultivating training environments that are not simply tolerant of neurodivergence but actively affirming, thereby reducing the need for concealment and its associated costs.

A particularly poignant question surfaced in participants' narratives: not only *Do I belong here?* but *Do I want to belong here?* This reflects an important turning point that some participants reached, and is a novel contribution to literature on neurodivergent students in higher education, particularly within the context of clinical psychology training. Rather than continuing to chase full acceptance, a number of trainees began to challenge the premise that they had to change themselves to fit in: "*I am me, I will dress like me, and talk like me, and that does not make me less effective as a psychologist."* (Ria). They asserted in various ways that perhaps the profession should change to accommodate them, offering empowering reminders to future neurodivergent trainees: *"You bring something valuable, different and needed."* (Callie). Such statements embody the Neurodiversity Paradigm (Singer, 1999; Walker, 2021), framing difference as valuable, and calling for systemic over individual change.

5.3.4 Theme 4: Reclaiming Identity, Belonging and Hope

While the earlier themes detailed many hardships, Theme 4 illuminated how participants were also resisting the deficit narrative and asserting a counter narrative of

difference as valuable; reclaiming their strengths, community and hope. This theme is best understood in light of the Neurodiversity Paradigm (Singer, 1999; Walker 2021) and related concepts of identity and community. As aforementioned, the paradigm reframes neurodivergent traits as part of natural variation with unique strengths, encouraging neurodivergent individuals to take pride in them. Participants listed many strengths directly tied to their neurodivergence, such as creativity, analytical thinking, heightened empathy and a justice-orientated perspective – all an asset to the profession of clinical psychology. These accounts align with and contribute to the small but developing evidence-base that neurodivergent clinicians can offer distinct strengths. For example, autistic counsellors often report exceptional attention to and memory for detail, the ability to break things down in ways clients can understand, identifying links and patterns, and depth of empathy and sensitivity (Taylor & Sims, 2025). Additionally, lived experience (whether of mental health challenges or neurodivergence) can enrich a clinician's practice (Cleary & Armour, 2022; Taylor, 2025). Such sentiments also support literature suggesting that neurodivergent individuals develop adaptive skills and creative problem-solving techniques, as highlighted in the SLR, precisely because they have had to navigate a world not ideally suited to them (Ortiz, 2020). This sub-theme connects to the concept of epistemic injustice; by insisting on their place in the profession due to the value of their neurodivergence, participants are working to correct the historical exclusion of neurodivergent voices in knowledge-making and practice (Russell & Wilkinson, 2023).

The sub-theme *'The Power of Finding Your People'* illustrated how community support was transformative, greatly reducing feelings of isolation and fostering resilience. For participants, connecting with neurodivergent peers provided emotional validation and collective self-esteem, confirming the protective function of Social Identity Theory's in-group formation (Tajfel & Turner, 1979). It also aligns with Botha and Frost's (2020) note

that a coping strategy for minority stress is community connection, buffering mental health by providing acceptance and group level coping. These findings are consistent with existing literature in higher education and the SLR about healthcare professions training, observing the strength and value that neurodivergent students derive from support networks, affinity spaces, peer mentorship, and staff who 'get it' (e.g., Clouder et al., 2020; Coyle et al., 2025). As Leanne shared, *"Find people who are also neurodivergent and get support from each other, knowing you are not alone makes a huge difference."*

Participants also began to imagine a different future for the profession. In the sub-theme '*Holding on to Hope',* a clear commitment was expressed to improve the experience for future neurodivergent trainees. This reflects a form of *critical hope* (Grain & Lund, 2017) – not naïve optimism, but a determination rooted in recognising injustice and focusing on altering it. It was acknowledged that their own survival and success could pave the way for others and that representation matters: *"Having neurodivergent psychologists in the workforce is so important and something I hope we can see more of in the future."* (Lauren). This mindset ties into Ecological Systems Theory thinking (Bronfenbrenner, 1979), where participants were essentially positioning themselves within the larger system and acknowledging their potential role at the exosystem and macrosystem levels. The dimension of time and change in Bronfenbrenner's chronosystem is also particularly relevant to consider, as trainees are part of a historical shift in understanding and working with neurodivergence, as discussed in Chapter 1. These findings speak to the notion of 'becoming change agents' that is seen among individuals who experience marginalisation and then work to reform the systems that marginalised them (Kosko et al., 2022). Overall, Theme 4's findings contribute a hopeful note: despite the challenges experienced on DClinPsy programmes, neurodivergent trainees are findings ways to ground themselves – in their own strengths, in each other, and in the belief that the system can change.

5.4 Strengths and Limitations of the Research

5.4.1 Strengths

To the author's knowledge, this is the first empirical research to explore the experiences of neurodivergent Trainee Clinical Psychologists on DClinPsy programmes in the UK, addressing a gap in the literature highlighted through the SLR (Chapter 2). In doing so, it supports the profession to not only examine the needs of neurodivergent clients, but to look within itself (Hawker et al., 2022), importantly providing a platform to amplify the voices of neurodivergent trainees. It offers timely insight into how training structures and cultures are experienced by this under-represented group, and generates recommendations with practical relevance across system levels. This research also contributes to the growing evidence base about the experiences of neurodivergent students in higher education and healthcare professions training more broadly, developing understanding and highlighting areas for further research.

The use of consultation with neurodivergent trainees as EbEs in the design stage of the research is a strength. Consultation is increasingly recognised as a key component of inclusive and ethical research, particularly when working with marginalised communities (Dwyer, 2022; Fletcher-Watson et al., 2021). The Consultants' contributions helped ensure that the questionnaire was accessible (language, content and design), respectful and meaningfully aligned with the priorities of the community being researched. This aligns with wider calls for participatory and neuro-affirmative research approaches that centre the perspectives of neurodivergent individuals, as well as Dwyer's (2022) recommendations for researchers seeking to apply the neurodiversity approach, and a commitment to addressing epistemic injustice (Shaw et al., 2024). For this reason, there is also value in the researcher being neurodivergent – an insider to the community being researched, which brought additional benefits such as a deep contextual sensitivity to the lived realities of participants

(Callander, n.d.), and an ability to attune to the nuances of language and meaning in their responses (Dwyer & Buckle, 2009; Greene, 2014).

Another key strength of this research is the sample. 70 neurodivergent trainees from 17 different DClinPsy programmes across the UK participated, making this a substantial and wide-ranging qualitative dataset for a small project (Braun et al., 2021), also highlighting the interest in the research area. The sample included trainees with a variety of neurodivergent identities, addressing a gap identified in existing literature (Clouder et al., 2020; McDowall & Kiseleva, 2024), and included trainees with formal diagnoses and/or those who self-identify, reflecting a more inclusive and neuro-affirmative approach. The breadth of the sample supports the transferability of findings across DClinPsy training contexts in the UK.

A final strength lies in the coherence between the research aims, methodological choices and epistemological positioning. The use of a qualitative questionnaire enabled wide and inclusive participation by trainees across the UK, and offered an anonymous, flexible and more accessible format (Terry & Braun, 2017) which could accommodate a range of neurodivergent communication needs and preferences. It supported the diversity of voices heard and sense-making in this under-explored area (Braun et al., 2021). RTA (Braun & Clarke, 2006, 2019) was well-suited to the exploratory nature of the research, offering a flexible yet rigorous way to construct meaning across the dataset, and appreciating the researcher's subjectivity (Clarke & Braun, 2017). Being underpinned by a critical realist epistemology enabled the analysis to be a layered understanding of participants' experiences – as both situated accounts of their lived experience and reflections of broader systemic and structural conditions, interpreted through the researcher's lens. This methodological coherence enabled the development of nuanced, contextually grounded themes that remained true to participants' narratives.

5.4.2 Limitations

The use of a qualitative questionnaire, whilst offering important strengths, meant that the depth of responses varied. The majority of participants provided rich, reflective narratives, however some provided brief and/or thin answers. This contrasts with interview-based designs, where researchers can prompt for elaboration and co-construct meaning in real time (Robinson, 2023). The analysis of the briefer responses was consequently less rich, however the sample size was increased during recruitment to account for any data quality issues. In addition, a related limitation and consideration was the question: "We often develop stories based on our experiences - what stories do you hold about yourself as a neurodivergent trainee?". Although piloted with Consultants, and being one of the richest and most emotive sources of data, several participants responded with *"Not sure"* or *"I don't understand"*. This may reflect the complexity of self-narrative and identity within neurodivergence and/or the training context, but it may also indicate that the language did not resonate equally across participants' neurocognitive styles. This highlights a challenge of designing questions that are inclusive in questionnaire format, even within a neurodivergent-informed framework (Braun et al., 2021; Fletcher-Watson et al., 2021). It is also important to note that, given the methodology, the findings reflect self-reported written accounts from neurodivergent trainees who chose to participate within a particular methodological, temporal and training context. As such, the analysis supports interpretative insight into shared experiences and meanings, but does not allow conclusions about prevalence, causality or representativeness across all neurodivergent trainees or DClinPsy programmes.

Whilst the research focused on inclusivity by inviting both formally diagnosed and/or self-identifying trainees under the umbrella term 'neurodivergent' – as it was the first known empirical study and addressed a gap in literature – it meant that within-neurodivergent identity differences (or conditions) were not explored. As such, the findings speak to the

shared experiences of neurodivergent trainees as a collective, recognising that neurodivergent individuals are not a homogenous group.

There was a gender and ethnicity bias in the sample of participants which is a limitation. Of the 70 participants, 56 (80%) self-identified as ‘female or ‘cisgender female’ and 51 (73%) self-identified as ‘White British’ or ‘White’. Therefore, the findings may not fully represent the wider neurodivergent trainee population. In addition, although the research collected demographic data, it did not explore intersectionality – considering how intersecting aspects of identity, such as race, gender, sexuality and class, interact to shape experiences within clinical psychology training. This is a notable gap given evidence that intersectional factors significantly impact access, inclusion and wellbeing in higher education (Ahn & Davis, 2023; Bhowmik, 2023).

Lastly, this research was conducted within the context of clinical psychology training in the UK, drawing on Western conceptualisations of neurodivergence. Understandings of neurodivergence are culturally and historically situated, as mentioned in Chapter 1, and findings may therefore differ significantly in other contexts or with other lenses. For example, the Māori term for autism which was developed in 2019 by Keri Opai is ‘Takiwātanga’, which means in “my/his/her own time and space” (Tupou et al., 2021 p.1852). Such differences in cultural framing highlight the importance of cross-cultural and decolonising approaches in neurodivergent research (Tafla et al., 2024).

5.5 Implications of the Research

The findings of this research raise important implications. While other studies offer implications at the individual level, such as coping strategies, assistive technology or self-advocacy techniques (McDowall & Kiseleva, 2024), this research takes a different stance. Given the systemic and relational nature of the barriers identified, it was deemed

inappropriate to place the burden of change on neurodivergent trainees themselves. Consistent with the Social Model of Disability (Oliver, 1990) and Neurodiversity Paradigm (Singer, 1999; Walker, 2021), the implications below focus on the systems, structures, relationships and professional cultures that must evolve to better support inclusion, wellbeing and overall experiences of neurodivergent trainees completing DClinPsy programmes in the UK. These are in addition to the implications of the SLR. It is important to note that participants' specific universities were not considered in the analysis, nor were the perspectives of staff, and therefore some programmes may be implementing some of these recommendations already.

5.5.1 Programme Design

Participants described DClinPsy programmes as shaped by ableism and therefore structurally misaligned with their needs, citing inaccessible teaching methods, unclear expectations and inconsistent support. To address this, it is recommended for programmes to adopt the following suggestions:

- *Embed UDL*. Participants highlighted that conventional, didactic teaching formats were challenging to engage with. UDL offers a proactive framework for embedding accessibility into the core of learning environments (Capp, 2017). Practical steps could include providing lecture materials in advance, offering multimodal content (e.g., visual, written, audio), providing explicit instructions, incorporating regular breaks into lectures, and offering flexibility in participation and assessment (Coffman & Draper, 2022; McDowall & Kiseleva, 2024). UDL has been shown to improve outcomes not only for neurodivergent learners but for all students (Capp, 2017).

- *Redesign Adjustments Processes*. Many participants described having to repeatedly justify their needs, navigate opaque processes, educate staff about their neurodivergence, and often not receiving personalised, adequate or even any adjustments. Programmes should design clear and proactive systems for developing personalised support for trainees, for example via a reasonable adjustments consultation with their tutor, which can then be formalised into a study needs agreement. There should also be a clear process developed for communicating adjustments between universities and placement supervisors to ensure continuity of support (Godfrey-Harris & Shaw, 2023).
- *Build Flexibility into Timelines*. Participants described having different processing speeds, and burnout resulting from unmanageable, overlapping pressures and consequential work in personal time to 'keep up'. Programmes can reduce this by mapping workload intensity across the year and avoiding clustering of major deadlines. This is supported by research showing that additional time is required and important for neurodivergent minds (Clouder et al., 2020).
- *Co-Production with Neurodivergent Trainees.* Programmes should establish standing advisory groups of neurodivergent trainees and staff to co-design teaching content, accessibility initiatives and evaluation processes. This aligns with calls to embed lived experience and reduce epistemic injustice (Russell & Wilkinson, 2023), and the importance of co-production with neurodivergent students (Cumming et al., 2023).
- *Update the Clearing House Website*. Providing clear communication about what support is available to neurodivergent trainees within each university's programme, via the Clearing House website (n.d.), is important so prospective

trainees can consider this as part of their decision-making process for the DClinPsy.

5.5.2 Relational Practice

Relational experiences – especially within supervision, teaching and peer connection – played a central role in shaping trainees' experiences and sense of safety, identity and inclusion. The following suggestions are recommended:

- *Training in Neurodivergence.* Participants described a painful sense of not being understood, and experiences of stigma, stereotyping and discrimination as a result. Training for staff and supervisors about neurodivergence, how to foster an environment for disclosure, and ways to support a neurodivergent trainee, is therefore crucial. Training could be embedded into induction for new supervisors, offered annually as CPD, and should be co-produced with and ideally co-delivered by neurodivergent trainees (Cumming et al., 2023).
- *Establish Peer Affinity Spaces and Neurodivergent Working Groups.* Participants found solace, validation and empowerment in spaces where they felt understood by fellow neurodivergent peers, which countered the loneliness some felt within the wider training system. The value aligns with Social Identity Theory (Tajfel & Turner, 1979) and existing literature (e.g., Butcher & Lane, 2024). Programmes should facilitate the creation of ongoing peer support spaces and neurodivergent working groups that are embedded into the programme and have resource allocation.
- *Appoint Neurodivergent Allies.* Participants discussed the value of staff and supervisors who 'got it'. Therefore, programmes could designate neurodivergent staff, including qualified Clinical Psychologists in the local regions, to act as

formal allies, mentors, and points of contact for neurodivergent trainees. These connections will not only offer support, but visibility and representation, which sends a powerful message about belonging in a context where this is being questioned by neurodivergent trainees (Wong et al., 2023).

5.5.3 Professional Culture and Structures

Beyond individual programmes, participants' narratives called attention to the broader norms, values and expectations embedded within the profession of clinical psychology. The questioning of belonging, and whether they want to belong, speaks to a wider need for cultural and systemic change. Therefore, the following is recommended:

- *Increase Neurodivergent Representation*. Relevant institutions, such as universities and the NHS, should proactively include neurodivergent professionals in leadership roles, research posts, panel interviews, course teams and advisory boards. Visibility normalises difference, challenges epistemic injustice, and models diverse ways of being competent (Praslova, 2025).
- *Embed Neurodivergent Inclusion in Accreditation and Policy.* Professional bodies, notably the BPS and the Health and Care Professions Council (HCPC), should strengthen their guidance and frameworks around equity and inclusion with regards to neurodivergence. For example, the new BPS accreditation criteria (BPS, 2025), include a Foundational Programme Standard regarding equality, equity, anti-discrimination and inclusion. The aim of the standard is to "ensure all programmes conform to the Equality Act 2010 and enable the delivery of the NHS's Public Sector Equality Duty" (BPS, 2025, p. 14). The Foundational Programme Standard underpins all eight standards of accreditation and will be an opportunity for programmes to consider how they embody equality, equity, anti-

discrimination and inclusion on their programme, in relation to teaching, research and clinical practice. In addition, accreditation standards could require evidence of inclusive pedagogy and consistent adjustments processes from training providers. Lastly, a national neurodivergent-affirming framework for the profession, co-produced with neurodivergent trainees and Clinical Psychologists, would provide much needed consistency and accountability across programmes in the UK.

5.6 Suggestions for Future Research

It is highly important for researchers to continue to amplify the voices of neurodivergent Trainee Clinical Psychologists. This research marks an initial step in understanding their experiences, and therefore future research can build on this foundation in several ways.

First, alternative qualitative research methodologies could be adopted, such as in-depth interviews and focus groups, to support a more developed understanding of experiences. Interviews, particularly when conducted by neurodivergent researchers or within participatory frameworks (Greene, 2014), may help co-construct deeper insights into areas such as identity, belonging, internalised ableism and navigation of training.

Second, given heterogeneity in neurodivergent identities, it could offer value and align with existing healthcare professions research to explore experiences by neurodivergent identity/condition, for example autistic or dyslexic trainees. This may also inform more targeted support which arose largely as an unmet need in this research.

Third, this research collected data about when participants' neurodivergence was identified (see Table 7 in Chapter 3), and interestingly 22 out of 70 participants were either formally diagnosed and/or self-identified during the DClinPsy programme. This highlights a potentially significant developmental period in which neurodivergent identity is discovered

and shaped. Research in this area could therefore be valuable to understand the experiences of this group of trainees, such as discovery/diagnosis, identity formation, disclosure and adjustments within the training context.

Fourth, as aforementioned this research did not explore intersectionality. Therefore, it is important for future research to consider different *social graces* (aspects of social identity that can influence power and privilege) (Burnham, 2012) and focus on the experiences of neurodivergent trainees who occupy multiple marginalised identities.

Fifth, as the global relevance of the findings remains unclear and unexamined, cross-cultural research could investigate how neurodivergent trainees in clinical psychology are understood, positioned and supported in different national or cultural training contexts. Such research could also contribute to ongoing efforts to decolonise neurodivergent research, recognising that UK and/or Western conceptualisations are not universal (e.g., Tafla et al., 2024; Tupou et al., 2021).

Lastly, the findings of the present research and the SLR highlight that neurodivergent trainees feel there is a lack of understanding, structures and practices of how best to support them. For example, participants identified the value of flexible and accessible pedagogy and peer affinity spaces. Therefore, evaluative research into what practically supports neurodivergent trainees could be transformative, and build an evidence base for inclusive practice.

5.7 Final Reflections

One of my participants wisely advised *"Try not to lose who you are too much"* in the ableist systems (Ebony). I can say, having completed this research as an insider researcher, that I have not lost who I am – rather, I have found more of who I am, and who we are, than ever before. It has been a privilege, albeit with many challenges along the way, to formally

amplify the voices and experiences of neurodivergent Trainee Clinical Psychologists. I deeply hope that this research will be a seed of change in our profession – helping enhance understanding, and contributing tangible recommendations to better protect the 'spoons' of those who need them.

This research process has not been a neutral or detached endeavour. It is not lost on me that conducting research about navigating neurodivergence, whilst trying to navigate my neurodivergence, had its own layered complexities. It has required a great deal of me, cognitively and emotionally. At times, I recognised myself in participants' words; at others, their stories stretched my understanding of what it means to be neurodivergent within clinical psychology training. Returning to participants' narratives often felt like returning to a space of recognition and resistance – one that reminded me, constantly, of why this research matters.

In the absence of being able to fulfil my childhood wish of having the superpower to pause time, I instead had to practise a lot of self-acceptance in the research process. It is said that 'slow and steady wins the race' (see Appendix L). Whilst there are no winners or losers, I have most definitely identified with the tortoise throughout my DClinPsy journey; drawing on all of my persistence and determination to keep moving, at my own pace. So, as I conclude these final reflections, I am so proud that I have finally won (or completed) the race.

5.8 Conclusion

This research explored the experiences of neurodivergent Trainee Clinical Psychologists completing DClinPsy programmes in the UK. Four key themes were constructed from participants' narratives. Together, these themes capture experiences marked by systemic ableism, relentless hidden labour and burnout, precarious belonging, and a

meaningful reclamation of identity and community. While neurodivergence was often described as a valuable part of participants' personal and professional selves, it was felt that the training system often failed to accommodate, understand or affirm these identities, leading to enhanced difficulties and unmet expectations. The findings are discussed in relation to theory and wider literature, including the SLR, and centre the voices of neurodivergent trainees to build the currently limited evidence-base. This research highlights the need for clinical psychology training systems that are designed with, not just adjusted for, neurodivergent trainees – where accessibility, relational safety and inclusion are embedded, not optional. While individualised support remains important, the responsibility for change must sit with the profession and institutions at a systemic level, rather than trainees. This research offers both critique and hope – calling for clinical psychology training to not only recognise and understand difference amongst its own, but to actively make space for and embrace it, to improve the experiences of neurodivergent Trainee Clinical Psychologists.

References

Ahn, M. Y., & Davis, H. H. (2023). Students' sense of belonging and their socio-economic status in higher education: A quantitative approach. Teaching in Higher Education, 28(1), 136–149. https://doi.org/10.1080/13562517.2020.1778664

Alcorn, A. M., McGeown, S., Mandy, W., Aitken, D., & Fletcher-Watson, S. (2024). Learning About Neurodiversity at School: A feasibility study of a new classroom programme for mainstream primary schools. *Neurodiversity*, *2*, 27546330241272186. https://doi.org/10.1177/27546330241272186

Alexander, D. A. (2024). The dyslexic academic: Uncovering the challenges faced as neurodiverse in academia and establishing a research agenda. *Disability & Society*, *39*(11), 3036–3041. https://doi.org/10.1080/09687599.2024.2312227

Ali, K., Kisielewska, J., Subhan, M. M. F., & Tredwin, C. (2020). How does dyslexia impact on the educational experiences of healthcare students? A qualitative study. *European Journal of Dental Education*, *24*(1), 154–162. https://doi.org/10.1111/eje.12479

Allen, S.L. (2013). The Journey to Becoming-Authentic from the Voices of Nursing Students Living with Attention Deficit Hyperactivity Disorder [Unpublished doctoral thesis]. University of Southern Mississippi.

Back, E., Main, E., Schur, P., Manitsa, I., Clifford, K., Barlow-Brown, F., Parchment, S., & Spurin, H. (2025). The Benefits of an Autism Peer Network in Higher Education. *Neurodiversity*, *3*, 27546330251329558. https://doi.org/10.1177/27546330251329558

Bagatell, N. (2010). From Cure to Community: Transforming Notions of Autism. *Ethos*, *38*(1), 33–55. https://doi.org/10.1111/j.1548-1352.2009.01080.x

Baron-Cohen, S. (2017). Editorial Perspective: Neurodiversity – a revolutionary concept for autism and psychiatry. *Journal of Child Psychology and Psychiatry, 58*(6), 744–747.

Beals, K. P., Peplau, L. A., & Gable, S. L. (2009). Stigma Management and Well-Being: The Role of Perceived Social Support, Emotional Processing, and Suppression. *Personality and Social Psychology Bulletin*, *35*(7), 867–879. https://doi.org/10.1177/0146167209334783

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bhaskar, R. (1975). *A Realist Theory of Science*. Leeds, UK: Leeds Books.

Bhaskar, R. (2008). *A realist theory of science* (2nd ed.). Routledge.

Bhowmik, D. (2023). Gender Inequality in Higher Education and Research. *Business Ethics and Leadership*, *7*(3), 108–119. https://doi.org/10.61093/bel.7(3).108-119.2023

Black, K. Z., Hardy, C. Y., De Marco, M., Ammerman, A. S., Corbie-Smith, G., Council, B., Ellis, D., Eng, E., Harris, B., Jackson, M., Jean-Baptiste, J., Kearney, W., Legerton, M., Parker, D., Wynn, M., & Lightfoot, A. (2013). Beyond incentives for involvement to compensation for consultants: Increasing equity in CBPR approaches. *Progress in Community Health Partnerships: Research, Education, and Action*, *7*(3), 263–270. https://doi.org/10.1353/cpr.2013.0040

Boeije, H. R., Van Wesel, F., & Alisic, E. (2011). Making a difference: Towards a method for weighing the evidence in a qualitative synthesis. *Journal of Evaluation in Clinical Practice*, *17*(4), 657–663. https://doi.org/10.1111/j.1365-2753.2011.01674.x

Bolourian, Y., Zeedyk, S. M., & Brown, H. (2024). Faculty training in neurodiversity: Stakeholder feedback on social validity and perceived effectiveness. *Psychology in the Schools*, *62*(2), 535–549. https://doi.org/10.1002/pits.23337

Botha, M., & Frost, D. M. (2020). Extending the Minority Stress Model to Understand Mental Health Problems Experienced by the Autistic Population. *Society and Mental Health*, *10*(1), 20–34. https://doi.org/10.1177/2156869318804297

Botha, M., & Gillespie-Lynch, K. (2022). Come as You Are: Examining Autistic Identity Development and the Neurodiversity Movement through an Intersectional Lens. *Human Development*, *66*(2), 93–112. https://doi.org/10.1159/000524123

Branicki, L. J., Brammer, S., Brosnan, M., Lazaro, A. G., Lattanzio, S., & Newnes, L. (2024). Factors shaping the employment outcomes of neurodivergent and neurotypical people: Exploring the role of flexible and homeworking practices. *Human Resource Management*, *63*(6), 1001–1023. https://doi.org/10.1002/hrm.22243

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. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1), 26152. https://doi.org/10.3402/qhw.v9.26152

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. (2020): One size fits all? What counts as quality practice in (reflexive) thematic analysis?, Qualitative Research in Psychology. DOI: 10.1080/14780887.2020.1769238.

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2021). The online survey as a *qualitative* research tool. *International Journal of Social Research Methodology*, *24*(6), 641–654. https://doi.org/10.1080/13645579.2020.1805550

British Medical Association. (2020). *Disability in the medical profession: Disabled doctors speak out*. https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/disability-equality-in-medicine/disability-and-neurodivergence-in-the-medical-profession#:~:text=Over%20three%2Dquarters%20(77%25),had%20led%20to%20improved%20support.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Harvard University Press.

Bukamal, H. (2022). Deconstructing insider–outsider researcher positionality. *British Journal of Special Education*, *49*(3), 327–349. https://doi.org/10.1111/1467-8578.12426

Burnham, J. (2012). Developments in Social GRRRAAACCEEESSS: Visible-invisible and voiced-unvoiced. In I.-B. Krause (Ed.), *Culture and reflexivity in systemic psychotherapy: Mutual perspectives* (pp. 139–160). Karnac Books.

Butcher, L., & Lane, S. (2024). Neurodivergent (Autism and ADHD) student experiences of access and inclusion in higher education: An ecological systems theory perspective. *Higher Education*. https://doi.org/10.1007/s10734-024-01319-6

Callander, K. (n.d.). *Shared Lenses: Reflections on complexity as an insider in neurodivergent research.* https://sentiojournal.uk/wp-content/uploads/2024/10/I6_Katrine_Callander.pdf

Cameron, H. (2023). Runners at the Gates: Growing Around the Barriers to Diagnosis in Autism, adhd and SpLDs. *Journal of Disability Studies in Education*, *3*(2), 217-241.

Cameron, H., Coleman, B., Hervey, T., Rahman, S., & Rostant, P. (2019). Equality law obligations in higher education: Reasonable adjustments under the Equality Act 2010 in assessment of students with unseen disabilities. *Legal Studies*, *39*(2), 204–229. https://doi.org/10.1017/lst.2018.31

Campbell, K., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive Thematic Analysis for Applied Qualitative Health Research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2021.5010

Caplan, R. D., & Van Harrison, R. (1993). Person-Environment Fit Theory: Some History, Recent Developments, and Future Directions. *Journal of Social Issues*, *49*(4), 253–275. https://doi.org/10.1111/j.1540-4560.1993.tb01192.x

Capp, M. J. (2017). The effectiveness of universal design for learning: A meta-analysis of literature between 2013 and 2016. *International Journal of Inclusive Education*, *21*(8), 791–807. https://doi.org/10.1080/13603116.2017.1325074

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). SAGE Publications.

Child, J., & Langford, E. (2011). Exploring the learning experiences of nursing students with dyslexia. *Nursing Standard*, *25*(40), 39–46. https://doi.org/10.7748/ns2011.06.25.40.39.c8565

Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology*, *12*(3), 297–298. https://doi.org/10.1080/17439760.2016.1262613

Cleary, R., & Armour, C. (2022). Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy. *Counselling and Psychotherapy Research*, *22*(4), 1100–1111. https://doi.org/10.1002/capr.12569

Clouder, L., Karakus, M., Cinotti, A., Ferreyra, M. V., Fierros, G. A., & Rojo, P. (2020). Neurodiversity in higher education: A narrative synthesis. *Higher Education*, *80*(4), 757–778. https://doi.org/10.1007/s10734-020-00513-6

Coffman, S., & Draper, C. (2022). Universal design for learning in higher education: A concept analysis. *Teaching and Learning in Nursing*, *17*(1), 36–41. https://doi.org/10.1016/j.teln.2021.07.009

Connolly, S. E., Constable, H. L., & Mullally, S. L. (2023). School distress and the school attendance crisis: A story dominated by neurodivergence and unmet need. *Frontiers in Psychiatry*, *14*, 1237052. https://doi.org/10.3389/fpsyt.2023.1237052

Cook, A. (2024). Conceptualisations of neurodiversity and barriers to inclusive pedagogy in schools: A perspective article. *Journal of Research in Special Educational Needs*, *24*(3), 627–636. https://doi.org/10.1111/1471-3802.12656

Cook, J., Hull, L., & Mandy, W. (2024). Improving Diagnostic Procedures in Autism for Girls and Women: A Narrative Review. *Neuropsychiatric Disease and Treatment*, *Volume 20*, 505–514. https://doi.org/10.2147/NDT.S372723

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cornwell, M., & Shaw, S. C. K. (2023). Applying to medical school with undiagnosed dyslexia: A collaborative autoethnography. *Advances in Health Sciences Education, 29*(3), 443–463. https://doi.org/10.1007/s10459-023-10258-3

Cottingham, M., & Spear, T. (2025). Embracing Neurodivergence: Essential considerations in family law practice. *Family Court Review*, *63*(1), 71–85. https://doi.org/10.1111/fcre.12840

Covidence Systematic Review Software. (2025). Veritas Health Innovation. www.covidence.org

Coyle, A., O'Hare, L., & Ramey, D. (2025). Synapse: A co-designed neurodivergent peer support programme for higher education settings. *Autism*, *29*(7), 1711–1726. https://doi.org/10.1177/13623613251320448

Critical Appraisal Skills Programme (CASP). (2024). *CASP qualitative checklist*. Retrieved from https://casp-uk.net/casp-checklists/CASP-checklist-qualitative-2024.pdf

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

Cumming, T. M., Bugge, A. S.-J., Kriss, K., McArthur, I., Watson, K., & Jiang, Z. (2023). Diversified: Promoting co-production in course design and delivery. *Frontiers in Education*, *8*, 1329810. https://doi.org/10.3389/feduc.2023.1329810

Dabbs, C., Harris, A., & Shaw, S. C. K. (2024). Unmasking bias: Neurodivergent experiences of clinical training. *Frontiers in Psychiatry, 14*, 1160994. https://doi.org/10.3389/fpsyt.2023.1160994

den Houting, J. (2019). Neurodiversity: An insider's perspective. *Autism*, *23*(2), 271–273. https://doi.org/10.1177/1362361318820762

Department for Education & Department of Health and Social Care. (2014). Special Educational Needs and Disability *Code of Practice: 0 to 25 years*. GOV.UK. https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

Department for Work and Pensions. (2018). *Access to Work: Qualitative research with applicants, employers and delivery staff.* Department for Work and Pensions. https://www.gov.uk/government/publications/access-to-work-research-review

Dhakal, K. (2022). NVivo. *Journal of the Medical Library Association*, *110*(2). https://doi.org/10.5195/jmla.2022.1271

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

Durgungoz, F. C., & Durgungoz, A. (2025). "Interactive lessons are great, but too much is too much": Hearing out neurodivergent students, Universal Design for Learning and the case for integrating more anonymous technology in higher education. *Higher Education*. https://doi.org/10.1007/s10734-024-01389-6

Dwyer, P. (2022). The Neurodiversity Approach(es): What Are They and What Do They Mean for Researchers? *Human Development*, *66*(2), 73–92. https://doi.org/10.1159/000523723

Dwyer, P., Mineo, E., Mifsud, K., Lindholm, C., Gurba, A., & Waisman, T. C. (2023). Building Neurodiversity-Inclusive Postsecondary Campuses: Recommendations for Leaders in Higher Education. *Autism in Adulthood*. https://doi.org/10.1089/aut.2021.0042

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Edwards, J. R., & Shipp, A. J. (2007). The Relationship Between Person–Environment Fit and Outcomes: An Integrative Theoretical Framework. In C. Ostroff & T. A. Judge (Eds.), *Perspectives on Organizational Fit* (pp. 209–258). Jossey-Bass.

Edwards, J. R., Caplan, R. D., & Harrison, R. V. (1998). Person–environment fit theory: Conceptual foundations, empirical evidence, and directions for future research. In C. L. Cooper (Ed.), *Theories of organizational stress* (pp. 28–67). Oxford University Press.

Elsherif, M. M., Tamelga, Y., & Nunes, M. (2022). Strengths-based approaches for successful inclusion of neurodiverse students in higher education. *Education Sciences, 12*(10), 692.

Fagundes, D., & Gouhie, F. (2025). Overdiagnosis of Autism Spectrum Disorder: Diagnostic and Management Challenges in a Pediatric Outpatient Clinic (P6-6.003). *Neurology*, *104*(7_Supplement_1), 2015. https://doi.org/10.1212/WNL.0000000000208876

Farrant, F., Owen, E., Hunkins-Beckford, F, L., & Jacksa, M. (2022, May 9). *Celebrating neurodiversity in higher education.* The Psychologist. https://www.bps.org.uk/psychologist/celebrating-neurodiversity-higher-education

Fielding, C., Streeter, A., Riby, D. M., & Hanley, M. (2025). Neurodivergent pupils' experiences of school distress and attendance difficulties. *Neurodiversity, 3*(1). (First published online April 2025)

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209–230. https://doi.org/10.1177/146879410200200205

Finlay, L. (2021). Thematic Analysis: the 'good', the 'bad' and the 'ugly'. *European Journal for Qualitative Research in Psychotherapy*, 103-116 Pages. https://doi.org/10.24377/EJQRP.ARTICLE3062

Fletcher-Watson, S., Brook, K., Hallett, S., Murray, F., & Crompton, C. J. (2021). Inclusive Practices for Neurodevelopmental Research. *Current Developmental Disorders Reports*, *8*(2), 88–97. https://doi.org/10.1007/s40474-021-00227-z

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Fugard, A. J. B., & Potts, H. W. W. (2015). Supporting thinking on sample sizes for thematic analyses: A quantitative tool. *International Journal of Social Research Methodology*, *18*(6), 669–684. https://doi.org/10.1080/13645579.2015.1005453

Gibbs, K., Simpson, K., Paynter, J., Easte, C., & Fowler, J. (2025). Exploring the perspectives of Australian neurodivergent university students. *The Australian Educational Researcher*, *52*(3), 2665–2687. https://doi.org/10.1007/s13384-025-00828-2

Gillespie-Lynch, K., Daou, N., Sanchez-Ruiz, M.-J., Kapp, S. K., Obeid, R., Brooks, P. J., Someki, F., Silton, N., & Abi-Habib, R. (2019). Factors underlying cross-cultural differences in stigma toward autism among college students in Lebanon and the United States. *Autism*, *23*(8), 1993–2006. https://doi.org/10.1177/1362361318823550

Gisev, N., Bell, J. S., & Chen, T. F. (2013). Interrater agreement and interrater reliability: Key concepts, approaches, and applications. *Research in Social and Administrative Pharmacy*, *9*(3), 330–338. https://doi.org/10.1016/j.sapharm.2012.04.004

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

Goering, S. (2015). Rethinking disability: The social model of disability and chronic disease. *Current Reviews in Musculoskeletal Medicine*, *8*(2), 134–138. https://doi.org/10.1007/s12178-015-9273-z

GOV.UK. (n.d.-a). *Equality Act 2010: guidance*. UK Government. https://www.gov.uk/guidance/equality-act-2010-guidance

GOV.UK. (n.d.-b). *Disabled Students' Allowance (DSA)*. UK Government. https://www.gov.uk/disabled-students-allowance-dsa/print

GOV.UK. (n.d.-c). Data Protection Act 2018. https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Grain, K. M. & Lund, D. E. (2017). The Social Justice Turn: Cultivating "Critical Hope" in an Age of Despair. *Michigan Journal of Community Service Learning*, *23*(1). https://doi.org/10.3998/mjcsloa.3239521.0023.104

Gray, C., Morris, D., Thompson, H., & Lee, S. (2025). Navigating neurodivergence: A scoping review to guide health professions educators. *Medical Education*. Advance online publication. https://doi.org/10.1111/medu.15676

Greene, M. (2014). On the Inside Looking In: Methodological Insights and Challenges in Conducting Qualitative Insider Research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2014.1106

Griffin, E., & Pollak, D. (2009). Student experiences of neurodiversity in higher education: Insights from the BRAINHE project. *Dyslexia*, *15*(1), 23–41. https://doi.org/10.1002/dys.383

Hamilton, L. G., & Petty, S. (2023). Compassionate pedagogy for neurodiversity in higher education: A conceptual analysis. *Frontiers in Psychology*, *14*, 1093290. https://doi.org/10.3389/fpsyg.2023.1093290

Hawker, D., Muggleton, J., Henshaw, E., Horne, K., Hutchinson, J., Little, L., Nicholls, A., & Welsh, P. (2022, February 7). *Neurodiversity is not just for those we work with.* The Psychologist. https://www.bps.org.uk/psychologist/neurodiversity-not-just-those-we-work

Hayhoe, S., Roger, K., Eldritch-Böersen, S., & Kelland, L. (2015). Developing Inclusive Technical Capital beyond the Disabled Students' Allowance in England. *Social Inclusion*, *3*(6), 29–41. https://doi.org/10.17645/si.v3i6.410

Hornby, G., & Kauffman, J. M. (2024). Inclusive Education, Intellectual Disabilities and the Demise of Full Inclusion. *Journal of Intelligence*, *12*(2), 20. https://doi.org/10.3390/jintelligence12020020

Hull, L., Petrides, K. V., Allison, C., Smith, P., Baron-Cohen, S., Lai, M.-C., & Mandy, W. (2017). "Putting on My Best Normal": Social Camouflaging in Adults with Autism Spectrum Conditions. *Journal of Autism and Developmental Disorders*, *47*(8), 2519–2534. https://doi.org/10.1007/s10803-017-3166-5

Islam, G. (2014). Social identity theory. In T. Teo (Ed.), *Encyclopedia of critical psychology* (pp. 1781–1783). Springer. https://doi.org/10.1007/978-1-4614-5583-7_574

Johnson, C., Rossiter, H., Cartmell, B., Domingos, M., & Svanaes, S. (2019). *Evaluation of disabled students' allowances: research report.* Department for Education. https://assets.publishing.service.gov.uk/media/5f5241a08fa8f542a1f8dc36/Evaluation_of_disabled_students_allowances.pdf

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.

Kastner, M., Tricco, A. C., Soobiah, C., Lillie, E., Perrier, L., Horsley, T., Welch, V., Cogo, E., Antony, J., & Straus, S. E. (2012). What is the most appropriate knowledge synthesis method to conduct a review? Protocol for a scoping review. *BMC Medical Research Methodology*, *12*(1), 114. https://doi.org/10.1186/1471-2288-12-114

Kennedy, L. J., Richdale, A. L., Gore, K. E., & Lawson, L. P. (2025). 'A Menu Would be Sweet': A Framework Analysis of the Disclosure and Supports Experiences of Higher Education Students with Neurodivergent or Mental-health Conditions. *Neurodiversity*, *3*. https://doi.org/10.1177/27546330251352326

Ker, G., & Van Gorp, R. (2023). Embracing Neurodiversity: Supporting Learners to Success. *Scope: Contemporary Research Topics (Work-Based Learning)*, *5*, 36–45. https://doi.org/10.34074/scop.6005003

Khan, F., & Spepherdson, N. (2024, November 26). *'Find your neurodivergent tribe'.* The Psychologist. https://www.bps.org.uk/psychologist/find-your-neurodivergent-tribe

Kosko, S. J., Dastin, A., Merrill, M., & Sheth, R. (2022). Marginalised Youth Activism: Peer-Engaged Research and Epistemic Justice. *Journal of Human Development and Capabilities*, *23*(1), 136–156. https://doi.org/10.1080/19452829.2021.2019691

Krazinski, M. (2023). Celebrating Neurodivergence amid Social Injustice. *Hypatia*, *38*(4), 726–745. https://doi.org/10.1017/hyp.2023.79

Lang, K. (2024). Autism and ADHD place "unprecedented" demand on NHS. *BMJ*, q802. https://doi.org/10.1136/bmj.q802

Lawani, A. (2021). Critical realism: What you should know and how to apply it. *Qualitative Research Journal*, *21*(3), 320–333. https://doi.org/10.1108/QRJ-08-2020-0101

Le Gallais, T. (2008). Wherever I go there I am: Reflections on reflexivity and the research stance. *Reflective Practice*, *9*(2), 145–155. https://doi.org/10.1080/14623940802005475

Leadbitter, K., Buckle, K. L., Ellis, C., & Dekker, M. (2021). Autistic Self-Advocacy and the Neurodiversity Movement: Implications for Autism Early Intervention Research and Practice. *Frontiers in Psychology*, *12*, 635690. https://doi.org/10.3389/fpsyg.2021.635690

Lewis, C. J., & Arday, J. (2023). We'll see things they'll never see: Sociological reflections on race, neurodiversity and higher education. *The Sociological Review*, *71*(6), 1299–1321. https://doi.org/10.1177/00380261231184357

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Lumivero. (2023). *NVivo* 14. https://lumivero.com/products/nvivo/

Manalili, M. A. R., Pearson, A., Sulik, J., Creechan, L., Elsherif, M., Murkumbi, I., Azevedo, F., Bonnen, K. L., Kim, J. S., Kording, K., Lee, J. J., Obscura, M., Kapp, S. K., Röer, J. P., & Morstead, T. (2023). From Puzzle to Progress: How Engaging With Neurodiversity Can Improve Cognitive Science. *Cognitive Science*, *47*(2), e13255. https://doi.org/10.1111/cogs.13255

Maxwell, J. A. 2012. *A realist approach for qualitative research*. SAGE Publications.

McAleese, S., & Kilty, J. M. (2019). Stories Matter: Reaffirming the Value of Qualitative Research. *The Qualitative Report*, *24*(4), 822-845. https://doi.org/10.46743/2160-3715/2019.3713

McDowall, A., & Kiseleva, M. (2024). A rapid review of supports for neurodivergent students in higher education. Implications for research and practice. *Neurodiversity*, *2*. https://doi.org/10.1177/27546330241291769

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Milton, D. E. M. (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

Miserandino, C. (2003). *The Spoon Theory.* But You Don’t Look Sick. https://butyoudontlooksick.com/articles/written-by-christine/the-spoon-theory/

Morris, D., & Turnbull, P. (2006). Clinical experiences of students with dyslexia. *Journal of Advanced Nursing*, *54*(2), 238–247. https://doi.org/10.1111/j.1365-2648.2006.03806.x

Morris, D., & Turnbull, P. (2007). The disclosure of dyslexia in clinical practice: Experiences of student nurses in the United Kingdom. *Nurse Education Today, 27*(1), 35–42. https://doi.org/10.1016/j.nedt.2006.01.017

Muggleton, J., & Johnston, K. (2016). 'You've hired a psychologist with autism?!': Reflections on being a trainee clinical psychologist with autism. *Clinical Psychology Forum*, *1*(288), 5–8. https://doi.org/10.53841/bpscpf.2016.1.288.5

Murphy, F. (2011). On being dyslexic: Student radiographers' perspectives. *Radiography, 17*(2), 132–138. https://doi.org/10.1016/j.radi.2010.10.005

Newman, M., & Gough, D. (2020). Systematic reviews in educational research: Methodology, perspectives and application. In O. Zawacki-Richter, M. Kerres, S. Bedenlier, M. Bond & K. Buntins (Eds.), *Systematic Reviews in Educational Research: Methodology, Perspectives and Application* (1st ed., pp. 3-22). Springer Fachmedien Wiesbaden. https://doi.org/10.1007/978-3-658-27602-7

Odegard, T. N., & Dye, M. (2024). The gift of dyslexia: What is the harm in it? *Annals of Dyslexia*, *74*(2), 143–157. https://doi.org/10.1007/s11881-024-00308-9

Oliver, M. (1990). *The Politics of Disablement*. Macmillan Education UK. https://doi.org/10.1007/978-1-349-20895-1

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability & Society*, *28*(7), 1024–1026. https://doi.org/10.1080/09687599.2013.818773

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, *45*(3), 241–251. https://doi.org/10.1080/0142159X.2022.2057287

Ortiz, L. A. (2020). Reframing Neurodiversity as Competitive Advantage: Opportunities, Challenges, and Resources for Business and Professional Communication Educators. *Business and Professional Communication Quarterly*, *83*(3), 261–284. https://doi.org/10.1177/2329490620944456

Paez, A. (2017). Gray literature: An important resource in systematic reviews. *Journal of Evidence-Based Medicine*, *10*(3), 233–240. https://doi.org/10.1111/jebm.12266

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, n71. https://doi.org/10.1136/bmj.n71

Paget, A., Parker, C., Henley, W., Heron, J., Ford, T., & Emond, A. (2015). Which children and young people are excluded from school? Findings from the Avon Longitudinal Study of Parents and Children (ALSPAC). *The Lancet*, *385*, S76. https://doi.org/10.1016/S0140-6736(15)60391-9

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Paul, J., & Barari, M. (2022). Meta-analysis and traditional systematic literature reviews—What, why, when, where, and how? *Psychology & Marketing*, *39*(6), 1099–1115. https://doi.org/10.1002/mar.21657

Peters, L. A. (2023). Embracing neurodiversity to enhance the post-graduate researcher experience: Reflections from a doctoral student. *Fields: Journal of Huddersfield Student Research*, *1*(1). https://doi.org/10.5920/fields.1295

Pigato, G. (2024). Contributing to an inclusive education for neurodivergent students: Sharing reflections, practices, and experiences. *FEMS Microbiology Letters*, *371*, fnae046. https://doi.org/10.1093/femsle/fnae046

Poletti, M., Preti, A., & Raballo, A. (2025). Debate: Are we over-pathologizing young people's mental health? The inflationary risk of autism diagnosis. *Child and Adolescent Mental Health*, camh.70013. https://doi.org/10.1111/camh.70013

Praslova, L. (2025). The future of leadership: neurodiversity in leadership teams. *Leader to Leader*, *2025*(116), 39–45. https://doi.org/10.1002/ltl.20873

Price, G. A., & Gale, A. (2006). How Do Dyslexic Nursing Students Cope with Clinical Practice Placements? The Impact of the Dyslexic Profile on the Clinical Practice of Dyslexic Nursing Students: Pedagogical Issues and Considerations. *Learning Disabilities: A Contemporary Journal*, *4*(1), 19-36.

Qualtrics. (2025). *Qualtrics & GDPR Compliance*. https://www.qualtrics.com/support/survey-platform/getting-started/qualtrics-gdpr-compliance/

Quinn, D. M., & Earnshaw, V. A. (2013). Concealable Stigmatized Identities and Psychological Well-Being. *Social and Personality Psychology Compass*, *7*(1), 40–51. https://doi.org/10.1111/spc3.12005

Ralph, S. (2013). Do we really want to include disabled people in society? *Seminare. Poszukiwania Naukowe*, *2013*(33), 95–114. https://doi.org/10.21852/sem.2013.33.07

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: Are there special issues for health services research? *Family Practice*, *19*(2), 135–139. https://doi.org/10.1093/fampra/19.2.135

Richardson, L. (2000). Evaluating Ethnography. *Qualitative Inquiry*, *6*(2), 253–255. https://doi.org/10.1177/107780040000600207

Riddell, S., & Weedon, E. (2014). Disabled students in higher education: Discourses of disability and the negotiation of identity. *International Journal of Educational Research*, *63*, 38–46. https://doi.org/10.1016/j.ijer.2013.02.008

Ridley, C. (2011). The experiences of nursing students with dyslexia. *Nursing Standard*, *25*(24), 35–41. https://doi.org/10.7748/ns2011.02.25.24.35.c8342

Riessman, C. K. (2008). *Narrative methods for the human sciences*. SAGE Publications.

Rivera, R. A., & Bennetto, L. (2023). Applications of identity-based theories to understand the impact of stigma and camouflaging on mental health outcomes for autistic people. *Frontiers in Psychiatry*, *14*. https://doi.org/10.3389/fpsyt.2023.1243657

Robinson, O. C. (2023). Probing in qualitative research interviews: Theory and practice. *Qualitative Research in Psychology*, *20*(3), 382–397. https://doi.org/10.1080/14780887.2023.2238625

Ross, L. E. (2017). An account from the inside: Examining the emotional impact of qualitative research through the lens of "insider" research. *Qualitative Psychology*, *4*(3), 326–337. https://doi.org/10.1037/qup0000064

Russell, G., & Wilkinson, S. (2023). Co-opting the "neuro" in neurodiversity and the complexities of epistemic injustice. *Cortex*, *169*, 1–4. https://doi.org/10.1016/j.cortex.2023.09.002

Russell, G., Stapley, S., Newlove-Delgado, T., Salmon, A., White, R., Warren, F., & Ford, T. (2021). Time trends in autism diagnosis over 20 years: A UK population-based cohort study. *Journal of Child Psychology and Psychiatry, 62*(8), 978–986.

Scotch, R., & Sutton, K. (2021). The Disability Rights Movement. In R. Lewis Brown, M. Maroto, & D. Pettinicchio (Eds.), *The Oxford Handbook of the Sociology of Disability* (1st ed., pp. 790–806). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190093167.013.44

Shaw, S. C. K., & Anderson, J. L. (2018). The experiences of medical students with dyslexia: An interpretive phenomenological study. *Dyslexia, 24*(3), 220–233. https://doi.org/10.1002/dys.1587

Shaw, S. C. K., Brown, M. E. L., Jain, N. R., George, R. E., Bernard, S., Godfrey-Harris, M., & Doherty, M. (2025). When I say … neurodiversity paradigm. *Medical Education*, *59*(5), 466–468. https://doi.org/10.1111/medu.15565

Shaw, S. C. K., Doherty, M., & Anderson, J. L. (2023). The experiences of autistic medical students: A phenomenological study. *Medical Education*, medu.15119. 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*, 1160994. https://doi.org/10.3389/fpsyt.2023.1160994

Shaw, S. C. K., Harris, A., & Anderson, J. L. (2023). Experiences of autistic medical students: A phenomenological study. *Medical Education, 57*(4), 382–392. https://doi.org/10.1111/medu.14937

Shaw, S. C. K., Hennessy, L. R., & Anderson, J. L. (2022). The learning experiences of dyslexic medical students during the COVID-19 pandemic: A phenomenological

study. *Advances in Health Sciences Education*, *27*(1), 107–124. https://doi.org/10.1007/s10459-021-10074-7

Singer, J. (1999). "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.

Sisulu, K., Glew, S., Dempsey, A., Law, J., & Marsden, A. (2024, January 2). *Neurodivergence – change, complexity and challenge.* The Psychologist. https://www.bps.org.uk/psychologist/neurodivergence-change-complexity-and-challenge

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research* (2nd ed.). SAGE Publications.

Smith, M. C. F., Mukherjee, R. A. S., Müller-Sedgwick, U., Hank, D., Carpenter, P., & Adamou, M. (2023). UK adult ADHD services in crisis. *BJPsych Bulletin*, 1–5. https://doi.org/10.1192/bjb.2023.88

Spaeth, E., & Pearson, A. (2023). Reflective Analysis on Neurodiversity and Student Wellbeing: Conceptualising Practical Strategies for Inclusive Practice. *Journal of Perspectives in Applied Academic Practice*, *11*(2), 109–120. https://doi.org/10.56433/jpaap.v11i2.517

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist*, *52*(6), 613–629. https://doi.org/10.1037/0003-066x.52.6.613

Sulaimani, M. F., & Gut, D. M. (2019). Hidden Curriculum in a Special Education Context: The Case of Individuals With Autism. *Journal of Educational Research and Practice*, *9*(1). https://doi.org/10.5590/JERAP.2019.09.1.03

Syharat, C. M., Hain, A., Zaghi, A. E., Gabriel, R., & Berdanier, C. G. P. (2023). Experiences of neurodivergent students in graduate STEM programs. *Frontiers in Psychology*, *14*, 1149068. https://doi.org/10.3389/fpsyg.2023.1149068

Tafla, T. L., Teixeira, M. C. T. V., Woodcock, K. A., & Sowden-Carvalho, S. (2024). Autism spectrum disorder diagnosis across cultures: Are diagnoses equivalent? *Neurodiversity*, *2*. https://doi.org/10.1177/27546330241226811

Taherdoost, H. (2022). What are Different Research Approaches? Comprehensive Review of Qualitative, Quantitative, and Mixed Method Research, Their Applications, Types, and Limitations. *Journal of Management Science & Engineering Research*, *5*(1), 53–63. https://doi.org/10.30564/jmser.v5i1.4538

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33–47). Brooks/Cole.

Tan, D. W., Rabuka, M., Haar, T., & Pellicano, E. (2024). 'It's a symbolic violence': Autistic people's experiences of discrimination at universities in Australia. *Autism*, *28*(6), 1344–1356. https://doi.org/10.1177/13623613231219744

Taylor, J. R., & Sims, M. (2025). To understand the experiences of autistic counsellors: A United Kingdom phenomenological study. *Counselling and Psychotherapy Research*, *25*(2). https://doi.org/10.1002/capr.12839

Taylor, M., Turnbull, Y., Bleasdale, J., Francis, H., & Forsyth, H. (2016). Transforming support for students with disabilities in UK Higher Education. *Support for Learning*, *31*(4), 367–384. https://doi.org/10.1111/1467-9604.12143

Taylor, S. (2025). The wounded healer: The history and implications of lived experience in mental health care. *Australasian Psychiatry*, *33*(3), 339–341. https://doi.org/10.1177/10398562241303267

Terry, G., & Braun, V. (2017). Short but often sweet: The surprising potential of qualitative survey methods. In V. Braun, V. Clarke, & D. Gray (Eds.), *Collecting qualitative data: A practical guide to textual, media and virtual techniques* (pp. 15-44). Cambridge University Press.

The Brain Charity. (2021, September 18). *What is neurodiversity? Explaining how some people's brains work differently.* https://www.thebraincharity.org.uk/what-is-neurodiversity/

The British Psychological Society. (2024). *Draft accreditation standards: Committee on Training in Clinical Psychology* (Version 2.0, March 2024). British Psychological Society. https://cms.bps.org.uk/sites/default/files/2024-03/Draft%20Accreditation%20Standards%20-%20Committee%20on%20Training%20in%20Clinical%20Psychology.pdf

The British Psychological Society. (2025). *Standards for the accreditation of doctoral programmes in clinical psychology.* https://cms.bps.org.uk/sites/default/files/2022-07/Clinical%20Psychology%20-%20Standards%20for%20Accreditation.pdf

The Clearing House (n.d.). *The Clearing House*. https://www.clearing-house.org.uk/

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*, 45. https://doi.org/10.1186/1471-2288-8-45

Tracy, S. J. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, *16*(10), 837–851. https://doi.org/10.1177/1077800410383121

Tupou, J., Curtis, S., Taare-Smith, D., Glasgow, A., & Waddington, H. (2021). Māori and autism: A scoping review. *Autism*, *25*(7), 1844–1858. https://doi.org/10.1177/13623613211018649

UK Government. (1995). *Disability Discrimination Act 1995*. https://www.legislation.gov.uk/ukpga/1995/50/contents

UNESCO Institute for Statistics. (2014). ISCED Fields of education and training 2013 (ISCED-F 2013): Manual to accompany the International Standard Classification of Education 2011. UNESCO Institute for Statistics. https://doi.org/10.15220/978-92-9189-150-4-en. Accessed from: https://uis.unesco.org/sites/default/files/documents/isced-fields-of-education-and-training-2013-en.pdf

Vivolo, M., Owen, J., & Fisher, P. (2024). Psychological therapists' experiences of burnout: A qualitative systematic review and meta-synthesis. *Mental Health & Prevention*, *33*, 200253. https://doi.org/10.1016/j.mhp.2022.200253

Walker, N. (2021). *Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic Empowerment, and Postnormal Possibilities*. Fort Worth, TX: Autonomous Press. https://doi.org/10.1080/02604027.2022.2094194

Wang, K. D., McCool, J., & Wieman, C. (2024). Exploring the learning experiences of neurodivergent college students in STEM courses. *Journal of Research in Special Educational Needs*, *24*(3), 505–518. https://doi.org/10.1111/1471-3802.12650

Whelpley, C. E., Holladay-Sandidge, H. D., Woznyj, H. M., & Banks, G. C. (2023). The biopsychosocial model and neurodiversity: A person-centered approach. *Industrial and Organizational Psychology*, *16*(1), 25–30. https://doi.org/10.1017/iop.2022.95

Wong, B., Boheler, G., Selvaggi Hernandez, S., McGinley, K., Nguyen, A. T., Reyes, R. L., & Brown, Z. (2023). The importance of neurodivergent mentorship for the development of professional identity. *Neuroscience Research Notes*, *6*(1), 167. https://doi.org/10.31117/neuroscirn.v6i1.167

Zajic, M. C., & Gudknecht, J. (2024). Person- and identity-first language in autism research: A systematic analysis of abstracts from 11 autism journals. *Autism*, *28*(10), 2445–2461. https://doi.org/10.1177/13623613241241202

Appendices

Appendix A: Reflective Diary Extracts

The Idea
Yesterday morning, whilst having a cup of tea and reflecting on how burnt out I feel from training, I had an idea for my thesis: the experiences of neurodivergent trainees on the DClinPsy. I Googled it straight away, expecting to find lots of existing research, however I couldn't find anything specifically about trainees… Am I missing something? How surprising given our profession. I emailed my supervisor to ask for a meeting where we discussed my initial thoughts and ideas, and theirs, and then they asked "How would you feel being an insider researcher?". My stomach dropped at the thought of it being exposing, as I fully realised in that moment that this research would not just be about others' stories and improving their experiences, but about reckoning with my own too. I was left sitting with mixed feelings, and then the clarity set in – if this research is missing and I have the privilege and platform to do it, surely it's meant to be done.

SLR
I have just finished my SLR, and honestly it has been the most cognitively challenging part of the thesis so far. The intensive cognitive load of screening hundreds of papers, the slow and effortful process of extracting data, the demand to hold themes and meaning across all included studies in mind… I am left wondering whether other neurodivergent trainees have found this part of the process similarly difficult, and whether this is an area where we could have more support. *I had already suspected that there wouldn't be much literature about the experiences of neurodivergent trainees in clinical psychology, and that was frustrating to see confirmed, however it also validated the need for my empirical research. What I didn't expect was how much I would see echoes of my own experiences in papers from other healthcare disciplines (e.g. medicine and nursing). This showed me how much change is needed across the board for neurodivergent trainees, and a big reminder that whilst research can be exhausting (particularly for a neurodivergent brain), the gaps we find in literature are the ones we're meant to write into.*

Consultants
I have just finished meeting with my third (and final) Consultant, and I feel even more energised about this research. Across the meetings, the Consultants shared their personal experiences of navigating training and their hope that this will support future neurodivergent trainees. I discovered that they have different neurodivergent identities, to each other and to me. I didn't realise this beforehand and it wasn't intentional (I only recruited 'neurodivergent trainees' as with the rest of my research), but their diverse reflections and suggestions after piloting the questionnaire were a powerful example of the importance of consultation, and that insider researchers most definitely do not hold all the perspectives of their community. One Consultant shared that they struggled, given the training context, with the question asking them to identify the strengths of their neurodivergence, which I really resonated with – therefore, we decided together that it was even more important for the question to stay in. It all feels very real now my questionnaire has been piloted!?

Recruitment
I cannot believe how quickly things have taken off! I emailed my questionnaire to all the DClinPsy programmes three days ago and I have nearly reached my recruitment limit of 30 participants! This is very exciting and also a bit overwhelming (particularly as I don't want to breach my ethics approval). So I quickly re-read literature on suggested sample sizes for qualitative questionnaire research, and then called my supervisor. We reviewed the responses I've received so far, noticing that some were incredibly detailed, but others were less so. We therefore decided it was best to increase the sample size to 70 (so I did an ethics amendment), to improve data quality and impact, and also because so many neurodivergent trainees want to share their experiences(!). This has reminded me of the importance of flexibility in qualitative research, particularly supported by my research methods – and sometimes, the volume of responses itself is a finding, reflecting how ready and willing people are to be heard. As the responses keep coming in, I'm feeling this growing sense of community.

Data Familiarisation
Today I began data familiarisation and read my participants' questionnaire responses for the first time. It was so emotional, even more than I anticipated. I feel so much resonance in some of the experiences shared… it is both validating and strangely comforting to see aspects of my own story reflected back. But it was also deeply painful, and at times shocking, to read what other neurodivergent trainees have experienced/are still experiencing across courses. I am a bag of mixed emotions, feeling connection, anger, grief, privileged that these narratives have been shared with me, and more motivated than ever to use this research as a platform for change. I very much feel like an insider researcher today, with all the benefits and complexity it comes with, so I will be taking this to supervision to ensure reflexivity in my process. When designing this research, I read that it was a myth that qualitative questionnaire data lacked emotiveness, and thankfully that was correct!

Coding
As I've moved deeper into coding – which has been very time-intensive! – it has been so interesting to notice the nuances of where participants' experiences are similar to mine, but also where they are different. A strong pattern/theme I have seen in their narratives is questioning their belonging in the profession. Firstly, I feel very sad and angry about this, and secondly, it is not something I have personally struggled with. I wonder why? Could it be because my neurodivergence was only recently identified on training? I am noting this down here to ensure that I do not unintentionally miss/minimise the significance of this questioning in their narratives when I move into theme development. This coding phase has intensified the huge responsibility I feel, particularly as an insider researcher, to accurately and thoughtfully represent the stories shared by participants.

Theme Development and Write-Up
Moving into theme development has been enjoyable and also emotionally and ethically loaded – requiring me to step back and shape the bigger story that represents participants' collective experiences. I have found myself questioning "What if I've missed something important?" and "What if my decisions about grouping have unintentionally flattened some of the nuance?", so I have been continuously grounding myself back in participants' responses, and reminding myself that I can't keep every code and detail now. One piece of feedback I just received from my supervisor relates to my use of adverbs in the write-up. Reflecting on this, I think it's because I feel such a strong sense of responsibility to do justice to participants' stories and convey/emphasise the weight for the reader. However, re-reading the illustrative quotes I have included, I can see participants' words speak for themselves. It feels meaningful seeing the data as themes and a shared story, not just as individual narratives – it is now something bigger.

Final Reflections
Navigating my own neurodivergence through this research process has been challenging to say the least, and at times I have worried about finishing it. So I can't quite believe this is my last journal entry… The journey of being an insider researcher has definitely been bi-directional – it didn't just shape the research, it has shaped me. Now my thesis is (finally) written, I hope it becomes more than a big document and is a step towards change.

Appendix B: SLR Search Terms

Scopus

(neurodivergent OR neurodiverse OR neurodiversity OR neurodivergence OR adhd OR autism OR dyslexia OR dyspraxia AND "healthcare profession*" OR "health profession*" OR "medical" OR "nursing" OR "allied health*" AND student OR trainee AND experience* OR perception OR perspective)

PubMed

(neurodivergent OR neurodiverse OR neurodiversity OR neurodivergence OR ADHD OR Autism OR Dyslexia OR Dyspraxia) AND ("healthcare profession*" OR "health profession*" OR "medical" OR "nursing" OR "allied health*") AND (student OR trainee) AND (experience* OR perception or perspective)

CINAHL Plus

(neurodivergent OR neurodiverse OR neurodiversity OR neurodivergence OR ADHD OR Autism OR Dyslexia OR Dyspraxia) AND ("healthcare profession*" OR "health profession*" OR "medical" OR "nursing" OR "allied health*") AND (student OR trainee) AND (experience* OR perception or perspective)

Education Research Complete

(neurodivergent OR neurodiverse OR neurodiversity OR neurodivergence OR ADHD OR Autism OR Dyslexia OR Dyspraxia) AND ("healthcare profession*" OR "health profession*" OR "medical" OR "nursing" OR "allied health*") AND (student OR trainee) AND (experience* OR perception or perspective)

Appendix C: Ethics Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Rachel Ison
CC	Dr Scott Steen
FROM	Dr Simon Trainis, Health, Science, Engineering and Technology ECDA Chair
DATE	18/06/2024

Protocol number: **aLMS/PGR/UH/05636(2)**

Title of study: Navigating Neurodivergence on the DClinPsy: Experiences of Neurodivergent Trainee Clinical Psychologists

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Rachel Ison (Primary Researcher) – 20000460
Dr Scott Steen (Principal Supervisor) – 765141
Dr Barbara Rishworth (Secondary Supervisor) – 758698

Modification:

Increase the maximum number of participants from 25 to 70 as detailed in the approved EC2 application.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 18/06/2024

To: 31/08/2024

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix D: Participant Information Sheet

(Hosted on the platform Qualtrics)

PARTICIPANT INFORMATION SHEET

Title of study

Navigating Neurodivergence on the DClinPsy: Experiences of Neurodivergent Trainee Clinical Psychologists Across UK Courses

Introduction

You are invited to consider taking part in a research study. I am a Trainee Clinical Psychologist at the University of Hertfordshire and I am completing this study as part of my Doctorate in Clinical Psychology (DClinPsy).

Before you decide whether to participate, it is important that you read this Information Sheet to understand the aims of the study, who is eligible to take part, and what it will involve. Please take the time to read the following information carefully, and there are contact details provided at the end if you wish to get in touch with the Primary Researcher for further information.

Thank you for reading this information sheet.

What is the purpose of this study?

This study aims to develop an understanding of the experiences of neurodivergent trainees completing the DClinPsy across UK courses. It also hopes to identify practical recommendations for DClinPsy programmes in the UK to better support neurodivergent trainees.

Who can participate?

We are inviting individuals who meet the following criteria to participate in the study:

1) Currently enrolled on a DClinPsy course in the UK

2) Identifies as neurodivergent (diagnosed and/or self-identified) based on a definition that includes the following conditions:

- Autism Spectrum Condition (ASC)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Dyslexia
- Dyspraxia
- Dyscalculia
- Other specific learning difficulties
- Intellectual disability
- Developmental Language Disorder

3) 18+ years old

If you do not meet the criteria outlined above, you are not eligible to participate in this study. Please note: if you identify as neurodivergent solely on the basis of mental health difficulties (for example, anxiety or Obsessive Compulsive Disorder), you are also not eligible to participate.

What will taking part involve?

If you would like to participate in this study, you will first be asked to confirm that you consent at the end of this Information Sheet. Participation will involve completing an online questionnaire via the platform Qualtrics, about different aspects of your experiences of the DClinPsy. The questionnaire will take approximately 20 minutes to complete. If you wish and/or need to take breaks, you will be able to do so by saving your progress at the bottom of each page. It is important to note that we are not looking at aspects such as spelling and grammar so energy/time is not required to be spent on this.

After you have submitted your responses, you will have the option to enter a prize draw using your email address to win a £50 Love2Shop voucher.

Do I have to take part?

No, your involvement in the study is entirely voluntary. Agreeing to join the study also does not mean you have to complete it – you are free to withdraw at any time before the electronic submission of your questionnaire by simply closing the browser window. Due to the anonymisation process, it will not be possible to remove your responses following submission of the questionnaire.

What are the possible benefits of taking part?

Participation in this study will help to develop understanding about, and give voice to, the experiences of neurodivergent trainees on the DClinPsy. It will also contribute to practical suggestions to hopefully improve the experience for current and future neurodivergent trainees. In addition, following participation, you will have the option to enter a prize draw to win a £50 Love2Shop voucher.

What are the possible risks of taking part?

Whilst the research has been designed in a way to minimise harm, it is possible that you may feel emotional reflecting on and writing about your experiences. If this does happen, we encourage you to take care of yourself, which may include taking a break from completing the questionnaire and returning to it when you feel able to. If you feel it would be helpful to access support after participating, details will be provided upon submitting the questionnaire.

Will my taking part in this study be confidential?

Yes, the questionnaire is confidential and you will not be asked to share information such as your name or address. You will be asked about your age, gender, ethnicity and university you are training at. There is an option to be included in a prize draw upon completion by providing your email address, but this will be kept entirely separately and is not a requirement of participation.

What will happen to the data collected in this study?

Data collected in this study will be processed and kept in accordance with the Data Protection Act (2018) and the BPS's ethical guidelines for internet mediated research (2021). Any email addresses provided by participants for the prize draw will be stored separately to their questionnaire data and in a password protected file, and will be deleted following the prize draw. The anonymised data will be stored for 5 years after completion of the study in accordance with the University of Hertfordshire's policies, and destroyed thereafter.

Will the data be required for use in further studies?

The anonymised data may be included in further analysis as part of a future ethically-approved study.

Who has reviewed and approved this study?

This study has been reviewed and approved by the University of Hertfordshire Social Sciences, Arts and Humanities Ethics Committee with Delegated Authority. The University of Hertfordshire's protocol number is: aLMS/PGR/UH05636(2).

Who is in the research team and who can I contact if I have any questions?

If you wish to obtain further information about this study, please contact the Primary Researcher, Rachel Ison, using the contact details below:

Primary Researcher: Rachel Ison
Trainee Clinical Psychologist
Doctorate in Clinical Psychology Programme, University of Hertfordshire
r.ison@herts.ac.uk

Principal Supervisor: Dr Scott Steen
Clinical Psychologist and Senior Lecturer
Doctorate in Clinical Psychology Programme, University of Hertfordshire
s.steen@herts.ac.uk

Secondary Supervisor: Dr Barbara Rishworth
Clinical Psychologist and Academic Lead
Doctorate in Clinical Psychology Programme, University of Hertfordshire
b.rishworth@herts.ac.uk

If you have concerns or complaints about any aspect of this study, you can write to the university's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB

Thank you very much for reading this information sheet and considering taking part in this study.

Appendix E: Participant Consent Form

(Hosted on the platform Qualtrics)

CONSENT FORM

Having read the research study's Participant Information Sheet, do you consent to participating based on the following three statements? [Closed response option]

- I confirm that I have read and understood the Information Sheet
- I understand that I am free to withdraw at any point prior to electronic submission (at which point I will not be able to due to the anonymisation process)
- I voluntarily agree to participate in this research study

Yes
No (if no, questionnaire ends)

Appendix F: Participant Debrief Sheet

(Hosted on the platform Qualtrics)

Thank you very much for participating in this research!

Research Aims:
1) To develop an understanding of the experiences of neurodivergent Trainee Clinical Psychologists completing DClinPsy courses across the UK.
2) To identify recommendations for DClinPsy programmes in the UK to better support neurodivergent trainees.

Confidentiality:
Your questionnaire responses are confidential and will be handled in accordance with the Data Protection Act (2018) and the BPS's ethical guidelines for internet mediated research (2021). If you provided an email address for the optional prize draw, this will be stored separately to your questionnaire data and in a password protected file, and will be deleted following the prize draw.

Support if Required:
It is possible that you may feel emotional having reflected on and written about your experiences. Given the confidentiality of the research, the Primary Researcher (Rachel Ison) cannot individually support participants, which is why we have created the list of suggestions below should you require further support.

- Your Course/Personal Tutor on the DClinPsy
- Your university's Wellbeing Service
- Your GP
- If you are in need of urgent support, please contact 999 or the Samaritans on 116 123

Contact:
If you would like to contact the Primary Researcher, please email: r.ison@herts.ac.uk.

If you would like to contact someone independent of the research team, you can write to the University of Hertfordshire's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB

Appendix G: Research Poster

Appendix H: Participant Pseudonyms

1. Bethany
2. Laurie
3. Lily
4. Mary
5. Monica
6. Lauren
7. Sarah
8. Barbara
9. Eden
10. Callie
11. Addie
12. Daphne
13. Charlotte
14. Hannah
15. McCa
16. Green
17. Casey
18. Loren
19. Alice
20. Ryan
21. Freya
22. Montgomery
23. Louise
24. Leon
25. Olivia
26. Gerald
27. Rosie
28. Taylor
29. Ruby
30. Noah
31. Tom
32. Sophie
33. Amy
34. Becky
35. Matilda
36. Ria
37. Tamsin
38. Faye
39. Isla
40. Gabrielle
41. Louisa
42. Georgia
43. Anya
44. Riley
45. Poppy
46. Soumya
47. Mango
48. Elodie
49. Ebony
50. Avery
51. Kallie
52. Amal
53. Evelyn
54. Rebecca
55. Toby
56. Stevie
57. Maddie
58. Samantha
59. Billy
60. Lina
61. Emma
62. George
63. Tayla
64. Leanne
65. Jago
66. Kelly
67. Sadie
68. Fiona
69. Joyce
70. Jenna

Appendix I: Qualitative Questionnaire

(Hosted on the platform Qualtrics)

Navigating Neurodivergence on the DClinPsy: Experiences of Neurodivergent Trainee Clinical Psychologists

Reminder: we are not looking at aspects such as spelling and grammar so energy/time is not required to be spent on this, and you can take breaks when you need by saving your progress at the bottom of each page.

1. **Are you a current DClinPsy Trainee in the UK?** **[Closed response options]**
- Yes
- No (if no, questionnaire ends)

2. **What course are you studying on?** *(N.B: this information will not be used in the analysis, it is about representation across programmes)* **[Closed response options]**

1. Bangor University – North Wales
2. University of Bath
3. University of Birmingham
4. Cardiff University – South Wales
5. Coventry and Warwick
6. University of East Anglia
7. University of East London
8. University of Edinburgh
9. University of Essex
10. University of Exeter
11. University of Glasgow
12. University of Hertfordshire
13. University of Hull
14. IoPPN – King's College London
15. Lancaster University
16. University of Leeds
17. University of Leicester
18. University of Liverpool
19. University of Manchester
20. Newcastle University
21. Oxford
22. University of Plymouth
23. Queen's University Belfast
24. Royal Holloway
25. Salomons – CCCU
26. University of Sheffield
27. University of Southampton
28. Staffordshire University
29. University of Surrey
30. Teesside University
31. Trent – Lincoln and Nottingham
32. UCL – North Thames

3. **Do you identify as neurodivergent? [Closed response options]**
- Yes
- No (if no, questionnaire ends)

4. **Has your neurodivergence been formally diagnosed and/or is it self-identified? [Closed response options]**
- Formally diagnosed
- Self-identified
- A mix of formally diagnosed and self-identified

5. **Under the umbrella term 'neurodivergent', which of the following do you identify with? *(Please select as many as apply)* [Closed response options]**
- Autism Spectrum Condition (ASC)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Dyslexia
- Dyspraxia
- Dyscalculia
- Other specific learning difficulties
- Intellectual disability
- Developmental Language Disorder

6. **If you have received formal diagnoses, please specify which: *(please select as many as apply)* [Closed response options]**
- Autism Spectrum Condition (ASC)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Dyslexia
- Dyspraxia
- Dyscalculia
- Other specific learning difficulties
- Intellectual disability
- Developmental Language Disorder

7. **When was your neurodivergence identified? [Closed response options]**
- Prior to school years (approximately 0-5 years old)
- During school years (approximately 5 to 18 years old)
- During a previous undergraduate or postgraduate degree
- In adulthood whilst not in education (18+ years old)
- During the DClinPsy

-

8. **What has been your overall experience of the DClinPsy as a neurodivergent trainee? [Open text box]**

9. **We often develop stories based on our experiences – what stories do you hold about yourself as a neurodivergent trainee? [Open text box]**

-

This section is broken down into the three streams of the DClinPsy programmes – academic, research and clinical placements:

ACADEMIC

10. **What challenges have you experienced in relation to academic work as a neurodivergent DClinPsy trainee? [Open text box]**

11. **What adjustments (if any) have been made for you for academic work? [Open text box]**

12. **How do you think the DClinPsy can improve its academic stream for neurodivergent trainees? [Open text box]**

RESEARCH

13. **What challenges have you experienced in relation to research as a neurodivergent DClinPsy trainee? [Open text box]**

14. **What adjustments (if any) have been made for you for the research component of the DClinPsy? [Open text box]**

15. **How do you think the DClinPsy can improve its research stream for neurodivergent trainees? [Open text box]**

CLINICAL PLACEMENTS

16. **What challenges have you experienced in relation to clinical placements as a neurodivergent DClinPsy trainee? [Open text box]**

17. **What adjustments (if any) have been made for you for clinical placements? [Open text box]**

18. **How do you think the DClinPsy can improve its clinical placement stream for neurodivergent trainees? [Open text box]**

-

19. **What supports you to navigate your neurodivergence on the DClinPsy? [Open text box]**

20. **What strengths do you feel your neurodivergence brings to training and Clinical Psychology? [Open text box]**

21. **What top three pieces of advice would you give to neurodivergent trainees starting the DClinPsy? [Open text box]**

22. **Is there anything else you feel is important to share that has not been covered elsewhere? [Open text box]**

-

Each participant will be allocated a pseudonym for the write up of the research – if you would like to choose your own, please write a first name: *(N.B: for anonymity and confidentiality, please choose a name different to your own)* **[Open text box]**

What is your age? [Open text box]

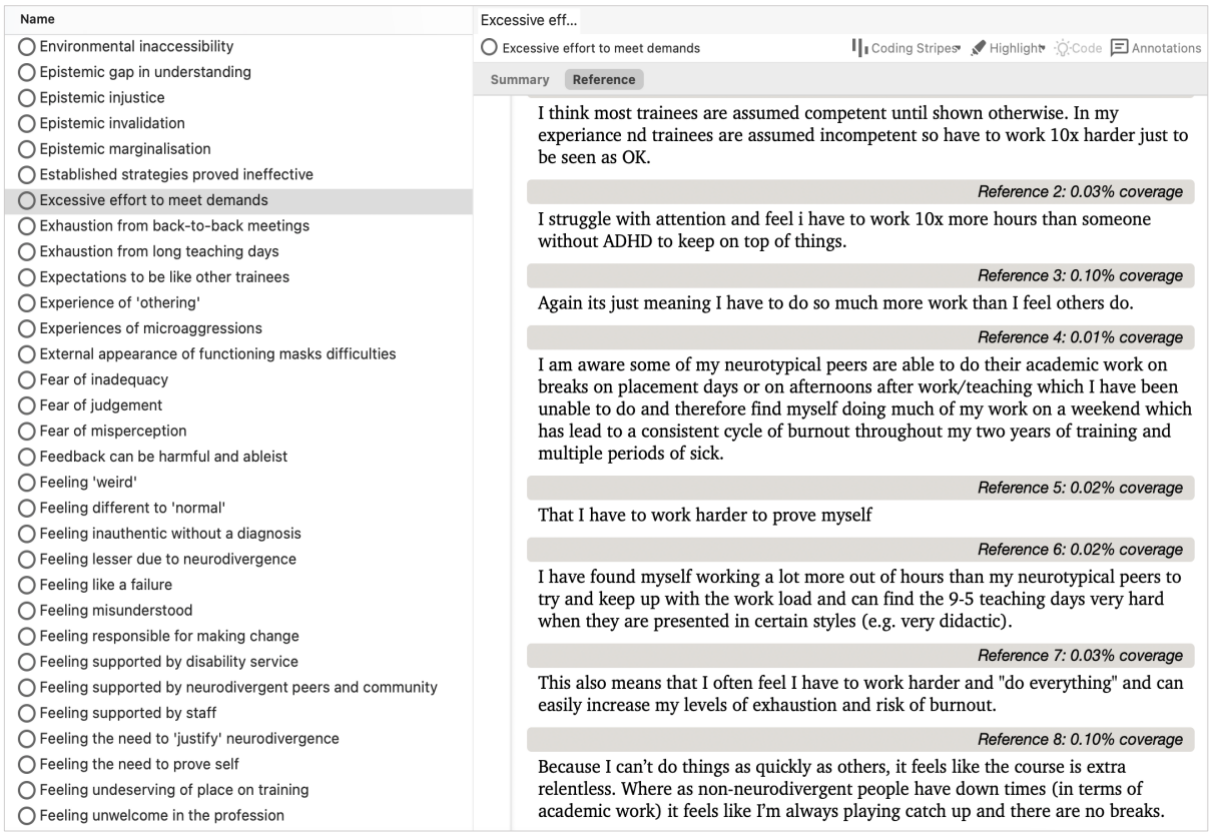
How do you define your gender identity? [Open text box]

How do you define your ethnicity? [Open text box]

If you would like to enter the optional prize draw to win a £50 Love2Shop voucher, please write your university email address here: *(N.B: this will be stored separately to your questionnaire data in a password-protected file and deleted following the prize draw).* **[Open text box]**

Appendix J: Coding Phase in NVivo

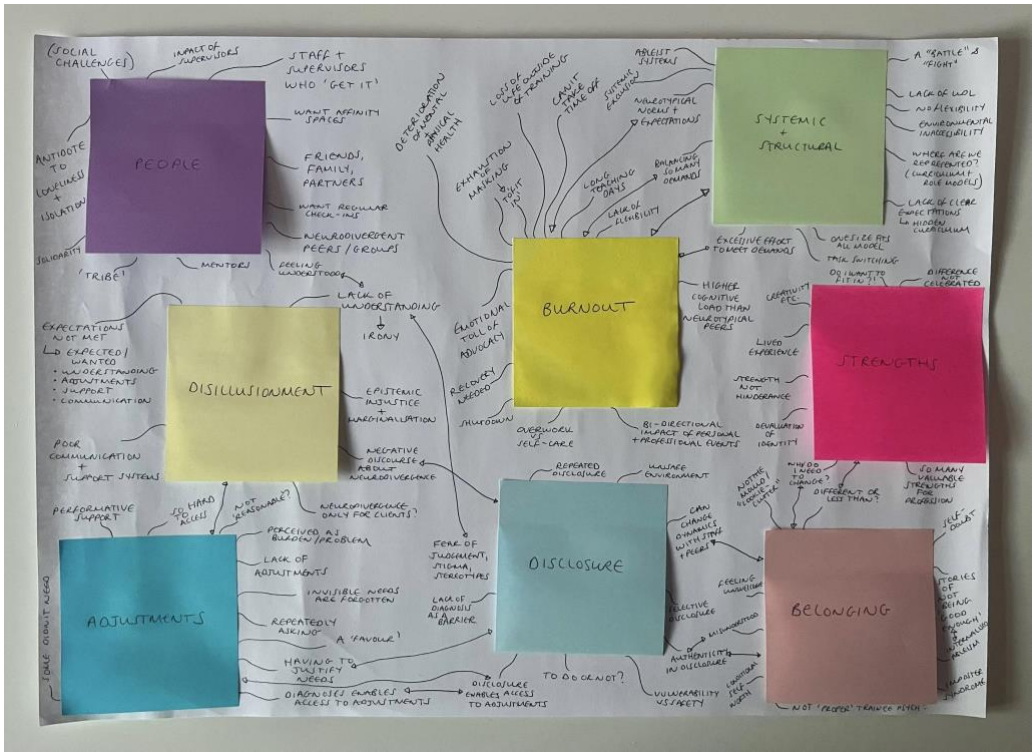
Example codes and related extracts



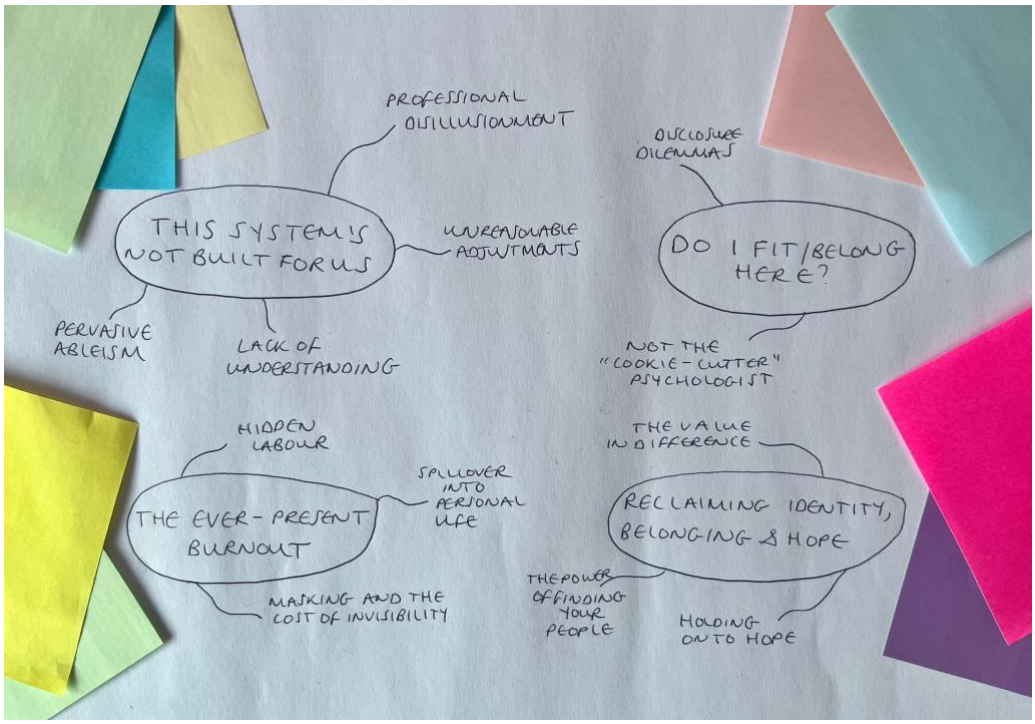
Appendix K: Theme Development Process

Grouping codes into initial patterns (colour coded)

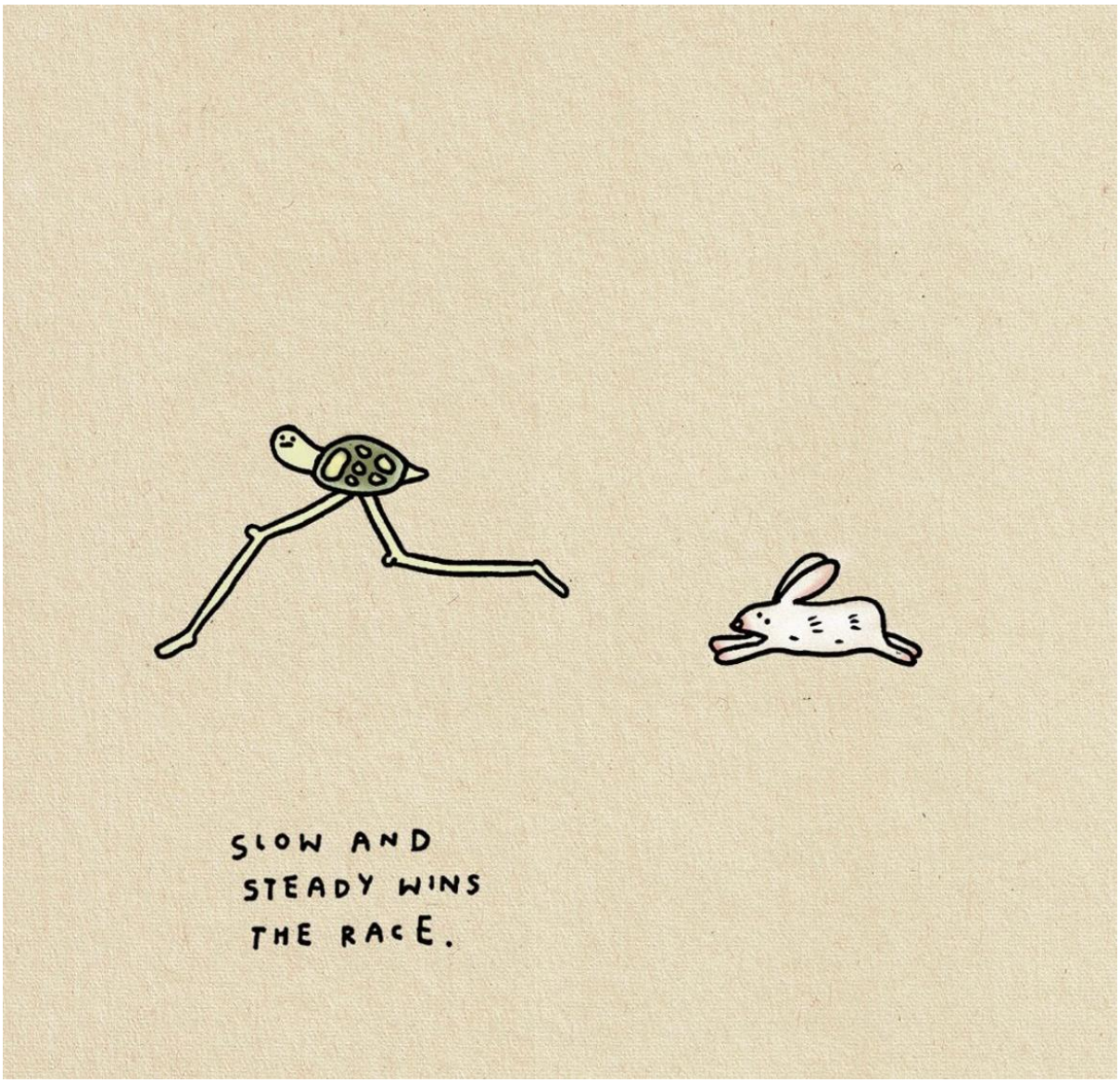
Initial thematic map



Final thematic map



Appendix L: 'Slow and Steady Wins the Race'



With permission: @kiplines (May 2024)