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ORIGINAL ARTICLE

Bridging the gap: Co-produced neurodiversity-affirming resources for undiagnosed children aged 7–11: Insights from children, families and stakeholders

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Abstract

This qualitative study investigated the acceptability and suitability of neurodiversity-affirming psychoeducational resources for children aged 7–11 years without formal autism or attention deficit hyperactivity disorder (ADHD) diagnoses. Using a reflexive thematic analysis of semi-structured interviews with 24 families and written feedback from seven stakeholders, the research explored perceptions of repurposed resources. One overarching theme 'Empowering Individualised Engagement' and six themes were developed: (1) Active Participation, (2) Harnessing Words, (3) Personal Resonance, (4) Communication, (5) Tailoring for Growth and (6) Strategies for Challenges. These were driven by the resources' engaging, co-produced design, strengths-based language non-clinical terminology, and ability to foster personal resonance. The resources enabled children to develop a shared vocabulary for their needs and equipped families with practical strategies, which fostered a positive identity. This study concludes that non-clinical, strength-based resources can bridge service gaps for children on diagnostic waitlists or with suspected neurodivergent traits, offering a scalable inclusive model for supporting child well-being by prioritising empowerment over deficit-based approaches.

KEYWORDS
co-production, lived experience, neurodiversity, psychoeducation, qualitative methods, school-age children

Key points

- Bridging Diagnostic Gaps: This study demonstrates that co-produced, neurodiversity-affirming resources provide essential first-line support for children on diagnostic waitlists. By removing medical gatekeeping, these tools offer a scalable, inclusive model that supports well-being and self-understanding in mainstream settings regardless of a formal ADHD or autism diagnosis.
- Language as a Catalyst for Inclusion: Findings indicate that replacing pathologising, deficit-based terminology with affirming, neutral language is a primary driver of engagement. Using strengths-based frameworks (e.g. 'superpowers' or 'traits') reduces the stigma of 'disorder,' empowering children to view their cognitive profiles as natural variations rather than personal failings.
- Fostering Shared Understanding: The resources function as a 'third space' for communication, equipping families and educators with a shared, non-clinical vocabulary. This shifts the support dynamic from 'management' to 'collaboration,'

enabling children to advocate for their needs and helping adults provide better-targeted adjustments in daily classroom and home routines.
- Universal Design and Personal Resonance: Effective psychoeducation requires flexible, child-led design that prioritises personal and cultural relatability over abstract celebrity examples. Applying Universal Design for Learning (UDL) principles, such as multiple response modes like drawing or note-passing, ensures accessibility across diverse developmental stages, supporting long-term identity formation and self-acceptance.

INTRODUCTION

Supporting neurodivergent children and young people (CYP), such as those who are autistic or ADHDers (attention deficit hyperactivity disorder; identity first term to refer to people diagnosed with ADHD), is a priority in mainstream education (UK Parliament, 2022). However, many CYP who exhibit neurodivergent traits remain excluded from support because provision is frequently restricted to those with a formal clinical diagnosis (Autistica, 2024). This diagnostic gatekeeping creates a critical service gap for children on waitlists, those below diagnostic thresholds, or families opting out of assessment (Powell et al., 2024). This population represents an under-researched group whose needs are unmet or excluded within current provision (Hadders-Algra, 2021). Here, exclusion refers to the structural denial of service-level support, often resulting in 'micro-exclusions', where a child's specific needs are overlooked in daily classroom interactions.

Barriers to inclusion and the role of language

CYP with neurodivergent traits face significant barriers to inclusion, particularly without a formal label (Cook, 2024). Diagnostic delays, the under-recognition of traits in girls and minoritised groups, and variability in teacher knowledge contribute to inequitable support access (Autistica, 2024). Prolonged periods without recognition are associated with school disengagement, reduced self-esteem and an increased risk of anxiety and depression (French et al., 2023). Without affirming tools, children may internalise these challenges as personal failings (Crane et al., 2019).

While psychoeducation can enhance quality of life (Powell et al., 2025), many resources rely on pathologising terminology (e.g. 'disorder' and 'symptom'). Such framing creates barriers to engagement as it positions neurodivergence as a deficit, suggesting support depends solely on medical diagnosis (Chapman & Botha, 2023). Children without formal labels may disengage from materials that lack accessible, neutral language (Cook, 2024), limiting the acceptability of resources for undiagnosed populations. Crucially, while the Equality Act (2010) entitles children to reasonable adjustments without a formal diagnosis, this legal entitlement is inconsistently applied (Ward & Powell, 2025). Consequently, there is an urgent need for strengths-based, non-clinical resources that promote belonging regardless of diagnostic status.

The neurodiversity paradigm as a framework

Adopting a neurodiversity paradigm frames cognitive differences as natural rather than inherent deficits (Kapp, 2020). When psychoeducational interventions are delivered in neurodiversity-affirming ways, they foster identity development and practical coping strategies (Ward & Powell, 2025). From this perspective, the goal is not to 'fix' individuals but create affirming environments (Taylor et al., 2023). By repurposing existing resources into accessible, non-pathologising forms, we can extend support to CYP in the early stages of self-recognition, including those from ethnic minority backgrounds who face systemic barriers to diagnostic pathways (Powell et al., 2025).

Co-production and repurposing resources

Recent shifts toward co-produced psychoeducational resources for diagnosed CYP demonstrate the value of embedding lived experience into design to enhance usability and relevance and have established effectiveness in supporting self-understanding and affirming identity (Armitt et al., 2024; Powell et al., 2021, 2024).

Building on this foundation, the current study evaluates the repurposing of existing co-produced resources (originally designed for diagnosed populations) into inclusive, non-pathologising forms. By removing medical labels and focusing on universal traits and strategies, these repurposed tools aim to reach underserved groups. This includes those from ethnic minority backgrounds and socio-economically disadvantaged communities, both of whom face systemic barriers and significant inequalities in accessing diagnostic pathways (Aylward et al., 2021; Uzoaru et al., 2025; Powell et al., 2025).

Qualitative rationale: Centring neurodivergent voices

Qualitative methods are uniquely suited to exploring the nuanced lived experiences of neurodiversity, capturing

how individuals make sense of their cognitive profiles (Botha et al., 2023; Lilley et al., 2022). A qualitative approach enables researchers to navigate the 'double empathy problem' (Milton, 2012) by prioritising the child's narrative and terminology over standardised medical descriptors. Reflexive thematic analysis (RTA) is employed here, acknowledging the researcher's subjectivity as an interpretive tool (Braun & Clarke, 2021). Previous neurodiversity-affirming studies have successfully employed RTA to identify how environmental and linguistic shifts, rather than internal 'deficits', shape a child's sense of belonging and agency (Crane et al., 2019). When grounded in critical realism, this approach enables attention to participants' accounts of the resources while theorising socio-structural mechanisms (such as diagnostic gatekeeping) that shape their experiences (Bhaskar, 2013).

The present study

This study makes a unique contribution by focusing specifically on children aged 7–11 without a formal diagnosis. While previous co-production has focussed on diagnosed populations, there is a gap in understanding how non-clinical strengths-based language shapes engagement and belonging (Leadbitter et al., 2021). Therefore, by evaluating two repurposed resources originally designed for autistic and ADHDer CYP (Powell et al., 2021, 2024), we ask: *How do children aged 7–11 without formal diagnoses, their families, and professional stakeholders perceive the acceptability and utility of neurodiversity-affirming psychoeducational resources in supporting self-understanding and inclusion?*

METHODOLOGY AND METHODS

Researcher positionality and epistemological grounding

Anchored in a critical realist framework, and the neurodiversity paradigm, this research centres insider perspectives to challenge deficit-based narratives (Bhaskar, 2013). Knowledge is viewed as socially constructed through researcher–participant interactions (Braun & Clarke, 2021), where neurodivergent traits exist independently of perception, but understanding is mediated by social frameworks. Insider perspectives included author XX: a late-diagnosed AuDHD (autistic and ADHD-er) woman whose experiences without diagnosis inform her commitment to inclusive psychoeducation, and ES; a late-diagnosed autistic woman. This dual positioning enhanced rigour, fostered nuanced interpretation and facilitated power-sharing in co-production (Bertilsdotter Rosqvist et al., 2023b; Powell, 2025).

Design and procedure

Following ethical approval (reference 2719), this qualitative study evaluated prototype psychoeducational resources through stakeholder feedback and family interviews (April–July 2025). There were two concurrent phases: (1) stakeholder written feedback and (2) semi-structured family interviews. While data collection occurred during the same window, the sequencing was iterative: initial stakeholder insights regarding terminology and layout were reviewed in real-time to inform the prompts used in family interviews. However, to maintain consistency in the evaluation, all 24 families engaged with the same prototype versions of the resources. This allowed the final analysis to triangulate 'expert' stakeholder suggestions for school-setting feasibility with 'lived experience' family feedback on daily utility, ultimately informing a single, comprehensive set of post-study revisions (McKenney & Reeves, 2013).

Participant context

The study was conducted in England, where affirming views of neurodivergence are growing, but diagnostic delays and limited school support persist. The sample comprised 24 families (parent/carer and one child aged 7–11 years in mainstream education; see Table 1), from diverse ethnic and geographical contexts (NHS England, 2024; 2025; Nuffield Trust, 2024), who were recruited through school and community networks. Participants included those on diagnostic wait lists, and those with suspected traits or associated challenges, ensuring breadth and transferability of findings.

Potential participants were provided with information sheets that explicitly framed the study around the neurodiversity paradigm, inviting families of children who experience challenges with attention, activity levels or social-sensory processing, but have no confirmed ADHD or Autism diagnosis. Inclusion required parental identification of attention, activity or social-sensory challenges without a formal ADHD/Autism diagnosis. This two-stage screening process (expression of interest followed by a confirmational correspondence with ES) prioritised lived-experience recognition over clinical pathways to support those currently excluded from formal support. Ethical considerations included informed consent, child assent, and neurodiversity-affirming practices (e.g. flexible questioning, sensory accommodations) (Bertilsdotter Rosqvist et al., 2023b; Powell, 2025).

Stakeholder involvement

Stakeholders included teachers, educational psychologists, clinicians and advocacy representatives recruited via convenience sampling (see Table 2). They reviewed

TABLE 1 Participant characteristics of CYP and parents/carers.

Pseudonym (child/parent or carer); relationship to child	Age (years)	Gender	Ethnicity	School area	SEN support?	On a diagnostic waitlist?	Notes
Group A Families[a]							
Lucy/Natalie (Mother)	8	Female	White British	Leeds	Yes	Yes	
Hazel/Sadie (Mother)	9	Female	White British	Leeds	No	Yes	
Rose/Marcia (Mother)	7	Female	White British Iraqi Arab	Leeds	Yes	Yes	
Charlotte/Brian (Father)	11	Female	White Asian	Kent	No	No	
Jihong/Tian (Mother)	9	Male	Chinese	Leeds	No	No	Learning disability
Matthew/Niel (Father)	7	Male	African	Chester	No	Yes	
Farah/Nazia (Mother)	8	Female	White British	Leeds	No	No	
Harisson/Debbie (Mother)	8	Male	White British	Wakefield	Yes	Yes	
Kristi/Janet (Mother)	7	Female	Not provided	Chester	Not reported	Yes	
Bob/Miranda (Mother)	8	Male	White British	Sheffield	Yes	Yes	Also in group B
Lewis/Esther (Mother)	7	Male	White British	Leeds	Yes	Yes	Dyslexia
Adan/Rena (Mother)	7	Male	White British	Tyne and Wear	No	No	
Rory/Katy (Mother)	9	Male	White British	Tyne and Wear	No	No	
Group B Families[a]							
Jim/Daphne (Mother)	9	Male	White British	Leeds	No	No	
Thomas/Mary (Mother)	7	Male	White British	Leeds	No	No	
Sophia/Tabitha (Mother)	8	Female	White British	Leeds	No	No	
Emily/Tracey (Mother)	7	Female	White British	Leeds	No	No	
Antony/Mavis (Mother)	8	Male	White British	Leeds	No	No	
Bob/Miranda (Mother)	8	Male	White British	Sheffield	Yes	Yes	Also in group A
Scottie/Christopher (Father)	10	Male	White British	Tyne and Wear	No	No	
Chidi/Amara (Mother)	11	Male	Other mix	Leeds	No	No	
Pippa/Gemma (Mother)	10	Female	White British	Tyne and Wear	No	No	
Ethan/Kim (Mother)	8	Male	White British	Tyne and Wear	No	No	
Reid/Kim (Mother)	11	Male	White Scottish	Tyne and Wear	No	No	

[a]Group label A reflects participant allocation to the ADHD-focussed resource, while Group B reflects allocation to the autism focussed resource.

TABLE 2 Participant characteristics of stakeholders.

ID	Stakeholder category	Organisation type	Generalised locality
S1	Education professional	Local Authority	Yorkshire & Humber
S2	Health professional	NHS	North-East
S3	Education professional	Academy Trust	Yorkshire & Humber
S4	Education professional	Primary School	Yorkshire & Humber
S5	Education professional	ADHD Support Group (Voluntary Sector)	Yorkshire & Humber
S6	Health professional	Professional Association	National
S7	Advocacy professional	Youth Advocacy	National

the prototype resources that aligned with their expertise and provided written feedback on acceptability, suitability and feasibility of alignment with school needs. Feedback was thematically analysed and integrated with family interviews to guide resource revisions, enhancing the resource's suitability for implementation within schools and other real-world settings (Armitt et al., 2024; McKenney & Reeves, 2013).

Data collection

Families received two 20-page prototype booklets (either ADHD- or autism-focused) by post, engaging with the activities and text for at least 2 weeks before their interview. This ensured their reflections were based on practical experience rather than initial impressions.

ES conducted virtual semi-structured interviews (up to 60 min), utilising her autistic identity to create a neuro-accessible environment (sensory breaks, flexible questioning, spaces for non-verbal responses). Interviews addressed suitability, acceptability and improvements, using age-appropriate prompts for children and probes for parents. Questions addressed suitability (e.g. daily life relevance), acceptability (e.g. engagement, cultural appropriateness), ease of use (e.g. clarifying non-clinical language) and suggested improvements. Interviews were tailored with age-appropriate prompts for children (e.g. 'Which activity did you most enjoy?') and detailed probes for parents/carers (e.g. 'How might this strategy fit your child's school day?'). Participants received a £20 voucher, and verbatim transcripts were anonymised with pseudonyms chosen by families (Itzik & Walsh, 2023).

The resources

The resources comprised two interactive booklets: the 'Hero Activity Book' and the 'Learning About You' booklet which were repurposed from resources intended for ADHDer and autistic CYP, respectively. Both were designed to support flexible, child-led engagement through non-prescriptive activities. For example, they feature open-ended 'About Me' sections (e.g. 'Write or draw what makes you unique') and customisable reward systems, allowing families to define their own incentives.

To enhance cultural relatability and neutrality, particularly for ethnic minority families who may find generic celebrity or Western-centric examples alienating, the resources utilised universal metaphors and blank templates. Rather than prescribing specific social norms, the resources encouraged children to input their own hobbies and social contexts. Final versions of both booklets are provided in the supplemental materials.

Data analysis

Data were analysed using RTA (Braun & Clarke, 2021, 2024), prioritising exploration of the nuances of how families engaged with the resources. This approach explicitly aligns with the neurodiversity paradigm by prioritising the subjective lived experience of participants over clinical observation, focusing on how individuals navigate identity and agency rather than mapping responses against medical-model benchmarks. By framing neurodivergence as a natural and valuable form of human variation (Bertilsdotter Rosqvist et al., 2023a; Kapp, 2020), this approach allows for an exploration of how affirming, non-pathologising resources can support CYP in mainstream education, regardless of diagnostic status.

An inductive, primarily semantic approach captured explicit meanings, while latent analysis explored underlying values (e.g. inclusivity and belonging). Analysis followed Braun and Clarke's six iterative steps (Braun & Clarke, 2021):

1. Data Familiarisation: Author XX immersed herself in the data by reading transcripts multiple times, noting initial impressions in a reflexive journal.
2. Code Generation: Initial codes were applied to meaningful data segments, capturing semantic content (e.g. preferences for 'pictures', 'superpowers', 'relating to sensory content') and latent meanings (e.g. 'proud of what makes them unique', 'want child to be accepted', 'self-discovery').
3. Theme Searching: Codes were grouped into potential themes reflecting patterns across data.

4. Theme Review: XX refined themes, supported by YY, ensuring they captured diverse participant voices and aligned with study aims.
5. Theme Definitions and Names: Each theme was clearly articulated and named to reflect its significance.
6. Results Write-Up: Themes were illustrated with anonymised quotes, adhering to Big Q reporting standards (Braun & Clarke, 2024) to represent the breadth of experiences.

Throughout the process, XX maintained a reflexive journal documenting interpretative decisions, shaped by her AuDHD identity. These reflections were discussed with YY, providing a critical reflexive dialogue that ensured themes were grounded in the data and lived-experience expertise. Triangulation of family and stakeholder feedback strengthened analytic rigour and ensured a holistic evaluation of the resources' suitability and acceptability (Braun & Clarke, 2006; Denzin, 2017).

FINDINGS

Terminology

To distinguish between participant groups, this study uses the labels 'Group A' to refer to families who reviewed the ADHD-focused resource, and 'Group B' to refer to those who reviewed the autism-focused resource. References to *ADHD-relevant* or *autism-relevant* traits describe patterns children/families recognised in their experiences.

Participant summary

The two non-clinical resources were evaluated through the perspectives of 24 children/families (Group A: $n=13$; Group B: $n=11$) (see Table 1) and seven stakeholders (see Table 2). Group A (mean age 8.1, 54% male, 69% White British) included 54% receiving SEN support and 62% on diagnostic waitlists. Group B (mean age 8.9, 82% male, 82% White British) included 9% receiving SEN support or on a waitlist. This purposive sampling enhanced diversity across age, gender, ethnicity, locality and diagnostic pathways, strengthening transferability and analytic rigour.

Six themes were developed through reflexive thematic analysis (see Table 3). These are captured under the overarching theme: Empowering Individualised Engagement. Across groups, the data explores how the removal of clinical language influenced approachability and agency, enabling children to interact with strategies and articulate needs without the requirement of a formal diagnosis.

TABLE 3 Outlining the overarching theme, themes, subthemes and which participant groups provided support for each theme.

Overarching theme	Theme	Subtheme	*n* supporting subtheme	Group A cohort support	Group B cohort support	Stakeholder support
Empowering Individualised Engagement	Theme 1: Active Participation and the Power of Engaging Design	Visual Appeal	20	✓	✓	✓
		Interactive Exploration	27	✓	✓	✓
		Motivational Reinforcement	8	✓	✓	✓
	Theme 2: Harnessing Words as a Foundational Principle	Clarity, Simplicity and Positive Framing	20	✓	✓	✓
		Accuracy & Explanation	3	✗	✓	✓
	Theme 3: Personal Resonance as a Mechanism for Self-Acceptance	Personal/ Sensory Relatability	11	✓	✓	✓
		Social/Cultural Relatability	13	✓	✓	✗
	Theme 4: Communication as a First-Line Support Tool	Navigating Social Worlds Through Shared Understanding	12	✓	✓	✓
		Family-Supported Coping	11	✓	✓	✓
	Theme 5: Tailoring for Growth in a Universal Design	Accessibility for Ability Levels	15	✓	✓	✓
		Learning New Horizons	9	✓	✓	✓
	Theme 6: Strategies for Challenges to Enhance Well-Being	Coping & Regulation, Planning & Adaptability	16	✓	✓	✓
		Fostering Well-being: Self-esteem & Acceptance	11	✓	✓	✓

Theme 1: Active participation and the power of engaging design

Participants described the resources as catalysts for hands-on, child-led engagement, noting that the non-clinical framing converted complex psychoeducational concepts into approachable activities. Stakeholders (S2, health professional; S5, education professional) observed that this active format was particularly suitable for classroom integration compared to traditional text-heavy materials, fostering a sense of agency.

Visual appeal

Vibrant illustrations, colour schemes and intuitive layouts enhanced accessibility and were endorsed by 20 participants (n=9 group a, n=7 group B, n=4 stakeholders). Participants across groups noted that visuals boosted motivation and comprehension, making the resources engaging and accessible with one child noting that '…looking at pictures give me a bit of motivation than just words' (Pippa, child, group B) and an advocacy professional similarly noted that the illustrations kept the resources 'eye-catching and visual' (S7, advocacy professional).

Interactive exploration

Varied interactive elements, such as quizzes, puzzles, and activity prompts, were frequently cited as key drivers of 'engagement' (S6, health professional), shifting learning from passive absorption to active involvement and fostering a sense of agency 'to suit all minds' (S7, advocacy professional). This was the most prominently supported subtheme, endorsed by n=12 group A, n=10 from group B, n=5 stakeholders. Group A families valued short, rewarding tasks that built 'self-confidence' (Tian, mother, group A), while group B families emphasised the activities' role in facilitating social–emotional connections:

> It's good because …if one of my friends is feeling sad …I'll go over to them and ask if they're alright and then if they're one of my friends, then I'll tell them something that'd make them, laugh, and then they'd feel a bit better….
> (Reid, child, group B)

Interactive features were therefore deemed to provide normalised strategy-testing through playful, low-pressure activities.

Motivational reinforcement

The resources incorporated motivational elements, such as progress trackers, positive affirmations, and achievement-based rewards, which supported persistence and pride particularly for children who may previously have internalised challenges (n=4 group A families, n=3 group B families, n=1 stakeholder). One child shared that they were 'really proud' of their work on the activity where they 'write or draw what makes you unique or what you like to do.' (Rory, group A). In addition to feelings of accomplishment, one child noted how the resource 'made me feel confident'. The same child liked that she could then say she '…can grow up to …have an amazing job and I felt confident myself so that I could.' (Sophie, group B).

Parents reinforced engagement through individualised rewards, aligning with the neurodiversity-affirming approach, with one parent stating how 'keen' their child was for her to 'get it (the reward) sorted' (Katy, group A). Similarly, a health professional agreed that they didn't just like the reward certificate, but how the reward can be 'specific to the child' (S6).

Active Participation created an engaging environment that aligned with the neurodiversity paradigm, affirming diverse interaction styles. Group A families prioritised practical applications, while group B families emphasised relational depth and stakeholders highlighted educational relevance.

Theme 2: Harnessing words as a foundational principle

Families and stakeholders consistently identified the shift from deficit-based to strengths-based language as the primary factor in the resources' accessibility. Parents in both groups noted that the removal of clinical labels like 'disorder' reduced the 'intimidation' (Natalie, group A).

This reflects a shift in power dynamics; by removing medical jargon, the resources strip away the 'expert-led' clinical gaze, returning the power of definition to the child. This suggests that non-clinical language does not just simplify information but validates the child's expertise over their own lived experience.

Clarity and Simplicity and positive framing

Endorsed by 20 participants (n=10 group A, n=4 group B, n=6 stakeholders), this subtheme refers to the resource's functional accessibility. Straightforward wording provided a 'clear outline of challenges' (S1, education professional) and was described as 'broken down nicely' (Natalie, mother, group A) and including 'simple language' (S4, education professional), which reduced the cognitive load and intimidation often associated with clinical documents. For group A families, this clarity was essential for immediate usability, allowing them to identify relevant sections without navigating complex terminology.

Furthermore, strengths-based terms such as 'traits' or 'superpowers' empowered children to view their

characteristics as assets; for instance, Harrison (child, group A) reframed his high energy as being 'super quick.' Stakeholders noted that this 'empowering' (S7, advocacy professional) and 'positive tone' (S4, education professional) was particularly effective for engaging children who might otherwise feel marginalised by deficit-based language.

Accuracy & Explanation

While the previous subtheme focuses on *how* information is delivered, this subtheme ($n=2$ group B families, $n=1$ stakeholder) refers to the conceptual depth and accuracy of explanations provided. It highlights the value of providing a 'why' behind neurodivergent experiences, such as the internal mechanics of sensory processing by using precise non-clinical frameworks.

This subtheme resonated more selectively with group B families, suggesting a distinction in participant priorities. Group A families, many of whom were navigating significant barriers to support or were on diagnostic waitlists, prioritised clarity and actionable tools. In contrast, group B families, who often had fewer immediate SEN requirements, utilised the resources for identity-mapping, where conceptual accuracy and the validation of their child's internal world were the primary goals. For example, Sophia (child, group B) accepted the 'Super Senses' framework as an accurate explanation of her sensitivities, stating it helped her 'feel like I know which ones are my favourite ones.' Supporting this, S4 (education professional) noted that such accurate, age-appropriate explanations are 'incredibly valuable for helping young people understand themselves' at a conceptual level, rather than just following instructions. Thus, *Harnessing Words* illustrates how language shapes understanding, enabling inclusive, empowering engagement for children regardless of diagnostic status.

Theme 3: Personal resonance as a mechanism for self-acceptance

Data from children revealed that the resources functioned as 'mirrors,' allowing them to recognise their own experiences in the traits described. By presenting cognitive differences as natural variations rather than personal failings, the resources enabled children to discuss their needs with self-awareness and acceptance.

Personal/sensory relatability

Supported by 11 participants, this subtheme highlights how content helped children make sense of their internal world. Sophia (child, group B) and health professionals (S2) specifically valued the 'Super Senses' framing, while group A children identified with examples that mirrored their 'everyday routine'. Rory (child, group A) found it 'interesting' to learn about himself, reinforcing the resources' role as mirrors for self-awareness.

Social/cultural relatability

Thirteen participants emphasised that cultural relevance was achieved through the resources' ability to be personalised to their specific social worlds, rather than using external cultural figures. While the resources were designed to be inclusive, children across both groups expressed that pre-existing celebrity examples often lacked resonance, preferring instead to anchor the materials in their own lived experiences. For instance, group A children Matthew, Harrison, and Bob suggested that *'famous'* examples were unfamiliar.

This suggests a preference for relational authenticity over abstract representation. For these children, the 'superpower' or 'trait' only became meaningful when it was situated within their immediate social ecology – such as 'making my friends laugh' (Matthew, group A) or personal hobbies like 'drawing these soldiers' (Jihong, group A). The lack of celebrity resonance could stem from the 'distance' between a child's private struggle with a trait and a celebrity's public success with it. By utilising the 'blank canvas' design (e.g. *Learning About You*, p. 3), the resources functioned not as a top-down instruction manual, but as a co-produced narrative space. This allowed children to bridge the gap between their neurodivergent traits and their cultural identity on their own terms, making the resources a tool for identity-construction rather than just providing information.

Theme 4: Communication as a first-line support tool

Participants identified the resources as a vital bridge for externalising internal experiences, creating a shared, non-judgemental vocabulary that facilitated understanding between the child, their peers and adults. By moving away from clinical labels, the resources provided a neutral medium for discussions without the child feeling they were being 'corrected' or 'diagnosed'.

Navigating social worlds through shared understanding

By presenting concepts in relatable, non-clinical ways, the resources empowered children to reflect on behaviours and advocate for their needs. This fostered peer and family understanding, with stakeholders noting the resources' role in building pride and community:

> … it's (resource) sort of relatable because I like talking about …my karate or parkour. … if one of my friends is talking about a different hobby I haven't heard of, I can ask questions and …learn a bit more about their hobby.
>
> (Reid, child, group B)

This suggests that the primary barrier for these children is not lack of social skills, but a lack of shared 'meaning making' tools. When Reid (group B) uses the resource to discuss hobbies, he is bypassing the 'social deficit' narrative and engaging in reciprocal connection. Stakeholders (S7, advocacy professional) observed that the physical nature of the booklet, which could be 'shown' to others, acted as a tangible proxy for the child's voice, allowing them to be understood by adults without pressure of verbalising complex emotions.

> Liked the concept of Merlin (character) for children completing it by themselves. The 'us approach' enables thinking that they are not the only one. Then moves on to how they might present or find things difficult and approach the challenges.
>
> (S6, Health professional)

Family-supported coping

11 families used the resources to identify solutions, respect preferences, and address sensory/emotional challenges. One mother noted that her daughter prioritised predictability and utilised the planning activities to reduce anxiety (Natalie, group A). This reflects a shift from 'parent-as-manager' to 'parent-as-collaborator.' Because the resource focuses on universal traits rather than 'symptoms,' parents reported feeling more 'informed' (Janet, group A) rather than burdened, suggesting that non-pathologising tools can reduce the relational strain often caused by 'diagnostic waits.'

Stakeholders valued the non-judgemental tone, which enabled collaborative problem-solving and resilience and even referred to the resource as a 'go-to resource for children and parents that need extra support' (S3, education professional). The resources therefore empowered families to work as a team, building resilience and strengthening relationships in the absence of formal diagnoses.

Theme 5: Tailoring for growth in a universal design

Participants reported that the resources supported diverse ability levels while opening new pathways for self-insight. By offering adaptable engagement options, resources empowered children to interact meaningfully in ways that aligned with their specific developmental stages and learning styles. Stakeholders (S1 education professional; S2 health professional) confirmed that this flexibility was a direct result of the non-prescriptive design, which moved away from rigid educational expectations toward a more individualised approach.

Accessibility for ability levels

Concise text and visuals aided comprehension, with several children expressing a preference for alternative response modes that aligned with their comfort levels. For Harrison (group A), the requirement for written output was a primary barrier to engagement, leading his mother to observe, 'he didn't want to do any of the writing, so I had to write it all for him.' However, data revealed a shift in Harrison's agency when engaging with drawing-based prompts. When discussing his superhero illustration, he described his identity in his words: 'I draw like the letter for my first name. Like Batman has a bat symbol, I had a H symbol… [I am] a superhero… with a cape.' By moving from the less accessible task of writing to the creative task of drawing, Harrison was able to articulate a strengths-based self-concept: 'I was skinny, but I am strong.'

In contrast, while Bob (groups A/AB) found certain drawing prompts intimidating, stating he avoided the hero frame 'because I'm not good at drawing people', his mother (Miranda) noted that he frequently used writing and note-passing as a safe communication tool during periods of emotional dysregulation: 'He will write and pass notes underneath the door… that's the only time he'll ever willingly read and write.' This demonstrates that resource accessibility is not static, but a dynamic interaction between the child's profile and the medium provided. For Bob, writing acted as a protective communication buffer during social overwhelm, whereas for Harrison, it was a hurdle to bypass via illustration. Data suggests that providing multiple, low-pressure response methods – including Bob's suggestion that the resources should explicitly state 'you can colour in the pictures' – is essential for supporting agency across different neurodivergent profiles. Similarly, comic-style layouts boosted motivation for Pippa (group B), who explained: 'looking at pictures give me a bit of motivation than just words.' Stakeholders reinforced these perspectives, noting that the 'small chunks of writing' (S5, education professional) and 'child-friendly presentation' (S2, health professional) were essential for maintaining engagement.

Learning new horizons

Beyond immediate usability, the resources acted as catalysts for self-discovery. Participants reported that

the absence of pathologising labels created a safe psychological space for children to explore traits they had previously not identified or understood. For example, group A families described the resources as 'really useful' for identifying specific challenges that had previously gone unnamed (Charlotte, child, group A). Lewis (child, group A) noted that the neutral framing allowed him to explain 'specific emotions' that were previously 'quite new' to him.

Stakeholders confirmed that this was a direct result of the linguistic approach, noting that 'use of neutral language… fosters inclusion and promotes self-reflection' (S1, education professional). This suggests that when the barrier of clinical 'deficit' language is removed, children are more willing to venture into 'new horizons' of self-understanding. As S6 (health professional) observed, this was particularly important for 'helping them to understand their own challenges and problem-solving solutions' independently, moving the child from a passive recipient of a label to an active learner of their own cognitive profiles.

Theme 6: Strategies for challenges to enhance well-being

Participants highlighted the transition from understanding traits to applying practical tools in home and school contexts. Data suggests that these strategies fostered practical regulation skills and a broader sense of self-acceptance.

Coping & Regulation, Planning & Adaptability

Children and families identified the resources as practical toolkits for navigating daily transitions and emotional fluctuations. By providing structured yet adaptable templates, they enabled children to trial regulation strategies, moving the focus from managing behaviour to building autonomy.

For instance, Kim (Group B mother) described how the strategies helped her son manage a significant school transition: 'it helped him with the teacher change (understanding what was happening next.)' This was echoed by stakeholders, who praised the proactive, 'solutions-focussed' (S6, health professional), with a youth advocacy professional (S7) noting that the 'stand-alone page for the young person to add their day's plan' (*Hero Activity Book*, p. 11) was 'a really useful tool' for building executive function skills. Even for children who struggled with formal writing, like Harrison (group A), the planning elements were accessible because they focused on his goals rather than school-imposed tasks.

This subtheme reveals that the resources functioned as an executive functioning 'scaffold'. Rather than prescribing a rigid routine, the resources provided a framework where children could externalise their internal need for predictability. For children like Bob (groups A/B), who used note-passing to regulate during social overwhelm, the planning and coping tools helped him communicate boundaries to adults without the need for verbal negotiation during a crisis. Stakeholders (S6, health professional) highlighted that this 'proactive' rather than 'reactive' stance is crucial for first-line support, as it builds a child's resilience before clinical intervention is accessible.

Fostering well-being, Self-esteem & Acceptance

Participants appreciated that 'neurodiversity affirming' activities (S1, education professional) promoted self-esteem. Rory (group A) demonstrated this by drawing a superhero with traits like 'intelligence' and 'bravery,' while Matthew (group A) valued his ability to 'make my friends laugh.' This affirmed identity and amplified well-being across cohorts.

Overarching theme: Empowering individualised engagement

Across all themes, data demonstrates that the resources fostered empowerment through a non-clinical, co-produced design that prioritises active involvement, affirming language and personal resonance. By removing the requirement of a formal diagnosis, the resources created an accessible entry point for children to explore their cognitive profiles with agency, not anxiety. This empowerment was most visible in how children reframed their internal experiences. For Harrison (group A), the shift from a medicalised view of his energy to a self-defined strengths-based identity was clear: 'I draw like the letter for my first name… [I am] a superhero… I was skinny but I am strong.' This individualised engagement allowed children to bypass the *expert* clinical narrative and instead build a self-concept that felt authentic to them, such as Matthew (group A) valuing his ability to 'make my friends laugh.'

Stakeholders confirmed that this individualisation was the key mechanism for inclusion. S1 (education professional) noted that the 'use of neutral language… fosters inclusion and promotes self-reflection,' while S7 (advocacy professional) observed that the booklets provided a platform for pride, acting as 'a booklet they can be proud of, rather than a plain typed out document that is often used.'

Ultimately, the resources functioned as a 'go-to resource for children and parents that need extra support' (S3, education professional) in the absence of a diagnosis. By enabling families to work as a team, as seen in

Miranda's (group A/B) collaborative note-passing with Bob, the resources provided immediate, first-line support that bridged the gap between internal struggle and social belonging. As Tian (father, group A) summarised, the resources helped his child learn 'what kind of things that [he] can do and let society accept them,' demonstrating that when the barrier of diagnostic gatekeeping is removed, individualised engagement becomes a powerful tool for well-being.

DISCUSSION

This study evaluated the suitability and acceptability of repurposed psychoeducational resources for children and families navigating neurodivergent traits without formal diagnoses. The findings make three original contributions: (1) demonstrating that non-pathologising psychoeducation can support children outside clinical contexts, (2) highlighting the role of affirming language in fostering engagement and belonging, and (3) providing clear implications for mainstream practice and policy. By honing inclusive, non-pathologising language and an engaging co-produced design, the study offers a universal model that does not depend on medical confirmation.

Reflexive thematic analysis revealed that the resources fostered a personal sense of resonance, empowered children to communicate their needs, and equipped families with strategies to navigate everyday challenges. Importantly, these outcomes were achieved without reliance on clinical terminology or diagnostic labels. This highlights the potential for a universal model relevant across school, family and health contexts, providing a framework for support that does not depend on medical confirmation.

Prior studies have demonstrated that psychoeducation can support children with confirmed diagnoses (Powell et al., 2021, 2022, 2024), but few studies have centred the voices of children who show traits but remain undiagnosed. Likewise, much existing material continues to use clinical, deficit-based language. Our findings extend this body of work by evidencing that affirming, strengths-based language is not a superficial adaptation, but a key factor perceived by participants to foster engagement, support identity formation, and promote a sense of belonging. In particular, the use of non-pathologising terms allowed children to see themselves reflected in the materials without the stigma of a deficit-based label, which families identified as a crucial precursor to feeling included within the resource's narrative. In health settings specifically, this model functions as a low-intensity, pre-diagnostic intervention. It empowers families to navigate their child's needs with affirming language during the 'waiting well' period, bridging the gap between initial concern and clinical assessment.

Active participation and the power of engaging design

A central finding was that children engaged most strongly when resources were interactive, visually stimulating, and adaptable to individual preferences. This echoes prior research showing that co-produced materials can foster motivation and participation by making psychoeducation accessible and relatable (Crane et al., 2019; Powell et al., 2021, 2024). Playful design elements did not dilute the seriousness of the content; instead, they acted as enablers of active learning, lowering barriers for children who might otherwise disengage from traditional, text-heavy resources (Austistica, 2024).

Active participation was not limited to children. Families reported that shared activities facilitated collaboration and strengthened relational bonds, consistent with co-production literature highlighting the dual benefits of usability and empowerment (Crane et al., 2019; Powell et al., 2021). This aligns with calls for inclusive pedagogy that prioritises engagement over remediation, particularly for learners with diverse attentional and sensory profiles (Bertilsdotter Rosqvist et al., 2023a; van Heijst & Geurts, 2015).

From a theoretical perspective, the importance of engaging design resonates with neurodiversity-informed approaches which view participation as essential for self-advocacy and well-being (Benton et al., 2014; Chapman & Botha, 2023; Kapp, 2020; Leadbitter et al., 2021). Rather than being passive recipients of information, children became active agents in exploring their own traits and needs. This shift reflects broader moves in education and health research toward participatory, child-centred practices (Botha et al., 2023; van Heijst & Geurts, 2015).

Design cannot be considered an aesthetic afterthought; it is central to accessibility and impact (McKenney & Reeves, 2013; Meyer et al., 2014; Rose & Meyer, 2002). By embedding interactive, co-produced features, psychoeducational tools can catalyse empowerment and strengthen children's capacity to engage meaningfully with their support networks (Armitt et al., 2024; Kapp, 2020).

Harnessing words: A foundational principle of neurodiversity-affirming resources

Language was consistently identified as central in shaping how children engaged with the resources. Participants emphasised that affirming neutral language strongly influenced how the resources were understood and internalised. This reflects wider literature on the role of language in constructing meaning around neurodivergence (Botha et al., 2023; Kapp et al., 2013).

For children, plain and concrete wording supported accessibility, with metaphors and imagery aiding comprehension. This echoes findings that child-friendly, developmentally appropriate phrasing helps to reduce barriers

to understanding complex concepts (Crane et al., 2019; Fletcher-Watson & Happé, 2019; Vygotsky, 1978). Importantly, participants stressed that words should validate lived experience rather than present deficit-based framings, aligning with neurodiversity-affirming practice (Chapman & Botha, 2023; Milton, 2012).

Stakeholders highlighted that resources must be flexible to accommodate different ways children relate to language. For some, identity-first terms (e.g. 'autistic person') supported belonging, while for others, descriptive rather than diagnostic labels felt less stigmatising (Kenny et al., 2016). This tension underscores the need for adaptable materials that allow children to choose and shape words that resonate most with them (Botha et al., 2023; Kapp et al., 2013). Findings therefore reinforce that language is not a neutral vessel but a pedagogical tool whereby words chosen directly affect accessibility, identity formation and emotional responses (Botha et al., 2023; Kapp et al., 2013).

Personal resonance as a mechanism for self-acceptance

Children in both groups often connected most strongly with resource elements they could relate to and they described feeling understood. This sense of resonance appeared crucial for validating their identities and self-acceptance. Prior research suggests that recognition and affirmation of one's own experiences is a cornerstone of positive self-concept for neurodivergent individuals and reduced stigma (Robertson, 2010; Kapp, 2020).

Children actively engaged with the resources, identifying elements that did and did not resonate with their lived experiences, thereby contributing to the co-production process (Pellicano et al., 2014). Importantly, resonance operated differently across contexts: some children highlighted humour or creativity as key entry points, while others valued emotional validation. For ethnic minority families, culturally relevant content was critical to fostering resonance, as generic examples (e.g. celebrity references) were less effective. Such variation underscores the importance of flexible, personalised resources that enable diverse children to see themselves within the material, a process that may support longer-term identity development and self-acceptance (Cage & Troxell-Whitman, 2019; Powell et al., 2025; Robertson, 2010).

Communication as a first-line support tool

Children in the present study frequently emphasised the role of communication, both as something they struggled with and as a potential source of support. They described challenges with being understood by peers or adults but also highlighted that having the right words or metaphors helped them explain their experiences. This aligns with research showing that access to affirming language can empower children to articulate needs, reduce frustration and promote self-advocacy (Leadbitter et al., 2021).

Resources that framed communication in playful or relatable ways such as through metaphors or visual supports appeared particularly effective. This reflects wider evidence that child-friendly, strengths-based approaches to communication foster both engagement and confidence (Ferreira et al., 2024). Importantly, children did not position communication tools as clinical or diagnostic; rather, they saw them as practical, everyday aids for navigating relationships.

Positioning communication as a first-line support therefore avoids the risks of over-pathologising, instead providing children with accessible strategies that fit within their social worlds. By enabling children to express themselves more clearly and be better understood, such tools may act as protective factors for well-being and self-esteem (Cage & Troxell-Whitman, 2019; Ferreira et al., 2024).

Tailoring for growth in a universal design

A key insight from this study was the importance of flexibility in resource design to support children with overlapping traits and varied needs. Participants reported that resources allowing multiple pathways for engagement such as adjustable difficulty levels, optional prompts and diverse visual representations enabled them to interact with the material in ways that suited their individual learning styles and sensory preferences. This reflects principles of Universal Design for Learning (UDL), which advocate for multiple means of representation, action and engagement to accommodate variability in learners (Rose & Meyer, 2002).

By embedding adaptable features, resources can simultaneously provide equitable access and personalised experiences (McKenney & Reeves, 2013; Meyer et al., 2014). For example, some children preferred concrete step-by-step guidance, while others valued exploratory or imaginative activities; the capacity to choose between these approaches enhanced engagement, autonomy and a sense of competence. Similarly, families reported being able to tailor their use of the materials according to home routines, priorities, or the child's current emotional state. These findings illustrate that universal design is not a one-size-fits-all solution but a framework that integrates flexibility with consistent core messages, enabling children to experience both support and empowerment (Meyer et al., 2014; Rose & Meyer, 2002).

Strategies for challenges to enhance well-being

This study highlights the value of resources in equipping children with strategies to navigate everyday challenges,

encompassing both strengths and needs-based approaches. Participants described how materials offered practical techniques for managing behavioural, sensory, and social–emotional difficulties, framing these strategies not as attempts to 'fix' the child but as tools to support thriving in diverse contexts.

Children identified a variety of approaches that aligned with their own coping styles. Some engaged with structured routines or behavioural prompts, while others benefited from sensory regulation tools or creative expression. This aligns with research emphasising proactive, strengths-based strategies in promoting self-regulation, resilience and positive mental health outcomes in neurodivergent populations (Pellicano & den Houting, 2022). By embedding strategies within playful, relatable contexts, the resources reinforced self-efficacy, encouraged experimentation and normalised the use of coping techniques as part of everyday life (Bottema-Beutel et al., 2021).

Importantly, these strategies were perceived as actionable first line supports rather than clinical interventions, providing children with agency to implement techniques independently or collaboratively with caregivers (Bearss et al., 2015). For schools, this suggests that psychoeducational resources can function as a bridge between home and classroom, equipping children with tools to proactively manage challenges while fostering well-being. Overall, the findings support a model in which strength-informed, adaptable strategies operate alongside universal design to enhance resilience, autonomy, and self-confidence in children with diverse neurodevelopmental profiles (Meyer et al., 2014; Pellicano & den Houting, 2022; Taylor et al., 2023).

Practical implications

The findings demonstrate that non-clinical, strengths-based resources can act as first-line, scalable supports for children in mainstream education. Their emphasis on affirming language and shared vocabulary offers a way to empower children and families while reducing reliance on diagnostic gatekeeping. This has direct relevance to current policy debates in the UK, including long waiting lists for autism and ADHD assessments and the Equality Act (2010), which establishes entitlement to reasonable adjustments without a clinical label. Schools and local authorities could integrate similar resources into classrooms and family support pathways, while policymakers could consider commissioning such tools as low-intensity, early interventions to reduce inequities in access to support.

For families

The resources acted as a tool for communication and rapport building. Parents/carers could use non-clinical, affirming language to foster a collaborative approach to coping and emotional regulation (Anderson & Stevenson, 2019; Rajotte et al., 2025). By framing challenges as a shared effort, as one mother noted, it 'felt like we were a team'. Families can also be encouraged to use these resources as a low-pressure way to discuss a child's traits and interests, reinforcing self-worth and reducing stigma (Anderson & Stevenson, 2019; Rajotte et al., 2025).

For schools and educators

Educators can integrate similar resources into mainstream classrooms as a universal support (Alcorn et al., 2024; Cole et al., 2024). The findings demonstrate that the materials' engaging visuals and interactive elements successfully captured the children's attention and made complex ideas accessible. Schools should adopt this proactive, non-pathologising approach to foster empathy and inclusion among mainstream students who do not have a clinical diagnosis. Using a shared vocabulary and affirming language provides psychoeducation that supports both self-understanding and peer understanding, laying foundations for inclusive school cultures (Cook, 2024; van Heijst & Geurts, 2015).

For resource developers and policymakers

This study provides a strong rationale for commissioning similar resources for a broader, non-diagnosed audience. To enhance personal resonance, materials must be culturally relevant and flexible enough for children to see themselves reflected in the content. As the findings show, relatable examples beyond generic celebrity figures are critical (McKenney & Reeves, 2013; Pellicano et al., 2014). Policymakers should consider such resources as first-line low-intensity support, particularly for children on long diagnostic waitlists, empowering them with agency and voice before formal support is in place (NHS England, 2024; NHS England, 2025; Morris, 2024).

For health professionals and clinicians

In health contexts, this model provides a 'waiting well' strategy that can be implemented immediately upon referral. Clinicians can utilise these non-clinical resources to provide immediate support while children remain on years-long diagnostic waitlists. This helps manage parental anxiety and provides clinicians with a common language to discuss a child's profile during eventual assessments. Furthermore, for children who may not meet the full clinical threshold for ADHD or autism, these resources offer a way for health professionals to validate the child's struggles and provide meaningful

'signposting' without requiring a formal label (Hadders-Algra, 2021; Powell et al., 2024).

Strengths and limitations of this study

This study advances understanding of neurodiversity-affirming resources through several strengths. A primary strength is the inclusion of a hard-to-reach but underserved group: children with suspected neurodivergent traits, children who are on diagnostic waitlists or those who choose not to pursue a diagnostic pathway (Nuffield Trust, 2024; Ragan, 2015). By engaging this group, the research directly addresses a significant gap and provides insight into how non-clinical resources can empower children and families (Cook, 2024; Hadders-Algra, 2021). Reflexive thematic analysis of semi-structured interviews yielded rich, in-depth qualitative data, moving beyond outcome metrics to capture lived experience. The triangulation of perspectives across families and professionals further strengthened the credibility and applicability of findings (Braun & Clarke, 2006; Denzin, 2017).

Despite these strengths, limitations remain. Participants were volunteers, likely motivated to engage with neurodiversity topics, creating potential self-selection bias (Braun & Clarke, 2006). The majority of families resided in specific UK regions, which limits its cultural or socioeconomic applicability (Braun & Clarke, 2006; Denzin, 2017). The sample was relatively homogeneous, with low representation from minority ethnic and non-binary groups, and a gender imbalance within the group B family cohort. This constrains understanding of how neurodivergence intersects with other marginalised identities, particularly given under recognition in girls and minority groups (Alcorn et al., 2024; Cole et al., 2024). Finally, this evaluation captures a snapshot in time and cannot provide long-term impact.

A limitation of this study is its reliance on qualitative data rather than a mixed-methods design. However, this was a deliberate choice to provide an in-depth exploration of an under-researched population, undiagnosed children, whose voices are often absent from research. Findings offer rich, contextualised insights that quantitative designs may overlook.

Future research recommendations

Longitudinal studies on sustained impact

Future research should employ longitudinal designs to track long-term impacts on children's well-being, self-efficacy and academic/social outcomes. This would show whether early gains in self-understanding and confidence persist and evolve as children mature (Pellicano & den Houting, 2022; van Heijst & Geurts, 2015).

Investigating intersectionality and demographic diversity

Future research should recruit more diverse participant groups to understand how resources function across ethnicity, gender and socioeconomic backgrounds. Given the documented inequalities in diagnostic access for children from lower socioeconomic backgrounds (Kelly et al., 2017), exploring how neurodiversity-affirming resources can mitigate these disparities remains a priority.

Comparative and contextual research

Comparative studies could assess outcomes of neurodiversity-affirming resources against deficit-based materials or no intervention groups, providing stronger causal evidence. Research should also explore use across different educational systems, including special education and international contexts (Alcorn et al., 2024; Pellicano et al., 2014; Pellicano & den Houting, 2022).

Exploring stakeholder and educator training

Future research could explore how involving educators and professionals in neurodiversity-informed practices enhances, such as through co-production or programme implementation, enhances resource use, professional confidence and child outcomes (Alcorn et al., 2024; Armitt et al., 2024; Fletcher-Watson & Aitken, 2023).

CONCLUSIONS

This study evaluated the suitability and acceptability of two repurposed psychoeducational resources, demonstrating that a neurodiversity-affirming approach supports children without formal diagnoses and their families. Findings, structured around the overarching theme *Empowering Individualised Engagement*, showed how co-produced resources with non-clinical affirming language fostered active participation and created personal resonance by reflecting children's lived experiences. Resources provided shared vocabulary and practical strategies, without reliance on diagnostic labels. Importantly, these findings do not suggest replacing clinical resources or supports for children with a diagnosis, but highlight how inclusive, non-clinical resources can complement them, ensuring that all children have access to affirming and useful tools.

The findings contribute to the field by evidencing a universal, non-clinical model of support that can bridge gaps for children on diagnostic waitlists or with suspected neurodivergent traits. For children in

mainstream settings, these resources serve as a first point of contact, affirming their identity and supporting self-understanding. This research demonstrates that effective support does not require diagnostic labels but instead rests on fostering acceptance and equipping children with tools to engage confidently with their unique cognitive profiles.

In conclusion, this study highlights the transformative potential of thoughtfully designed, neurodiversity-affirming resources. By prioritising relatability, positive framing and practical strategies, these materials offer a scalable and compassionate model of child well-being. They serve not only as aids for individuals, but as catalysts for cultural change in education and beyond, aligning with the broader societal shift toward embracing and celebrating neurodiversity.

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DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

Ethical approval was granted by the University of Leeds School of Psychology ethics committee (ref: 2719) on the 3rd of April 2025. Respondents gave written informed consent for review and signature before interviews.

CONSENT

Written informed consent was obtained from a legally authorised representative for anonymised patient information to be published in this article.

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