When Home Sends Mixed Messages

Neurodivergence, Culture and Intergenerational

Psychological Conflict within Families

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Abstract

Over the past three decades, the neurodiversity paradigm has fundamentally reshaped how the world understands autism, ADHD, dyslexia and other neurological differences. What was once framed almost exclusively as deficit is now increasingly recognised as variation - differences in how human brains are wired, differences that can bring distinctive strengths alongside real challenges. Public awareness has grown considerably, and with it, a more nuanced conversation about what it means to be neurodivergent.

Yet for all that progress, remarkably little attention has been paid to where that conversation matters most: inside the family home.

This white paper explores the psychological consequences that arise when parents and extended family members interpret neurodivergence in conflicting ways. Drawing on practical family support work conducted through The Neuro Pioneer Hub, alongside contemporary research in developmental psychology and cross-cultural studies, it examines how cultural expectations, parental coping strategies and intergenerational beliefs shape the environment in which neurodivergent young people form their sense of who they are.

The paper introduces Double Jeopardy Syndrome, a conceptual framework describing the layered identity pressures experienced by neurodivergent individuals who must navigate not only societal misunderstanding but also culturally embedded family narratives about ability, discipline, reputation and belonging. In multicultural contexts, where neurological differences may be interpreted through lenses that have nothing to do with neuroscience, these pressures can be particularly acute.

Through cross-cultural case studies and empirical research, this paper argues that effective support for neurodivergent individuals must reach well beyond diagnosis. It must extend into the relational dynamics of the family itself, encompassing parental psychological support, family alignment work and culturally informed policy responses.

1. Introduction

For many neurodivergent young people, the most complex challenges they face do not arise in schools or workplaces.

They arise at home.

This is not a comfortable truth. Families are supposed to be the primary environment of emotional safety, the place where a young person first learns that they belong. And most families, in their own way, are trying to provide exactly that. But when a neurodevelopmental diagnosis — autism, ADHD, dyslexia, or any combination — enters the household, it can quietly destabilise the stories a family has been telling itself about ability, parenting and what a good life is supposed to look like.

Through practical work undertaken via The Neuro Pioneer Hub, a recurring and deeply human pattern has emerged across families from all kinds of cultural backgrounds. Parents frequently interpret a neurodivergent diagnosis through different emotional and cultural lenses and those differences do not always resolve neatly.

One parent may embrace the diagnosis as a framework for understanding their child more fully. They may engage with the neurodiversity movement, seek out specialist educational support, read voraciously, and begin to recognise the real strengths that sit alongside their child's challenges. The diagnosis becomes, for this parent, something close to relief, a way of making sense of years of observations that never quite had a name.

The other parent may experience the diagnosis very differently. Concerns about stigma, about what people will say, about how the label might narrow their child's future — all of these can make the diagnosis feel not like an explanation, but like a sentence. This parent is not in denial out of cruelty. They are frightened. And their fear often has deep roots in their own upbringing, their community, and the cultural narratives they have internalised about what it means to succeed.

Neither reaction reflects a lack of love. Both, in almost every case, stem from a genuine and often overwhelming concern about the child's wellbeing.

But here is what is so often missed: when these two interpretations coexist under the same roof, the neurodivergent young person receives conflicting signals about something far more fundamental than their diagnosis.

They receive conflicting signals about their identity.

For adolescents and young adults who are already navigating the turbulence of identity formation and already trying to work out who they are and where they fit, these contradictions can produce profound emotional strain. The home, rather than being a shelter from the world's confusion, becomes another arena in which they must perform, translate and adapt.

This paper examines how and why these family dynamics develop, what they cost, and what can be done to shift them. Because if we are serious about supporting neurodivergent young people, we cannot only reform schools, workplaces and public policy. We have to be willing to look at what happens behind the front door.

2. Literature Review

2.1 The neurodiversity paradigm

The concept of neurodiversity emerged from autistic self-advocacy movements in the late twentieth century. Singer (1999) argued that neurological differences should be understood as natural variations within the human population rather than solely as disorders requiring correction, a proposition that was, at the time, quietly radical.

What Singer was really saying, in essence, was that the human brain does not come in a single correct configuration. There is no neurological gold standard against which all other minds should be measured. Subsequent scholars built on this foundation, emphasising the importance of recognising both the strengths and the real challenges that accompany neurodivergent profiles (Armstrong, 2010; Milton, 2012). The double empathy problem, as Milton described it, reframed social difficulties not as one-sided deficits but as mutual misunderstandings between different cognitive styles.

Research has consistently shown that neurodivergent individuals who develop a positive sense of identity, who come to understand their neurological profile as a legitimate part of who they are rather than something to be ashamed of experience improved psychological wellbeing and reduced internalised stigma (Kapp et al., 2013; Botha & Frost, 2020).

But identity does not develop in a vacuum. It is shaped, sometimes gently and sometimes brutally, by the social feedback a person receives from the people closest to them: family members, peers and the institutions they move through. A young person can read every empowering blog post about neurodiversity in the world, and it will still struggle to take root if the people around their kitchen table are telling a different story.

2.2 Parenting stress and adaptation

Parents of neurodivergent children frequently experience elevated levels of psychological stress, and it would be dishonest to pretend otherwise.

Hayes and Watson (2013) conducted a meta-analysis demonstrating significantly higher stress levels among parents of autistic children compared with parents of neurotypical children. This is not a failure of character. Parenting is already one of the most demanding things a human being can do. When a child's needs diverge from what a parent expected, planned for or feels equipped to handle, the emotional toll can be considerable.

Yet stress alone does not determine how a family responds to neurodivergence. What matters far more is how that stress is interpreted and metabolised.

Gray (2003) found that parents frequently adopt divergent coping strategies following a diagnosis. Some respond by actively seeking information, joining support networks and reframing their child's differences as part of a broader cognitive profile. Others respond through avoidance, minimisation or quiet reinterpretation of what the diagnosis means, perhaps telling themselves it is a phase, an overreaction by professionals, or something that willpower and discipline can overcome.

Neither strategy is inherently wrong. But when two parents within the same household adopt fundamentally different approaches, the result is an inconsistent narrative about what the diagnosis means, what the child should expect from themselves, and what kind of future is possible. The child, caught between these two narratives, must somehow reconcile them or, more often, learn to perform a different version of themselves depending on which parent is in the room.

2.3 Masking and psychological wellbeing

This brings us to one of the most important and, until recently, most overlooked phenomena in neurodivergence research: masking, sometimes referred to as social camouflaging.

Hull et al. (2017) found that autistic individuals frequently modify their behaviour, suppress natural responses and rehearse social scripts in order to meet the expectations of those around them. Masking is not simply "pretending to be normal". It is an exhausting, moment-by-moment act of self-surveillance, requiring the individual to monitor their own gestures, tone, eye contact and timing, all while trying to participate in the very interaction being so carefully performed.

While masking may facilitate short-term social integration, its long-term costs are severe. Cassidy et al. (2020) found strong associations between sustained masking and increased anxiety, depression and emotional exhaustion. The effort required to maintain the performance drains cognitive resources that could otherwise be directed toward genuine engagement, creative work or simply resting.

What is particularly significant for this paper is where masking often begins.

It does not always start in the school playground or the office. For many neurodivergent individuals, the very first audience they learn to perform for is their family. When certain aspects of a young person's natural behaviour are met with discomfort, correction or silence, even well-intentioned silence, they learn with remarkable speed that parts of who they are, need to be hidden in order to maintain belonging.

This is the quiet cost that rarely appears in clinical literature. The mask is fitted at home, long before the world demands it.

3. Methodology

The insights presented in this paper draw upon family support work undertaken through The Neuro Pioneer Hub, which works with families, educators and organisations to support neurodivergent individuals across diverse cultural contexts.

The case studies presented here are anonymised composite narratives derived from multiple real family engagements. Identifying details have been modified to protect confidentiality while preserving the underlying relational dynamics observed. These are not individual stories, but they are truthful patterns: distillations of what emerges, again and again, across different families, cultures and circumstances.

This qualitative approach reflects established research practices in psychology and sociology, where case studies are used not to prove universal laws but to illuminate lived experiences and inform conceptual frameworks. The value of this method lies in its capacity to capture the texture of human experience in ways that quantitative data alone cannot reach.

4. Culture, Reputation and the Interpretation of Difference

Family responses to neurodivergence are never culturally neutral. They are deeply shaped by the frameworks through which behaviour, ability and identity are understood within a given community.

Cross-cultural psychology research has long demonstrated that societies differ significantly in how they interpret individual behaviour (Markus & Kitayama, 1991). In more individualistic societies, broadly speaking those shaped by Western liberal traditions, behavioural differences tend to be interpreted as personal characteristics. A child who thinks differently may be seen as quirky, gifted or eccentric. The emphasis falls on the individual.

In collectivist cultures, the interpretive lens is different. Behaviour is understood not only as an expression of the individual but as a reflection of the family, the community, the lineage. A child's conduct carries symbolic weight far beyond what an individualistic framework would assign to it. Success and failure are shared. Reputation is communal. And a diagnosis, particularly one carrying any trace of stigma, does not attach only to the child. It attaches to the family name.

This distinction has profound implications for how neurodivergence is received within households.

A diagnosis may be interpreted not simply as a neurological explanation but as something that reflects upon the family itself: its parenting, its genes, its standing within the community. Recent research examining stigma surrounding autism confirms that concerns about social reputation remain widespread across cultures (Turnock et al., 2022). In some contexts, a diagnosis may be experienced by parents less as clinical information and more as a social verdict.

These dynamics are not exclusive to any single culture. They exist on a spectrum, and they manifest differently in different communities. But the pattern is remarkably consistent: where academic success carries significant symbolic meaning, where a family's worth is partly measured by the achievements of its children, a neurodevelopmental diagnosis can feel like a threat to something much larger than the child's educational pathway.

The result, too often, is concealment. Families minimise or hide diagnoses. Parents avoid using clinical language. Extended family members are told vague stories, or nothing at all. And the young person, observing all of this, absorbs a devastating message: there is something about me that cannot be spoken aloud.

5. Intergenerational Influence: Grandparents and Extended Family

In many families, the most powerful voices do not belong to the parents.

Grandparents, aunts, uncles and other extended family members frequently play a significant role in shaping the narratives that govern family life. In cultures where elders are accorded particular respect, and in diasporic communities where the extended family remains tightly woven into daily life, their views may carry an authority that rivals or exceeds that of the parents themselves.

This can be a source of great strength. Intergenerational closeness provides children with a rich sense of belonging, continuity and identity. But when a neurodevelopmental diagnosis enters the picture, generational differences in understanding can create painful tensions.

Many of today's grandparents grew up in contexts where autism, ADHD and dyslexia were rarely, if ever, diagnosed. Behavioural differences were interpreted through entirely different frameworks, frameworks built around discipline, willpower, personality and sometimes moral judgement. A child who struggled to concentrate was lazy. A child who did not make eye contact was rude. A child who could not sit still needed firmer boundaries.

These frameworks were not invented out of malice. They were the product of a particular historical moment, a particular understanding of human development. But they persist. And when grandparents carry these views into the present, they may dismiss a diagnosis as an unnecessary label, as modern overthinking, or as an excuse.

> *Importantly, such views frequently coexist with deep, genuine affection for the child. A grandmother who adores her grandson can simultaneously refuse to accept his diagnosis. This combination of love and invalidation, of warmth and erasure, creates a confusing emotional environment that is extraordinarily difficult for a young person to navigate.*

The young person knows they are loved. They also know that a fundamental part of who they are is being denied. And they have no language, no framework, no permission to name that contradiction.

6. Case Studies from Practical Family Support Work

Marcus – British-Caribbean family

Marcus was diagnosed with autism at eleven.

His father embraced the diagnosis almost immediately. He recognised in it an explanation for years of observations: Marcus's extraordinary focus on engineering and design, his intensity when absorbed in a project, and his difficulty with the unpredictable social dynamics of secondary school. For his father, the diagnosis was not a limitation. It was a lens that finally brought his son into sharper focus.

Marcus's mother responded differently, though no less lovingly. Within her extended family, autism was rarely discussed openly. There was no hostility toward the concept, simply an absence of language for it. She worried about what the diagnosis might mean for Marcus's future, for how he would be perceived, for what doors it might close before he ever had the chance to reach them.

Marcus's grandmother adored him. She would tell anyone who would listen about his cleverness, his gentle nature, his beautiful drawings. But she dismissed the diagnosis entirely. "He's just a quiet boy who thinks too much," she would say, with complete confidence and complete affection.

By the age of sixteen, Marcus described feeling as though he carried three different identities depending on which family member he was with. With his father, he could be openly autistic. With his mother, he sensed that the topic made her anxious, so he softened it. With his grandmother, he performed a version of himself that had no diagnosis at all.

This is a phenomenon commonly observed in family systems theory: individuals adapt their behaviour and self-presentation to maintain emotional stability across different relational environments. It is, in a sense, a survival strategy. But over time, such identity compartmentalisation exacts a significant psychological toll. The effort of maintaining multiple selves produces anxiety, emotional fatigue and a growing uncertainty about which version of oneself is real.

Arjun – British-Indian family

Arjun was diagnosed with ADHD at nine.

His mother, an educator herself, recognised many of his behaviours as expressions of curiosity and creative energy. She had read widely, attended workshops, and understood that ADHD was not a character flaw. She saw in Arjun a mind that moved

quickly, made unexpected connections and grew restless when under-stimulated, qualities she believed the right environment could channel into genuine strengths.

His father initially struggled with the diagnosis. He had grown up in a family where academic achievement was not simply valued. It was the primary currency of respect, belonging and future security. The idea that his son had a named condition that might affect concentration and academic performance felt like a verdict on Arjun's potential and, at some deeper level, on his own adequacy as a parent.

Arjun's paternal grandparents reinforced this unease. In their view, what Arjun needed was not a diagnosis but discipline, structure and higher expectations. They spoke of cousins who had done well, of their own childhoods marked by hardship and focus. The implicit message was clear: the family had always found a way through difficulty. A label was not the way.

For Arjun, these conflicting narratives created a particular kind of uncertainty, one that no amount of information could resolve, because the conflict was not about facts. It was about belonging. He was caught between two versions of what his ADHD meant: his mother's version, in which it was a legitimate neurological difference that could coexist with success, and his father's and grandparents' version, in which it was a weakness that should be overcome through effort and willpower. Arjun could not hold both without fracturing.

Daniel – Malaysian Chinese family

Daniel was diagnosed with dyslexia after years of struggling with reading.

His mother accepted the diagnosis quickly and with visible relief. She had watched Daniel's distress build year by year, had seen the gap between his obvious intelligence, evident in his art, his robotics projects, his sharp spatial reasoning, and his anguish when confronted with text on a page. The diagnosis gave her something she had been desperately seeking: an explanation that did not require her son to be lazy or stupid.

His father's response was more guarded. In the world he understood, academic performance was the gateway to everything that mattered: professional standing, financial security, family pride. A diagnosis of dyslexia felt less like an explanation and more like a foreclosure. He did not reject it outright, but he struggled to integrate it into his understanding of who Daniel could become.

Daniel's grandparents, who remained integrally involved in the family's daily life, added another layer. They praised Daniel's intelligence, for they could see it plainly, but dismissed dyslexia as an excuse for poor study habits. In their generation, the

explanation for reading difficulty was straightforward: the child was not trying hard enough.

As a result, Daniel began hiding his reading difficulties when visiting his grandparents. He would avoid situations where he might be asked to read aloud. He developed elaborate strategies for concealing what he experienced as a shameful secret, not because anyone had told him to be ashamed, but because the emotional logic of his family had taught him that this part of himself was not welcome.

> *"I realised my fear wasn't about my son's autism. It was about how I thought the world would judge him, and judge me." — Parent reflection during a counselling session.*

7. Double Jeopardy Syndrome: A Theoretical Framework

The experiences described in the case studies above are not isolated. They reflect a pattern that recurs across families, cultures and diagnostic categories. The concept of Double Jeopardy Syndrome provides a framework for understanding why these patterns emerge, how they operate, and what they cost.

This section sets out the theoretical foundations of Double Jeopardy Syndrome, its relationship to existing scholarship, and the mechanisms through which it produces its effects. It then illustrates those mechanisms with empirical evidence and case study examples drawn from the family support work of The Neuro Pioneer Hub.

7.1 Theoretical origins

The concept of double jeopardy has a long history in social science. The term was first applied by Beal (1970) to describe the compounded disadvantage experienced by Black women in the United States, who faced both racial discrimination and gender inequality simultaneously. Critically, Beal argued that these two forms of disadvantage did not simply exist in parallel. They interacted, producing a form of marginalisation that was qualitatively different from either dimension alone.

Crenshaw (1989) formalised this insight through her theory of intersectionality, demonstrating that systems of oppression do not operate independently but overlap and reinforce one another. Intersectionality has since been applied across a wide range of contexts, including disability studies, migration research and mental health scholarship.

Within the field of neurodivergence specifically, scholars have begun to examine how neurological difference intersects with other dimensions of identity. Botha and Frost (2020) applied minority stress theory to the autistic population, arguing that autistic

individuals experience chronic stress arising from their marginalised position within neurotypical society, and that this stress is compounded when other minority identities are present. Lai et al. (2020) noted that co-occurring mental health difficulties among autistic individuals are shaped not only by neurology but by social context, including cultural attitudes and family dynamics.

Double Jeopardy Syndrome builds on this body of work but makes a specific and, to the author's knowledge, novel contribution. It focuses not on the intersection of neurodivergence with broad demographic categories such as race or gender, but on the intersection of neurodivergence with the culturally embedded family narratives through which a young person's identity is first formed. It locates the site of compounded pressure not in society at large, but in the relational environment of the home.

7.2 Defining Double Jeopardy Syndrome

Double Jeopardy Syndrome describes the layered identity pressures experienced by neurodivergent individuals who must navigate two distinct but interacting systems of misunderstanding simultaneously.

The first system is societal. Neurodivergent individuals encounter stigma, stereotypes, institutional barriers and the daily friction of moving through educational, professional and social systems designed for neurotypical minds. This dimension is well documented in existing literature (Milton, 2012; Pellicano & den Houting, 2022).

The second system is familial and cultural. Within the home, the meaning of a neurodevelopmental diagnosis is not fixed. It is interpreted through the cultural frameworks, generational beliefs, and emotional responses of each family member. In multicultural and diasporic families, these frameworks may include expectations around discipline, academic success, family reputation and conformity to culturally embedded definitions of a good life.

The defining feature of Double Jeopardy Syndrome is that these two systems do not merely coexist. They interact, compound and amplify one another, producing a form of identity pressure that is qualitatively different from either dimension experienced in isolation.

Table 1: The Two Pressure Systems of Double Jeopardy Syndrome

Dimension	Sources of Pressure	Experienced As
Societal misunderstanding	Stigma, stereotypes, institutional exclusion, neurotypical social norms,	*"I am deficient. I do not belong in the world as it is."*

	diagnostic labelling, media misrepresentation	
Cultural and family narratives	Discipline expectations, academic pressure, family reputation, intergenerational beliefs, concealment norms, communal definitions of success	*"I am a disappointment. I do not belong in my family as they understand it."*
Double Jeopardy (compound effect)	Societal stigma reinforces family concealment; family concealment reinforces internalised stigma; neither system validates the full identity	*"There is nowhere I can be fully myself."*

7.3 The interaction mechanism: how the pressures compound

The critical distinction between Double Jeopardy Syndrome and a simple additive model of disadvantage lies in the interaction between its two dimensions. The societal and familial pressures do not merely accumulate. They create feedback loops that intensify both.

Consider the following dynamic, which recurs across the case studies presented in this paper.

A neurodivergent young person experiences stigma or misunderstanding at school. They return home seeking reassurance. But the home environment is itself divided. One parent offers validation; the other, shaped by cultural frameworks that interpret the diagnosis differently, offers a competing narrative. The young person cannot fully access the validation being offered by one parent, because the other parent's response undermines it. Meanwhile, the external stigma they experienced at school is reinforced by the family's own ambivalence.

The result is a closed loop. External stigma drives the need for family acceptance. Family ambivalence prevents full acceptance. The absence of full acceptance increases vulnerability to external stigma. And the cycle continues.

Figure 1: The Double Jeopardy Feedback Loop

SOCIETAL STIGMA AND MISUNDERSTANDING
Stereotypes, exclusion, institutional barriers, neurotypical social norms

▼ Young person seeks reassurance at home ▼
FAMILY ENVIRONMENT: DIVIDED NARRATIVES *Parent A validates | Parent B minimises or reinterprets | Grandparents dismiss*
▼ Partial validation is undermined by competing narratives ▼
NEURODIVERGENT IDENTITY UNDER PRESSURE *Identity fragmentation, masking, internalised shame, loss of authentic self*
▼ Increased vulnerability to external stigma ▼
↻ **CYCLE REINFORCES** ↻ *External stigma drives need for acceptance; family ambivalence prevents it; vulnerability increases*

7.4 Empirical evidence supporting the framework

While Double Jeopardy Syndrome is presented here as a new conceptual framework, its constituent elements are well supported by existing empirical research.

Minority stress and neurodivergence

Botha and Frost (2020) extended Meyer's (2003) minority stress model to the autistic population, demonstrating that autistic individuals experience chronic psychological stress arising from their marginalised social position. Their study found that experiences of everyday discrimination, expectations of rejection and internalised stigma were each independently associated with poorer mental health outcomes. Crucially, they found that these stressors were cumulative: the more minority stress dimensions an individual experienced, the greater the impact on their wellbeing.

This finding directly supports the additive dimension of Double Jeopardy Syndrome. But it does not fully capture the interaction effect that the present framework describes, because it does not account for the specific role of family dynamics in mediating or amplifying that stress.

Masking, family context and mental health

Cassidy et al. (2020) found strong associations between sustained masking and increased rates of anxiety, depression and suicidal ideation among autistic adults. Hull et al. (2017) demonstrated that masking is not a binary behaviour but a spectrum of strategies including compensation, assimilation and concealment, each carrying distinct psychological costs.

What is particularly relevant for Double Jeopardy Syndrome is the finding, reported by Livingston and Happé (2017), that masking behaviours are shaped by social context. Individuals mask more in environments where they perceive their authentic behaviour

to be unwelcome. The family home, when it sends mixed messages about neurodivergence, precisely becomes such an environment, and does so at the developmental stage when identity is most malleable.

Cultural stigma and diagnostic concealment

Turnock et al. (2022) conducted a systematic review of autism stigma and found that concerns about social reputation were a primary driver of diagnostic concealment across cultures. Families in collectivist societies were particularly likely to minimise or hide diagnoses, driven by concerns about family honour, community standing and marriage prospects for the diagnosed individual or their siblings.

Markus and Kitayama's (1991) foundational work on independent versus interdependent self-construal's provides the theoretical grounding for why this pattern is culturally specific. In societies where the self is understood as fundamentally relational, where identity is defined in terms of one's connections to and responsibilities toward others, a diagnosis that carries stigma does not attach solely to the individual. It radiates outward across the family system.

Parenting stress and divergent coping

Hayes and Watson (2013) demonstrated elevated stress among parents of autistic children, while Gray (2003) showed that parents within the same household frequently adopt divergent coping strategies following a diagnosis. Karst and Van Hecke (2012) found that family-centred interventions significantly improved both parental coping and child outcomes, supporting the argument that the family system, rather than the individual child, is the appropriate unit of intervention.

Taken together, these findings provide robust empirical support for each component of the Double Jeopardy Syndrome framework. What the framework adds is a model for how these components interact within the specific relational context of the family home.

7.5 Illustrating the framework: case study evidence

The case studies presented in Section 6 of this paper offer concrete illustrations of how Double Jeopardy Syndrome operates in practice. Each case demonstrates the interaction mechanism described above, though the specific cultural dynamics differ.

Marcus: identity compartmentalisation as a survival strategy

Marcus, diagnosed with autism at eleven within a British-Caribbean family, described carrying three different identities depending on which family member he was with. This is a textbook illustration of Double Jeopardy Syndrome in operation. The societal dimension was present in his difficulty with the social dynamics of secondary school.

The family dimension was present in the conflicting responses of his father (acceptance), his mother (anxious ambivalence) and his grandmother (loving dismissal). The compound effect was Marcus's progressive identity fragmentation: he could not be fully himself in any single context, because no single context acknowledged all of who he was.

By sixteen, Marcus reported that he was unsure which version of himself was real. This is the hallmark outcome of Double Jeopardy Syndrome: not simply stress, not simply masking, but a fundamental uncertainty about one's own identity, produced by the interaction of external stigma and internal family contradiction.

Arjun: when the conflict is about belonging, not facts

Arjun, diagnosed with ADHD at nine within a British-Indian family, illustrates a subtly different mechanism. His mother offered a clear, informed understanding of ADHD as a neurological difference compatible with success. His father and paternal grandparents offered an equally clear, culturally grounded understanding of it as a weakness to be overcome through discipline.

The critical insight from Arjun's experience is that the conflict was not resolvable through information alone. His mother's evidence-based understanding and his grandparents' experience-based understanding were not competing on the same terms. They were operating from different frameworks of meaning. For Arjun, the resulting pressure was not cognitive but existential. Accepting his mother's narrative meant implicitly rejecting his grandparents' worldview. Accepting his grandparents' narrative meant denying his own neurological reality. There was no position from which he could honour both without splitting himself.

Daniel: concealment as the logical response to family ambivalence

Daniel, diagnosed with dyslexia within a Malaysian Chinese family, demonstrated a third variant of the syndrome. His concealment of reading difficulties when visiting his grandparents was not an irrational response. It was a perfectly logical adaptation to an environment in which one part of his identity was welcomed (his intelligence, his creativity) while another part (his neurological difference) was denied.

Daniel's case illustrates a particularly important feature of Double Jeopardy Syndrome: the young person's response to the contradictory environment is often invisible to the family itself. Daniel's grandparents did not know he was hiding. His parents may not have fully appreciated the extent of his concealment. The damage occurred quietly, in the gap between what the family believed it was communicating and what Daniel actually received.

Figure 2: Spectrum of Family Responses and Their Impact on Neurodivergent Identity

UNIFIED DENIAL	DIVIDED NARRATIVES	SHARED UNDERSTANDING
All family members reject or minimise the diagnosis. The young person receives a consistent but invalidating message.	Family members hold conflicting views. The young person receives contradictory messages and must fragment their identity.	Family members develop a shared, evolving understanding. The young person can be themselves without performing for different audiences.
Impact: Internalised shame, suppressed identity, withdrawal	**Impact:** Identity fragmentation, chronic masking, anxiety, relational exhaustion	**Impact:** Integrated identity, reduced masking, improved wellbeing, stronger family bonds
DJS RISK: HIGH	**DJS RISK: HIGHEST**	**DJS RISK: LOW**

Figure 2 illustrates an important and perhaps counterintuitive finding from family support work. The highest risk of Double Jeopardy Syndrome is not found in families where every member denies the diagnosis. While unified denial is harmful, it at least provides a consistent environment. The young person knows where they stand, even if where they stand is invalidating.

The greatest risk occurs in families with divided narratives, precisely because the young person is caught between competing versions of reality. They cannot commit to either narrative without betraying the other. The result is not simply confusion but the active fragmentation of identity, as the individual learns to present different versions of themselves to different audiences within the same household.

7.6 The compounding role of intersecting identities

Double Jeopardy Syndrome does not operate in a demographic vacuum. Its severity is influenced by additional dimensions of identity, including ethnicity, socioeconomic status, gender, migration history and religious background.

A neurodivergent young person in a diasporic family, for example, may already be navigating the tension between their parents' culture of origin and the culture of the society in which they are growing up. The addition of a neurodevelopmental diagnosis introduces a third layer of identity negotiation. The young person must now reconcile not two but three frameworks: the cultural expectations of their heritage community,

the social norms of their country of residence, and the neurological reality of their own mind.

Gender adds further complexity. Research suggests that neurodivergent girls and women are significantly underdiagnosed compared with their male counterparts (Mandy, 2019), and that they engage in higher levels of masking (Lai et al., 2020). In family environments where gendered expectations around behaviour, compliance and emotional regulation are particularly strong, the pressure on a neurodivergent girl to conceal her differences may be compounded by the expectation that she should simply cope.

Socioeconomic factors shape access to diagnosis, to post-diagnostic support, and to the specialist services that might help families develop shared understanding. Families without access to these resources are more likely to be left to navigate the tensions of neurodivergence using only the cultural frameworks available to them, frameworks that may not include any concept of neurological variation as a legitimate category of difference.

7.7 Implications of the framework

Double Jeopardy Syndrome has several implications for how support is designed, delivered and evaluated.

First, it argues that interventions targeting only the societal dimension of neurodivergent disadvantage, such as awareness campaigns, workplace adjustments and anti-stigma programmes, will always be insufficient if the family dimension remains unaddressed. A young person who receives validation at school but contradiction at home cannot integrate their identity. The external support is undermined by the internal environment.

Second, it argues that interventions targeting only the family dimension, such as parent education programmes, will be insufficient if the structural barriers that reinforce stigma are left intact. A family that develops internal understanding but continues to encounter societal prejudice may retreat into concealment as a protective strategy, reactivating the very dynamics the intervention sought to resolve.

Third, it suggests that the most effective interventions will be those that address both dimensions simultaneously: working with families to develop shared understanding while also advocating for structural changes in education, healthcare and employment that reduce the stigma families are responding to.

Fourth, it highlights the importance of culturally informed practice. The family narratives that contribute to Double Jeopardy Syndrome are not irrational. They are the product of specific cultural histories, community expectations and generational

experiences. Interventions that dismiss or pathologise these narratives will fail. Effective practice must engage with them respectfully, helping families to integrate their child's neurological reality into the values they already hold, rather than asking them to abandon those values.

> *Effective support must hold both layers in view. It must work simultaneously on the external conditions that produce stigma and the internal family dynamics that determine whether a young person can come home and breathe.*

8. Why Parental Counselling Transforms Family Dynamics

The previous section introduced Double Jeopardy Syndrome as a framework for understanding the layered identity pressures experienced by neurodivergent individuals in families with divided narratives. The question that follows naturally is: what breaks the cycle?

The answer, consistently observed across family support work conducted through The Neuro Pioneer Hub, is parental counselling. Not counselling for the child. Counselling for the adults.

This section examines why parental counselling is so effective, how it relates to the mechanisms of Double Jeopardy Syndrome described in Section 7, and what it looks like in practice across different cultural contexts. It also considers the limitations of current provision and the conditions under which counselling is most likely to produce lasting change.

8.1 The counterintuitive logic of parental intervention

When a child receives a neurodevelopmental diagnosis, the instinct of most professionals and most families is to focus intervention on the child. This instinct is understandable. The child is the one who has been diagnosed. The child is the one who is struggling. The child, it seems, is the one who needs help.

But this instinct, however well-intentioned, rests on a fundamental misunderstanding of where the difficulty actually lies.

In many cases, the child is not the one who most urgently needs support. The child already knows who they are. They may not have the language for it, and they may not yet understand the clinical category into which their experience falls, but at a felt level, they know how their mind works. They know what comes easily and what does not. They know when they are pretending and when they are being themselves.

It is the adults around them who are struggling to make sense of what they are seeing. And it is the adults' struggle, not the child's neurodivergence, that most often determines whether the home becomes a place of safety or a place of performance.

This distinction is critical for understanding how parental counselling relates to the Double Jeopardy Syndrome framework. As Section 7 demonstrated, the compound identity pressure experienced by neurodivergent young people is produced not by their neurodivergence alone, but by the interaction between societal stigma and the divided narratives within their family. Parental counselling intervenes directly at the family narrative level. It does not eliminate societal stigma, but it can transform the internal

family environment from one that amplifies that stigma into one that buffers against it.

8.2 What happens inside the family when a diagnosis arrives

A diagnosis often triggers a cascade of complex emotional responses in parents. These responses are rarely simple and almost never uniform between partners. Understanding their texture is essential for understanding why counselling works.

Grief

Many parents experience something resembling grief following a diagnosis. This is not grief for the child they have. It is grief for the imagined future they had constructed, often unconsciously, from the moment that child was born. The future in which their son would follow them into the family profession. The future in which their daughter would achieve the academic success that had been the family's measure of worth for generations. A diagnosis can shatter these imagined futures in an instant, and the grief that follows is real, even if the child standing in front of them is unchanged.

Worden's (2009) model of grief tasks is instructive here. Parents must accept the reality of the diagnosis, process the pain of the loss of imagined futures, adjust to a world in which their child's trajectory looks different from what they expected, and find a way to emotionally relocate the future they had imagined while remaining fully invested in the child they actually have. Without support, many parents stall at the first or second task: they either deny the reality of the diagnosis or become trapped in the pain of what they perceive as having been lost.

Guilt

Guilt is pervasive and takes multiple forms. Some parents experience genetic guilt, wondering whether they passed on the neurological difference. Others experience diagnostic guilt, asking themselves whether they should have noticed earlier, whether they missed signs, whether years of struggle could have been prevented by earlier identification. Still others experience parenting guilt, questioning whether their approach to discipline, schooling or emotional support caused or worsened their child's difficulties.

These forms of guilt are rarely rational, but they are deeply felt. And when they are not addressed, they can calcify into one of two destructive patterns: overcompensation, in which the parent becomes excessively protective or indulgent in an attempt to atone, or withdrawal, in which the parent distances themselves emotionally from the diagnosis because the guilt associated with it is too painful to bear.

Fear

Fear is perhaps the most powerful and least acknowledged of the parental responses. Parents fear for their child's future: will they be able to hold a job, form relationships, live independently? Parents fear social judgement: what will the extended family think? What will the community say? In cultures where family reputation is communal, this fear can be overwhelming, because the diagnosis is experienced not as a private matter but as a public exposure.

This fear maps directly onto the cultural and family narrative dimension of Double Jeopardy Syndrome. When a parent's primary emotional response to a diagnosis is fear of social judgement, they are far more likely to adopt a strategy of minimisation or concealment. This strategy, in turn, sends the young person the message that their neurodivergence is something to be hidden, reinforcing the very internalised stigma that makes them vulnerable to societal misunderstanding.

Confusion and information overload

Many parents describe feeling overwhelmed by the volume of information that follows a diagnosis. Clinical terminology, educational pathways, therapeutic options, medication decisions, legal rights, support services: all of this arrives at a moment when the parent is least emotionally equipped to process it. The result is often decision paralysis or, alternatively, the seizing upon one particular interpretation of the diagnosis that offers the most psychological comfort, regardless of whether it is the most accurate or helpful.

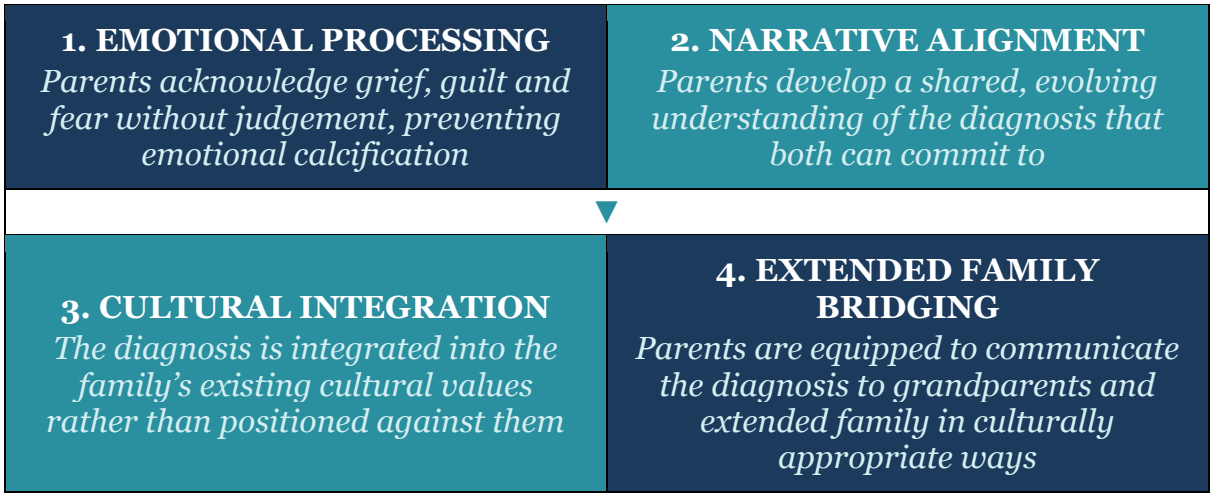
Gray's (2003) research on divergent coping strategies within families becomes particularly relevant here. The parent who responds to confusion by immersing themselves in information may arrive at a very different understanding of the diagnosis from the parent who responds to confusion by seeking reassurance from their own parents or community. Both are coping. Neither is wrong. But the gap between their two positions is the gap in which the child's identity becomes contested.

8.3 How counselling interrupts the Double Jeopardy cycle

The Double Jeopardy feedback loop described in Section 7 operates through a specific mechanism: societal stigma drives the need for family acceptance; family ambivalence prevents full acceptance; the absence of full acceptance increases the young person's vulnerability to societal stigma; and the cycle continues.

Parental counselling interrupts this cycle at the family ambivalence stage. It does so through four interconnected processes.

Figure 3: How Parental Counselling Interrupts the Double Jeopardy Cycle



Process 1: Emotional processing

Counselling provides parents with a space in which they can acknowledge their own emotional responses without judgement. A father can say, "I am terrified that my child will be left behind," without being told he is wrong. A mother can say, "I don't know how to explain this to my own parents," without being made to feel inadequate.

This is not a therapeutic luxury. It is a structural necessity. Without a safe space to process grief, guilt and fear, these emotions calcify into fixed positions: denial, overprotection, excessive pressure or emotional withdrawal. These positions, once established, shape everything: how the parent speaks about the diagnosis, what language is used at home, whether the child feels permission to be themselves, and what version of the future the family imagines.

The connection to Double Jeopardy Syndrome is direct. The "divided narratives" that produce the highest risk of DJS (see Figure 2, Section 7) are, in many cases, the product of unprocessed parental emotion. One parent has processed their grief and arrived at acceptance. The other has not. The gap between them is not a gap of information. It is a gap of emotional readiness. Counselling closes that gap.

Process 2: Narrative alignment

Once parents have processed their individual emotional responses, counselling can facilitate the development of a shared narrative about what the diagnosis means for the family. This does not require perfect agreement. It requires a commitment to an evolving conversation in which both parents are oriented in the same direction, even if they are at different points along the journey.

Bowen's (1978) family systems theory is relevant here. Bowen argued that families operate as emotional units, and that anxiety within the system is transmitted between members through predictable patterns. When parents hold conflicting narratives about a diagnosis, the anxiety associated with that conflict is transmitted to the child,

who absorbs it as uncertainty about their own identity. Narrative alignment reduces the anxiety in the system by giving the family a coherent story to tell, both to themselves and to the young person.

Research by Karst and Van Hecke (2012) supports this analysis. Their review of family-centred interventions found that programmes which treated the family as a system, rather than focusing solely on the diagnosed individual, produced significantly better outcomes for both parental wellbeing and child adjustment. The mechanism, they suggested, was precisely this narrative alignment: when parents shared a coherent understanding of the diagnosis, the home environment became more predictable, more emotionally stable, and more supportive of the child's developing identity.

Process 3: Cultural integration

This is perhaps the most delicate and most important process, and it is the one most frequently neglected in existing provision.

For many families, particularly those from collectivist cultural backgrounds, the difficulty with a diagnosis is not a lack of information about the condition itself. It is the perceived incompatibility between the diagnosis and the family's cultural values. A father who prizes academic excellence does not need to be told that ADHD exists. He needs help to see that his son's ADHD is not an obstacle to excellence but a different pathway toward it. A grandmother who expresses love through high expectations does not need to be educated about neurodiversity. She needs help to understand that her grandchild's brain works differently, and that the expectations she holds can be met in ways she may not yet have imagined.

Culturally informed counselling does not ask families to abandon their values. It helps them to expand those values to accommodate a reality they did not anticipate. This distinction is crucial. Interventions that position the family's cultural framework as the problem will always encounter resistance, because they are asking the family to choose between their heritage and their child. Effective counselling reframes the choice: the family's values and the child's neurodivergence are not in opposition. They can coexist within an enlarged understanding of what it means to succeed, to belong and to be a good family.

Process 4: Extended family bridging

Section 5 of this paper described the powerful role that grandparents and extended family members play in shaping household narratives about neurodivergence. One of the practical outcomes of parental counselling is that it equips parents to communicate the diagnosis to their extended family in ways that are culturally appropriate and emotionally calibrated.

This is not a simple matter of providing parents with a script. It requires helping them to anticipate the likely emotional responses of their own parents, to understand those responses with compassion rather than frustration, and to find language that honours the older generation's framework of understanding while gently introducing a new dimension to it.

In practice, this often means helping a parent to say something like: "You are right that discipline matters. And you are right that our family has always worked hard. What we are learning is that his brain processes information differently, and that the hard work you value in him needs to be directed in a way that works with how his mind actually functions, not against it." This kind of bridging language does not dismiss the grandparent's values. It translates the diagnosis into their existing framework of meaning.

8.4 Evidence from family support practice

The Neuro Pioneer Hub's family support work provides consistent evidence that parental counselling produces measurable shifts in family dynamics. While the case studies presented in this paper are anonymised composites, the patterns they reflect are replicated across engagements.

Shifts in parental language

One of the earliest observable changes following parental counselling is a shift in the language parents use when speaking about their child's neurodivergence. Parents who initially described the diagnosis in terms of limitation ("he can't", "she struggles with", "it's a problem") begin to adopt language that acknowledges both the challenge and the strength ("her mind works differently", "he needs a different approach", "it's part of who she is"). This linguistic shift may seem superficial, but its effects are profound. Language shapes perception, and the language a parent uses about their child's neurodivergence is heard by the child constantly, shaping their own self-understanding at a foundational level.

Reduction in masking behaviours

Parents who undergo counselling frequently report that their child begins to mask less at home. The child does not consciously decide to stop masking. Rather, as the home environment becomes less contradictory, the need for masking diminishes. The child senses, often before they can articulate it, that the emotional temperature of the household has changed, that the adults around them are no longer sending competing signals about who they are permitted to be.

This observation aligns with the findings of Livingston and Happé (2017), who demonstrated that masking behaviours are context-dependent: individuals mask more in environments where they perceive their authentic behaviour to be unwelcome. When the family environment shifts from ambivalence to acceptance, the trigger for masking is reduced.

Improved family cohesion

Families who engage in counselling report improved communication between parents, reduced conflict about the diagnosis, and a greater sense of being "on the same team". This is consistent with Karst and Van Hecke's (2012) finding that family-centred interventions improve not only child outcomes but also marital satisfaction and parental mental health.

From a Double Jeopardy Syndrome perspective, this shift is significant. The move from "divided narratives" to "shared understanding" on the spectrum described in Section 7 (Figure 2) represents a fundamental change in the relational environment in which the young person's identity is being formed. It does not eliminate the societal dimension of DJS, but it transforms the family dimension from a source of compounded pressure into a source of resilience.

8.5 The relationship between counselling and DJS outcomes

Figure 4: Parental Counselling as the Intervention Point in the Double Jeopardy Cycle

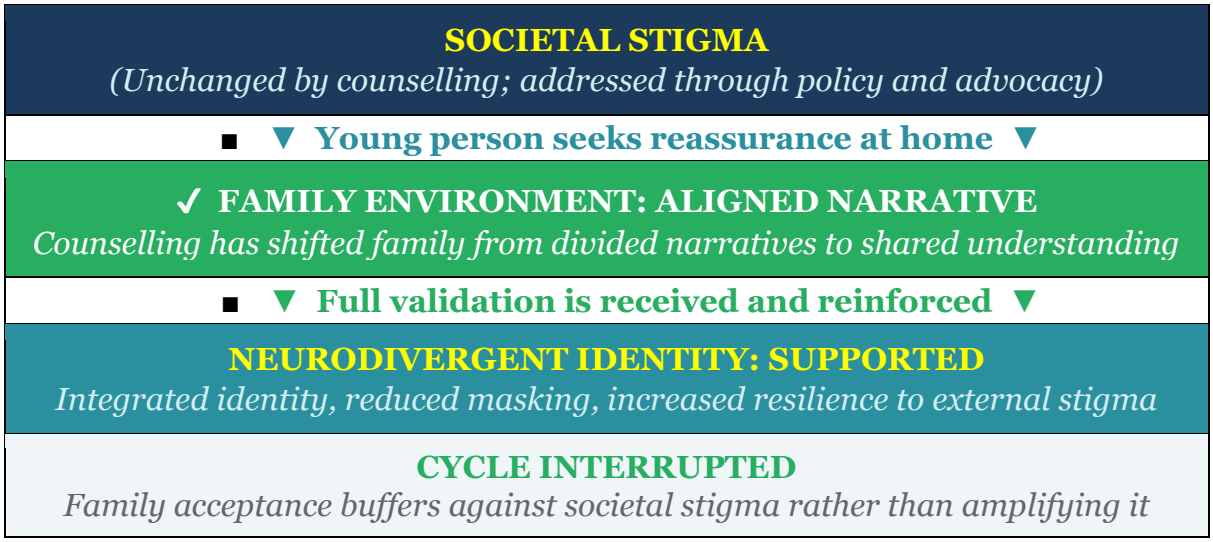


Figure 4 illustrates the contrast with the feedback loop presented in Section 7 (Figure 1). In the uninterrupted cycle, family ambivalence amplifies the young person's vulnerability to societal stigma. In the interrupted cycle, family alignment transforms the home from a site of compounded pressure into a buffer against external misunderstanding.

This does not mean that societal stigma ceases to affect the young person. It means that they now have a secure base from which to encounter it. The experience of returning home to a family that understands, that uses consistent language, which sees the whole person rather than only the diagnosis or only the potential, fundamentally changes the young person's capacity to withstand the pressures of the external world.

8.6 Limitations and conditions for effectiveness

It would be misleading to suggest that parental counselling is a universal solution. Several conditions influence its effectiveness.

First, both parents must be willing to engage. Counselling cannot align a narrative if one parent refuses to participate. In cases where one parent is unwilling, the counsellor may need to work initially with the willing parent alone, building their capacity to hold the diagnostic narrative within the household even without their partner's full agreement.

Second, counselling must be culturally informed. Generic counselling models developed within Western, individualistic frameworks may not resonate with families from collectivist cultural backgrounds. The counsellor must understand the cultural values at play, the intergenerational dynamics, and the specific forms that stigma takes within the family's community of origin. Without this understanding, well-intentioned counselling can

inadvertently position the family's culture as the problem, producing resistance rather than progress.

Third, counselling is most effective when it is offered early, ideally as a standard component of the post-diagnostic pathway rather than as a crisis intervention accessed months or years later. The longer divided narratives persist within a family, the more deeply entrenched they become, and the harder they are to shift.

Fourth, counselling cannot substitute for structural change. The societal dimension of Double Jeopardy Syndrome, the stigma, stereotypes and institutional barriers that neurodivergent individuals encounter, requires policy-level intervention. Parental counselling can transform the family dimension, but it cannot on its own dismantle the external conditions that produce the stigma to which families are responding.

8.7 Conclusions: from divided narratives to shared understanding

The evidence presented in this section supports a clear conclusion: parental counselling is the most consistent and most accessible intervention available for disrupting the Double Jeopardy cycle within the family home.

It works not by providing parents with more information, though information is part of it. It works by giving parents a space to process the emotional impact of a diagnosis, to develop a shared narrative about what it means, to integrate that narrative into their existing cultural values, and to bridge the understanding gap with the extended family.

When this process succeeds, the outcome is not merely a calmer household. It is a fundamental transformation of the relational environment in which the young person's identity is being formed. The home shifts from a site of performance to a site of belonging. The young person no longer has to carry multiple identities for multiple audiences within their own family. They can, at last, be one person.

> *When parents are supported, the household narrative begins to shift. And when the household narrative shifts, the young person experiences something they may never have had before: the sense that all the people who love them are, finally, telling the same story.*

That is not a small change. For many neurodivergent young people, it is the change that makes everything else possible.

9. Policy and Practice Implications

The analysis presented in this paper, and in particular the Double Jeopardy Syndrome framework introduced in Section 7, points toward several interconnected policy and practice implications. If we accept that neurodivergence is experienced not only by individuals but within relational systems, within families, communities and cultural networks, then our support structures must reflect that reality.

This section examines current policy landscapes in the United Kingdom and Malaysia, identifies the gaps that the present analysis exposes, and proposes a more effective model for neurodiversity support that places family dynamics at its centre. These two jurisdictions are chosen deliberately: the UK represents a system with relatively mature diagnostic infrastructure but significant gaps in post-diagnostic family support, while Malaysia represents a system in which awareness is growing rapidly but structural and cultural barriers remain deeply embedded.

9.1 The current landscape: United Kingdom

The United Kingdom has a comparatively well-developed framework for identifying and supporting neurodivergent children and young people, built upon the Equality Act 2010, the Children and Families Act 2014, and the Special Educational Needs and Disabilities (SEND) Code of Practice. Education, Health and Care Plans (EHCPs) provide a mechanism for coordinating support across agencies, and the NHS has established diagnostic pathways for autism, ADHD and other neurodevelopmental conditions.

Yet the system is under considerable strain. Demand for neurodevelopmental assessments has risen sharply, with NHS referrals to children's mental health services increasing substantially since 2014. Waiting times for autism and ADHD assessments routinely exceed twelve months in many regions, and in some areas extend beyond two years. The SEND system itself has been the subject of sustained criticism, with costs projected to reach eleven billion pounds per year.

In 2024, the Buckland Review of Autism Employment made recommendations across five areas including awareness, workplace adjustments and employer engagement. In January 2025, the Department for Work and Pensions launched an independent panel of academics to advise on neurodiversity awareness and workplace inclusion, building on the Buckland Review with a broader scope covering ADHD, dyslexia, dyspraxia and other conditions. The Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme has been piloted in over 1,600 primary schools, aiming to bring education and health workforces together.

These are meaningful steps. But from the perspective of Double Jeopardy Syndrome, they share a common limitation: they are overwhelmingly individual-focused and institution-focused. They address the neurodivergent person's experience in schools and workplaces. They do not systematically address the family environment in which that person's identity was first formed and continues to be negotiated.

What is missing in the UK model

The UK diagnostic pathway typically delivers a diagnosis to parents and then signposts them toward information resources, support groups and, in some cases, parenting programmes. What it rarely provides is structured, culturally sensitive counselling for parents as a standard component of the post-diagnostic pathway. The emotional cascade described in Section 8 of this paper, the grief, guilt, fear and confusion that a diagnosis triggers, is left for parents to navigate largely on their own.

This gap has particular consequences for families from minority ethnic and diasporic communities. The UK's neurodiversity infrastructure was designed primarily within a Western, individualistic framework. It assumes that parents will access information in English, that they will engage with support services modelled on Western therapeutic norms, and that the primary challenge is the individual child's adjustment. For families in which neurodivergence is interpreted through collectivist frameworks, in which the diagnosis carries implications for family reputation, community standing and intergenerational expectations, the existing provision is structurally inadequate.

The result, as this paper has argued, is that many families from diverse cultural backgrounds are left to manage the internal dynamics of a diagnosis using only the cultural frameworks available to them, frameworks that may have no concept of neurological variation as a legitimate category of difference. The conditions for Double Jeopardy Syndrome are created not by any failing of the family, but by the failure of the system to provide support at the level where it matters most.

9.2 The current landscape: Malaysia

Malaysia presents a different but instructive picture. Neurodiversity awareness has grown significantly in recent years, driven in part by corporate initiatives such as the PETRONAS and EY collaboration on developing a neurodiversity ecosystem, and by the advocacy work of organisations including the Malaysian High Functioning Autism Association (MAHFAA), Enabling Academy and United Voice.

However, structural challenges remain significant. Research has identified service gaps in the assessment of learning difficulties, including limited healthcare professionals trained in neurodevelopmental assessment and an absence of standardised, linguistically and culturally applicable diagnostic tools. The Malaysian

education system, while operating a zero-reject policy for inclusive education, continues to be shaped by a deficit model of disability in which neurodivergent students are often sifted toward vocational pathways rather than supported to thrive within mainstream education.

The terminological landscape itself reflects ongoing tensions. In Malaysia, neurodivergent conditions are categorised under the umbrella of Orang Kurang Upaya (OKU), a term that translates broadly as "persons with reduced ability" or, in its more recent formulation, Orang Kelainan Upaya, meaning "persons with different abilities." While the shift in terminology reflects growing awareness, the underlying framework remains deficit-oriented, and significant stigma continues to attach to the OKU classification.

Employment data underscores the challenge. Statistics from the Department of Statistics Malaysia show inconsistent and low numbers of neurodivergent individuals in formal employment. While organisations such as PETRONAS, Maybank, RHB Bank and Gamuda have begun to include neurodiversity within their diversity and inclusion strategies, Malaysia still lacks localised national guidelines that organisations can readily adopt.

What is missing in the Malaysian model

The gaps in the Malaysian context are both structural and cultural. Diagnostically, the shortage of trained professionals means that many neurodivergent children, particularly those from lower-income families or rural areas, are never identified at all. Those who are identified often receive a diagnosis without any structured family support, leaving parents to interpret the diagnosis through whatever cultural frameworks are available to them.

The cultural dimension is particularly significant. Malaysia's three major ethnic communities, Malay, Chinese and Indian, each carry distinct cultural frameworks through which neurodivergence may be interpreted. Concerns about family reputation, academic performance and community standing are pervasive across all three communities, though they manifest in culturally specific ways. The case of Daniel, presented in Section 6 of this paper, illustrates how the interaction between a dyslexia diagnosis and the cultural emphasis on academic achievement within a Malaysian Chinese family can produce precisely the concealment dynamics that Double Jeopardy Syndrome describes.

Extended family involvement is particularly pronounced in the Malaysian context. Grandparents frequently play an active role in childcare and family decision-making, and their views on neurodevelopmental diagnoses carry significant authority. Yet

there are almost no resources, in any of Malaysia's major languages, designed to help grandparents understand neurodivergence in terms that connect with their own generational frameworks of understanding.

9.3 A comparative analysis: where both systems fall short

Despite the significant differences between the UK and Malaysian contexts, the gaps identified in both systems share a common characteristic: they are gaps at the family level.

Both systems have invested, to varying degrees, in improving diagnostic infrastructure, educational inclusion and workplace awareness. Both systems recognise, at least in principle, that neurodivergent individuals face barriers to participation. But neither system has systematically addressed the family environment as a site of intervention.

Table 2: Comparative Gap Analysis: United Kingdom and Malaysia

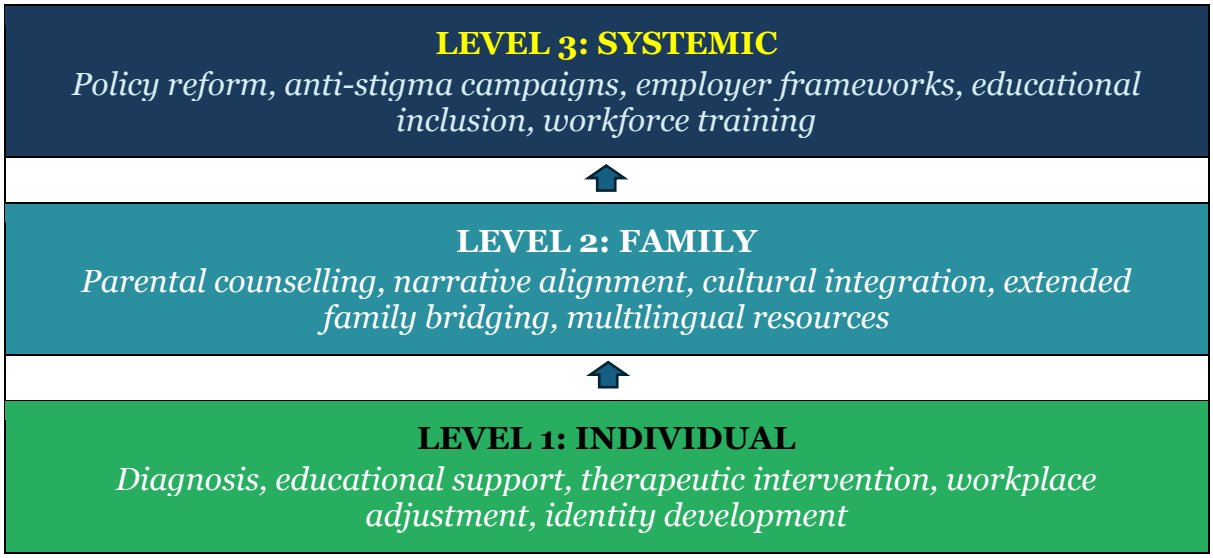
Domain	United Kingdom	Malaysia
Diagnosis	Established but overstretched; long waiting times; individual-focused	Limited professionals; absence of culturally applicable tools; urban concentration
Post-diagnostic family support	Minimal; information-based; rarely includes parental counselling	Largely absent; no structured pathway; families left to interpret through cultural frameworks
Cultural competence	Low; services designed within Western individualistic frameworks	Low; deficit model persists; OKU terminology carries stigma
Extended family engagement	Not systematically addressed	Not addressed despite high intergenerational involvement in family life
Workplace inclusion	Growing; Buckland Review, ACAS guidance, employer indices	Emerging; PETRONAS/EY initiative, but no national guidelines
Education	SEND framework and PINS programme, but under strain	Zero-reject policy exists but deficit model shapes implementation

The pattern is clear. Both systems have focused their resources on the individual and the institution. Neither has built a systematic model for intervening at the family level, where, as this paper has argued, the most consequential dynamics shaping a neurodivergent young person's identity are actually taking place.

9.4 Toward a family-centred neurodiversity ecosystem

The analysis in this paper suggests that effective neurodiversity policy must operate across three interconnected levels simultaneously: the individual, the family and the system. Addressing any one level in isolation produces incomplete outcomes.

Figure 5: A Three-Level Model for Neurodiversity Support



Current policy in both the UK and Malaysia operates primarily at Levels 1 and 3. Level 2, the family level, remains the missing layer. This is precisely the level at which Double Jeopardy Syndrome operates, and precisely the level at which parental counselling (as described in Section 8) produces its effects.

9.5 Specific policy recommendations

The following recommendations are designed to be applicable across both the UK and Malaysian contexts, with adaptations for each jurisdiction noted where relevant.

Recommendation 1: Integrate family-centred support into diagnostic pathways

A diagnosis should never be delivered to a family without structured follow-up support that addresses the emotional and relational impact on the household as a whole. This means embedding parental counselling, not as an optional referral but as a standard component of the post-diagnostic pathway.

In the UK, this would require NHS diagnostic services to commission culturally competent family counselling as part of the assessment process, funded through Integrated Care Boards alongside clinical assessment. In Malaysia, where diagnostic infrastructure is still developing, this could be integrated into the community health system through partnerships between government clinics, NGOs such as MAHFAA and the Enabling Academy, and family counselling services.

Recommendation 2: Develop culturally informed counselling provision

Generic counselling models are insufficient. Parental counselling for neurodivergence must be culturally informed, which means understanding not only the clinical condition but the cultural, intergenerational and community dynamics through which the diagnosis is interpreted.

In the UK, this requires investment in training counsellors and psychologists to work with families from South Asian, East Asian, Caribbean, African and other diasporic communities, understanding the specific forms that stigma, reputation anxiety and intergenerational influence take within each context. In Malaysia, it means developing counselling approaches that are sensitive to the distinct cultural frameworks of Malay, Chinese and Indian communities, and that can be delivered in Bahasa Malaysia, Mandarin and Tamil as well as English.

Recommendation 3: Create multilingual resources for grandparents and extended family

The intergenerational dimension of neurodivergence cannot be addressed through resources aimed solely at parents. Grandparents and extended family members need their own pathways to understanding, delivered in language that connects with their generational and cultural frameworks.

In both the UK and Malaysia, this means producing accessible, non-clinical materials in multiple languages, using culturally appropriate examples and narratives. Video content is particularly effective for reaching older generations who may not engage with written materials. Community and faith leaders can serve as trusted intermediaries for dissemination.

Recommendation 4: Train professionals in cultural competence around neurodivergence

Teachers, social workers, healthcare professionals and employers need training that goes beyond awareness of neurodevelopmental conditions. They need to understand the cultural, intergenerational and family dynamics that shape how a young person experiences their diagnosis at home.

In the UK, the PINS programme provides a foundation for this, but its scope must expand to include cultural competence as a core component, not an optional module. In Malaysia, teacher training programmes at universities need to move beyond the deficit model of disability toward a neurodiversity framework that acknowledges both the strengths and the challenges associated with neurodivergent profiles.

Recommendation 5: Establish workplace transition support that accounts for family dynamics

Neurodivergent young people entering the workforce carry with them not only their individual skills and challenges, but the family narratives that have shaped their sense of identity. Workplace inclusion strategies that ignore this dimension will always be incomplete.

The UK's emerging neurodiversity employment frameworks, building on the Buckland Review and the work of organisations such as Autistica, should incorporate family context into their models of supported employment. In Malaysia, the corporate neurodiversity initiatives led by PETRONAS and EY provide a platform for piloting family-aware approaches to neurodiverse talent management, recognising that the employee's confidence, self-advocacy and resilience are shaped in large part by whether their family environment has been supportive or contradictory.

Recommendation 6: Fund research into the family dimension of neurodivergent outcomes

The Double Jeopardy Syndrome framework presented in this paper is grounded in existing empirical research and practical observation, but it requires further validation through dedicated research. Longitudinal studies examining the relationship between family narrative alignment and neurodivergent identity outcomes would provide the evidence base needed to justify the policy investments recommended above.

Both the UK's research councils and Malaysia's academic institutions are well positioned to commission such research, particularly in collaboration with community organisations that have direct access to the families in question.

9.6 An ecosystem, not a programme

It is important to emphasise that the recommendations above do not describe a single programme. They describe an ecosystem: a set of interconnected interventions operating across the individual, family and systemic levels, each reinforcing the others.

Anti-stigma campaigns at the systemic level reduce the societal pressure that drives families toward concealment. Family counselling at the relational level transforms the home from a site of compounded pressure into a source of resilience. Individual

support at the personal level equips the neurodivergent young person with the tools and the self-understanding to navigate the external world.

No single intervention, operating at a single level, can address Double Jeopardy Syndrome in its entirety. But an ecosystem of interventions, designed with the family at its centre and delivered with cultural competence, can.

> *None of these recommendations require wholesale reinvention. Many of the structures already exist. What they require is a widening of the lens, a willingness at the level of policy and practice to recognise that the most powerful variable in a neurodivergent young person's trajectory is often not the quality of their school or their access to therapy, but whether the people who love them most can agree on who they are.*

10. Conclusion

Neurodivergence does not exist in isolation. It is interpreted, narrated and negotiated within families, cultures and communities. The way a diagnosis is received at home shapes a young person's relationship with themselves more profoundly than any clinical report, any school intervention, or any public awareness campaign ever could.

This paper has examined how that process unfolds, and what happens when it goes wrong.

What this paper has shown

The evidence and case studies presented throughout this paper converge on several core findings.

First, neurodivergent identity does not develop in a vacuum. It is shaped by the social feedback a young person receives from the people closest to them. When that feedback is affirming, identity can flourish. When it is contradictory, identity fragments.

Second, parents frequently interpret a neurodevelopmental diagnosis through different emotional and cultural lenses, and neither interpretation is necessarily wrong. One parent may see the diagnosis as a framework for understanding. The other may experience it as a threat to their child's future, their family's reputation, or both. The difficulty arises not from either response in isolation, but from the coexistence of both under the same roof.

Third, extended family members, particularly grandparents, play a powerful and often underestimated role in shaping how neurodivergence is understood within the

household. Generational frameworks built around discipline, willpower and moral judgement can coexist with genuine love for the child, creating an emotional environment in which warmth and invalidation operate simultaneously.

Fourth, masking frequently begins at home. Long before the workplace or the school demands it, neurodivergent young people learn which parts of themselves are welcome in which room. The mask is not fitted by society first. It is fitted by family, often without anyone realising it is happening.

Fifth, the concept of Double Jeopardy Syndrome captures the layered identity pressures experienced by neurodivergent individuals navigating both societal misunderstanding and culturally embedded family narratives. These pressures do not simply coexist. They compound, creating a form of exhaustion that is specific, relentless and largely invisible.

Why this matters

The consequences of these dynamics are not abstract. They are measurable in the anxiety, depression and emotional exhaustion reported by neurodivergent individuals who mask. They are visible in the identity fragmentation described by young people like Marcus, Arjun and Daniel. And they are present in the quiet withdrawal of families who choose concealment over the risk of stigma.

When families send mixed messages about neurodivergence, when one parent sees a strength and the other sees a problem, when a grandparent's love coexists with their denial, the young person at the centre of it all may feel compelled to fragment their identity in order to maintain belonging. They learn to be one person at the breakfast table and another at the dinner table. They learn which parts of themselves are welcome in which room. And over time, they may lose track of which version is actually them.

This is not a small thing. It is the kind of quiet damage that does not show up in diagnostic criteria or school reports, but that shapes a person's relationship with themselves for years. It affects educational outcomes, career trajectories, mental health and the capacity for authentic relationships. It is, in many cases, the single greatest barrier to a neurodivergent young person fulfilling their potential, and it is almost entirely preventable.

What can be done

Yet the reverse is also true, and this is where the real opportunity lies. When families develop a shared understanding, not perfect agreement but a genuine, evolving conversation about what neurodivergence means for their child and for their household, the home can become the single most powerful source of support a

neurodivergent young person will ever have. Not because the family suddenly has all the answers, but because the young person no longer has to hide.

The evidence presented in this paper points to parental counselling as the most consistent lever for achieving this shift. When parents are given a safe space to process their own emotional responses to a diagnosis, the household narrative begins to change. Guilt, grief and fear, left unaddressed, calcify into denial or overprotection. Given room to breathe, they can transform into understanding, acceptance and practical support.

This is not a matter of educating parents out of their cultural values. It is a matter of supporting them to integrate their child's neurological reality into the values they already hold. A father who prizes academic excellence does not need to abandon that value. He needs support to see that his child's neurodivergence is not an obstacle to excellence but a different pathway toward it. A grandmother who expresses love through high expectations does not need to be told she is wrong. She needs help to understand that her grandchild's brain works differently, and that the expectations she holds can be met in ways she may not yet have imagined.

A call to action

The findings of this paper carry implications for everyone involved in the lives of neurodivergent young people: clinicians, educators, policymakers, employers and families themselves.

> *For clinicians and diagnostic services: a diagnosis should never be delivered to a family without structured follow-up support that addresses the emotional and relational impact on the household as a whole. The point of diagnosis is not an endpoint. It is the beginning of a family's journey, and that journey needs to be supported.*
>
> *For educators and schools: cultural competence in understanding neurodivergence must extend beyond awareness of the conditions themselves. Professionals need to understand the cultural, intergenerational and family dynamics that shape how a young person experiences their diagnosis at home, because those dynamics walk through the school gates with them every morning.*
>
> *For policymakers: funding and commissioning frameworks must recognise family-centred support as a core component of neurodevelopmental services, not as a supplementary luxury. The cost of failing to support families is borne not only by the young person but*

> *by health services, educational systems and employers for decades to come.*
>
> *For employers and organisations: neurodivergent employees do not leave their family histories at the office door. Workplace inclusion strategies that account for the broader relational context in which neurodivergent identity has been shaped will always be more effective than those that treat the individual in isolation.*
>
> *For families: if you are navigating a neurodevelopmental diagnosis within your household, know that disagreement between family members is not a failure. It is a normal response to something unfamiliar and, at times, frightening. What matters is not that every family member reaches the same understanding at the same time, but that the conversation remains open, and that the young person at the centre of it feels safe enough to be themselves.*

Often, the most important step is not changing the young person.

It is helping the adults around them understand what they are seeing.

And that is not a failure. That is the beginning.

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About The Neuro Pioneer Hub

The Neuro Pioneer Hub is a mission-driven initiative founded by a core team with lived experience of neurodiversity and decades of commercial leadership. It exists to break down barriers and open up meaningful pathways to leadership, entrepreneurship and high-impact careers for neurodivergent individuals, including those with autism, ADHD, dyslexia, dyspraxia and other forms of neurodivergence.

The Hub works with families, educators, employers and organisations to create environments where neurodivergent minds are not simply included but empowered to thrive. Its flagship mission - the Neuro Pioneer Hub Accelerator Programme, is a first-of-its-kind 20-week programme that takes participants through four phases: self-discovery and confidence building, business and digital skills development, leadership training and industry placement, and real-world application through investor pitching and business refinement.

Unlike conventional accelerators built around rigid norms, the programme is designed around different thinking styles, communication preferences and sensory needs. Every participant receives individualised coaching, adaptive tools and access to a network of corporate partners who mentor, sponsor and hire from the programme.

Through its research and advocacy work, the Hub also addresses the cultural and psychological factors shaping how neurodivergence is understood across societies, recognising that meaningful support must reach beyond the individual to include the family systems, intergenerational dynamics and community narratives in which neurodivergent identity is formed. The white paper you are reading is one expression of that commitment.

For further information, visit www.theneuropioneerhub.com or contact Dr Bimal Roy Bhanu at drbimalroy.bhanu@theneuropioneerhub.com