

Neurodiversity And Social Exclusion: Understanding Marginalization of Neurodevelopmental Differences

Sayani Banerjee

Lecturer, Department of Psychology, Loreto College, Kolkata
sayanibanerjee8621@gmail.com

Abstract:

Marginalization is a multilayered concept resulting from the actions of human society that are conceived socio-economically and politically, where a person or group is made to feel of lesser importance by those in power. The dominant society identifies a marginal group, which leads to discrimination and subordination. This often results in these groups being perceived as less human, useless, or undesirable for progression. Marginalization can manifest in various contexts, including towards individuals who are suffering from mental health conditions. Neurodevelopmental disorders are conditions that typically begin in the early developmental period of life, causing impairments in the social, academic, or occupational function. The DSM-5-TR categorizes intellectual developmental disorders, communication disorders, Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder, Motor Disorders, and Specific Learning Disorders under Neurodevelopmental Disorders. Because these conditions diverge from societal norms, individuals with Neurodevelopmental disorders are often stigmatized and viewed as less capable. People with such conditions and their families often internalize these negative attitudes, resulting in low self-esteem, anxiety, and social withdrawal. Caregivers frequently report a lack of social support and acceptance

from family or community, leading them to withdraw from public life. Historically, people with cognitive or behavioural differences were derogatorily labelled and often segregated from society. This legacy of dehumanization persists even today, with many schools, workplaces, and public services failing to accommodate neurodiverse learners, so individuals with Neurodevelopmental disorders cannot access needed resources or opportunities. The present chapter incorporates a narrative review-based approach to outline the key psychosocial frameworks and sociological models that explain how neurodivergent identities become marginalized in various contexts in society. The chapter also explores the attitudes of others toward individuals with neurodevelopmental disorders, the ways in which they cope with everyday challenges, and the forms of discrimination they encounter in different social contexts.

Key words: *Neurodevelopmental Disorders, Marginalization, Stigma, Social Exclusion, Neurodiversity*

INTRODUCTION

The concept of neurodiversity is a revolutionary perspective through which society may re-evaluate the natural variation in human cognitive functioning. The term “neurodiversity” was first coined by Judy Singer, an Australian Sociologist, in her thesis (De & Basu, 2025). She argued that cognitive variations should be viewed politically as minority groups who are deserving of human rights. The concept was further mainstreamed by works such as Steve Silberman’s book on “NeuroTribes” which highlighted the history of autism and the need for acceptance, and through online communities where neurodivergent individuals could connect and advocate for themselves. However, the prevailing social reality for neurodivergent individuals remains one of deep-seated marginalization.

Marginalization is a sociological process through which individuals or groups are pushed to the edges of society. It limits their access to resources, opportunities, and participation in social life. The concept of social exclusion is closely related to marginalization and often overlaps with it (Singh et al., 2024). For those with neurodevelopmental disorders, marginalization often stems from social attitudes that view neurological differences as deficits or disabilities instead of variations in human functioning. This deficit-focused mindset creates barriers in education, employment, healthcare, and social relationships. As a result, the challenges faced by individuals with neurodevelopmental disorders arise not only from their neurological differences but also from structural inequalities and discriminatory practices in society.

Historically, disability and neurodevelopmental conditions have been understood through the medical model of disability. This model sees disability as a problem within the individual that needs treatment or correction (Oliver, 1990). In this view, neurodevelopmental disorders are seen mostly as abnormal changes in natural development. While the medical model has helped create diagnostic criteria and clinical treatments, it has also promoted negative views that label individuals with neurodevelopmental disorders as deficient or incapable. In contrast, the social model of disability suggests that disability arises from the interaction between a person's impairments and societal barriers. These barriers include inaccessible environments, discriminatory attitudes, and exclusionary practices (Shakespeare, 2013). From this viewpoint, the marginalization of individuals with neurodevelopmental disorders is largely a result of social structures that do not support neurological diversity. The idea of neurodiversity further challenges negative views of

neurodevelopmental disorders. First popularized by the autistic self-advocacy movement, neurodiversity sees neurological differences, such as autism and ADHD, as natural variations of the human brain rather than conditions that need to be fixed (Singer, 1999). Supporters of neurodiversity believe that individuals with neurodevelopmental differences have unique strengths and perspectives that can benefit society when they receive the right support and acceptance. Despite the growing influence of the neurodiversity movement, many individuals with neurodevelopmental disorders still face social stigma and systemic discrimination. Research shows that societal attitudes toward these conditions are often shaped by misconceptions, stereotypes, and a lack of understanding, which continue to drive marginalization. The educational setting is one of the main settings where marginalisation is visible. According to Humphrey and Symes (2013), children with neurodevelopmental disorders frequently face obstacles to inclusive education, such as insufficient support services, a lack of teacher preparation, and unfavourable peer attitudes. Despite the fact that many nations have adopted inclusive education policies, students with neurodevelopmental disorders often face social exclusion, bullying, and lowered academic expectations. Research shows that compared to their peers who are typically developing, children with autism spectrum disorder and ADHD are much more likely to be victimised and rejected by their peers (Hebron & Humphrey, 2014). These experiences have an impact on academic performance as well as long-term psychological effects like depression, anxiety, and low self-esteem. Beyond childhood, marginalisation persists into adulthood, especially when it comes to work and economic engagement. Due to workplace discrimination, a lack of accommodations, and a

lack of awareness of neurodiversity among employers, adults with neurodevelopmental disorders frequently face significant challenges in finding and keeping a job (Scott, Falkmer, Girdler, & Falkmer, 2015). For instance, studies on adults with autism spectrum disorder indicate that, despite having similar or even better skills in areas like analytical thinking and attention to detail, employment rates among this population are still much lower than those of the general population (Baldwin, Costley, & Warren, 2014). These differences in employment show how marginalisation is often caused by structural obstacles rather than personal weakness. The experiences of people with neurodevelopmental disorders are also significantly shaped by healthcare systems. Depending on socioeconomic status, location, and cultural context, access to appropriate diagnosis, treatment, and support services frequently varies greatly (Daniels & Mandell, 2014). Inadequate access to specialised services and delayed diagnosis can worsen developmental difficulties and reduce opportunities for early intervention. According to Nicolaidis et al. (2015), people with neurodevelopmental disorders also often report negative experiences in healthcare settings, such as professional misunderstandings, a lack of patient-centred communication, and inadequate accommodation of sensory or cognitive needs. These obstacles exacerbate feelings of exclusion within institutional systems intended to deliver care and contribute to health disparities. Another area where marginalisation is commonly encountered is in social interactions and community involvement. Due to social communication differences, stigma, and limited opportunities for inclusive interaction, people with neurodevelopmental disorders frequently struggle to establish and sustain friendships (Müller, Schuler, Burton, & Yates, 2003). People with atypical social patterns are frequently disadvantaged in

environments created by societal expectations regarding normative behaviour and communication styles. People with neurodevelopmental disorders may consequently feel excluded from community activities, lonely, and socially isolated. These incidents demonstrate how cultural expectations and social norms can unintentionally marginalise people whose actions deviate from accepted norms. One of the main ways that marginalisation is maintained is through stigma. According to Goffman (1963), stigma is a social process that results in discrimination and decreased social acceptance by devaluing particular characteristics. Stigma frequently takes the form of labelling, stereotyping, and unfavourable presumptions about competence or capability when it comes to neurodevelopmental disorders. For example, people with autism may be stereotyped as intellectually limited or socially uninterested, whereas people with ADHD may be seen as lazy or unruly. These false beliefs may affect how people are treated in social situations, at work, and in educational institutions. Additionally, people with neurodevelopmental disorders may develop negative self-perceptions as a result of internalised stigma, which could have an impact on their self-advocacy and mental health. The marginalisation that people with neurodevelopmental disorder experience is made more difficult by intersectionality. The term “intersectionality” describes how social identities like gender, race, class, and disability are interrelated and collectively influence experiences of privilege and oppression (Crenshaw, 1989). People with neurodevelopmental disorders may experience additional disadvantages if they are members of other marginalised groups. For instance, studies show that due to differences in healthcare access and cultural biases in diagnostic procedures, children from minority ethnic backgrounds frequently have delayed diagnoses of autism

and ADHD (Mandell et al., 2009). In a similar vein, socioeconomic disadvantage may restrict access to advocacy support, counselling services, and educational materials. Therefore, an intersectional approach that takes into account how various forms of inequality interact to shape lived experiences is necessary to understand marginalisation. The psychological consequences of marginalization among individuals with neurodevelopmental disorders create substantial impacts. Social exclusion and discrimination combined with restricted access to opportunities lead to increased mental health issues which include anxiety, depression, and low self-esteem (Hedley et al., 2018). Unaccommodating spaces create chronic stress for people, which results in emotional exhaustion and decreased life satisfaction. Research establishes that resilience, community support and self-advocacy function as protective factors which decrease the harmful impacts of marginalization. Individuals with neurodevelopmental differences achieve better empowerment and well-being through supportive social networks and inclusive educational practices, and recognition of neurodiversity. In recent years, there has been an increased focus on recognizing the need to shift from deficit-based approaches to those that are more inclusive of human rights-based approaches. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) promotes a set of principles related to equality, accessibility, and full participation of persons with disabilities (including those with neurodevelopmental disorders) (United Nations, 2006). These principles create a framework from which legislators, educators, healthcare providers, and communities are encouraged to eliminate systemic barriers and create inclusive spaces that acknowledge diversity in neurological function. Although there is greater recognition

of these issues than ever before, substantial gaps still exist in our understanding of marginalized individuals with neurodevelopmental disorders. Past literature primarily examined clinical characteristics and treatment modalities, rather than examining the social environments that individuals and their families must navigate. Research now suggests that the best way to understand the impact of marginalization is to examine subjective experiences, the social context of the lived experience, and the structural inequalities that exist in everyday life for an individual with a neurodevelopmental disorder. The use of a subjective lens in studying experiences of marginalization provides significant information about how social systems create barriers to inclusion, and how best to create inclusive practices to promote equity and participation.

1. THEORETICAL FRAMEWORK OF MARGINALIZATION

To understand the marginalization of neurodivergent identities, it is important to understand the psychological and sociological models that explain how “difference” is transformed into “disadvantage”. Marginalization is a context-dependent othering process that leads to disadvantage (Fluit, 2024). Stigma is the primary vehicle for this transformation, as it acts as a social dynamic that reinforces existing power relations to control those who deviate from the norm (Rodrigues et al., 2025).

The post-colonial theory regarded marginalization as a legacy of colonial power, as colonizers constructed non-Western peoples as “other,” justifying their exclusion and control (Eve, 2015).

One of the most critical frameworks in the study of social exclusion is the conceptualization provided by Bruce Link and Jo Phelan, who define stigma as the co-occurrence of labelling, stereotyping, separation, status loss, and discrimination within a context where power is exercised (Link & Phelan, 2001). Within stigma theory, disability stigma is broken down into: public stigma, self stigma, and courtesy/affiliate stigma (Mueller et al., 2012). Public stigma occurs when large segments of society label a group (e.g., “autists” or “retards”) as untrustworthy or incapable. In the clinical context, the diagnostic process itself acts as the first step of labelling. Erving Goffman’s perspective provides further understanding of stigma. Goffman distinguishes between “discredited” those whose stigma is visible, and the “discreditable” those whose stigma is not visible but potentially discoverable (Chaudoir et al., 2013). In other words, Goffman noted that stigma can be either visible, such as skin colour, or hidden, such criminal record that may be revealed (Clair, 2024).

Colic (2023), highlighted that stigma can be understood by the following types:

Courtesy Stigma: It is originally coined by Goffman and refers to the stigma that individuals acquire not because of their own attributes but because of their relationship with a stigmatized person.

Experienced stigma: This refers to actual experiences of overt rejection or discrimination.

Perceived Stigma: This is defined as the beliefs parents hold regarding the negative attitudes of others toward themselves or their children.

Affiliate Stigma: Also known as internalized stigma, it happens when family members internalize others’ negative attitudes and apply the stigma to themselves.

Felt Stigma: It is the anticipation of discrimination and is characterized by emotions such as fear and shame

Double Stigma: The study briefly notes a phenomenon where a parent may internalize stigma due to their own characteristics, such as their own mental illness, and internalize stigma due to their child's disability, resulting in a "double stigma".

2. THE LANDSCAPE OF NEURODEVELOPMENTAL DISORDERS

The DSM-5-TR categorizes neurodevelopmental disorders as conditions that originate during the developmental period and cause significant impairments in functioning. The shift from DSM IV to DSM-5-TR reflects a shift in understanding neurodevelopmental disorders as a continuum rather than isolated pathologies. Currently, the DSM-5-TR categorizes Intellectual Disabilities, Communication Disorders, Autism Spectrum Disorders (ASD), Attention-Deficit/Hyperactivity Disorder, Specific Learning Disorder, Motor Disorders, and Other Neurodevelopmental Disorders under this category (American Psychiatric Association, 2022).

2.1. Intellectual Developmental Disorders

It is characterized by significant limitations in both intellectual functioning and adaptive behavior. The severity levels of this disorder, such as mild, moderate, severe, and profound, are no longer based solely on IQ scores but also depend on adaptive functioning, such as personal care and social participation. The marginalization of individuals with intellectual disabilities is linked to the historical belief that they are "unteachable" and other stereotypes that still influence community-based services even today.

2.2. Autism Spectrum and Communication Disorders

Autism Spectrum Disorder (ASD) is characterized by persistent deficits in social communication and interaction, along with restricted and repetitive patterns of behaviour, interests, or activities. Symptoms usually appear in early childhood and vary in severity depending on the level of support required. Communication disorders include language disorder, speech sound disorder, childhood-onset fluency disorder (stuttering), and social (pragmatic) communication disorder. These conditions involve persistent difficulties in the production, comprehension, or social use of language that significantly affect academic and social functioning.

2.3. ADHD and Specific Learning Disorders

Attention-Deficit/Hyperactivity Disorder (ADHD) involves a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with development and functioning. Symptoms must be present before the age of 12 and occur in multiple settings. Specific Learning Disorder (SLD) refers to persistent difficulties in learning academic skills such as reading, writing, or mathematics, despite adequate instruction and intelligence, and these difficulties significantly impact academic performance.

2.4. Motor Disorders

Motor disorders involve impairments in the acquisition and execution of coordinated motor skills. Developmental Coordination Disorder is marked by difficulties in performing age-appropriate motor tasks. Other conditions include stereotypic movement disorder, characterized by repetitive motor behaviours, and tic disorders such as Tourette's disorder, which involve sudden, recurrent motor movements or vocalizations.

Globally, neurodevelopmental disorders are common. The World Health Organization (WHO) estimates that about 317 million children and young people (under 20) in 2019 had conditions leading to developmental disabilities (World Health Organization, 2023). UNICEF similarly reports that roughly 1 in 6 children worldwide has a disability, with the majority of these in low-income regions (Chansa-Kabali et al., 2025). Precisely, about 240 million children and adolescents live with some disability, and over 53 million have serious developmental disabilities. There is a considerable phenotypic overlap and comorbidity among neurodevelopmental disorders. For example, between 22% and 83% of children with ASD also display symptoms that meet the criteria for Attention-Deficit/Hyperactivity Disorder (ADHD) (Morris et al., 2020). These numbers highlight the vast scale of neurodiversity.

3. METHODOLOGY

This chapter adopts a narrative review approach to synthesize existing research on the marginalization of individuals with neurodevelopmental disorders.

3.1. Search Strategy: A systematic search of relevant literature was conducted across several academic databases, including PubMed, Scopus, Directory of Open Access Journals (DOAJ), and Google Scholar. The search process involved combinations of keywords related to both neurodevelopmental disorders and social exclusion. The primary search terms included “neurodevelopmental disorders,” “neurodiversity,” “stigma,” “marginalization,” “social exclusion,” “intellectual disability,” “autism,” “ADHD,” “learning disability,” “communication disorders,” and “motor disorders”. Boolean operators such as AND and OR were used to combine keywords and refine search results.

3.2. Inclusion Criteria: Studies were selected based on their relevance to the themes of marginalization, stigma, and social experiences of individuals with neurodevelopmental disorders. The review included:

- Peer-reviewed journal articles
- Narrative reviews and systematic reviews
- Empirical research studies examining social, educational, healthcare, or workplace experiences
- Theoretical and sociological analyses relevant to disability and stigma

Only literature available in English was considered.

3.3. Data Extraction and Synthesis: After identifying relevant sources, duplicates were removed and the abstracts of the remaining articles were screened for relevance. Full-text articles that met the inclusion criteria were then reviewed in detail. Key information was extracted from each study, including the population examined, type of neurodevelopmental disorder, context of marginalization (education, employment, healthcare, or social settings), and major findings related to stigma or exclusion.

4. FINDINGS ON EXPERIENCES OF MARGINALIZATION

Individuals with neurodevelopmental disorders face exclusion across multiple societal domains, such as social, educational, employment, and healthcare settings, which reduces their participation and impacts their well-being. This section outlines disorder-specific marginalization faced by individuals with neurodevelopmental disorders and highlights how marginalization manifests across varied social settings.

A review by Chauhan et al. (2025) highlighted that individuals with neurodevelopmental disorders are historically marginalized by labels like “insane” or “feeble-minded”. It revealed that stigma is a barrier to social inclusion as it leads to discrimination against individuals in education and employment.

4.1. Intellectual Disability (ID): People with intellectual disabilities face compounded risks of institutionalization and social exclusion compared to others with disabilities. Even when living in the community, they often experience “virtual exclusion” where they remain socially isolated despite their physical presence (Bigby, 2012). A systematic review by Harrison et al (2021) highlighted that adults with ID experience “thwarted opportunities” that is, the desire for an “ordinary” life and relations, which is constantly blocked by systematic barriers. Ditchman et al (2013) found that while mental illness often elicits fear and blame, ID stigma is characterized by pity and perceptions of incompetence. In low-income countries, stigma can be extreme, where some children with intellectual disability are chained, beaten, denied basic services, such as health services, education, or employment, and are even abandoned by their families (Jansen-van Vuuren & Aldersey, 2020). As identified by Sonderlund et al. (2024), individuals with Intellectual Disabilities (ID) face barriers to preventative health checks due to systematic failures at three levels. At the individual level, a lack of practitioner training and poor communication increases mistrust and anxiety among patients. Organizationally, there is a “time famine” or lack of time faced by practitioners, and structurally, the rigid funding models, geographical inaccessibility, and socioeconomic deprivation ultimately lead to a health equity gap.

4.2. Learning Disability: As Monica et al. 2022 identified, children with learning disabilities face marginalization

primarily through the “segregationist system” of special institutions. Educational institutions often misinterpret equal opportunities as providing identical conditions, such as the same textbooks. However, this actually creates inequality by failing to provide “differentiated education” and personalized intervention plans. Individuals with Specific Learning Disorders (SLDs) are often labelled as “stupid”, “lazy”, or “careless”. The consequences of such labels are significant as higher levels of stigma has correlation with lower levels of self-esteem (Haft et al., 2022). The medical model treats these differences as “deficits” or “abnormalities” that need fixing, which leads to profound self-blame, self-hatred, and a persistent feeling of being “broken” (Peddigrew, 2023). Higher level of stigma is associated with less optimal outcomes, alongside poor academic performance, it increeases mental health issues such as anxiety, depression, and reduce self-efficacy (Ritcher et al., 2022). The label of “learning disability” significantly reduces teachers’ long term expectations for the long term achievement of the student, such as graduating, and they are more likely to recommend these students to a separate special school (Kashikar, 2026). There is a significant correlation between Specific Learning Disability (SLD) stigma and lower self-esteem, and stereotype threat undermines the self-efficacy and persistence of individuals with SLD (Haft et al., 2023).

4.3. Autism Spectrum Disorder (ASD): Autistic individuals similarly face a broad range of stigma based on their visible autistic characteristics. Public and professional misconceptions of ASD foster prejudice and discrimination (Turnock et al., 2022). In school settings, they are often misunderstood or socially rejected by their peers and teachers when they behave “differently” or struggle with communication (Davidson and Morales, 2023). A narrative review by Amate et al. (2025)

investigated the educational discrimination experienced by children with Autism Spectrum Disorder (ASD) during the COVID-19 pandemic. According to the findings, the global health crisis acted as a “magnifying glass” for the pre-existing structural weaknesses in inclusive education systems. The abrupt transition to remote learning disproportionately marginalized these students in four key dimensions: unequal access to digital resources, disruption of specialized services, impact on family dynamics, and institutional responses. Higher knowledge regarding the etiology and treatment of autism significantly predicts lower levels of stigma (Kitchin & Karlin, 2022). Parents of children with ASD often face familial shame and suspicions of child neglect, hence they refrain from disclosing their child’s condition to others (Park et al., 2024).

In adulthood stigma remains in workplace settings and the community. Doyle et al (2022) conducted an international survey to understand how intersecting marginalizing identities such as gender, race, or sexuality create a compound adverse impact on autistic individuals at workplace. The survey reveals that stigma surrounding autism at workplace still remains, and white individuals in Western nations are heavily favoured in autism specific hiring. Within the workplace, marginalized groups such as women, transgender, and non-binary autistic employees report lower feelings of inclusion and higher pressure to hide their autistic traits.

4.4. Attention-Deficit/ Hyperactivity Disorder (ADHD):

ADHD carries its own set of biases and misconceptions, which lead to discrimination throughout childhood and even in adulthood. Because ADHD involves inattention and hyperactivity, common people often mislabel it as being indisciplined or purposefully disruptive. Mueller et al (2012) highlight that stigmatization surrounding ADHD is largely driven by the uncertainty regarding the validity of the ADHD

diagnosis. People often do not understand the dangerousness associated with the disorders' externalising behaviors and blame the child or the parenting style for the condition. Adults with ADHD reports high level of public stigma, and they anticipate discrimination. Masuch et al (2019) found that 88.5% anticipated discrimination in daily life and 69.3% perceived public stigma, which were strongly associated with greater psychological distress, functional impairment, and lower quality of life. In schools and universities, labelled students are often treated as less capable than their performance actually suggests because teachers often limit them from opportunities (Metzger and Hamilton, 2020). These patterns contribute to marginalization. The labelling and misinterpretation causes under recognition of needs, barriers to education and employment, and reduced access to effective treatment.

4.5. Communication Disorders and Motor Disorders:

Speech, language, and communication impairments are another source of stigma, not only in individuals diagnosed with a neurodevelopmental disorder but also largely among the neurotypical population. Communication disorders significantly drive workplace discrimination and marginalization (Hasanbegovic & Kovacevic, 2019). Similarly, as motor disorders impact the physical abilities of a person, discrimination is also prevalent among people suffering from them. Gomes et al (2024) highlighted that Individuals with Tourette's syndrome face significant prejudice and marginalization, primarily driven by society's ignorance and unfamiliarity with the disorder. The involuntary motor and vocal tics characteristic of the condition, which can sometimes include abrupt movements or obscene gestures, often lead to alienation from people who do not know how to interact with them appropriately. Consequently, this widespread lack of

understanding creates deep barriers in social relationships and causes substantial social, academic, and professional harm to those living with the syndrome.

CONCLUSION

The review highlights that stigma, lack of awareness, and institutional barriers across education, healthcare, employment, and social environments contribute significantly to the exclusion experienced by neurodivergent individuals. Understanding marginalization through sociological and psychological frameworks emphasizes that many of these challenges arise not solely from the disorders themselves but from the social contexts in which individuals live. Promoting inclusive policies, increasing public awareness, and adopting a neurodiversity-informed perspective are therefore essential steps toward reducing stigma and fostering greater social participation and well-being for individuals with neurodevelopmental differences.

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Sayani Banerjee

Sayani Banerjee is a lecturer at the Department of psychology, Loreto College. She holds a master's degree in clinical psychology and is currently pursuing her Ph.D from University of Calcutta. Her research interests include psychometrics, cognitive processes, technology use, and problematic digital dependencies.