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Beyond Physical Presence: A Narrative Review of Meaningful Inclusion and Psychological Wellbeing for Autistic Individuals and Individuals with ADHD

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Abstract

Background: Inclusion is frequently measured by whether neurodivergent people gain entry into mainstream classrooms, workplaces, and communities. However, physical presence and formal access do not automatically guarantee genuine participation, acceptance, autonomy, or psychological wellbeing.

Objectives: The objective of this review is to critically evaluate whether contemporary inclusion practices genuinely benefit autistic people and people with ADHD beyond mere physical access. Specifically, it clarifies the distinction between nominal inclusion and meaningful inclusion, examines how environmental and social barriers—such as stigma, sensory demands, and camouflaging—impact psychological wellbeing, and outlines a biopsychosocial, neurodiversity-informed framework that pairs individual support with systemic accessibility and neurodivergent agency.

Methods: Focusing primarily on autism and ADHD, this narrative review evaluates whether modern inclusion practices truly serve neurodivergent individuals. It synthesizes existing research on the neurodiversity paradigm, stigma, social exclusion, camouflaging, psychological wellbeing, and participation across educational, professional, and community settings.

Results: The literature draws a clear distinction between nominal inclusion (institutional access) and meaningful inclusion, which requires accessible participation, social recognition, supportive relationships, tailored accommodations, and personal agency. Even within formally inclusive environments, wellbeing can be undermined by stigma, negative perceptions of neurodivergent traits, sensory and communication barriers, complex accommodation processes, and the pressure to conform to neurotypical norms. Furthermore, research highlights higher rates of internalizing difficulties among autistic adults and adults with ADHD, though these challenges stem from multiple factors beyond social exclusion alone.

Conclusion: Inclusion becomes authentic only when neurodivergent people can participate and belong without bearing an unfair burden to mask their traits, constantly self-advocate, or adapt to spaces not built for them. Achieving this requires a biopsychosocial, neurodiversity-informed framework that pairs individual support with systemic accessibility, anti-stigma initiatives, and the active involvement of neurodivergent people in shaping the decisions that affect their lives.

Key Words: *Neurodiversity, Inclusion, Autism, ADHD, Camouflaging, Psychological wellbeing*

1. Introduction

Neurodiversity is increasingly discussed within psychology, education, employment, healthcare, and disability policy, although the term is often used imprecisely. Neurodiversity refers to the natural variation in human neurocognitive functioning across the population; it is therefore a characteristic of humanity rather than a label for a particular group. By contrast, *neurodivergent* refers to people whose cognitive, sensory, developmental, or behavioural functioning differs from socially dominant expectations of neurotypicality (Shaw et al., 2025)[13]. The term is commonly associated with autism, ADHD, dyslexia, dyspraxia, Tourette syndrome, and related neurodevelopmental differences, although its scope remains contested (Doyle, 2020; Hughes, 2021)[5][9].

The neurodiversity paradigm developed partly in response to medical and deficit-oriented accounts that frame neurodevelopmental differences primarily as individual impairment. It does not deny disability, distress, or support needs; rather, it questions the assumption that difference is inherently pathological and directs attention to the environmental, cultural, and institutional conditions that can disable neurodivergent people (Pellicano & den Houting, 2022; Shaw et al., 2025)[12][13]. Pellicano and den Houting (2022)[12] argue that autism science has been constrained by an overemphasis on deficits, a focus on individual characteristics rather than social context, and limited inclusion of

autistic perspectives. However, Hughes (2021)[9] cautions that autistic people differ substantially in their strengths, impairments, co-occurring conditions, and support requirements. A neurodiversity-informed account should therefore not minimize disability or assume that all difficulties are attributable solely to discrimination.

These debates are central to the concept of inclusion. Inclusion is often represented through institutional access, such as enrolment in mainstream education, recruitment into employment, or admission to a community service. Yet access alone does not establish meaningful participation, social acceptance, belonging, autonomy, or influence over decisions affecting one's life. Cook (2024)[3] argues that deficit-based teacher beliefs and institutional

pressures towards standardization can impede inclusive pedagogy. Dwyer et al. (2023)[6] similarly contend that neurodiversity-inclusive higher education requires attention to stigma, sensory accessibility, communication, accommodation processes, mental-health support, and neurodivergent leadership. In workplace research, Doyle (2020)[5] emphasizes the interaction between individual profiles, environmental demands, legal protections, organisational culture, and reasonable adjustments.

Despite growing adoption of inclusion policies, significant gaps remain in how neurodivergent inclusion is measured and practised. Existing evaluations often rely on physical placement rather than lived belonging, overlooking the mental health costs of camouflaging and the unfair burden placed on individuals to navigate inaccessible environments. Additionally, current frameworks struggle to disentangle social exclusion from other complex drivers of internalising difficulties, while frequently excluding neurodivergent people from co-designing the policies and spaces meant to serve them.

The objective of this review is to critically evaluate whether contemporary inclusion practices genuinely benefit autistic people and people with ADHD beyond mere physical access. Specifically, it clarifies the distinction between nominal inclusion and meaningful inclusion, examines how environmental and social barriers—such as stigma, sensory demands, and camouflaging—impact psychological wellbeing, and outlines a biopsychosocial, neurodiversity-informed framework that pairs individual support with systemic accessibility and neurodivergent agency.

2. Conceptualizing Neurodiversity, Inclusion, and Psychological Wellbeing

2.1 *Neurodiversity and the Neurodiversity Paradigm*

The term neurodiversity may refer to neurological variation across the population, the neurodiversity movement, or the neurodiversity paradigm as a framework for understanding neurodevelopmental difference (Hughes, 2021; Shaw et al., 2025)[9][13]. The paradigm challenges accounts in which autism and other neurodevelopmental differences are understood only as deficits located within individuals. Instead, it highlights the contribution of inaccessible environments, social norms, and unequal power relations to disability and exclusion (Pellicano & den Houting, 2022; Shaw et al., 2025)[12][13].

A neurodiversity-informed perspective does not require the denial of impairment or support needs. Hughes (2021)[9] argues that autism's heterogeneity complicates claims that all autistic difficulties result from discrimination or unjust social arrangements. Doyle (2020)[5] similarly notes that neurodivergent adults may experience uneven profiles of strengths and difficulties with practical implications for occupational functioning and support. This review therefore adopts a biopsychosocial perspective: support needs may be genuine, but their effects are shaped by environmental demands, accessibility, social attitudes, and the availability of accommodations (Doyle, 2020; Pellicano & den Houting, 2022)[5][12].

2.2 *From Access to Meaningful Inclusion*

Inclusion is often operationalized through access to mainstream schools, workplaces, or community services. However, the literature indicates that access is only one component of inclusion. Cook (2024)[3] argues that educational inclusion is restricted when neurodiversity is interpreted through deficit-based assumptions or when institutional systems priorities standardization over responsive pedagogy. Dawson (2022)[4] likewise identifies teacher beliefs, institutional culture, and assumptions about the "normal" learner as relevant to equitable inclusion.

Dwyer et al. (2023)[6] describe neurodiversity inclusion in higher education as requiring accessible accommodation processes, sensory support, flexible communication, mental-health provision, and institutional leadership. Doyle (2020)[5] frames workplace inclusion through the fit between individual profiles and organisational conditions, including job design, reasonable adjustments, legal protections, and workplace culture. Accordingly, this review uses *nominal inclusion* to refer to physical or formal access without adequate participation, acceptance, or support. *Meaningful inclusion* refers to accessible and self-directed participation, appropriate support, dignity, social recognition, and influence over decisions affecting one's life (Cook, 2024; Doyle, 2020; Dwyer et al., 2023)[3][5][6].

2.3 *Belonging, Stigma, and Social Participation*

Belonging is relevant because participation may occur without social acceptance. Turnock et al. (2022)[15] identify stigma as a process shaped by public and professional understandings of autism, interpretations of visible autistic traits, cultural context, contact with autistic people, and diagnostic disclosure. Their review links stigma with reduced wellbeing, reduced social connection, and increased camouflaging. Kim and Gillespie-Lynch (2023)[10] likewise report that autism knowledge, contact with autistic people, endorsement of the neurodiversity movement, and perceived support needs are associated with stigma-related responses. These findings suggest that social participation should not be assessed only through attendance or membership. A neurodivergent student, employee, or community member may be present in a setting while experiencing social distance, misunderstanding, exclusion from informal relationships, or pressure to conceal neurodivergent characteristics. Meaningful inclusion therefore includes practical accessibility and social recognition. The literature does not suggest that all neurodivergent people seek identical forms of social participation; rather, it supports attention to whether participation is voluntary, accessible, respected, and compatible with individual preferences and support needs (Bhattacharya et al., 2026; Turnock et al., 2022)[1][15].

2.4 *Psychological Wellbeing*

Psychological wellbeing includes internalizing difficulties such as anxiety and depression, alongside positive dimensions such as self-acceptance, autonomy, life satisfaction, social connection, and participation. Hargitai et al. (2026)[8] found that autistic adults and adults with ADHD had higher odds of anxiety, depression, and overall internalizing problems than neurotypical adults. Although these findings do not establish that exclusion directly causes these outcomes, they demonstrate the relevance of mental-health outcomes to neurodivergent adulthood.

Neurodiversity-affirming psychological literature distinguishes support for distress from interventions intended to suppress neurodivergent identity or visible traits. Graf- Kurtulus and Gelo (2025)[7] argue that support should address co-occurring mental-health difficulties while protecting autistic identity and reducing environmental sources of distress. Cherewick and Matergia (2024)[2] identify strengths-based interventions as an emerging area of research, although they note that further evidence is required regarding mechanisms of change and long-term wellbeing outcomes.

3. Social Inclusion, Exclusion, and Psychological Wellbeing

3.1 *Stigma, Discrimination, and Social Exclusion*

Social exclusion includes more than formal denial of access. It may involve stigma, voidance, discriminatory attitudes, negative interpretations of neurodivergent behaviour, restricted opportunities, and institutional practices that privilege neurotypical norms (Doyle, 2020; Turnock et al., 2022)[5][15]. Turnock et al. (2022)[15] describe autism stigma as shaped by public and professional knowledge, interpretations of visible autistic traits, contact with autistic people, cultural context, gender, and diagnostic disclosure. Their review links stigma with reduced wellbeing, reduced social connection, and increased camouflaging.

Kim and Gillespie-Lynch (2023)[10] found that autism knowledge, contact with autistic people, endorsement of the neurodiversity movement, and perceived support needs predicted stigma-related responses in at least one domain of their cross-cultural study. Taneja et al. (2024)[14] also describe how stereotypes, limited awareness, and inadequate institutional support contribute to the marginalization of neurodivergent students in Indian higher education. These findings indicate that exclusion may arise through both interpersonal attitudes and institutional systems that are not designed to accommodate neurodivergent participation (Cook, 2024; Dwyer et al., 2023)[3][6].

3.2 *Participation, Belonging, and Social Support*

Formal access does not necessarily result in belonging or meaningful participation. Dwyer et al. (2023)[6] identify post-entry barriers in higher education, including inaccessible communication, sensory distress, stigma, burdensome accommodation procedures, and limited mental-health support. Doyle (2020)[5] similarly argues that occupational participation depends on interactions between individual profiles, workplace demands, organisational culture, legal protections, and reasonable adjustments.

Belonging concerns whether people are socially valued and can participate without being required to conceal important aspects of themselves. Turnock et al. (2022)[15] link stigma with reduced social connection, while Bhattacharya et al. (2026)[1] describe autistic adults' independence in India as involving self-determination alongside support, advocacy, and relationships. These findings challenge accounts that treat independence as the absence of support. Instead, meaningful participation may depend on accessible support and individual choice rather than conformity to conventional social or occupational expectations (Bhattacharya et al., 2026; Doyle,

2020)[1][5].

3.3 *Wellbeing, Identity, and Camouflaging*

Camouflaging is one possible mechanism through which stigma and social expectations may affect wellbeing. Turnock et al. (2022)[15] identify camouflaging as an outcome associated with autism stigma. Graf-Kurtulus and Gelo (2025)[7] similarly argue that interventions focused on normalization may contribute to camouflaging and mental-health challenges. These studies do not imply that all social adaptation is harmful; however, they indicate that apparent inclusion may involve psychological costs where acceptance depends on concealment.

Nagar et al. (2025)[11] found that late-diagnosed Indian women with ADHD described gendered and neurotypical expectations as contributing to masking, emotional exhaustion, anxiety, and burnout. Participants also described diagnosis as supporting validation and self-acceptance. These findings suggest that inclusion should be assessed not only through attendance or institutional membership, but also through whether participation is voluntary, accessible, respected, and compatible with identity and support needs (Nagar et al., 2025; Turnock et al., 2022)[11][15].

4. Barriers to Meaningful Inclusion

4.1 *Institutional and Environmental Barriers*

Institutional inclusion may be limited where systems are designed around standardised assumptions about communication, learning, productivity, behaviour, and sensory tolerance. Cook (2024)[3] argues that deficit-oriented conceptualizations of neurodiversity and external regulatory pressures can reduce teachers' ability to adapt pedagogy. Dawson (2022)[4] similarly identifies educational structures, teacher beliefs, and normative assumptions as barriers to equitable inclusion.

Dwyer et al. (2023)[6] identify barriers in higher education, including onerous accommodation procedures, inadequate transition support, inaccessible communication, sensory distress, and limited mental-health provision. Taneja et al. (2024)[14] report comparable concerns in India, including inflexible deadlines, conventional assessment demands, limited institutional awareness, and inadequate support. In employment, Doyle (2020)[5] identifies job design, managerial practice, legal protections, organisational culture, and reasonable adjustments as factors affecting workplace participation. Access to an institution therefore does not itself remove the barriers embedded within its routines.

4.2 *Attitudinal Barriers and Neurotypical Norms*

Negative attitudes, limited knowledge, and expectations of neurotypical behaviour may restrict inclusion even where formal accommodations are available. Turnock et al. (2022)[15] identify public and professional understanding of autism as an important influence on stigma. Kim and Gillespie-Lynch (2023)[10] similarly report associations between stigma-related responses, autism knowledge, contact with autistic people, and support for the neurodiversity movement.

The neurodiversity literature also critiques the assumption that social, academic, and occupational success requires a single "normal" cognitive or behavioural style. Pellicano and den Houting (2022)[12] describe autism science as historically centred on deficits and individual remediation. Shaw et al. (2025)[13] argue that the neurodiversity paradigm draws attention to the power relations through which some ways of thinking and learning are treated as normative. These norms may shape how direct communication, sensory regulation, movement, attention variation, or differences in social interaction are interpreted in schools, workplaces, and communities (Cook, 2024; Doyle, 2020)[3][5].

4.3 *Disclosure, Support, and the Burden of Self-Advocacy*

Access to support may depend on diagnosis, disclosure, and the ability to explain one's needs. Cook (2024)[3] notes that students without a formal diagnosis can experience barriers to support in education. Dwyer et al. (2023)[6] therefore recommend less burdensome eligibility requirements and more accessible accommodation procedures. However, disclosure may involve risks where neurodivergence is misunderstood or stigmatized; Turnock et al. (2022)[15] identify diagnostic disclosure as one factor shaping autism stigma.

Bhattacharya et al. (2026)[1] found that autistic adults in India described independence as involving advocacy and external support. Nagar et al. (2025)[11] document pressure on Indian women with ADHD to conceal traits in response to gendered and neurotypical expectations. These studies indicate that inclusion depends not only on whether support exists, but on whether people can request and receive it without stigma, excessive administrative burden, or pressure to mask.

4.4 *Cultural and Intersectional Barriers*

Neurodivergent experiences are shaped by gender, culture, social class, language, race/caste, and access to diagnosis and services. Taneja et al. (2024)[14] emphasize the need for systemic change in Indian higher education, while Nagar et al. (2025)[11] demonstrate that neurotypical and gendered expectations intersect in the experiences of Indian women with ADHD. These findings caution against treating inclusion as a uniform process or assuming that models developed in Western settings transfer unchanged across contexts. Meaningful inclusion requires attention to universal accessibility as well as to the social conditions that shape whose needs are recognised.

5. Inclusion Across Education, Employment, and Community Settings

5.1 *Schools and Higher Education*

Educational inclusion is often discussed through mainstream placement and learning support. However, Cook (2024)[3] argues that inclusive pedagogy depends on teachers' conceptualizations of neurodiversity, reflective practice, and the extent to which educational systems permit flexible teaching. Dawson (2022)[4] similarly frames neurodiversity as an equity issue requiring changes to institutional culture, pedagogy, and assumptions about the "normal" learner.

Dwyer et al. (2023)[6] recommend that higher-education institutions provide accessible accommodations, sensory support, flexible communication, neurodiversity training, mental-health provision, and neurodivergent leadership. Taneja et al. (2024)[14] report that neurodivergent students in India may encounter rigid academic expectations, limited awareness, insufficient support, and difficulties obtaining meaningful accommodations. These sources indicate that education is not inclusive merely because students are admitted. Inclusion also concerns whether curricula, assessments, deadlines, communication, and support services enable participation without disproportionate distress or disadvantage (Cook, 2024; Dwyer et al., 2023)[3][6].

5.2 *Workplaces*

Workplace neurodiversity initiatives have increasingly focused on recruitment, specialist hiring programmes, and potential strengths associated with particular neurodivergent profiles. Doyle (2020)[5] cautions that workplace inclusion should be understood through a biopsychosocial model rather than a narrow "business case." This model considers the interaction between strengths and difficulties, work demands, organisational culture, legal protection, and reasonable adjustments. Workplace inclusion therefore, concerns more than recruitment. It also concerns retention, career development, workplace relationships, psychological safety, and access to support. Conventional recruitment procedures, sensory environments, informal communication expectations, rigid performance measures, and inconsistent accommodation processes may create barriers to participation (Doyle, 2020; Shaw et al., 2025)[5][13]. The literature supports attention to job and workplace design rather than assigning responsibility for adjustment solely to neurodivergent employees (Doyle, 2020)[5].

5.3 *Community Participation and Everyday Life*

Community inclusion includes participation in healthcare, transport, leisure, family life, housing, and public services. Although these areas receive less attention than education and employment in the reviewed literature, existing work suggests that participation is affected by stigma, accessibility, social support, and opportunities for self-advocacy (Bhattacharya et al., 2026; Turnock et al., 2022)[1][15]. Turnock et al. (2022)[15] identify autism-friendly spaces, positive representation, public education, and systemic change as potential responses to stigma.

Bhattacharya et al. (2026)[1] show that autistic adults in India understood independence through self-determination, support, and advocacy. Nagar et al. (2025)[11] similarly indicate that cultural and gendered expectations shape whether ADHD traits are understood, concealed, or supported. Across educational, workplace, and community settings, meaningful inclusion depends on accessible environments, respectful relationships, adequate support, and opportunities to influence decisions (Bhattacharya et al., 2026; Dwyer et al., 2023; Turnock et al., 2022)[1][6][15].

6. The Contribution of Psychology to Meaningful Inclusion

6.1 *Psychological Models of Neurodivergence*

Psychology has contributed to neurodevelopmental research through diagnosis, assessment, intervention, and the study of mental-health outcomes (Doyle, 2020; Pellicano & den Houting, 2022)[5][12]. Neurodiversity-informed scholarship, however, questions approach that locate difficulties solely within neurodivergent individuals while giving limited attention to social environments, institutional practices, and autistic perspectives (Pellicano & den Houting, 2022; Shaw et al., 2025)[12][13]. Doyle's (2020)[5] biopsychosocial model proposes that neurodivergent outcomes are

shaped by individual functioning, environmental demands, social attitudes, legal protections, and accommodations. Hargitai et al. (2026)[8] found elevated odds of anxiety, depression, and internalizing problems among autistic adults and adults with ADHD. Graf-Kurtulus and Gelo (2025)[7] also identify anxiety and depression as important co-occurring concerns within autism. These findings support accessible mental-health care, while indicating that distress should be considered alongside stigma, environmental mismatch, exclusion, and limited support rather than being attributed to neurodivergence alone (Doyle, 2020; Turnock et al., 2022)[5][15].

6.2 *Neurodiversity-Affirming Support*

Neurodiversity-affirming practice distinguishes support for distress from attempts to suppress neurodivergent identity or traits. Graf-Kurtulus and Gelo (2025)[7] argue that interventions oriented towards social conformity may contribute to camouflaging and poorer mental-health outcomes. Cherewick and Matergia (2024)[2] identify perceptual, reasoning, expertise, and character strengths as potential resources within psychosocial interventions, while noting that the evidence base remains limited. Strengths-based practice should therefore be understood as an emerging approach requiring further evaluation rather than as a replacement for all clinical support. A neurodiversity-affirming approach may be most appropriate when it supports self-understanding, mental health, and adaptive environmental change without treating neurodivergent identity as a clinical problem to be eliminated (Cherewick & Matergia, 2024; Graf-Kurtulus & Gelo, 2025)[2][7].

6.3 *Psychology, Stigma, and Institutional Change*

Psychology may contribute through stigma-reduction research, professional training, consultation, and evaluation of support systems. Turnock et al. (2022)[15] identify autism-friendly environments, public and professional education, positive representation, and wider cultural change as possible responses to stigma. Kim and Gillespie-Lynch (2023)[10] found that autism knowledge, contact with autistic people, neurodiversity endorsement, and perceptions of support needs were associated with stigma-related responses. Educational and organisational research indicates that psychological support alone cannot address structural barriers. Cook (2024)[3] highlights teacher beliefs and reflective practice as factors in inclusive pedagogy, while Dwyer et al. (2023)[6] recommend reforms to accommodation, communication, sensory accessibility, mental-health support, and neurodivergent leadership in higher education. Psychology can therefore contribute most effectively when individual support is combined with institution-level accessibility, anti-stigma work, and meaningful participation by neurodivergent people in research and service design (Dwyer et al., 2023; Pellicano & den Houting, 2022)[6][12].

7. Discussion: Is Inclusion Truly Inclusive?

7.1 *From Presence to Meaningful Inclusion*

The reviewed literature indicates that inclusion is not adequately assessed through physical presence or formal access alone. Educational, workplace, and community literature identify barriers that may persist after a neurodivergent person enters a mainstream setting, including inaccessible communication, sensory demands, stigma, rigid procedures, limited support, and pressure to conform to neurotypical norms (Cook, 2024; Doyle, 2020; Dwyer et al., 2023; Turnock et al., 2022)[3][5][6][15]. Meaningful inclusion is therefore better understood through participation, social acceptance, belonging, accessible support, self-determination, and
agency.

7.2 *Inclusion, Support, and Wellbeing*

The literature does not support a simple claim that inclusion alone determines wellbeing. Hargitai et al. (2026)[8] demonstrate elevated internalizing difficulties among autistic adults and adults with ADHD, while Hughes (2021)[9] emphasizes heterogeneity in neurodivergent experience and support needs. Nevertheless, stigma, social disconnection, environmental mismatch, and camouflaging are repeatedly identified as relevant to participation and wellbeing (Graf-Kurtulus & Gelo, 2025; Kim & Gillespie-Lynch, 2023; Turnock et al., 2022)[7][10][15]. A biopsychosocial account is therefore required: individual characteristics and support needs interact with social attitudes, institutional practices, and environmental conditions (Doyle, 2020; Hughes, 2021)[5][9].

7.3 *Limitations and Implications for Research*

The evidence base has limitations. Much of the reviewed literature centres on autism, with less attention to ADHD and other neurodivergent groups (Hargitai et al., 2026; Hughes, 2021)[8][9]. Several sources are conceptual, narrative, or perspective-based rather than longitudinal or intervention studies, including work on inclusive pedagogy, neurodiversity-affirming therapy, and higher-education reform (Cook, 2024; Dwyer et al., 2023; Graf-Kurtulus & Gelo, 2025)[3][6][7]. These sources are valuable for identifying barriers and proposing reforms, but they cannot

independently establish causal effects on wellbeing.

The reviewed Indian literature also demonstrates the importance of cultural and intersectional research. Taneja et al. (2024), Nagar et al. (2025), and Bhattacharya et al. (2026)[14][11][1] indicate that inclusion, diagnosis, gender expectations, independence, and support are culturally situated. Future research would benefit from participatory designs, longitudinal methods, and measures that distinguish institutional access from participation, belonging, agency, and wellbeing (Pellicano & den Houting, 2022; Shaw et al., 2025)[12][13].

8. Conclusion

This review examined whether social inclusion is genuinely inclusive for neurodivergent individuals. The literature indicates that formal access to mainstream schools, universities, workplaces, and community settings does not necessarily ensure participation, acceptance, belonging, or agency (Cook, 2024; Doyle, 2020; Dwyer et al., 2023)[3][5][6]. Inclusion is more appropriately assessed through the quality of participation and relationships, environmental accessibility, available support, and the extent to which neurodivergent people can exercise choice and self-advocacy (Bhattacharya et al., 2026; Turnock et al., 2022)[1][15].

Stigma, inaccessible institutional norms, limited support, and pressure to camouflage may restrict meaningful inclusion and affect wellbeing (Graf-Kurtulus & Gelo, 2025; Kim & Gillespie-Lynch, 2023; Turnock et al., 2022)[7][10][15]. At the same time, mental-health outcomes cannot be explained through exclusion alone, and neurodivergent people have diverse strengths, needs, and experiences (Hargitai et al., 2026; Hughes, 2021)[8][9]. The reviewed literature therefore supports a biopsychosocial and neurodiversity-informed approach that combines individual support with changes to social environments, institutional practices, and public attitudes.

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The author(s) followed all ethical guideline applicable to this research. As the study is a review-based analysis no further ethical approval or prior consent from participants is needed.

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