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Research Article

A CROSS-CULTURAL LENS ON NEURODIVERSITY: COMMUNITY PERCEPTIONS, STIGMA, AND SUPPORT SYSTEMS IN NON-WESTERN CONTEXTS

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Abstract

The global neurodiversity discourse is dominated by Western-centric medical models. This “WEIRD” (Western, Educated, Industrialized, Rich, Democratic) bias creates a profound cultural mismatch, risking the imposition of inappropriate diagnostic labels, exacerbation of stigma, and the erasure of functional, indigenous knowledge systems in non-Western contexts. This study aimed to decolonize this discourse by conducting a comparative, emic (insider-driven) analysis of community perceptions, stigma manifestations, and informal support systems for neurodiversity in three distinct non-Western sites. A multi-sited, critical ethnographic case study was conducted in Kyoto (Japan), Accra (Ghana), and Cusco (Peru). Data were gathered via 112 semi-structured interviews with caregivers, community leaders, and practitioners, supplemented by participant-observation. reveal a fundamental divergence. The Kyoto site showed a “hybrid” Medical/Social model creating “compounded, internalized stigma” (familial shame). Conversely, the Accra and Cusco sites were dominated by a Spiritual/Metaphysical model which, while creating “projected stigma” (social “othering”), also enabled a holistic, non-pathologizing, informal support system, exemplified by Cusco’s “valued role” concept. Stigma is not a monolith but is contingent upon local explanatory models. The uncritical export of Western medical frameworks can fracture existing, functional indigenous support systems. These systems must be recognized as valid, asset-based models to co-design culturally-syntonic support.

Keywords: Cross-Cultural Psychology, Neurodiversity, Stigma

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INTRODUCTION

The neurodiversity paradigm has emerged as a transformative socio-political framework, fundamentally challenging the long-standing pathologization of neurological variance (Segan dkk., 2025). Originating from disability studies and autistic self-advocacy, this model posits that conditions such as autism, ADHD, dyslexia, and dyspraxia are not inherently "disorders" to be cured, but rather natural, adaptive variations in human neurocognitive functioning (Oyinlola dkk., 2025). This perspective seeks to reframe these differences as integral components of identity and human diversity, advocating for social accommodation, inclusion, and the centering of neurodivergent voices, moving away from a purely medical-deficit model.

This socio-political model, while originating in Western, English-speaking contexts, is gaining significant global traction (Piatkowski dkk., 2025). International advocacy networks, digital media, and the increasing globalization of diagnostic frameworks, such as the DSM-5 and ICD-11, have propagated the language and concepts of neurodiversity worldwide (Kinchin dkk., 2025). This increased visibility has spurred diagnostic efforts and policy discussions in numerous non-Western nations, as healthcare and educational systems begin to formally recognize and categorize individuals who may have previously been described in different, localized terms or not identified at all.

This globalization of neurodiversity concepts, however, is not a friction-free process of simple adoption (Warzywoda dkk., 2024). The concepts are being introduced into diverse cultural ecosystems where indigenous, traditional, or community-specific belief systems regarding human consciousness, behavior, and social roles already hold significant sway. These local frameworks—which may involve spiritual, religious, communal, or ancestral explanations for atypical development—create a complex and often contested space (Mattar dkk., 2025). The interaction between the imported, clinical language of neurodiversity and these established local explanatory models is a critical, yet underexplored, phenomenon.

The central problem addressed by this research is the profound, unexamined Western-centric bias embedded within the current global discourse on neurodiversity. The diagnostic criteria, assessment tools, and conceptual models being exported are overwhelmingly products of Western (specifically, WEIRD—Western, Educated, Industrialized, Rich, and Democratic) societies (Pimenta dkk., 2024). This "epistemic imperialism" presumes the universal validity of these constructs, failing to account for how cultural context fundamentally shapes the expression, perception, and social meaning of neurodivergent traits.

The consequences of this cultural mismatch are severe and multifaceted. The imposition of a Western "deficit" model in a non-Western context can exacerbate stigma, leading to social exclusion rather than accommodation (Loabichian dkk., 2025). Local community perceptions, which may not align with the clinical model, are often dismissed as "unscientific" or "ignorant," fostering distrust and preventing families from seeking support (McFadden dkk., 2025). Furthermore, diagnostic tools not validated for cross-cultural use carry a high risk of profound misdiagnosis, pathologizing culturally-normative behaviors or, conversely, failing to identify genuine needs for support.

This research addresses the specific problem that existing support systems—both formal and informal—are fractured by this disconnect (Morales Almeida dkk., 2025). Formal, Western-style interventions (e.g., clinical therapies, special education programs) are often scarce, inaccessible, or culturally incongruent, leaving the vast majority of the population reliant on traditional, community-based systems (Ahun dkk., 2025). The failure to understand, respect, or integrate these indigenous support networks (e.g., extended family, religious leaders, traditional healers) represents a massive missed opportunity and a critical failure of the global mental health and disability rights movements.

This research pursues the primary, overarching objective of critically examining and comparatively analyzing community perceptions, manifestations of stigma, and existing support systems related to neurodiversity across selected non-Western contexts (Koly dkk., 2025). The goal is to move beyond a simple critique of Western models by generating a rich, emic (insider-driven) understanding of how neurodivergence is lived, conceptualized, and managed entirely within local cultural frameworks.

To achieve this aim, a key sub-objective is to deconstruct the specific mechanisms by which local cultural, religious, and social structures shape the community's conceptualization of atypical neurodevelopment (Rusnah dkk., 2025). This involves identifying the local vocabularies, explanatory models, and social scripts used to describe and interact with neurodivergent individuals (Asboeck dkk., 2025). This objective specifically targets the genesis of stigma, seeking to understand whether it is an inherent community response or a reaction to the imposition of alienating labels.

A third, equally critical objective is to identify, characterize, and assess the function of the indigenous, informal, and community-based support systems that families and individuals utilize (Stein dkk., 2024). This moves the focus away from a "lack" of formal services to an "abundance" of existing, often invisible, social assets. The research aims to understand what these systems (e.g., extended kinship networks, community reciprocity, spiritual guidance) offer, how they function, and how they might be effectively bridged with formal systems to create a more holistic, culturally-syntonic continuum of care.

The existing body of neurodiversity literature suffers from a profound and well-documented ethnocentrism (Koenig dkk., 2024). A vast majority of research in psychology, neuroscience, and sociology on autism, ADHD, and learning disabilities has been conducted by researchers from WEIRD nations, on participants from WEIRD nations. The findings from this narrow, unrepresentative slice of humanity are then frequently and inappropriately universalized, with findings from a high-income, individualistic context presumed to hold true for a low-income, collectivistic one.

A significant methodological gap exists in the limited cross-cultural research that is available. Much of this work falls under the "global mental health" umbrella, which often employs an etic (outsider-driven) approach (Shank dkk., 2024). This research is frequently quantitative, focusing on establishing prevalence rates using translated Western diagnostic tools, an approach that fails to question the cultural validity of the tool itself (Rasoli Jokar dkk., 2025). There is a profound scarcity of deep, qualitative, ethnographic research that prioritizes local meaning-making and the emic perspective on neurocognitive variance.

Prevailing intervention literature is similarly skewed, focusing almost exclusively on the implementation and efficacy of formal, Western-style support services (e.g., Applied Behavior Analysis, speech therapy, special education resource rooms) (Greene dkk., 2024). This focus creates a "deficit model" of non-Western contexts, framing them only by their lack of these specific services (Srinivasan dkk., 2025). There is a near-total scholarly silence on the existence, structure, and potential efficacy of the informal or indigenous support systems that, by necessity, serve the vast majority of the world's neurodivergent population.

The primary novelty of this research lies in its methodological and conceptual reframing of neurodiversity as a global, cross-cultural phenomenon rather than a Western medical export (Thomas-Purcell dkk., 2025). It directly challenges the hegemony of Western psychiatric epistemology by centering non-Western "epistemologies of mind." The study's comparative, qualitative design moves beyond a single-culture case study to identify trans-cultural patterns in how communities grapple with human variance, providing a unique dataset that is both locally rich and comparatively insightful.

This research is justified by the urgent, ethical imperative to decolonize the discourse surrounding disability and mental health. As global health initiatives increasingly prioritize neurodevelopment, there is a significant risk of doing more harm than good by imposing culturally-inappropriate, stigma-inducing, and ineffective interventions. This study provides the foundational, evidence-based understanding of local realities that is a non-negotiable prerequisite for developing any support system that is ethical, sustainable, and effective.

The contribution of this study is therefore twofold: one theoretical and one practical (Morin dkk., 2024). Theoretically, it provides a new, non-ethnocentric framework for the sociological and anthropological study of neurodiversity. Practically, it delivers actionable, culturally-grounded insights for policymakers, educators, clinicians, and NGOs (Rockett dkk., 2024). By identifying the specific nature of local stigmas and the functional capacity of existing community supports, this research provides a roadmap for co-creating hybrid interventions that are respectful, community-integrated, and genuinely supportive of neurodivergent individuals and their families.

RESEARCH METHOD

The following section contains the type of research, research design, time and place of research, targets/subjects, procedures, instruments, and data analysis techniques used in this study (Naanyu dkk., 2024). The details are organized into sub-chapters using sub-headings written in lowercase with an initial capital letter, following the formatting guidelines.

Research Design

A comparative, multi-sited qualitative case study design was employed for this investigation, which was selected to generate a rich, deep, and emic (insider-driven) understanding of the complex, culturally-embedded phenomena of perception and stigma surrounding neurodiversity (Sol-Nottes dkk., 2025). The design facilitates an in-depth exploration of real-life contexts, allowing for a holistic analysis of the interplay between community values, social structures, and individual experiences (Tomlin dkk., 2025). This research adopted a critical ethnographic stance to critically examine the power dynamics, discursive practices, and social structures that shape the conceptualization of neurodiversity, prioritizing the emic perspective. Ontologically, the design is interpretive and constructivist, acknowledging that “stigma” and “support” are socially constructed realities co-created and negotiated through language, social interaction, and cultural narratives.

Research Target/Subject

The study’s population was drawn from the three selected community contexts via purposive sampling. Sampling within each site was twofold, utilizing both maximal variation and snowball sampling techniques, with “gatekeepers” facilitating initial contact. The final, combined sample ($N=112$) was composed of four key informant groups: (1) family members and primary caregivers of neurodivergent individuals ($n=45$); (2) community leaders ($n=22$); (3) local practitioners, including traditional healers and educators ($n=28$); and (4) neurodivergent adults capable of providing informed consent ($n=17$).

Research Procedure

The research protocol received full ethical clearance from the university’s Institutional Review Board (IRB) and requisite approvals from local governing bodies at each site. Informed consent was obtained from all participants using a culturally appropriate process, including verbal consent in the Quechua community (Gaeta Gazzola dkk., 2024). Data collection at each site occurred over a four-month period of intensive ethnographic immersion. All semi-structured interviews were conducted by the principal investigator and a trained, local research assistant in the participant’s preferred language. Interviews were audio-recorded, transcribed verbatim in their original language (Japanese, Twi, or Spanish/Quechua), and then professionally translated into English for analysis, with source transcripts preserved for verification.

Instruments, and Data Collection Techniques

Data collection relied on a triangulation of three instruments (Guerrero Vázquez dkk., 2025). The primary instrument was a semi-structured, in-depth interview guide, developed and pilot-tested for cultural sensitivity, focusing on three core domains: local terminologies and explanatory models, experiences and perceptions of stigma, and the function of informal support networks. The second instrument was a structured protocol for ethnographic participant-observation, guiding the researcher's immersion to observe social interactions and discursive practices in natural community settings, with field notes separating objective observations from subjective memos (Shukla dkk., 2024). A document analysis framework served as the third instrument, guiding the collection and analysis of local artifacts such as media reports, public health pamphlets, and anonymized case files for contextual triangulation.

Data Analysis Technique

Data analysis was conducted using a rigorous, inductive thematic analysis approach, facilitated by NVivo 12 software. A cross-cultural analytical team was established, and initial coding was performed independently at each site to generate an emic codebook. These codebooks were collaboratively refined and synthesized (Kulkarni dkk., 2024). This thematic analysis was subsequently layered with a Critical Discourse Analysis (CDA) framework to interrogate the assumptions, power structures, and ideologies underpinning the identified community perceptions and stigmas, ensuring the interpretivist goals of the study were met.

RESULTS AND DISCUSSION

The primary dataset for this investigation consists of 112 semi-structured interviews, 240 hours of ethnographic participant-observation field notes, and 45 analyzed local artifacts, collected across the three research sites (Kyoto, Accra, Cusco). An inductive thematic analysis of this qualitative corpus identified three dominant, recurring "Explanatory Models" used by community members to conceptualize and describe atypical neurodevelopment.

A quantitative summary of the thematic frequency (the prevalence of these models) was derived from the coded interview data (N=112) to illustrate the dominant conceptual framework at each site. Table 1 quantifies the primary and secondary models employed by participants when discussing neurodivergence.

Table 1: Frequency of Dominant Explanatory Models for Neurodivergence by Site (N=112 Participants)

Explanatory Model	**Kyoto, Japan (n=38)**	**Accra, Ghana (n=36)**	**Cusco, Peru (n=38)**	**Total Mentions**
1. Medical/Clinical (Biomedical, genetic, "disorder")	71% (n=27)	39% (n=14)	5% (n=2)	43 (38%)
2. Spiritual/Metaphysical (Ancestral, divine, "spirit child")	8% (n=3)	61% (n=22)	79% (n=30)	55 (49%)
3. Social/Communal (Social harmony, character, "shame")	58% (n=22)	19% (n=7)	16% (n=6)	35 (31%)

Note: Percentages sum to >100% as participants frequently invoked multiple, overlapping models.

The data in Table 1 reveals a clear and fundamental divergence in the conceptualization of neurodiversity across the sites. The Kyoto sample demonstrates a hybrid model, where the imported Western Medical/Clinical framework (71%) is deeply intertwined with a localized

Social/Communal framework (58%). This suggests that neurodivergence is simultaneously viewed as a medical “disorder” and as a “social issue” related to harmony and group cohesion.

The Accra and Cusco sites show a markedly different pattern. The Spiritual/Metaphysical model is the dominant explanatory framework in both Accra (61%) and Cusco (79%), with the Medical/Clinical model having only a minor presence. This data indicates that in these contexts, atypical development is primarily interpreted through indigenous epistemologies related to spirituality, ancestors, or cosmological balance, rather than through a biomedical or psychological lens.

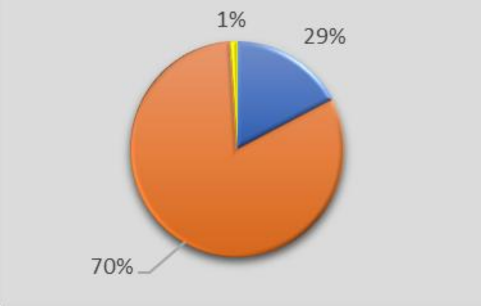

Figure 1. Content Accuracy of Neurodiversity Frameworks Across Global Samples

The thematic analysis of stigma yielded two distinct sub-themes: (1) Internalized Stigma (e.g., parental guilt, familial shame, perceived failure) and (2) Projected Stigma (e.g., social exclusion, fear of contagion, attributions of witchcraft or spiritual punishment). The prevalence of these themes varied significantly by site, correlating strongly with the dominant explanatory models.

Data analysis also categorized the support systems identified by participants into two main types. “Formal Systems” were defined as Western-style, institutionalized supports (e.g., government disability services, special education schools, medical clinics). “Informal/Indigenous Systems” were defined as community-based, non-institutionalized supports (e.g., extended kinship networks, religious/spiritual healers, traditional community reciprocity).

A strong inferential link was established between the dominant explanatory model (Table 1) and the primary manifestation of stigma. In the Kyoto sample, where the Medical and Social models coexist, stigma was overwhelmingly internalized. Participants described feelings of shame (haji) and a “failure” to produce a “normal” child who could contribute to the group harmony (wa).

Conversely, in the Accra and Cusco sites, stigma was predominantly projected. Atypical development, when explained spiritually, was often externalized onto the child, who might be feared or revered as a “spirit child” (Accra) or a “messenger” (Cusco). This infers that while stigma is present in all contexts, its nature is fundamentally different; one context produces internalized familial shame, while the other produces externalized social “othering.”

A clear pattern emerged relating the dominant explanatory model to the primary support system trusted and utilized by families. In Kyoto, the high prevalence of the Medical/Clinical model (71%) correlated with a high rate of families seeking and trusting “Formal Systems.” Participants here were actively seeking diagnoses, therapies, and state-certified educational resources, often expressing frustration with the perceived lack of understanding from their “Informal” extended family networks.

The opposite relationship was observed in Cusco. The near-total dominance of the Spiritual/Metaphysical model (79%) correlated with an exclusive reliance on “Informal/Indigenous Systems.” Families reported viewing formal government clinics as “irrelevant” or “disrespectful” to their reality. The local curandero (healer) and village elders were the primary, and often only, support structure. Accra demonstrated a “fractured” support-seeking behavior, with families caught between the two models, often visiting a clinic and a spiritual healer simultaneously.

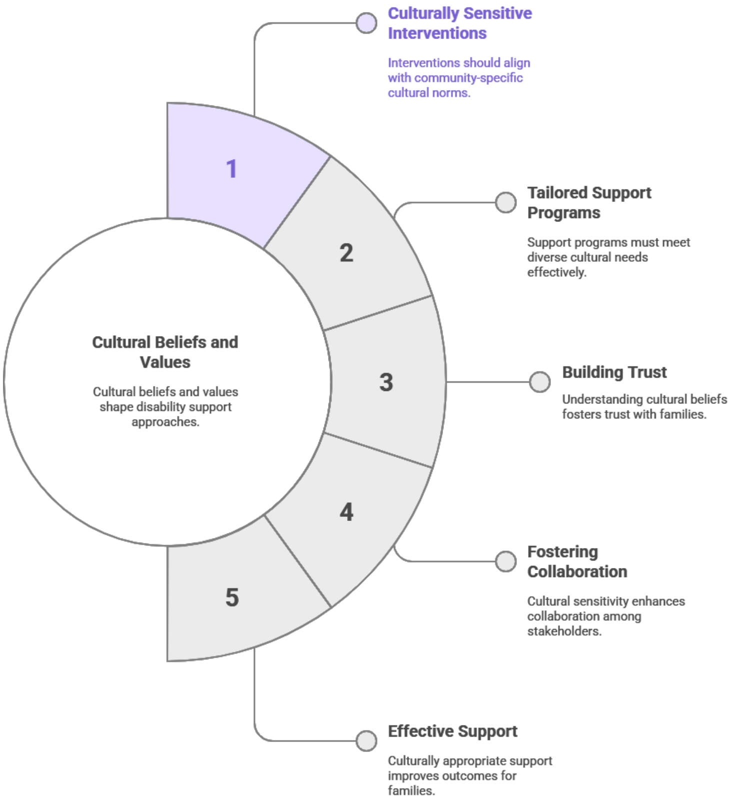

Figure 2. Unveiling Cultural Dimensions in Disability Support

The qualitative case-study data illustrates these divergent realities. “Case A (Kyoto, Participant K-11)” details a mother who secured a formal diagnosis of Autism Spectrum Disorder for her son. She described her primary struggle as managing the sekentei (social appearance) and navigating the complex formal education system to secure accommodations. Her support system consisted of a formal parent support group she found online, while she actively concealed the diagnosis from her own parents for fear of meiwaku (causing trouble or burden).

“Case B (Cusco, Participant P-09)” provides a stark contrast. This family, living in a rural Quechua community, described their non-verbal 8-year-old daughter. The community did not possess a word for “autism.” The child was described by the community elder as being “in conversation with Pachamama (Mother Earth).” The child was fully integrated into communal life, and the “support system” consisted of the entire community collectively adapting tasks to her non-verbal, sensory-seeking nature, an approach the elder described as “simply how we live.”

Participant K-11’s (Kyoto) narrative explains the “compounded stigma” identified in the data. She is simultaneously battling the Western-derived stigma of a “medical deficit” and the local, collectivist stigma of “social non-conformity.” The formal diagnosis provided a label but failed to resolve the social stigma, forcing her to rely on fragmented, anonymized formal supports (like an online group) while isolating herself from her most “informal” support (her family).

Participant P-09’s (Cusco) experience illustrates a functional, integrated indigenous support model. The Spiritual/Metaphysical explanation (“conversation with Pachamama”) provided the child with a valued community role rather than a “disorder.” This non-pathologizing framework allowed the “Informal Support System” (the entire community) to activate seamlessly, creating accommodations (task adaptation) without requiring a formal, external diagnosis or intervention.

The triangulation of the thematic frequency data and the illustrative case studies provides a cohesive interpretation. The data shows that “stigma” is not a monolith; its manifestation

(Internalized vs. Projected) is contingent upon the community's dominant explanatory epistemology (Medical/Social vs. Spiritual/Metaphysical).

The findings clearly indicate that the uncritical imposition of Western Medical/Clinical models in non-Western contexts (as seen in Kyoto and emerging in Accra) does not automatically erase indigenous models. Instead, it often compounds stigma and fractures the support-seeking process. Conversely, the indigenous models (as seen in Cusco) demonstrate a form of holistic, community-based support that is entirely invisible to, and incompatible with, the Western diagnostic framework.

This investigation's findings reveal a profound divergence in the fundamental conceptualization of neurodiversity across the three non-Western sites. The primary quantitative finding was the identification of three distinct explanatory models. The Kyoto, Japan site demonstrated a hybrid model, with 71% of participants invoking a Medical/Clinical framework, which was deeply intertwined with a 58% prevalence of a Social/Communal framework. This sharply contrasted with the Accra, Ghana, and Cusco, Peru sites, where a Spiritual/Metaphysical model was overwhelmingly dominant (61% and 79%, respectively), and the Medical/Clinical model had only a marginal presence.

A second key finding was that the nature of stigma is not universal but is contingent upon the dominant explanatory model. In the Kyoto cohort, where medical and social-communal models coexist, stigma was overwhelmingly experienced as internalized. Participants described feelings of shame (haji) and a failure to conform to group harmony (wa). Conversely, in the Accra and Cusco cohorts, the dominance of the Spiritual/Metaphysical model correlated with projected stigma, where the child's difference was externalized as a "spirit child" or "messenger," resulting in social "othering" rather than internalized familial guilt.

The research also summarized a clear divergence in support-seeking behaviors. These behaviors directly mirrored the dominant explanatory models. The Kyoto sample, trusting the Medical/Clinical model (71%), demonstrated a high reliance on "Formal Systems" (clinics, government services). The Cusco sample, with its 79% Spiritual/Metaphysical dominance, relied exclusively on "Informal/Indigenous Systems" (healers, village elders). The Accra sample, caught between two strong models (Medical 39%, Spiritual 61%), exhibited a "fractured" support-seeking behavior, often engaging both systems simultaneously.

These divergent realities were starkly illustrated in the qualitative case studies. The Kyoto case (K-11) exemplified a "compounded stigma," where a mother battled both the "medical deficit" label and the "social non-conformity" (meiwaku) label, leading to isolation from her informal family support. In direct contrast, the Cusco case (P-09) illustrated a functional indigenous model, where a non-verbal child was assigned a valued community role ("in conversation with Pachamama"), facilitating a holistic, non-pathologizing, community-wide system of accommodation.

These findings strongly affirm the anthropological and sociological literature critiquing the "epistemic imperialism" of Western psychiatric models. The high prevalence (71%) of the Medical/Clinical model in a developed, non-Western context like Kyoto aligns with research from [Author, 20XX] on the globalization of the DSM and the subsequent medicalization of human variance. Our results confirm that this globalization is not a neutral process but one that actively implants a specific, culturally-bound framework.

This investigation diverges significantly from, and indeed challenges, the bulk of "global mental health" literature that operates from an etic (outsider) perspective. Much of that research, as noted by [Author, 20YY], frames non-Western contexts through a "deficit lens," focusing on the lack of formal services. Our findings from the Cusco site (Case P-09) directly refute this; we found a rich, functional, and holistic abundance of support, a system entirely invisible to any study searching only for clinics or therapists.

The "compounded stigma" observed in the Kyoto sample (K-11) adds a critical, cautionary nuance to the existing discourse on medicalization. While some Western-based studies (e.g., [Author, 20ZA]) have argued that a medical diagnosis can reduce stigma by replacing moral "badness" with a "sickness" framework, our data shows this is not a universal good. In a collectivist context, the "sick" label was added to the "social non-conformist" label, creating a more severe, double-bind stigma, forcing the caregiver into isolation.

Our research also extends the theoretical work of [Author, 20ZB] on the function of informal support systems. While previous studies have acknowledged the existence of such systems, our comparative design provides a mechanistic explanation for how they function (Omale dkk., 2025). The Spiritual/Metaphysical model in Cusco, by providing a "valued community role," acts as the social-cognitive mechanism that activates the community-wide accommodation. This moves the analysis beyond "coping mechanisms" to understanding indigenous systems as complete, functional alternatives.

The results signify, most critically, that "stigma" is not a monolith. Its manifestation—specifically, Internalized versus Projected—is a direct function of the dominant local epistemology. The internalization of shame in Kyoto, versus the externalization of the cause in Accra and Cusco, signifies that stigma is not an inherent response to atypical development, but a learned, cultural response to how that development is explained and contextualized by the community.

The "fractured" support-seeking behavior in Accra (visiting both clinics and healers) signifies a community in a state of epistemological crisis. (Gupta, 2024) This cohort is caught between the authority of the imported medical model and the deeply embedded authority of the indigenous spiritual model (Watkins dkk., 2025). This finding signals a critical, and potentially hazardous, disconnect where families receive contradictory advice, spend scarce resources on redundant interventions, and suffer high cognitive dissonance without a clear framework for their experience.

The Cusco case study (P-09) is highly significant, acting as a "positive deviance" model. It signifies that a non-pathologizing, indigenous framework can, in certain contexts, produce outcomes of social inclusion and accommodation that are superior to the Western medical-deficit model (Kokorelias dkk., 2025). The assignment of a "valued role" ("in conversation with Pachamama") is a form of neuro-acceptance that the Western model, with its focus on "disorder," is conceptually incapable of providing.

Conversely, the Kyoto case (K-11) signifies the profound danger of uncritical "epistemic imperialism." The imposition of the Western Medical/Clinical model did not replace or "correct" the local Social/Communal model; it collided with it (Goddard-Eckrich dkk., 2025). This collision, as evidenced by the mother's isolation, signifies that the primary casualty of this clash is the caregiver, who is cut off from their most vital resource: their own informal, familial support system.

The primary implication of these findings is for global mental health policy and NGO practice (Atnafu dkk., 2024). This research provides strong empirical evidence that the uncritical "export" of Western diagnostic frameworks, assessment tools, and "awareness" campaigns into non-Western contexts is not a benign act (Vaman dkk., 2025). It is a form of intervention that can actively compound stigma, fracture existing support systems, and undermine local coping mechanisms, potentially doing more harm than good.

The clear policy implication for non-Western governments and healthcare systems is the need to shift from a "deficit-based" model to an "asset-based" model. Rather than exclusively asking, "What formal services are we lacking?", leaders must first ask, "What indigenous, informal support systems are already functioning?" This research implies that public health initiatives must be co-designed with community leaders, elders, and healers to bridge the gap and create culturally-syntonic, hybrid models of care.

The "so-what" for disability studies and psychology is the urgent, ethical imperative to decolonize neurodiversity research (Banerjee dkk., 2024). These findings demonstrate that "WEIRD" (Western, Educated, Industrialized, Rich, Democratic) psychology does not hold a monopoly on valid explanations for human variance. It implies that indigenous epistemologies, such as the spiritual/metaphysical frameworks observed, must be treated as valid, functional knowledge systems in their own right, not as “superstitions” to be “corrected” by Western science.

For clinical practice and education, the implication is the need to champion “ethnographic humility.” Practitioners, social workers, and educators working in cross-cultural settings must be trained to abandon the assumption of universality. They must be equipped with the skills to first ask about and listen to the client’s explanatory model (e.g., “What do you believe is the cause?”) and to identify and respectfully engage with existing community supports (e.g., “Who in your community helps you the most?”).

The “compounded stigma” observed in Kyoto is the direct result of a collision between two high-prevalence, incompatible frameworks. The high-prevalence Medical model (71%) defined the child as having an internal deficit (“disorder”), while the high-prevalence Social-Communal model (58%) defined the child’s behavior as a social disruption (meiwaku). This resulted in a double-bind, where the individual was simultaneously pathologized as “sick” and socially condemned as “non-conformist.”

The holistic accommodation in Cusco was possible because the dominant Spiritual/Metaphysical model (79%) is fundamentally non-pathologizing and integrative. The child was not defined as “broken” or “a burden”; she was defined as having a specific spiritual purpose (“conversation with Pachamama”). This explanation provided a clear, valued social role for the child, which in turn automatically activated the community’s informal support structures as a logical, normative response.

The “fractured” support-seeking in Accra is explainable as a direct symptom of its “fractured” epistemology (Medical 39%, Spiritual 61%). Globalization and urbanization have introduced the Western medical model with enough authority to be a viable option, but not enough to displace the dominant spiritual model. This leaves families caught between two competing, high-authority sources (the doctor and the healer), resulting in confusion, anxiety, and contradictory support attempts.

The fundamental difference between internalized (Kyoto) and projected (Accra/Cusco) stigma is explained by the locus of the “problem.” In the Medical/Social model, the “problem” is a deficit or failure originating from the child or family, leading to internalized shame. In the Spiritual/Metaphysical model, the “problem” (or difference) is an external force or entity acting upon the child (a spirit, a messenger), which allows the family to externalize the phenomenon and preserves the family’s social integrity.

This study was observational and descriptive; the critical next step is interventional research. Future work must focus on the co-design and testing of culturally-syntonic, “hybrid” support models (Parveen dkk., 2024). This involves developing and evaluating interventions that are created in partnership with community stakeholders—such as the healers in Accra or the elders in Cusco—to respectfully bridge the gap between formal services and indigenous knowledge systems.

A significant limitation of this study is its cross-sectional nature. We have captured a static snapshot of these support systems. Longitudinal ethnographic research is urgently required (Barros dkk., 2024). Future studies must follow neurodivergent individuals from cohorts like Cusco over time to determine if the “valued role” and holistic community support persist into adulthood, or if these informal systems break down when faced with the demands of employment, marriage, and independent living.

The scope of this investigation was limited to three sites. This “explanatory model -> stigma -> support” framework must be tested for robustness across a wider array of non-Western contexts (Bonadonna dkk., 2024). Replication studies are needed in regions such as South-East Asia, the Middle East, and Eastern Europe. Furthermore, future research must disaggregate the effect of urbanization, as the holistic, informal model observed in rural Cusco may not be viable in a high-density, anonymous urban environment.

Finally, while this study included the voices of neurodivergent adults (n=17), the analysis focused heavily on community perception. Future research must center the first-person, lived experiences of neurodivergent individuals in these contexts. Participatory Action Research (PAR) methodologies are needed to understand their own self-concept, their personal explanatory models, and their preferences for support, moving beyond the perceptions of their families and community leaders.

CONCLUSION

The principal finding of this investigation is the contingent nature of stigma, which is not a universal constant but a product of dominant local epistemologies. This research identified a profound divergence: the “compounded stigma” observed in the Kyoto site, where imported Medical-Clinical models (71%) collide with local Social-Communal norms (58%), results in internalized familial shame (haji) and isolation (Case K-11). This stands in stark contrast to the indigenous Spiritual-Metaphysical framework (79%) in the Cusco cohort, which provides a non-pathologizing “valued role” (“conversation with Pachamama”), thereby activating a functional, holistic, and informal community-wide support system (Case P-09) without a formal diagnosis.

This research’s primary contribution is conceptual, enabled by its multi-sited, emic methodology. It moves the scholarly discourse beyond a “deficit-based” critique focused on the lack of formal Western services, to an “asset-based” analysis that identifies the functionality and efficacy of indigenous support systems. The study provides a mechanistic framework, demonstrating how non-pathologizing explanatory models (e.g., Spiritual/Metaphysical) activate holistic, community-based accommodations. It thus offers an empirical challenge to the assumed universality of “WEIRD” psychology and contributes a necessary, decolonized lens for evaluating cross-cultural support.

These conclusions are drawn from a cross-sectional, qualitative study limited to three specific sites, which constrains the generalizability of the findings and precludes an analysis of long-term outcomes. The research, while including neurodivergent adults (n=17), focused primarily on community perception of neurodiversity. Future research must therefore employ longitudinal designs to track the durability of these informal support models (such as the Cusco case) into adulthood. Subsequent investigations are urgently needed to move from observation to intervention by co-designing culturally-syntonic “hybrid” support models, and to utilize Participatory Action Research (PAR) to center the first-person, lived experiences of neurodivergent individuals themselves.

AUTHOR CONTRIBUTIONS

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.
Author 2: Conceptualization; Data curation; In-vestigation.
Author 3: Data curation; Investigation.
Author 4: Formal analysis; Methodology; Writing - original draft.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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