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Cultural Stigma, Gender Stereotypes, And Socioeconomic Barriers In Autism Spectrum Disorder

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Abstract

Autism spectrum disorder (ASD) is increasingly recognized as a condition whose diagnosis, treatment, and management are shaped not only by clinical factors but also by cultural stigma, gender stereotypes, and socioeconomic status contexts. The review paper demonstrates how cultural stigma can affect diagnoses, access to treatment, and long-term management of autism through taboo, misattributions, and delays in seeking care. Similarly, gender stereotypes can result in masking and unfair gender expectations. In addition, the socioeconomic status in families with autistic children is examined by means of barriers in screening, cost of care, and persistent long-term inequalities, emphasizing the need for an intersectional lens. The study finds that the intersecting factors of cultural, stereotypical, and economic contexts systematically disadvantage autistic children and individuals. The purpose of this review is to emphasize the need for a holistic perspective that considers how these factors intersect and compound one another, systematically disadvantaging autistic individuals across global contexts. Recognizing these overlapping barriers underscores the importance of developing more inclusive diagnostic tools, equitable policies, and culturally responsive support systems in future research and practice.

Introduction

Autism Spectrum Disorder (ASD) is defined as a neurodevelopmental disorder characterized by persistent deficits in social communication and interaction, alongside restricted and repetitive patterns of behavior, interests, or activities. Symptoms must be present in early developmental periods, though they may not become fully manifest until social demands exceed capacities (American Psychiatric Association, 2022). Prevalence estimates suggest that ASD affects approximately 1% of the global population, though figures vary due to methodological and diagnostic differences. A systematic review of global prevalence studies and emphasized that autism is a universal condition, though diagnostic recognition remains uneven across countries, with marked disparities in low- and middle-income contexts (Elsabbagh et al., 2012).

Diagnosis and treatment of ASD are not simply clinical processes but are profoundly shaped by social context. Families often navigate stigma, limited service availability, and cultural beliefs that influence when and whether they seek professional help. A longitudinal study of Australian families found that parental adaptation to autism was characterized by ongoing negotiations of stigma and identity (Gray, 2002). Similarly, stigma in Middle Eastern communities created barriers to help-seeking, with some families concealing diagnoses to avoid social exclusion (Dababnah & Bulson, 2015). While autism is increasingly recognized worldwide, disparities remain in diagnosis and treatment. These inequities often follow three dimensions: cultural stigma, gender stereotypes, and socioeconomic class. For example, girls with autism were diagnosed later and less frequently than boys, partly because clinical criteria were historically based on male presentations (Ratto et al., 2018). Children from lower socioeconomic backgrounds are consistently diagnosed later and have reduced access to services, even when symptom severity is comparable (King & Bearman, 2011). Although each factor independently contributes to inequities, their intersections are often the most consequential. For instance, a girl from a low-income family in a conservative cultural context may face compounded disadvantages: gendered expectations obscure her symptoms, stigma discourages disclosure, and financial barriers block access to diagnostic evaluation. Most autism prevalence studies are concentrated in Western, higher-income countries, meaning intersectional challenges in diverse contexts remain underexplored (Elsabbagh et al., 2012). Addressing these gaps is significant for several reasons. First, inequities in diagnosis delay access to early intervention, which is consistently linked to better developmental outcomes. Second, disparities perpetuate long-term disadvantages in education, employment, and social inclusion. Finally, without attention to cultural, gendered, and socioeconomic contexts, research risks reinforcing a male-centric, Western-centric model of autism that excludes large populations. Addressing these gaps is significant for several reasons. First, inequities in diagnosis delay access to early intervention, which is consistently linked to better developmental outcomes. Second, disparities perpetuate long-term disadvantages in education, employment, and social inclusion. Finally, a better understanding of how cultural stigma, gender stereotypes, and socioeconomic status intersect can guide policies and services toward more equitable outcomes worldwide. This paper investigates how cultural stigma, gender stereotypes, and socioeconomic class influence the diagnosis, access to treatment, and long-term management of autism spectrum disorder.

Cultural Stigma and Autism

Cultural stigma exerts a powerful influence at the very first stage of autism diagnosis.

Stigma operates as a global but context-specific barrier in autism care. While autism is universally recognized as a neurodevelopmental condition, cultural interpretations often transform it into a source of shame or misattribution. In some societies, autism is associated with supernatural punishment or parental failure, while in others, stigma is subtler, tied to stereotypes of deviance or social inadequacy (Salleh et al., 2020). This variability matters because it shapes not only whether families pursue medical help but also how professionals respond when symptoms first appear.

In many contexts, autism is viewed through the lens of taboo, divine punishment, or supernatural causes, leading families to deny or hide symptoms (Dababnah & Bulson, 2015). In the West Bank, for instance, parents reported that pediatricians rarely use formal screening tools, and many diagnoses were inconsistent or delayed (Dababnah & Bulson, 2015). Such structural shortcomings are compounded by cultural beliefs, which normalize avoidance and contribute to families postponing or rejecting a medical explanation for their child's difficulties. Stigma also fosters misdiagnosis and secrecy. In Lebanon, mothers reported that their children's autistic traits were frequently reframed as behavioral problems or poor parenting, reflecting cultural resistance to labeling a child as autistic (Dababnah & Bulson, 2015). Girls, in particular, were described as 'rude' or 'naughty' rather than developmentally different, delaying recognition of underlying neurodevelopmental conditions. Families could often conceal symptoms from professionals or extended relatives, fearing gossip and social exclusion. This secrecy not only reduces opportunities for timely referrals but also entrenches cycles of misdiagnosis.

The combined effect of denial, secrecy, and misdiagnosis is a systemic delay in accessing care. In the West Bank, families described receiving no psychoeducation at the point of diagnosis, leaving them without tools to support their child (Dababnah & Bulson, 2015). By contrast, a longitudinal study in Australia shows that while stigma persists, it diminishes over time as families access formal diagnostic pathways (Gray, 2002). These differences highlight how stigma entrenches global inequities: in some contexts, it only complicates the journey, while in others, it blocks the very entry point into treatment.

Stigma does not stop at diagnosis; it actively limits access to treatment. Many families conceal their child's condition to avoid discrimination, even if this means forgoing services. In the West Bank, parents described avoiding formal centers because they feared their child would be labeled or rejected by schools and neighbors (Dababnah & Bulson, 2015). Similarly, mothers in Lebanon reported receiving little practical or emotional support from their social networks, noting that stigma undermined their ability to seek help (Obeid & Daou, 2015). This climate of fear and secrecy directly obstructs pathways into therapy. In contexts where autism carries stigma, families often turn away from biomedical services toward traditional or religious remedies. In Lebanon, mothers commonly relied on distraction and disengagement coping, strategies that were linked to poorer psychological outcomes (Obeid & Daou, 2015). In the West Bank, several families reported seeking guidance from spiritual healers or relying exclusively on home care, bypassing autism-specific therapies (Dababnah & Bulson, 2015). These patterns, rooted in stigma, deepen treatment delays and place families in precarious situations when professional support is eventually pursued. Stigma also amplifies existing structural barriers to treatment. In the West Bank, families already struggling with long travel times, security checkpoints, and prohibitive costs found their difficulties compounded by stigma, which discouraged them from publicly advocating for services (Dababnah & Bulson, 2015). In Lebanon, cultural expectations of strong social networks were undermined by stigma, as mothers reported limited support despite the high value placed on family and community ties (Obeid & Daou, 2015). In both contexts, stigma magnifies material barriers, leaving families unable or unwilling to pursue autism-specific care.

Such patterns are not unique to the Middle East. In Vietnam, autism is frequently reframed as poor behavior rather than a developmental difference. Nigerian families often attribute autism to spiritual causes, turning first to religious healers before medical professionals (Bakare & Munir, 2011). In Brazil, stigma has been tied to parental blame, reinforcing cycles of secrecy and exclusion (Campos, 2002). Even in Iran, where awareness is growing, stigma continues to drive avoidance of formal diagnoses (Shokouhi-Tabar, 2025). These examples underscore how stigma, though culturally specific in form, consistently delays or distorts access to care.

One of the most persistent long-term effects of stigma is social isolation. In the West Bank and Lebanon, many families withdrew from community activities, reporting feelings of shame and exclusion (Obeid & Daou, 2015). Mothers described being left alone to cope, reinforcing both personal and structural barriers to support (Dababnah & Bulson, 2015). By contrast, an Australian study found that while stigma remained present, parents eventually developed strategies to minimize its impact, either by building supportive networks or limiting social exposure (Gray, 2002). The comparison underscores how in less supportive cultural contexts, stigma enforces isolation as a de facto management strategy. Stigma also shapes educational and employment opportunities across the lifespan. In the West Bank, parents reported that schools outright refused admission for children with autism, reinforcing exclusion from early learning (Dababnah & Bulson, 2015). In Lebanon, stigma meant that institutional supports were minimal, placing disproportionate burdens on mothers and limiting children's integration (Obeid & Daou, 2015). Findings in Australia again highlight the contrast: while bullying and service gaps remained, children at least retained access to formal education (Gray, 2002). These differences reveal how stigma determines not only whether children are educated but also whether families can imagine future pathways into employment. Importantly, stigma does not disappear in resource-rich contexts; it evolves. In Germany, parents report that while diagnostic supports are widely available, stigma persists in subtle forms, shaping social interactions (Mitter, 2019). U.S. families face similar stigma but benefit from strong advocacy networks that normalize autism in public spaces (Stronach, 2019). In contrast, in China, stigma remains closely tied to "face" and family reputation, discouraging disclosure despite rising resources (Hu, 2025). Comparative work further shows how cultural orientation matters: in Korea, autism is framed as a family burden, while in the U.S., it is seen through the lens of individual difference (Kim & Gillespie-Lynch, 2022/23). Together, these findings highlight that stigma is not limited to low-resource settings but shifts shape according to cultural values and institutional support.

The consequences of stigma extend well into adulthood. The study in Australia illustrates that even in resource-rich contexts, parents remain anxious about long-term care, housing, and employment for their autistic children (Gray, 2002). In the Middle East, these challenges are magnified by stigma, which not only restricts services but also silences advocacy. Without community acceptance, families struggle to push for policy changes or demand inclusive programs, leaving autistic individuals marginalized throughout their lives (Obeid & Daou, 2015). Stigma thus transforms short-term barriers into lifelong disadvantages. In Taiwan, autistic youth reported exclusion from peer groups, illustrating how stigma disrupts social belonging (Lim, 2021). In Serbia, families described ongoing discrimination in schools, reinforcing cycles of educational exclusion (Čolić, 2020). Even in the United Kingdom, where services are comparatively strong, adolescents faced stigma that undermined friendships and mental health (White, 2019). These findings show that stigma does not end at diagnosis but instead extends across the lifespan, shaping opportunities for education, social integration, and eventual employment.

Gender Stereotypes and Autism

Gender stereotypes significantly shape the diagnosis of autism in girls. Autism has long been constructed through a male-centered lens. Early diagnostic criteria and research samples overwhelmingly drew on boys, reinforcing the assumption that autism was predominantly, if not exclusively, a "male disorder" (Rynkiewicz et al., 2019). This bias shaped how tools like the ADOS and ADI-R were designed, privileging traits more common in boys while overlooking subtler female presentations. This historical framing continues to shape not just diagnosis but entire treatment pathways, since girls who do not match the male prototype are less likely to be recognized, referred, or supported (R. M. Green et al., 2019). This 'male disorder' stereotype has shaped clinical research and public perception, contributing to significant under-recognition of autism in girls. This ratio is not due to an excess of males with autism, but instead due to a lack of females being diagnosed with autism.

Unlike boys, autistic girls are more likely to engage in camouflaging behaviors such as social imitation, which allows them to blend into peer groups. (Lai & Baron-Cohen, 2015) Their restricted interests often align with socially acceptable domains, making them less recognizable as symptoms of autism. (Lai & Baron-Cohen, 2015) These gendered patterns mean that diagnostic criteria, which were built on male samples, frequently overlook girls. This bias is evident in diagnostic tools. For instance, the Autism Diagnostic Observation Schedule (ADOS) module 4 is the only validated observational tool for diagnosing autism in adults (Lai & Baron-Cohen, 2015). It works well for men, distinguishing autism from psychopathy or typical development. The tool's sensitivity in identifying traits of autism spectrum diseases in high-functioning individuals, especially women, may be insufficient, as camouflaging and acquired behaviors in social contexts can diminish the number of items eligible for scoring in the algorithm. Due to the fact that girls tend to mask and the fact that there are gaps in the making of tools to diagnose autism, girls are often undiagnosed and overlooked.

Clinicians may dismiss or misinterpret autistic traits in girls due to a prior superficial comprehension of autism spectrum conditions may have resulted in erroneous myths, such as the belief that if a woman can engage in conversation and maintain eye contact, or if she is married or a mother, she cannot be autistic. (Lai & Baron-Cohen, 2015) These biases systematically delay diagnosis for girls by overlooking coping/camouflaging mechanisms and women who get by socially but struggle internally, limiting access to early interventions. Additionally, subtle indicators in girls such as excessive shyness, bossiness, overcontrolling behavior, perfectionism, social faux pas, demanding extreme loyalty, clingy attachments, systemizing social behaviors, niche interests, are often overlooked (Lai & Baron-Cohen, 2015). Research on women's lived experiences confirms how masking complicates recognition. Milner's (2019) study of autistic women in the UK found that many relied heavily on imitation and camouflaging strategies to "pass" socially, often adopting socially acceptable interests or mirroring peers to avoid standing out. While these strategies allowed them to appear typical in childhood and adolescence, they came at a high psychological cost, producing exhaustion and a sense of inauthenticity. These findings highlight why camouflaging is a double-edged sword: it protects girls socially in the short term but delays diagnosis and undermines mental health in the long run.

The gendered construction of autism underscores the need for diagnostic reform that accounts for female-specific presentations. Training clinicians to recognize camouflaging and updating diagnostic criteria would reduce underdiagnosis, allowing earlier access to interventions. Unless diagnostic frameworks adapt to recognize female-specific presentations, countless autistic girls will remain invisible to the system.

In addition to skewing diagnosis, gender stereotypes shape access to treatment and support systems. Gender stereotypes extend beyond diagnosis, they influence the treatment pathways available to autistic children. As previously discussed, girls who are diagnosed later often miss the critical early-intervention window which can severly affect their treatment plans. Girls who have been misdiagnosed are often denied access to the right treatment or any treatment at all. Moreover, intervention strategies have largely been modeled around male developmental patterns. Clinicians' and educators' expectations of 'typical female behavior' also shape the kinds of support girls are directed toward, often minimizing their autistic needs.

Although girls and boys often demonstrate similar developmental functioning, girls are referred for assessment less frequently. This study shows that while boys and girls score similarly on gold-standard autism tests, girls, especially those with higher intelligence quotient, are less likely to meet criteria on the Autism Diagnostic Interview-Revised (ADI-R), largely because they show fewer repetitive behaviors and less obvious early developmental delays. This disparity to gendered symptom profiles, where fewer repetitive/restricted behaviors makes their autism look "milder" (Ratto et al. 1702), shows that referral pathways themselves are biased , with girls underrepresented in clinical samples despite comparable autistic traits. Because referrals are the primary gateway to treatment, these biases exclude girls from early interventions such as speech therapy or social skills training, creating disparities at the very first step.

Girls tend to mask their autistic traits. Camouflaging intensifies referral bias, especially among high-IQ girls. Parents reported significant adaptive challenges in daily life that were not captured in standardized test scores (Ratto et al. 1702). Similarly, gold-standard diagnostic tools such as the ADOS and ADI-R were calibrated to male presentations, rendering them less effective for detecting female profiles. This is shown when "prior studies have also found that even when presenting with comparable levels of socio-communicative impairment females are less likely than males to be diagnosed with ASD and are more likely to be able to "camouflage" their social impairments on performance-based measures" (Ratto et al.) These dynamics produce a paradox: girls who appear 'high functioning' are denied treatment opportunities, even though they face substantial difficulties in practice. By masking autistic traits, these girls systematically miss the early intervention window that could mitigate future challenges.

The consequences of unequal access to treatment extend well into adulthood. Girls who miss early interventions are more likely to struggle with independence, mental health difficulties, and restricted access to tailored resources. These inequities are not incidental but the product of diagnostic and treatment systems that privilege male presentations. Unless intervention models are redesigned with gender-sensitive frameworks, autistic girls will continue to experience structural disadvantages throughout their lives. Addressing these disparities is essential for ensuring equity in both childhood intervention and long-term management.

During adolescence, autistic girls often rely heavily on masking and social imitation in order to fit in with peers. While these strategies allow them to achieve temporary acceptance, they come at the cost of emotional exhaustion and a heightened sense of difference (Tierney et al., 2015, p. 6). As peer relationships become increasingly complex during adolescence, many girls struggle to maintain these façades, leaving them vulnerable to rejection and internalized distress. The reliance on camouflaging strategies directly shapes long-term mental health outcomes for autistic girls. Many are first labeled with anxiety, depression, or even eating disorders, while their autism remains overlooked (Baldwin & Costley, 2016). The apparent normalcy created by masking conceals inner turmoil, leaving girls described as rude, naughty, or attention-seeking rather than recognized as autistic. Over time, this disconnect between outward appearance and internal struggle contributes to chronic stress, identity confusion, and poor psychological well-being.

Importantly, the male-centered framing of autism not only distorts diagnosis; it shapes treatment trajectories as well. Girls who are initially misdiagnosed with conditions such as anxiety or depression are often directed toward general mental health services rather than autism-specific interventions (R. M. Green et al., 2019). This means they may receive therapy that addresses symptoms superficially but misses the underlying neurodevelopmental profile, reinforcing cycles of delayed recognition. The consequence is that by the time autism is formally identified, girls have often missed the critical window for early intervention and carry entrenched mental health burdens.

For many autistic women, recognition does not come until adulthood, often around the age of twenty-five. This delay leaves years of education shaped by bullying, misunderstanding, and inadequate support. In employment, women are frequently well-qualified yet underemployed, as rigid workplace expectations and sensory demands prove overwhelming.

Masking continues into adulthood, but rather than securing long-term stability, it often results in burnout, unstable relationships, and pervasive loneliness (Tierney et al., 2016). These outcomes underscore the urgent need for gender-sensitive interventions that address the unique trajectories of autistic women. Early recognition, targeted mental health support, and workplace accommodations are essential, alongside recognition that masking represents risk rather than resilience.

Socioeconomic Class and Autism

Children from higher-socioeconomic neighborhoods were far more likely to be diagnosed early, particularly with milder presentations, as parents could afford multiple evaluations and push for answers (King & Bearman, 2011). By contrast, poorer families often faced delays, with pediatricians overlooking symptoms or attributing them to behavioral problems (King & Bearman, 2011). Neighborhood wealth shaped not only access to professionals but also awareness. Parents in affluent areas were more likely to hear about autism through advocacy groups and other parents (King & Bearman, 2011), while poorer families often had no such networks, leaving them isolated and unaware of diagnostic options. Children from higher-socioeconomic neighborhoods were more likely to receive early diagnoses, particularly for milder presentations, as parents could afford multiple evaluations and advocate persistently (King & Bearman, 2011). In contrast, poorer families often faced diagnostic delays: pediatricians overlooked symptoms, attributed them to behavioral problems, or misclassified autism as ADHD, leading to inappropriate treatments (King & Bearman, 2011).

Children from disadvantaged families were consistently diagnosed later and with more severe presentations than their higher-SES peers (Mazurek et al., n.d.). Similarly, in France, autism prevalence rates were substantially higher in deprived districts only after awareness diffused beyond affluent communities (Delobel-Ayoub et al., 2015). These findings confirm the 'epidemic of discovery,' underscoring that socioeconomic deprivation does not reduce autism incidence but delays its recognition and labeling. Wealth shaped not only access to professionals but also knowledge; parents in affluent areas were more likely to learn about autism through advocacy groups and peer networks, while low-income parents often remained isolated and unaware of diagnostic options. These disparities meant many children in poverty were not identified until school age, losing critical years for early intervention. For many low-income families, children were not diagnosed until school age, by which time opportunities for early
intervention were lost. In some cases, autism was misclassified as behavioral defiance or ADHD, leading to inappropriate treatments (King & Bearman, 2011). These diagnostic inequalities create a compounding disadvantage that widens class-based gaps over time.

Families in poverty face impossible trade-offs: whether to pay for therapy or for basic needs such as food and housing. For families living in poverty, diagnosis is only the beginning of impossible trade-offs: whether to fund therapy or cover essentials like food and housing. Out-of-pocket costs, combined with reduced maternal employment, pushed many families of disabled children into deeper poverty, particularly where supplemental security income was absent (Lukemeyer et al., 2000). Geography compounds this inequality: families in rural or low-income regions often travel hours for limited services, if they exist at all. In the West Bank, parents described crossing checkpoints only to find no autism-specific centers (Dababnah & Bulson, 2015). Even when poor and wealthy families accessed the same elite hospitals, differences persisted: parents with greater cultural health capital requested additional tests and corrected medical errors, while less resourced families deferred to doctors and missed critical opportunities.

Research shows that out-of-pocket costs, combined with reduced maternal employment, pushed many families of disabled children into deep poverty, especially when supplemental security income was not available (Lukemeyer et al., 2000). The burden of these trade-offs is echoed globally. In low- and middle-income countries, many families forego evidence-based therapies altogether because of prohibitive costs, often relying on fragmented or non-specialist care (Divan et al., 2021). Omani families are forced to choose between treatment and household necessities (Al-Farsi et al., 2013), while Spanish households experiencing catastrophic financial strain from autism-related expenses (Rosa et al., 2016). Together with the U.S. findings, these studies illustrate that the poverty burden of autism transcends borders, deepening existing inequalities.

Geography compounds inequality: families in poorer or rural areas often travel hours for limited services, if they exist at all. In the West Bank, parents reported crossing checkpoints and still finding no autism-specific centers (Dababnah & Bulson, 2015). Wealthier families, in contrast, can travel abroad or pay for private care. Even when poor and wealthy families reached the same elite hospital, differences persisted. Parents with more cultural health capital monitor care, request additional tests, and prevent mistakes, while less resourced families defer to doctors and missed opportunities. Inequality is thus reproduced even in the most resource-rich settings.

While affluent parents sustain long-term therapies and secure private tutoring,

low-income families are often forced to discontinue treatment, leaving children unsupported. In the West Bank, some families reported schools outright refusing to accept their children, underscoring how poverty magnifies exclusion (S. E. Green et al., 2016). Class also dictates the transition to adulthood: wealthier families access vocational programs and supported employment, while poorer families face a near-total absence of options (S. E. Green et al., 2016). Ten years on, parents reported ongoing anxiety about where their children would live or work, particularly those without financial resources. For low-income families, the weight of financial strain and stigma compounds caregiving stress. Class shapes adulthood trajectories, finding that autistic adults from low-income families were less likely to complete higher education, access stable employment, or live independently compared to those from more advantaged backgrounds (Eilenberg et al., 2019). These disparities persisted even when clinical severity was controlled for, suggesting that socioeconomic resources, not just individual functioning, determine life outcomes. This highlights the enduring impact of class: the disadvantages that begin with delayed diagnosis and reduced treatment access accumulate across the lifespan, leaving poorer families systematically disadvantaged. While some parents develop resilience and reframe 'normality,' the absence of systemic supports means poorer families are left to navigate alone, often at high personal and emotional cost .

Integration & Intersectionality

Autism diagnosis and treatment are not shaped by single factors in isolation; stigma, gender, and socioeconomic class often interact to compound disadvantage. Taken together, these barriers rarely operate in isolation. For example, studies on camouflaging show that girls often perform well on standard diagnostic tools like the ADOS despite struggling with daily functioning, which means that in communities where shyness is normalized, their challenges are even less likely to be flagged. At the same time, research on stigma in Middle Eastern families highlights how parents may conceal a child's diagnosis due to fears of social shame, preventing timely intervention. When combined with findings from U.S. studies showing that children from low-income households are diagnosed years later than their higher-income peers, the picture becomes clear: gender, stigma, and socioeconomic class do not just layer barriers; they magnify one another. Intersectional disadvantage compounds at every stage, transforming what might have been a manageable condition into lifelong exclusion.

Research on gender and autism has produced detailed analyses of camouflaging and diagnostic tools, while stigma studies in the Middle East provide vivid accounts of secrecy and misdiagnosis. Similarly, large-scale US studies have established clear class-based diagnostic inequalities. Research on gender and autism has yielded detailed insights into diagnostic disparities, particularly through the study of camouflaging in girls. These findings have led to the refinement of diagnostic checklists and a greater clinical awareness of how autism can present differently across genders. Stigma-focused studies provide rich qualitative accounts of family secrecy, parental blame, and concealment, demonstrating how cultural norms shape access to services. Meanwhile, epidemiological research has systematically documented socioeconomic inequalities, showing that children from higher-income families are more likely to be diagnosed earlier and receive intensive intervention. Collectively, these literatures establish strong evidence in its individual domains and highlights the significance of cultural, gendered, and class-based influences on autism outcomes. Despite these contributions, major gaps remain.

Few studies examine how gender, class, and cultural stigma converge. For instance, while there is evidence of stigma in Middle Eastern families, little is known about how low-income girls in such settings navigate diagnosis. Similarly, most research on socioeconomic status and autism is US-based, limiting its global applicability. The near-absence of adult-focused studies further underscores how systemic disadvantage continues beyond childhood yet remains poorly documented. Even in regions where stigma is well-documented, such as the Middle East, there is little evidence about how factors like gender or class shape the experience of stigma itself.

Beyond diagnosis, intervention pathways are rarely studied through an intersectional lens, making it unclear whether treatment access, adherence, and outcomes are similarly stratified. A further gap lies in adulthood: nearly all current research stops at childhood or adolescence, neglecting how compounded barriers influence employment opportunities, marriage prospects, and independent living for autistic adults. Addressing these gaps requires not only cross-cultural comparison but also longitudinal research that follows individuals across the life course.

Discussion & Conclusion

Autism disparities are not uniform but shaped by cultural stigma, gender stereotypes, and socioeconomic class. Together, these factors create compounding barriers that delay diagnosis, limit access to treatment, and undermine long-term management. A child in an affluent community may be diagnosed early because parents can afford repeated evaluations and leverage peer networks (King & Bearman, 2011; Mazurek et al., n.d.), while a girl in a low-income setting may have her traits dismissed as shyness or anxiety, delaying critical support. Stigma compounds these disadvantages: families in resource-limited contexts report reluctance to disclose symptoms or seek services (Salleh et al., 2020). Ultimately, what might be manageable with early support too often becomes entrenched exclusion, social isolation, and missed opportunities across the lifespan (Gray, 2002).

Despite these insights, the literature faces limitations. Research remains disproportionately Western and male-centered, reflecting diagnostic frameworks built on male samples and overlooking female presentation (S. E. Green et al., 2016). Stigma research often isolates single regions or factors, rather than examining how culture, class, and gender intersect to magnify inequities. Longitudinal data remain scarce, with only a handful of studies following autistic individuals and families over extended periods (Gray, 2002). Similarly, socioeconomic research often concentrates on U.S. or European contexts, neglecting low- and middle-income countries where systemic barriers are most acute (Divan et al., 2021).

Future research should therefore expand in three directions. First, diagnostic tools must be revised to capture female and culturally variable presentations of autism, rather than reproducing male, Western norms. Second, cross-cultural and comparative studies are needed to trace how stigma, class, and gender bias intersect across different societies, especially in low-resource settings (Divan et al., 2021). Third, adulthood outcomes such as, education, employment, and independence all require urgent attention, since most studies remain child-focused despite evidence that inequities intensify over the life course (Eilenberg et al., 2019; Gray, 2002). Participatory methods that center autistic voices and family perspectives could also enrich understanding and policy relevance.

The societal stakes are significant. Misdiagnosis or delayed diagnosis not only affects autistic individuals but also places long-term emotional and financial strain on families (Lukemeyer et al., 2000; S. E. Green et al., 2016). Inequities in access to therapy and schooling reinforce broader patterns of educational and economic inequality (Dababnah & Bulson, 2015). At a global level, stigma discourages help-seeking and entrenches exclusion, undermining disability rights and inclusion goals (Salleh et al., 2020). Addressing these inequities requires policy interventions that integrate autism screening into primary care, expand financial support for treatment, and develop gender- and culture-sensitive training for clinicians and educators.

Autism is a global condition, yet responses remain fragmented and unequal. Reducing these disparities is not only a research priority but a societal imperative.

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