PERCEPTIONS OF NEURODIVERGENT WORKERS:

UNDERSTANDING EXPECTED BEHAVIORAL REACTIONS USING THE STEREOTYPE CONTENT MODEL AND THE SOCIAL MODEL OF DISABILITY

by

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(Under the Direction of Malissa Clark)

ABSTRACT

As much as 17% of the U.S. workforce may be *neurodivergent*, a term used to describe individuals whose neurological functioning is at the tail ends of the distribution of naturally occurring variation. Despite this prevalence, there has been little research conducted specifically examining neurodivergent individuals in the workplace. Subsequently, we know little about the societal perceptions or personal experiences of neurodivergent individuals in the workplace. The purpose of the current study is to examine societal perceptions of neurotypical individuals in the workplace through the lens of the stereotype content model (SCM). Specifically, the study examined societal perceptions of the warmth and competence perceptions of three common neurodivergent conditions: autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and dyslexia. I use the stereotype content model to examine how perceptions of neurodivergent workers relate to behaviors towards these groups. Additionally, I examined the influence of the endorsement of the social model of disability on perceptions of competence of neurodivergent individuals in the workplace. Findings suggest that there are differences in the warmth perceptions of the neurodivergent groups examined. Further, I found evidence that the

social model endorsement is an individual difference that influences treatment of neurodivergent individuals in the workplace.

INDEX WORDS: Neurodiversity; Workplace diversity; Stereotype content model

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CHAPTER 1

INTRODUCTION

Neurodiversity is a term used to describe the natural variation in neurological functioning that occurs among people. Individuals whose neurological functioning lies outside of what is considered typical are commonly referred to as *neurodivergent* or members of the *neurominority* population. These terms are used to describe individuals living with a number of different neurologically based disabilities but are most commonly used to describe those with autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and/or dyslexia[1]. At nearly 20% of the population, the sheer number of individuals who fall into the category of neurodivergent in the workplace likely exceeds that of many of the minority groups that have traditionally been the focus of workplace discrimination research in I-O psychology (compare to ~13% Black[2] and 7.6% LGBTQ+; U.S. Bureau of Labor Statistics, 2023; Gallup, 2024).

However, little empirical work has examined the unique issues associated with how others perceive – or *stereotype* – neurodiverse individuals in the workplace. This stands in stark contrast to other historically marginalized groups (see LeFevre-Levy et al., 2023). Much of the research on workplace discrimination in the field of industrial-organizational (I-O) psychology has and continues to focus on racial, sexual, and gender minority groups in the workplace. There

[1] Throughout this paper I use the term dyslexia to refer to a type of learning disorder that falls under the umbrella of "specific learning disorder" in the DSM. Specific learning disorder refers to dyslexia, dysgraphia, and dyscalculia. However, because each of these three diagnoses have different diagnostic criteria and because dyslexia is the most common type of specific learning disability, I chose to focus this research on dyslexia (Shaywitz &Shaywitz, 2003).

[2] Throughout this paper I use the racial and ethnic terms currently used by the EEOC and the Department of Labor such as "Black", "White" and "Asian". However, I acknowledge that language used to refer to racial and ethnic groups is subject to change overtime and is subject to differences in personal preference among individuals.

is comparatively little research focusing on disabled populations in the workplace (Colella & Stone, 2005) and even less on the treatment and experiences of neurominority members in the workplace (LeFevre-Levy et al., 2023).

In some ways the lack of research in the areas of disability, and more specifically neurodiversity in the workplace, should not be surprising as it mirrors the relative recency of legislation and social movements around disability rights (Colella & Stone, 2005; LeFevre-Levy et al., 2023). Indeed, the Americans with Disabilities Act (ADA) and neurodiversity movement are both products of the 1990s. In comparison to other social justice movements such as the civil rights movement or the women's movement, which date back to as early as the 1960s and 1840s respectively, the rights of disabled and neurodivergent individuals have only more recently made their way into public awareness.

Despite the relative nascency of the neurodiversity movement, scholars and organizations are recognizing the importance of understanding the experiences of the neurominority population in the workplace. Neurodivergent individuals experience chronic under/unemployment at a rate significantly higher than that of the general public (Dow et al., 2020) and many minority groups (Statista Research Department, 2024). Further, this unemployment tends to start earlier and be more pervasive throughout life than that experienced by the neurotypical population, as neurodivergent individuals are more likely to experience unemployment starting in early adulthood (Huntly & Young, 2014; Krzeminska & Hawse, 2020; Schumacher et al., 2007). Unemployment has been linked to several negative outcomes, including lost income and poor mental and physical health (Brand, 2015; McKee-Ryan et al., 2005). It is therefore essential that we identify the barriers to successful employment for this population.

Stereotyping of neurodivergent individuals may play an important role in the under and unemployment of neurodivergent individuals. Research conducted on other marginalized groups (e.g., race- and gender-identity, persons with physical disabilities) has indicated that minority group stereotyping has implications for a number of important work and other outcomes including workplace bias and discrimination (Heilman, 2012; Stewart & Perlow, 2001), turnover intentions (Von Hippel et al., 2011), performance ratings (Dobbins et al., 1988), career progression (Heilman, 2012), and well-being (Schmitt et al., 2014). However, extrapolating from research on other minority groups in the workplace, or even disability in general, to neurodivergent individuals is difficult. The heterogeneity of disability identities means that stereotyping is likely to vary significantly across different types of disability groups (Beatty et al., 2019). As a result, our knowledge of the stereotyping of neurodivergent individuals in the workplace, such as those with ASD, ADHD and dyslexia, is limited. Differences in stereotypes could lead to varied treatment and outcomes for different neurodivergent groups.

The purpose of this research is to examine the stereotypes associated with individuals living with ASD, ADHD, or dyslexia, respectively, in a work context. In Study 1, drawing from the stereotype content model (SCM; Fiske et al., 2002) as a framework, I examine how individuals with each of these neurodivergent conditions are perceived by coworkers, and derive stereotype "profiles" for each of these three groups based on the SCM dimensions of warmth and competence. The findings from Study 1 then informed the hypotheses for Study 2 in which I linked these stereotype profiles to how people expect those persons to be *treated* in the workplace and test the SCM warmth and competence stereotype dimensions as an explanation for expectations regarding their differential treatment in the workplace.

In addition, I draw upon the disability perspectives literature to test the possible role of the endorsement of the social model of disability on the treatment of neurodivergent individuals in the workplace. I examine how adopting a social model perspective (vs medical model perspective) influences perceptions of competence of neurodivergent individuals in the workplace. The social model of disability is a lens which views disability as a product of societies' failure to adapt to differing needs, rather than as an inherent defect within a person (Areheart, 2008; Smith, 2008). Given this perspective, it is likely that viewing disability through this lens would lend itself to a more favorable judgment of the competence of neurodivergent individuals in the workplace. Therefore, a second goal of the proposed research is to examine how endorsement of the social model of disability influences predicted treatment of neurodivergent people in the workplace through its effect on perceptions of neurodivergent targets' competence.

The current research makes several contributions to the literature. First, by elucidating the stereotypes associated with ASD, ADHD, and dyslexia in the workplace, this research can help explain observed disparities in employment rates between neurodivergent and neurotypical individuals. Further, it may even help to shed some light on why some groups of neurodivergent people, such as those with autism, face unemployment levels that are quite a bit higher than other neurodivergent groups (i.e., people with ADHD, and people with dyslexia). Therefore, this research may help us understand not only why unemployment is rampant among neurodivergent individuals but also why some subgroups of neurodivergent people may face more difficultly securing employment than others.

Second, understanding how the perceptions and stereotypes of neurodivergent individuals in the workplace may impact others' behaviors towards this group will allow us to better

understand the potential barriers that each of these groups face in the workplace. A better understanding of how neurodivergent individuals are viewed and treated in the workplace is a fundamental step in growing the literature on neurodiversity in the workplace more broadly. It is a building block that will help inform future research regarding how we can foster a neurodiversity friendly and supportive climate in organizations and the identity management process of neurotypical individuals in the workplace.

Third, the proposed research contributes to the neurodiversity literature as well as the wider disability literature by examining the possible role of the endorsement of the social model of disability on the stereotyping and treatment of neurodivergent individuals in the workplace. This research is the first, to my knowledge, to empirically test these relationships. Understanding the ways individual perceptions of what "disability" means may have implications for training and interventions aimed at making workplaces more inclusive for those with disabilities. Ultimately, I hope that the findings from this research will help to increase our basic understanding of how stereotypes of neurodivergent employees drive others' behavior toward them in the workplace.

CHAPTER 2

NEURODIVERSITY AND NEURODIVERGENCE: DIAGNOSTIC CRITERIA AND ORIGINS

To understand how neurodivergent individuals are viewed in the workplace we must first understand the genesis of the term neurodiversity and how it is defined, and define the neurodivergent conditions commonly found in the workplace. The neurodiversity movement originated in the late 1990s from the autism spectrum rights movement. The term "neurodiversity" was coined by sociologist Judy Singer in her 1998 book chapter on disability and further popularized by *Atlantic* staff writer Harvey Blume, in his 1998 article entitled "Neurodiversity: On the Neurological Underpinnings of Geekdom." Neurodiversity, the idea that differences in neurological functioning are a part of naturally occurring human variation, was quickly adopted by other groups "traditionally pathologized for having neurological functioning considered outside of the norm" (LeFevre-Levy et al., 2023, p. 6). The term "neurodivergent" has been used to describe a wide variety of neurologically based disabilities ranging from ASD to Tourette syndrome. However, it is most commonly used to describe individuals with ASD, ADHD, and dyslexia.

While ASD, ADHD, and dyslexia are all conditions that fall under the umbrella of neurodiversity, they are also each unique conditions characterized by different patterns of cognitive functioning and behavior, and as a result may be viewed differently in the workplace. In the following sections I will discuss the definition and diagnostic criteria for each of these three brain differences. I will also introduce two prominent models of disability, the medical and

social models of disability, and discuss the importance of these models to understanding how neurodivergent individuals are viewed and treated in the workplace.

Characteristics and Diagnostic Criteria of ASD, ADHD, and Dyslexia

Broadly, autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and dyslexia all fall under the umbrella of neurodevelopmental disorders (APA, 2013). In describing them I will use the language used in their clinical descriptions (e.g., referring to "symptoms," "deficits" and "disorders"). In essence, all three of these neurodevelopmental disorders are conditions that stem from differences in brain functioning, but none of the three disorders is by definition related to intelligence. The symptoms of all three disorders start in childhood and (generally speaking) continue on through the lifespan. ADHD is the one caveat to this rule as only about 60% of individuals diagnosed with ADHD in childhood continue on to have the clinical features of the disorder into adulthood (Harpin, 2005). In addition, it is clear that there is a genetic component to all three neurodevelopmental disorders. If an individual has one of these disorders, there is an increased chance that a closely related relative will also have the disorder or at least have traits associated with the disorder (Antshell & Barkely, 2020; Habib, 2020; Mottron, 2020). However, despite these similarities, all three disorders vary greatly in their clinical presentation and in diagnostic criteria, and it is important to consider these differences in order to understand how members of each of these neurodivergent sub-populations may be viewed in the workplace. Note that the reported prevalence of each of the conditions depends on awareness of the condition, identification of it and the diagnostic criteria, all of which have varied historically and by cultural context.

Autism Spectrum Disorder

Autism spectrum disorder is a neurodevelopmental disorder associated with social and communication deficits (American Psychiatric Association, 2013). ASD has been reported to affect about 1% of the population (Dover & Le Couter, 2007) and is considered a spectrum because there is significant variation in the severity of the disorder. Indeed, ASD is a widely encompassing term that now includes Asperger's syndrome, and often the terms "high functioning" and "low functioning" are used to describe different degrees of severity. However, regardless of severity, there are several clinical criteria that must be met for an individual to be diagnosed as on the spectrum. First, as mentioned previously, individuals must have a history of social or communication deficits that started in childhood (Dover & Le Couter, 2007). For example, individuals may have trouble understanding social reciprocity, making eye contact, or reading facial expressions or body language.

Additionally, for diagnosis, an individual must have a history of repetitive or restrictive behaviors or interests. This might present itself as an extreme/ obsessive interest in a certain topic or hobby, ticks or repetitive speech. It may also present itself as sensory sensitivity (APA, 2013). It is also important to note that there is a subset/subpopulation of individuals on the spectrum who are largely non-verbal (often referred to as "low-functioning"; APA, 2013). However, autism can present with or without cognitive deficits.

Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder is thought to be a disorder of executive functioning (Harpin, 2005). It is estimated to affect about 5% of the population. In order to be diagnosed with the disorder, symptoms must present themselves before the age of twelve even if not formally diagnosed until later in life (APA, 2013). Clinically ADHD is divided up into three

subtypes. These include ADHD 1) mainly characterized by hyperactivity, 2) mainly characterized by inattentiveness, and 3) and a combination subtype that is characterized by both hyperactivity and inattentiveness. Further, for diagnostic purposes an individual must display six or more specific behavioral characteristics to be diagnosed in any of these three subcategories. For example, some signs of the hyperactivity subtype include: an inability to sit still during class, butting into other people's conversations/tendency to blurt out thoughts, or "bouncing off the walls." In contrast, some signs of the inattentiveness subtype include disorganization, difficulty getting places on time, or difficulty focusing on school or work tasks.

Dyslexia

Dyslexia is a neurodevelopmental disorder characterized by difficulties with the phonological processing of language (Demonet et al., 2004). This results in a history of difficulty with reading, writing, spelling, and sometimes with memory or math tasks (APA, 2013) and is diagnosed using a patient's history and often with cognitive testing. Dyslexia is often also referred to as "a specific learning disability" (APA, 2013) and is thought to affect anywhere from 5-17% of the population (Shaywitz & Shaywitz, 2003). Diagnostic criteria for dyslexia require specific and unexpected deficits in reading/writing. In other words, difficulties in this area cannot be better explained by a more general deficit in cognitive functioning. Interestingly, back in the late 1800s when doctors were first becoming aware of the condition, it was thought that the source of the condition was due to a visual impairment because that seemed like that most reasonable explanation for why an otherwise bright pupil would have this one area of difficulty (Shaywitz & Shaywitz, 2003).

Clinical Disorders, Disability and Stigma

The clinical characteristics and diagnostic criteria for ASD, ADHD and dyslexia describe differences in cognitive function and social behaviors (for ASD and ADHD) that clearly set individuals with those neurodivergent conditions apart from people without those characteristics. Other people's perceptions of individuals with ASD, ADHD and dyslexia are likely to reflect differences in these groups' cognitive and social functioning, resulting in stereotypes that could impact their treatment at work. The stereotypes for neurodivergent groups may be influenced by disability stereotypes in general, but may also be influenced by specific clinical characteristics, such as disruptiveness and effects on social interaction, described by Jones et al (1984) in his work on stigma. The stereotypes and stigma associated with ASD, ADHD and dyslexia in the workplace are unknown to date but may have important implications for the work experience of individuals with these neurodevelopmental disorders.

The Medical and Social Models of Disability

While the clinical features of each neurodivergence undoubtedly impact how neurodivergent individuals are viewed and treated in the workplace, it is likely not the only factor at play. Another important factor to consider is the lens through which individuals view disability. According to scholars there are two main models or lenses through which disability is viewed in society, the medical model of disability and the social model of disability. Further, research has found that individual differences in disability model endorsement (i.e., the extent to which individuals endorse the medical versus social model of disability) have been linked to differences in attitudes towards disabled people (Bogart et al., 2019) suggesting that these models play an important role in how disabled people are viewed. In the following I will

describe the medical and social models of disability as well as their implications for the stereotyping and treatment of neurodivergent individuals in the workplace.

The Medical Model

The medical model of disability views disability as a disorder. It is a paradigm that categorizes disability as a deficit on the part of the individual. This medical model of disability calls for remediation that will help individuals "fix" their disability (Areheart, 2008) and thus the focus is on treating the disability to return (or get) individuals to "normal functioning" to the furthest extent possible. For example, under the medical model the appropriate course of action for someone in a wheelchair would be to offer them treatments and therapies that would allow them to walk, thus allowing them the conventional mode of mobility (Comberousse, 2019). While offering treatments to individuals with disabilities so that they can function normally or typically is appropriate in many circumstances (e.g., carrying out surgery to improve vision or providing individuals with mobility issues with physical therapies to improve mobility), this kind of approach can also have negative repercussions. Research suggests that the medical model of disability can prevent individuals from developing a positive disability identity and from developing a sense of self-efficacy (Hahn & Belt, 2004; Weeber, 2004). This may be especially true in cases where there is no obvious or effective treatment for the disability or in cases where the treatment is able to ameliorate but not cure the disability.

The Social Model

The social model of disability, which forms the basis for the concept of neurodiversity, takes quite a different approach. The social model of disability provides a lens through which the concept of disability is socially constructed. In other words, "it is not the pattern of functioning itself that is inherently a trait of disability, rather it is the comparison of that functioning with

what society has deemed ‘normal’ that leads to categorizing individuals as ‘abled’ or ‘disabled’” (LeFevre-Levy et al., 2023, p.6). Indeed, according to the social model the concept of disability “stems largely from society’s failure to accommodate varying needs” and types of functioning rather than from inherent deficits within the individual (Comberousse, 2019; para. 6). As a result, the appropriate societal response to disability under the social model differs starkly from that of the medical model. Instead of focusing on treating the disabling condition, as prescribed by the medical model, the solution under the social model is for society to make accommodations for varying needs of individuals who are part of society. For example, proponents of the social model would advocate for policies that require buildings to have ramps and elevators to allow individuals in wheelchairs to function in society and improve accessibility. Rather than focusing on making all individuals function the same way, the focus is on providing individuals with various forms of functioning with the tools they need to be able to function in society as they are. The idea behind this approach is that by making these adaptations you are essentially able to take someone from “disabled” to almost unconstrained by their differences in function essentially overnight.

Implications of the Medical and Social Models

Of course, both the medical and social perspectives of disability have their own merit and may be more or less appropriate under various circumstances. However, it is important to consider the ways in which adherence to these two perspectives may color how neurodivergent individuals (and persons with disabilities more generally) are viewed in the workplace and may affect their employment experience and how they are treated. In adopting the medical model of disability, individuals may perceive disabled persons as innately physically or mentally inferior to others, and thus ill-fitted to perform in the workplace. This in turn may lead to the view that

discriminatory behavior (e.g., not hiring, promoting or mentoring) is a rational reaction to disabled individuals in the workplace. In contrast, the social model of disability views disability discrimination as a form of social discrimination parallel to race-based or sex-based bias and discrimination. Therefore, individuals who adopt the social model of disability may view discrimination towards neurodivergent others as a social injustice rather than a rational response. Although these differences in whether discriminatory behaviors toward disabled individuals are viewed as rational vs. social injustice have been suggested by legal scholars (Areheart, 2008), empirical evidence directly testing the prevalence and consequences of these differences within organizations is lacking. I will address this further in later sections, discussing the importance of understanding how individuals' views on disability more generally may impact how they view people with ASD, ADHD, and dyslexia in the workplace.

CHAPTER 3

STIGMA, STEREOTYPES, AND DISCRIMINATION IN THE WORKPLACE

Conceptualizations of Stigma and Stereotyping

Stigma refers to the devaluation of group-level or individual-level characteristics resulting in negative stereotyping, social rejection or devaluation, or discrimination (Goffman, 1963). According to Goffman (1963) certain individuals in society are viewed as deviant and this results in a stigmatized "spoiled identity." Stereotyping can play an integral role in the stigmatization process and individuals are often stereotyped based on their status regarding certain group memberships (Tajfel & Turner, 1986). According to social identity theory, social categorization—the process by which we sort individuals into "in" and "out" groups—has a direct impact on how we view and treat members of various groups. A long tradition of research has found that group categorization reliably dictates favoritism towards the "in-group" and discriminatory behavior towards the "out-group" (Tajfel & Turner, 1986). Research has found that these group processes have a significant impact on minority group outcomes in the workplace. For example, Dobbins and colleagues (1988) found that greater endorsement of traditional gender-based stereotypes resulted in lower performance appraisals of female workers. Similarly, researchers have found that negative racial stereotypes can place Black workers at a disadvantage compared to their White counterparts when it comes to personnel decisions around hiring, compensation, and performance appraisals (Breif et al., 2005).

However, it is important to note that while stereotypes regarding the "in-group" are typically positive in nature, there is a robust line of research that suggests that "out-group"

stereotypes can be comprised of both negative and positive features and that different out-groups are perceived in different ways. Indeed, research suggests that stereotypes regarding out-groups, rather than simply varying on a continuum of good or bad, positive or negative, are multi-dimensional. There is a substantial body of research that points to two key stereotype dimensions on which we judge others: warmth and competence. In the following section I will discuss these two dimensions of social perception and how they are related to the behavioral tendencies of the in-group towards out-group members.

The Stereotype Content Model

The stereotype content model (SCM) is a framework used to understand both the societal perceptions of a specific group and the behavioral tendencies of others towards that group. As mentioned previously, according to the SCM there are two key dimensions from which group stereotypes are formed: 1) warmth (e.g., liking, trustworthiness, friendliness); and 2) competence (e.g. capability, assertiveness; Fiske et al., 2002; Fiske et al., 2007). Indeed, warmth and competence have been identified as important components of how we evaluate others (Asch, 1946: Rosenberg et al., 1968; Wojciszke et al., 1998).

Evidence of warmth and competence as primary dimensions of social perception date back to the 1960s in an experiment in which Rosenberg and colleagues (1968) supplied college students with a series of traits (e.g., humorous, warm, sociable, cold, irritable, intelligent, industrious, foolish, naive; see Appendix A, Figure 1) and asked them to rate how likely it would be for these traits to be associated with the same person. Analyses indicated two main dimensions to which these traits belonged: social good-bad and intellectual good-bad (Fiske et al., 2007). This research formed the basis for the subsequent research on the fundamental dimensions of social cognition. Starting in the 1990s researchers adapted the social and

intellectual dimensions of social cognition examined by Rosenberg and colleagues in their 1968 publication. Researchers Susan Fiske, Amy Cuddy, and Peter Glick developed the stereotype content model and the warmth and competence dimensions of the SCM soon became analogous to the social and intellectual dimensions proposed by Rosenberg and colleagues (1968).

Work using the SCM suggests that stereotypes can vary greatly and not all out-groups will experience the same type or amount of stereotyping. In their seminal paper, Fiske and colleagues (2002) explored the type of stereotyping different groups (e.g., the elderly, the poor, Asian people, professionals, the disabled, Christians) experience by asking participants to rate the societal perception of these groups on the dimensions of warmth and competence. They then performed a cluster analysis and found that distinct clusters formed based on participant perceptions of warmth and competence. Two clusters with unambivalent stereotypes were identified. These groups were viewed as either relatively high in both competence and warmth (e.g., ingroup members) or relatively low in both traits (e.g., poor people; Fiske et al., 2002).

Other groups cluster into what the literature refers to as ambivalent (or mixed) stereotyping, meaning that there are positive stereotypes along one dimension of social perceptions for that group and negative perceptions along another dimension of social perception. For example, some groups (e.g., Jewish people) are viewed as highly competent but cold and unfriendly, while other groups (e.g., elderly people) are viewed as relatively incompetent but high in warmth.

Further, according to the SCM, the stereotypes associated with group membership have implications for how individuals belonging to that group are treated. Specifically, Cuddy and colleagues (2007) extended the SCM by creating the behaviors from intergroup affect and stereotypes (BIAS) map which links warmth and competence perceptions to emotions and

behaviors in social interactions. The BIAS Map links warmth perceptions to active behaviors (i.e., harming vs. helping behaviors), such that groups who are perceived to be low in warmth elicit harming behaviors, while groups perceived as high in warmth elicit helping behaviors (Cuddy et al., 2007). Similarly, the BIAS Map links competence perceptions to passive behaviors (i.e., the behavioral tendency to associate with or socially distance oneself from others), such that groups perceived to be low in competence elicit social distancing behaviors while groups perceived to be high in competence elicit associative behaviors (Cuddy et al., 2007).

In a series of studies Cuddy and colleagues (2007) used several different methodologies to examine the relationship between the dimensions of the stereotype content model (i.e., warmth and competence) and expected behavioral tendencies towards social groups. In the first of several studies researchers used a telephone survey methodology to gather data on the general public's perceptions of the warmth and competence of a number of different out-group populations within the United States. They asked the following questions to evaluate the various out-groups on perceived warmth and competence: "consider how [group, e.g., the elderly] are viewed by Americans in general. As viewed by most Americans, how [e.g., competent/ warm] are [group]?" (Cuddy et al., 2007; p 648). In addition, using a behavioral tendencies scale, they asked participants to report on how likely the general public was to engage in four different types of behaviors e.g., active harm, passive harm, active facilitation, and passive facilitation) towards the group. For example, "Do people tend to [behavior, e.g., help] [group]?" (Cuddy et al., 2007; p 648). All questions were asked in the context of society generally to account for the social desirability concern associated with asking participants about their views and behaviors directly. Cuddy and colleagues (2007) then ran a series of correlations and found that, as predicted,

perceptions of competence correlated positively with passive facilitation behaviors (e.g,, cooperation, association) and negatively with passive harm behaviors (e.g,, exclusion). Similarly, as expected, perceptions of warmth correlated positively with active facilitation behaviors (e.g., helping behaviors) and negatively with active harm behaviors (e.g., fighting).

In a subsequent study Cuddy and colleagues (2007) went on to test causality using an experimental vignette technique. In this study the researchers manipulated the warmth and competence descriptions of a "fictitious ethnic group expected to immigrate soon in large numbers to the United States" (Cuddy et al, 2007; p 640). As in the previous study, participants were then asked to fill out behavioral tendencies scales to indicate how likely this group would be to experience passive facilitation, passive harm, active facilitation and active harm behaviors from the general public. In line with their hypotheses, the researchers found that the high warmth condition elicited expectations that the immigrant group would experience more active facilitation behaviors and less active harm behaviors as compared to the low warmth condition. They also found that the high competence condition elicited expectations that the immigrant group would experience more passive facilitation behaviors and less passive harm behaviors as compared to the low competence condition. These findings support the assumption that there is a causal relationship between warmth and competence perceptions of a given group and expectations of behavioral tendencies towards that group.

The Stereotype Content Model and Disability

Disability as a broad category was included as one of the out-groups in studies conducted by both Fiske and colleagues (2002) and Cuddy and colleagues (2007). While understanding disability stereotyping was not one of the objectives of these studies, the cluster analysis gives us some insight into how disability is viewed broadly. Both sets of studies indicated that disabled

people are clustered into the ambivalent stereotype of high warmth and low competence and are likely to be viewed through a paternalistic lens (Cuddy et al., 2007; Fiske et al., 2002). In line with the findings from the studies discussed above regarding the relationship between perceptions of group warmth and competence and expected behavioral tendencies toward said group, this would suggest that disabled groups would experience relatively higher levels of active facilitation/lower levels of active harm and lower levels of passive facilitation/ higher levels of passive harm. In other words, research on the SCM would suggest that disabled people would have helping (rather than harm) behaviors directed towards them, but that people would be more hesitant to be associated with them and may have a tendency to actually distance themselves from them.

However, recent research suggests that by viewing disability as a broad category, we are likely missing important nuances in how specific disability conditions are viewed. While there is evidence that there is an overarching stereotype of "the disabled" (i.e., high warmth and low competence), there is also research to suggest that specific disabilities differ in the extent to which they elicit these warmth and competence perceptions. A recent study by Canton and colleagues (2023) examined this very question by asking participants to rate how society views the warmth and competence of twelve different disabled groups of people (e.g., people with paraplegia, schizophrenia, depression, down syndrome, ADHD). They then conducted a cluster analysis using the same methods described by both Fiske and colleagues (2002) and Cuddy and colleagues (2007). Canton and colleagues (2023) found four distinct clusters of disability: 1) low warmth/ low competence, 2) moderate warmth/ low competence, 3) high warmth/ low competence, and 4) high warmth/ moderate competence. These findings suggest that there are differences in how individuals with disabilities are viewed depending on the disabled group to

which they belong. Individuals with down syndrome or traumatic brain injury, for example, clustered into a high warmth/low competence grouping, while individuals with schizophrenia or depression clustered into a low warmth/ low competence group. Further, Canton and colleagues (2023) found that, out of the four clusters, the two clusters that were rated lowest in warmth and competence were also rated as the most likely to experience both active and passive harm. The clusters that were highest in perceived warmth and competence were rated as the most likely to experience active and passive facilitation.

Another study conducted by Sadler and colleagues (2012) examined the differences in warmth and competence perceptions of a specific sub-group of the disabled population, those living with mental illness. In their study Sadler et al. (2012) asked participants to rate the warmth and competence of thirteen different mental illness out-groups. Results indicated that there were four distinct clusters of mental illnesses, each with different warmth and competence perceptions associated with them. For example, bipolar disorder, eating disorder, and obsessive compulsive disorder were a few of the conditions that made up the "medium warmth/ medium competence" cluster, while multiple personality disorder and schizophrenia were among the conditions that made up the "low warmth/ low competence" cluster. Such findings lend further credence to the idea that a single stereotype of high warmth and low competence encompassing all disability is an oversimplification. Further research is needed to understand the stereotyping of disabled out-groups such as those with various neurodivergent conditions. Together, these findings suggest that there is heterogeneity in the way different groups of disabled people are viewed on stereotype dimensions and that these differences may result in different treatment.

Stereotype Content Model in the Workplace

Although research is relatively scarce, it is logical that social perceptions along the dimensions of warmth and competence would have implications for how different groups of people are viewed and treated not only in society as a whole but in the workplace as well. In their 2011 review article, Cuddy and colleagues suggest that the SCM can have a number of implications for the workplace. In one of the few studies exploring links between the SCM and the work context, Cuddy and colleagues (2004) used vignettes to examine how warmth and competence perceptions were impacted by the parental status of female employees. They found that when women become parents and make the transition from "working women" to "working mothers" their perceived competence in the workplace decreases while their perceived warmth increases. Further, they found that the parental status of the woman impacted how participants stated they would treat her in the workplace. The participants reported that they would be less likely to hire, promote or put resources into training the female employee who recently became a parent as compared to the childless female employee. Competence perceptions were significantly positively correlated with intention to hire, promote and train the target described in the vignette (r = .54).

Given these findings, it is clear that understanding the societal perceptions of members of various outgroups (e.g., neurodivergent individuals) along the dimensions of competence and warmth in the workplace is important because it provides insight into the potentially discriminatory behavioral reactions others have to these groups. Further, because in the workplace relationships are often more structured around professional roles and tasks and less casual, people may be more concerned about how working with a disabled person might reflect on them and this may make those stereotypes more salient. To my knowledge, no research has

examined how warmth and competence stereotypes impact the experiences of neurodivergent employees in the workplace.

CHAPTER 4

ESTABLISHING WARMTH AND COMPETENCE STEREOTYPES (STUDY 1)

To inform predictions about the connections between stereotypes and behavioral tendencies within specific neurodivergent sub-populations, it's essential to first understand what the differences in stereotypes are between neurodivergent groups. Therefore, the purpose of Study 1 is to explore and establish the stereotype profile – with regard to warmth and competence perceptions – that people generally associate with each of the three neurodivergent populations of interest (i.e., ASD, ADHD and dyslexia) in the workplace.

Neurodivergent populations are likely to elicit specific and distinct stereotypes from other groups. Although, as discussed above, warmth and competence perceptions of disability in general have been examined (suggesting stereotypes of high warmth and low competence; Fiske et al., 2002), research suggests that stereotyping is not uniform across all types of disabilities (Canton et al., 2023; Sadler et al., 2012). The stigma literature suggests that reactions to stigmatized individuals vary depending on specific attributes (e.g., social disruptiveness, origin, aesthetic qualities, concealability) of the stigmatized identity (Jones et al., 1984; McLaughlin et al., 2004). Since these attributes vary greatly from one type of neurodevelopmental condition to another (e.g., the social disruptiveness of someone with autism is likely to be perceived very differently than the social disruptiveness of someone with dyslexia), it is only logical that associated stereotypes would also vary.

Along these lines, I suggest that the stereotypes associated with individuals with ASD, ADHD and dyslexia in the workplace will differ due to the distinct attributes of each of these

three neurodivergent conditions. In the following subsections I discuss the specific clinical attributes of ASD, ADHD, and dyslexia in relation to their implications for the warmth and competence perceptions of these neurodivergent populations in the workplace. However, given the paucity of research on the perceptions of neurodivergent individuals, it is unclear to what extent the general population is aware of the clinical attributes of each neurodivergent conditions. Given that there is very little research on this, I offer general research questions where I take an exploratory approach.

Warmth Perceptions

Perceptions of warmth are intertwined with perceptions of social proactiveness (Fiske et al., 2007) or the extent to which we perceive others as friendly and well-intentioned towards us. According to research, our judgments of others' warmth occurs rapidly (Cuddy et al., 2007; Willis & Todorov, 2006) and is derived from behaviors as well as facial cues/ body language (Berry & McArthur, 1985; Biancardi et al., 2017; Cuddy et al., 2011; Willis & Toodrov, 2006). According to Cuddy and colleagues (2011), it is possible to increase others' perceptions of your warmth by smiling, nodding, learning forward, or mirroring the nonverbal behaviors of those you are interacting with (See Cuddy et al., 2011). Further, Fiske and colleagues (1999) found that those who are stereotyped as lacking social skills, such as Asian people, are viewed as being low in warmth.

Therefore, perceptions of the warmth of different neuoratypical groups are likely to be influenced by the types of social behaviors associated with the neurodevelopmental condition. Deficits regarding social interaction is a key diagnostic criterion in ASD, whereas it is not a key part of the diagnosis of ADHD or dyslexia. Research suggests that autistic individuals are more likely to be viewed as having poor communication and social skills, as being introverted and

withdrawn or as having a “difficult personality” (Wood & Freetch, 2016, p. 131), suggesting that individuals with ASD may be viewed as particularly low in warmth.

Similarly, it is possible that the clinical attributes of ADHD may have some negative implications for warmth perceptions. While difficulty with social interaction is not an essential criterion for ADHD diagnosis, certain behaviors associated with ADHD (e.g., restlessness or inattentiveness, wearing others out with their activity, blurting out thoughts) conflict with social norms (Chew et al., 2009). Research suggests that individuals with ADHD are viewed by others as irritating and disruptive (Miller-Johnson et al., 2002). Given this, individuals with ADHD may also suffer from some negative warmth stereotypes in the workplace, although to a much lesser extent than individuals with ASD.

In contrast to ASD and ADHD, diagnostic criteria for dyslexia have no direct implications for how these individuals will be perceived socially. Therefore, it seems likely that individuals with dyslexia will not suffer from low warmth perceptions. Given the above logic, it is likely that individuals with ASD, ADHD, and dyslexia are perceived to have different levels of warmth. Therefore, I propose the following research question:

RQ1: What are the differences in societal perceptions of warmth of individuals with ASD, ADHD, and dyslexia in the workplace?

Competence Perceptions

The different clinical attributes of ASD, ADHD and dyslexia are also likely to result in differences in perceptions of the competence of these three groups in the workplace. For example, it seems likely that individuals with dyslexia will be subjected to negative stereotypes regarding competence due to the reading difficulties that are associated with the condition. As a neurodivergent condition characterized by relative difficulties with phonological decoding of

written language and slow reading speeds, dyslexia is likely to be particularly stigmatizing when it comes to competence perceptions despite being unrelated to intelligence (Ferrer et al., 2010; Tanaka et al., 2011). To my knowledge there has not been any research directly looking at perceptions of dyslexic individuals in the workplace. However, educational research has found that dyslexic children are often viewed as less competent, and parents and teachers have lower performance expectations of them as compared to non-dyslexic children (Lackaye & Margalit, 2006; Rimkute et al., 2014).

Additionally, there is reason to think that perceptions of the competence of autistic individuals may be different from perceptions of the competence of with those ADHD or dyslexia; however, it is difficult to predict whether autistic individuals would be viewed as higher or lower in competence than that of the two other groups. On the one hand, while not an essential diagnostic criterion, ASD can occur with intellectual or language impairment (APA, 2013). This association with intellectual impairment may result in particularly low perceptions of competence in the workplace. On the other hand, ASD has been linked to several special skills including talents in mechanical and spatial tasks, mathematical calculations, and detailed memorization (Itzchak et al., 2013). Although not all autistic individuals display these special talents, often referred to as "savant skills", it is possible that the prevalence of such portrayals in the media may positively color perceptions of the competence of autistic people in the workplace.

ADHD, on the other hand, may or may not be viewed as a condition associated with incompetence to the same degree as dyslexia and autism. Research indicates that students with ADHD are perceived by their teachers as weaker academic performers than their peers, even when test scores indicate otherwise (Metzger, 2016). This suggests that children with ADHD

may be seen as less competent than their neurodevelopmentally typical peers by their teacher, however, it is unclear how this might translate to adults in the workplace when comparing ADHD to other neurodevelopmental disorders. While unlike autism, savant skills are not associated with ADHD, there are also no intellectual or language impairments associated with the condition. Similarly, the difficulties in reading and language processing associated with dyslexia are not characteristic of ADHD, and, therefore, it may be that those with ADHD are seen as relatively more competent than those with dyslexia or autism. In order to address this, I propose the following research question:

RQ2: What are the differences in societal perceptions of the competence of individuals with ASD, ADHD and dyslexia in the workplace?

CHAPTER 5

METHODS

Participants and Procedure

Participants for Study 1 consisted of working adults recruited through Cloud Research, an online survey participant recruitment platform. Participants who completed the study were paid $1.25 for their time. In order to be eligible for the study, participants had to a) be 18 years of age or older, b) work 35 or more hours a week outside of Cloud Research, and c) reside within the continental United States. Participants who passed the eligibility criteria and consented to participate were then asked to continue on to the main part of the study.

Three-hundred and ten participants completed Study 1. Ten participants (approximately 3%) were removed from the data due to poor data quality, resulting in three-hundred and one participants included in the final analyses after data quality screening (process described in subsequent sections) which was in line with the target sample size. A sample size of three hundred was determined as more than adequate after conducting power analysis for a one-way analysis of variance using G-power (moderate effect size of $f = 0.25$, an alpha of .05, a power of .8 and three conditions) which indicated a necessary sample size of 159.

After identifying and removing poor quality data, descriptive statistics were run regarding the demographic information of the participants was determined. The average age of the participants was 34 years old (*SD* =11.2). Approximately 23% of participants reported identifying as male, 75% female, with the remaining 2% identifying as “other”. Seventy-one percent of participants identified as White, 8% identified as Hispanic or Latino, 8% Asian, and

7% as Black or African American. Approximately 5% of the participants identified as mixed race. Less than one percent of the participants identified as Hawaiian or Pacific Islander.

Participants who passed the eligibility screening were then asked to move on to the main part of the study. Participants were randomly assigned to one of three experimental conditions in which they were asked to consider how people in their workplace would view a coworker with 1) autism spectrum disorder, 2) attention deficit hyperactivity disorder, or 3) dyslexia. After being presented with a short description of the characteristics of the neurodevelopmental condition, participants were asked to respond to a series of items measuring how the target (i.e., a person with ASD, ADHD, or dyslexia) would be likely to be viewed in their workplace. These included perceptions of warmth and competence (see Appendix B).

Measures

Warmth and Competence

Each participant was asked to rate how their coworkers in their profession would perceive the warmth and competence of a person with the neurodivergent condition described to them (e.g., ASD, ADHD, and dyslexia) using the 6-item measures developed by Fiske et al. (2002; previous coefficients were α = .83 and α = .93 for warmth and competence respectively). Example items include as viewed in your current occupation "how friendly are individuals with [autism spectrum disorder/attention deficit-hyperactivity disorder/dyslexia] perceived to be?" for assessing the warmth dimension, and as viewed by those in your current occupation, "how capable are individuals with [autism spectrum disorder/attention deficit-hyperactivity disorder/dyslexia] perceived to be?" for the competence dimension. In line with previous research (e.g., Cuddy et al., 2007; Cuddy et al., 2008; Fiske et al., 1999; Fiske et al., 2002), items were asked in the context of the workplace more generally in order to reduce the impact of social

desirability on responses. The responses will be recorded on a five-point Likert-like scale will be used (1 = “Not at all” to 5 = “Extremely”).

Attention Checks

I included an attention check to further ensure that participants paid attention to the survey questions. The first attention check was an item from Meade and Craig’s (2012) careless responding scale. This item is “I do not speak a word of English”. The second attention check item is a more generic attention check item and simply consists of “Please select ‘Moderately’ for your response to this question.” If participants failed both attention checks their data was excluded from the study.

CHAPTER 6

STUDY 1 RESULTS

Analytical Approach

The purpose of Study 1 was to determine if there are differences in the perceptions of warmth and competence of the three neurodivergent groups of interest (i.e., workers with autism, ADHD, and dyslexia) in the workplace. To test if there are differences, two one-way ANOVAs were run using R as the statistical software, one with warmth as the outcome variable and one with competence as the outcome variable. Follow up multiple comparisons were run as appropriate (i.e., when the omnibus F-test for the ANOVA was significant) to determine which paired conditions (i.e., autism vs. ADHD, autism vs. dyslexia, ADHD vs. dyslexia) are significantly different from each other in perceived warmth and/or competence. In such cases the bonferroni correction was used to avoid the potential for increased Type 1 error that occurs as result of multiple comparisons.

Warmth Perceptions

An ANOVA was run to test for differences in warmth perceptions among the three neurodivergent groups. There was a significant difference in warmth perceptions between the three conditions, $F(2, 297) = 9.40$, $p < .05$. Follow up comparison results indicated that the dyslexia target condition ($M = 4.08$, $SD = .76$.) and the ADHD target condition ($M = 4.09$, $SD = .68$) received significantly higher warmth perceptions as compared to the ASD target condition ($M = 3.69$ $SD = .78$). There was no significant difference in warmth perceptions between the ADHD target condition and the dyslexia target condition.

Competence Perceptions

Next an ANOVA was run to test for differences in competence perceptions among the three neurodivergent groups. The results of the omnibus test also found a significant difference between the three neurodivergent conditions, $F(2, 297) = 5.35$, $p < .05$. Follow up comparisons indicated that the ADHD condition ($M = 3.76$, $SD = .73$) was the recipient of significantly higher competence perceptions than the ASD target condition ($M = 3.40$, $SD = .90$) and the dyslexia target condition ($M = 3.41$, $SD = .93$.). No significant difference in competence perceptions were found between the ASD target condition and the dyslexia target condition.

CHAPTER 7

STUDY 1 DISCUSSION

The results from Study 1 suggest that there are indeed differences in the warmth and competence stereotypes associated with ASD, ADHD, and dyslexia in the workplace. Specifically, results indicate that people with dyslexic and ADHD are expected to be viewed as warmer coworkers than autistic people and that people with ADHD are expected to be viewed as more competent in the workplace as compared to autistic people or dyslexic people. While illuminating, these results are not completely surprising. It seems logical that the difficulties around social interaction and communication that is characteristic of autistic people (APA, 2013) could be interpreted by others as a particular lack of warmth. Similarly, due to the difficulty with reading associated with dyslexia and that some autistic people are low functioning (i.e., have low IQs) it seems reasonable that people may judge these two groups as lower in competence in the workplace as compared to ADHD.

However, it is interesting to note that in this study the clinical attributes of ADHD did not appear to have any negative implications for warmth perceptions. Behaviors associated with ADHD (e.g., restlessness or inattentiveness, wearing others out with their activity, blurting out thoughts) conflict with social norms (Chew et al., 2009). Research suggests that individuals with ADHD are viewed by others as irritating and disruptive (Miller-Johnson et al., 2002). However, these previous findings did not translate into lower warmth perceptions of individuals with ADHD in the workplace.

The findings from Study 1 regarding differences in warmth and competence perceptions suggest that further investigation is warranted to understand how these perceptions may be linked to differences in the treatment of the three neurodivergent groups in the workplace. Warmth perceptions have been positively linked in the literature to facilitation behaviors (e.g., helping behaviors) and negatively linked to active harm (e.g., harassing behaviors; Cuddy et al, 2007). Competence perceptions have been linked positively to passive facilitation behaviors (e.g., associative behaviors) and negatively to passive harm behaviors (e.g., distancing behaviors: Cuddy et al, 2007). This is investigated in Study 2 as detailed in subsequent sections.

CHAPTER 8

LINKING WARMTH AND COMPETENCE PERCEPTIONS TO BEHAVIORAL TENDENCIES (STUDY 2)

As discussed preciously, the SCM links perceptions of warmth and competence to behavioral tendencies. Prior research has found that warmth and competence perceptions mediate the relationship between group membership (e.g., gender, race, disability status) and behavioral tendencies towards members of that group (Boysen, 2017; Cuddy et al., 2004; Cuddy et al., 2007; Cuddy et al., 2008). Therefore, the purpose of my second study was to link the stereotypes found to be associated with neurodivergent groups in the workplace from Study 1 to behavioral tendencies towards these groups in the workplace.

Linking Stereotypes to Behavioral Tendencies towards Neurodivergent Individuals

Understanding behavioral tendencies in the workplace towards different neurodivergent groups is important as the extent to which others have the tendency to help and associate with them has obvious implications for a number of important career-related outcomes such as hiring, promotion, and task assignments (Cuddy et al., 2011). According to the SCM and the BIAS Map, stereotypes along the dimensions of warmth and competence emerge as a result of group membership. These perceptions in turn elicit emotional responses which influence our behaviors towards groups of people. In other words, the "fundamental dimensions of warmth and competence… combine to create specific patterns of… behaviors toward members of various social groups" (Cuddy et al., 2011, p. 22). Indeed, research has found that warmth and competence perceptions mediate the relationship between group membership (e.g., gender, race,

disability status) and behavioral tendencies towards members of that group (Boysen, 2017; Cuddy et al., 2004; Cuddy et al., 2007; Cuddy et al., 2008) further supporting this notion.

Warmth perceptions have been positively linked in the literature to facilitation behaviors (e.g., helping behaviors) and negatively linked to active harm (e.g., harassing behaviors; Cuddy et al, 2007). Competence perceptions have been positively linked in the literature to passive facilitation behaviors (e.g., cooperation) and negatively linked to passive harm behaviors (e.g., exclusion behaviors; Cuddy et al., 2007). Thus, the findings regarding the warmth and competence perceptions of each neurodivergent group from Study 1 inform the following hypotheses for Study 2.

Due to the differences found in Study 1 in perceptions of the warmth and competence among the three neurodivergent groups, I expect there to be group differences in the behavioral tendencies towards each group in the workplace. Specifically due to the perceptions of low warmth of individuals with ASD as compared to individuals with ADHD and dyslexia found in Study1, I hypothesize the following regarding the mediating role of warmth in the relationship between neurodivergent condition and both expected active facilitation behaviors and active harm behaviors:

Hypothesis 1a: Warmth perceptions mediate that relationship between neuroatypical condition (i.e., ASD, ADHD, and dyslexia) and expected active facilitation behaviors (e.g., helping behaviors): the ASD condition will elicit lower levels of perceived warmth as compared to the ADHD and dyslexia conditions, which in turn will lead to lower levels of active facilitation.

Hypothesis 1b: Warmth perceptions mediate the relationship between neuroatypical condition (i.e., ASD, ADHD, and dyslexia) and expected active harm behaviors (e.g., harassing

behaviors): the ASD condition will elicit lower levels of perceived warmth as compared to the ADHD and dyslexia conditions, which in turn will lead to higher levels of expected active harm behaviors.

Similarly, due to the differences found in Study 1 in perceptions of competence among the three neurodivergent groups, it would be expected that different neurodivergent groups would experience differing levels of passive facilitation and passive harm behaviors directed towards them in the workplace. Specifically, due to Study 1 results indicating that dyslexic and autistic individuals are perceived as less competent as compared with individuals with ADHD, it would be expected that they would be more likely to be the target of passive harm behaviors in the workplace and less likely to be the target of passive facilitation behaviors in the workplace as compared to individuals with ADHD. Therefore, I propose the following hypotheses regarding the mediating role of competence in the relationship between neurodivergent condition and both expected passive facilitation behaviors and passive harm behaviors:

Hypothesis 2a: Competence perceptions will mediate the relationship between neuroatypical condition (i.e., ASD, ADHD, and dyslexia) and expected passive facilitation behaviors (e.g., cooperative behaviors): the ADHD condition will elicit higher levels of perceived competence as compared to the ASD and dyslexia conditions, which in turn will lead to higher levels of expected passive facilitation behaviors.

Hypothesis 2b: Competence perceptions will medicate the relationship between neuroatypical condition (i.e., ASD, ADHD, and dyslexia) and expected passive harm behaviors (e.g., exclusion behaviors): the ADHD condition will elicit higher levels of perceived competence as compared to the ASD and dyslexia conditions, which in turn will leader to lower levels of expected passive harm behaviors.

Role of Endorsement of the Social Model on Perceptions of Competence

There is reason to believe that individual differences in the endorsement of the social model of disability would play a role in perceptions of competence across neurodivergent groups. Specifically, Study 2 examines whether endorsement of the social model of disability impacts participants' competence perceptions and in turn impacts their expectations of how neurodivergent people are likely to be treated in the workplace. To my knowledge there is no previous research examining the relationship between disability perspectives and treatment/behaviors towards individuals with disability. However, logically it would make sense that individual differences in how people view disability would color how they expect disabled people to be treated.

As discussed above, the social model of disability is a perspective under which disability is seen as a difference in functioning rather than an inherent inability to function (Areheart, 2008; Smith, 2008). This is in contrast to the medical model of disability, which is a framework under which disabled persons are considered physically or mentally inferior to the majority in some way. Each of these perspectives has different implications for disabled people in the workplace. In the context of the workplace, the social model would seem to suggest that rather than being unable to perform at work (e.g., being unable to complete tasks effectively), disabled people may need to perform their job duties in different ways than is typical. For example, someone who is vision impaired may need to write emails to colleagues by using dictation software rather than by typing on a keyboard. Given this, it seems logical that under this perspective a disabled person is less likely to be viewed as incompetent and more likely to be viewed as simply a colleague who has different ways of doing things. In other words, rather than being viewed as ill-fitted to the workplace due to inability (e.g., incompetence) they simply function differently.

Indeed, past research suggests that the model of disability one subscribes to (i.e., social vs medical) can impact one's attitudes towards persons with disabilities. For example, in a university sample Bogart and colleagues (2019) found that endorsement of the social model of disability was negatively related to scores on the Attitudes Towards Disabled Persons Scale (ATDS) "which operationalizes unfavorable attitudes as cognitions, affect, and behavioral intentions indicating that people with disabilities are different from, less competent than, and inferior to people without disabilities" (p. 200).

Based on Bogart and colleagues' (2019) findings, it is expected that the lens through which disability is viewed would impact the perceptions of neurodivergent individuals in the workplace. Specifically, it would be logical that people who view disability more strongly through the social model of disability would view neurotypical individuals as more competent as compared those who have low endorsement of the social model, and that, in turn, this would impact their expectations that neurodivergent individuals would be the targets of both a) passive facilitation behaviors and b) passive harm behaviors. Therefore, I propose the following hypotheses:

Hypothesis 3: There is a significant main effect of the endorsement of the social model of disability such that participants who more strongly endorse the social model will perceive neurodivergent workers as more competent than those who weakly endorse the social model.

Further, endorsement of the social model is also likely to interact with the type of neurodivergent condition such that endorsement of the social model may actually lessen any differences we see in perceptions of competence between the autistic, ADHD and dyslexia targets. As discussed earlier, each neurodivergent condition being examined has unique clinical attributes and these attributes are likely to impact perceptions of competence differently. For

example, Study 1 indicated that people with dyslexia are considered less competent than people with ADHD in the workplace likely due to the difficulties in decoding written language associated with dyslexia. However, since people who strongly endorse the social model of disability are more likely to see more labored reading as the result of a different way of processing written information rather than a deficit or character flaw, they may be less likely to view these difficulties in reading as a sign of incompetence, thus tending to see those with (dyslexic people) and without (in this example people with ADHD) these reading difficulties as similarly competent. Based on this logic, I would expect that endorsement of the social model would lessen the differences in perceptions of competence that were found in sutdy1. In other words, I would expect that individuals who more highly endorse the social model of disability will view individuals with ASD and dyslexia as having similar levels of competence as individuals with ADHD. Specifically, I hypothesize the following:

Hypothesis 4: There is an interaction between neurodivergent condition and endorsement of the social model such that the differences between perceived competence of the three neurodivergent groups will be greater when the endorsement of the social model is low compared to when endorsement of the social model is high.

CHAPTER 9

METHODS

Procedure

The eligibility requirements for Study 2 were the same as for Study1. Again, study participants consisted of working adults recruited through Cloud Research. In order to be eligible for the study, participants had to a) be 18 years of age or older, b) work 35 or more hours a week outside of Cloud Research, and c) reside within the continental United States. Participants who passed the eligibility criteria and consented to participate were then asked to continue on to the main part of the study.

Four hundred and seventeen participants completed Study 2. Eleven participants (approximately 3%) were removed from the data due to poor data quality, resulting in four-hundred and six participants included in the final analyses after data quality screening which was over the target sample size. The target sample size was determined after conducting power analysis for the interaction term in a linear multiple regression using G-power (small effect size of $f = 0.02$, an alpha of .05, a power of .8 and three total predictors), and consulting the literature for the necessary sample size to test the mediation proposed in the study. The results of the G-power analysis suggested that a sample size of 395 will yield adequate power. According to monte carlo simulations conducted by Fritz and Mackinnon (2007), a sample size of 148 (moderate effect sizes of $f = .26$ and power of .80) is adequate for testing mediation using a bootstrapping methodology. Given this, a sample size of 406 should be large enough to have adequate power for all analyses.

After identifying and removing poor quality data, descriptive statistics were run regarding the demographic information of the participants was determined. The average age of the participants was 34 years old (*SD* = 11.2). Approximately 54% of participants reported identifying as male, 45% female, with the remaining 1% identifying as "other". Fifty-nine percent of participants identified as White, 5% identified as Hispanic or Latino, 9% Asian, and 21% as Black or African American. Approximately 5% of the participants identified as mixed race. Less than 1% of the participants identified as Hawaiian or Pacific Islander.

As in Study 1, participants who passed the eligibility screening were then asked to proceed to the main part of the study. Participants were randomly assigned to one of three experimental conditions in which they were asked to consider how people in their workplace would view a coworker with 1) autism spectrum disorder, 2) attention deficit hyperactivity disorder, or 3) dyslexia. After being presented with a short description of the characteristics of the neurodevelopmental condition, participants were asked to respond to a series of items measuring how the target (i.e., a person with ASD, ADHD, or dyslexia) would be likely to be viewed and treated in their workplace[3]. These included perceptions of warmth and competence and behavioral tendencies (see Appendix B & Appendix C).

Measures

Warmth and Competence

Each participant was asked to rate their expectation of society's warmth and competence perceptions of persons with each of the three neurodivergent conditions (ASD, ADHD, and dyslexia) using the 6-item measures developed by Fiske et al. (2002). There was a high level of

[3] I chose to add a short description of the neurodevelopmental condition rather than a more detailed vignette because this approach allowed participants to rely more strongly on their preconceived notions of the condition and was most consistent with the descriptions employed in the original stereotype content model literature. I was unable to find any vignettes in the stereotyping literature that would have lent itself to this purpose.

internal consistency for both the competence and warmth measures (α = .93 and α = .91 respectively). Example items include "As viewed by those in your current occupation how friendly are individuals with [autism spectrum disorder/attention deficit-hyperactivity disorder/dyslexia] perceived to be by others in your occupation?" for assessing the warmth dimension, and "As viewed by those in your occupation, how capable are individuals with [autism spectrum disorder/attention deficit-hyperactivity disorder/dyslexia] perceived to be by others in your occupation?" for the competence dimension. In line with previous research (e.g., Cuddy et al., 2007; Cuddy et al., 2008; Fiske et al., 1999; Fiske et al., 2002), items were asked in the context of the workplace generally rather than the participants individual view in order to reduce the impact of social desirability on responses. The responses were recorded on a five-point Likert-like scale will be used (1 = "Not at all" to 5 = "Extremely"). Table 2 contains the correlations between warmth perceptions and competence perceptions, as well as the means and standard deviations for each of these variables.

Behavioral Tendencies

Participants will be asked to rate the general behavioral tendencies towards employees with ASD, ADHD, and dyslexia respectively. These items have been adapted from Cuddy et al.'s (2007) eight-item behavioral tendencies scale to fit the workplace context (i.e., by asking how people were likely to react to a coworker in the workplace). There are two items for each of four behavioral tendencies: (a) active facilitation; (b) active harm; (c) passive facilitation; and (d) passive harm. Scale reliabilities were as follows: active facilitation α = .92, active harm α = .87, passive facilitation α = .76, and passive harm α = .88. Participants will be asked to "answer the following questions about how individuals in your occupation generally behave, or would behave, towards a coworker with autism spectrum disorder [attention deficit hyperactivity

disorder, dyslexia]." In line with previous research (e.g., Cuddy et al., 2007; Cuddy et al., 2008; Fiske et al., 1999; Fiske et al., 2002), items will be asked in the context of the occupation generally, rather than the individual, in order to reduce the impact of social desirability on responses. Example items include "Do people in the workplace tend to want to associate with other employees who have [autism spectrum disorder/ADHD/dyslexia]?" and "Do people in the workplace tend to want to help other employees who have [autism spectrum disorder/ ADHD/ dyslexia]?" A five-point Likert-type scale will be used (1 = Not at all to 5 = Extremely). Table 2 contains the correlations between active facilitation, passive facilitation, active harm, and passive harm, as well as the means and standard deviations for each of these variables.

Social Model Endorsement

Participants rated the extent to which they endorse the social model of disability. A four-item measure developed by Dirth and Brandscombe (2017) was used. Example items are "Disability is not the problem that needs to be fixed" and "It is not the disability that is the issue, but rather inaccessible environments and negative social attitudes." A seven-point Likert-type scale will be used (1 = Strongly disagree to 7 = Strongly Agree).

CHAPTER 10

STUDY 2 RESULTS

Analytical Approach

The purpose of Study 2 was to connect the findings from Study 1 regarding the warmth and competence perceptions of neurodivergent groups in the workplace to treatment of these groups in the workplace. Specifically, Hypothesis 1 stated that warmth plays a mediating role between neurodivergent condition and both active facilitation (H1a) and active harm behaviors (H1b). Hypothesis 2 stated that competence plays a mediating role between neurodivergent condition and both passive facilitation (H2a) and passive harm behaviors (H2b).

In addition, Study 2 examined the possible role of endorsement of the social model of disability on behavioral tendencies through its effect on competence perceptions. Specifically, Hypothesis 3 states that there is a significant main effect of the endorsement of the social model of disability such that participants who more strongly endorse the social model will perceive neurodivergent workers as more competent than those who weakly endorse the social model. Hypothesis 4 states that there is an interaction between neurodivergent condition and endorsement of the social model such that the differences between perceived competence of the three neurodivergent groups will be greater when the endorsement of the social model is low compared to when endorsement of the social model is high (see Appendix E for models used to test hypotheses).

An initial set of ANOVAs, examining warmth and competence, were run for Study 2 for the purpose of replicating the results found in Study 1. First, as in Study 1, an ANOVA was run

to test for differences in warmth perceptions among the three neurodivergent groups. Again, a significant difference in warmth perceptions between the three conditions, $F(2, 403) = 20.57$, $p < .001$. Follow up comparison results indicated, again, that the dyslexia target condition ($M = 4.07$, $SD = .82$) and the ADHD target condition ($M = 3.93$, $SD = .77$) were the recipients of significantly higher warmth perceptions compared to the ASD target condition ($M = 3.49$, $SD = .74$). Further, in line with the results of Study 1, there was no significant difference in warmth perceptions between the ADHD target condition and the dyslexia target condition. Second, as in Study 1, an ANOVA was run to test for differences in competence perceptions among the three neurodivergent groups. This time the ANOVA yielded no evidence that there was a significant difference in how the ASD target condition ($M = 3.29$, $SD = .93$), ADHD target condition ($M = 3.44$, $SD = .84$), and the dyslexia condition ($M = 3.27$, $SD = .97$), $F(2, 403) = 1.43$, $p = .24$. Therefore, no follow-up comparisons were conducted.

Due to these null findings (i.e., the lack of difference in the perceptions of competence of the three neurodivergent groups), it was apparent that I would not find significant results for Hypotheses 2a and 2b which state that perceptions of competence mediates the relationship between neurodivergent condition and passive facilitation and passive harm behaviors. Further, because the ANOVA in Study 2 did not uncover any evidence supporting differences in perceptions of competence of the three neurodivergent groups it is apparent that Hypothesis 4, which states that endorsement of the social model moderates this process, will also not be supported.

However, for the sake of thoroughness for this dissertation, analyses to test all previously hypothesized relationships were still run. Specifically, two simple mediation models were used to test for the hypothesized role of warmth as a mediating mechanism between neurodivergent

condition and both active facilitation behaviors (H1a) and active harm behaviors (H1b) respectively. This was conducted using Hayes (2013) model 4 Process macro for IBM SPSS Statistics (see Appendix E, Figures 3 & 4) which uses a bootstrap methodology in order to avoid the common issue of nonnormality of the indirect pathway. Neurodivergent condition was dummy coded to allow for a three-level categorical variable and entered the models as the predictor variable. Because the predictor variable (neurodivergent condition) has three levels (ASD, ADHD, and dyslexia), the model had two indirect pathways, one for each of the two comparison groups being compared to the referent group. In this case, because of the preliminary findings, ASD was entered as the referent group and ADHD and dyslexia as the two comparison groups. The macro yielded a 95% bootstrap confidence interval and a p-value for the indirect effects being tested. Confidence intervals that do not include zero, along with a significant p-value would suggest a significant indirect effect, providing support for the mediating relationships proposed. A confidence interval that includes zero and a p-value greater than .05 indicated a lack of support for the hypothesized mediation models.

Two additional models were run to test the hypothesized role of competence as a mediating mechanism between neurodivergent condition and passive facilitation behaviors (H2a) and passive harm behaviors (H2b). However, because Hypotheses 3 and 4 propose both a direct effect of endorsement of the social model of disability on competence perceptions (H4) and a moderating effect of endorsement of the social model of disability on the relationship between neurodivergent condition and competence perceptions, I used Hayes (2013) model 7, which integrates first stage moderation into the mediation model (see Appendix E, figures 5 & 6). Again, because the predictor variable (neurodivergent condition) has three levels (ASD, ADHD, and dyslexia), the model had two indirect pathways, one for each of the two comparison groups

being compared to the referent group. In this case, because preliminary findings from Study 1 indicated differences in competence perceptions between ADHD and ASD and ADHD and dyslexia, ADHD was used as the referent group. ADHD was entered as the referent group and ASD and dyslexia as the two comparison groups. The presence of mediation would be evidenced by a confidence interval not including zero and a statistically significant p-value. Similarly, a p-value of .05 or below for the interaction term would indicate a significant interaction between neurodivergent condition and endorsement of the social model of disability.

Hypothesis Testing

Hypothesis 1a proposed that there is a positive indirect relationship between neuroatypical condition (i.e., autism, ADHD, and dyslexia) and expected active facilitation behaviors (e.g., helping behaviors) through warmth perceptions. Results supported this hypothesis. The indirect effect of neurodivergent condition on expected active facilitation behaviors through warmth perceptions was significant both when comparing the ADHD condition to the ASD condition, effect = .26, 95% CI = [.15, .37], and when comparing the dyslexic condition to the ASD condition, effect = .34, 95% CI = [.21, .47].

Similarly, Hypothesis 1b proposed that there is a negative indirect relationship between neuroatypical condition (i.e., autism, ADHD, and dyslexia) and expected active harm behaviors (e.g., harassing behaviors) through warmth perceptions. Again, results supported this hypothesis. The indirect effect of neurodivergent condition on expected active harm behaviors through warmth perceptions was significant both when comparing the ADHD condition to the ASD condition, effect = -.10, 95% CI = [-.18, -.04], and when comparing the dyslexic condition to the ASD condition, effect = -.13, 95% CI = [-.23, -.05].

Hypothesis 2a proposed a positive indirect relationship between neuroatypical condition (i.e., autism, ADHD, and dyslexia) and expected passive facilitation behaviors (e.g., cooperative behaviors) through competence perceptions. As expected, given the results of the preliminary ANOVA analysis for Study 2 discussed above, the results did not support this hypothesis. The indirect effect of neurodivergent condition on expected passive facilitation behaviors through competence perceptions was not significant when comparing the ASD condition to the ADHD condition, effect = -.03, 95% CI = [-.13, .06], or when comparing the dyslexic condition to the ADHD condition, effect = -.04, 95% CI = [-.13, .06].

Hypothesis 2b proposed a negative indirect relationship between neuroatypical condition (i.e., autism, ADHD, and dyslexia) and expected passive harm behaviors (e.g., exclusion behaviors) through competence perceptions. As expected, given the results of the preliminary ANOVA analysis for Study 2 discussed above, the results did not support this hypothesis. The indirect effect of neurodivergent condition on expected passive harm behaviors through competence perceptions was not significant when comparing the ASD condition to the ADHD condition, effect = -.02, 95% CI = [-.04, .09], or when comparing the dyslexic condition to the ADHD condition, effect = -.03, 95% CI = [-.04, .09].

Hypothesis 3 proposes that there is a significant main effect of the endorsement of the social model of disability such that participants who more strongly endorse the social model will perceive neurodivergent workers as more competent than those who weakly endorse the social model. This was supported ($B = .39$, $p < .001$). These results indicate that on average, with every one point increase in social model endorsement participants' ratings of competence increased .39 points across neurodivergent conditions.

Hypothesis 4 proposed that there is an interaction between neurodivergent condition and endorsement of the social model such that the differences between perceived competence of the three neurodivergent groups will be greater when the endorsement of the social model is low compared to when endorsement of the social model is high. Because neurodivergent condition has three levels to it (ASD, ADHD, and dyslexia), the analysis for this model yields two interaction terms as described previously. There was one interaction term for the interaction between endorsement of the social model and condition with ADHD and ASD being the neurodivergent conditions of interest ($B = .12$, $p > .05$). The analysis produced a second interaction term for the interaction between endorsement of the social model and condition with ADHD and dyslexia being the neurodivergent conditions of interest ($B = .08$, $p > .05$). Neither of these interaction terms were significant.

Supplemental Analyses

The analyses for Study 2 indicated that, as proposed in Hypothesis 3, there is a direct effect of social model endorsement on perceptions of competence of neurodivergent individuals in the workplace. However, because there was no significant difference in competence perceptions among the neurodivergent groups and because social model endorsement was entered into the model as a first stage moderator, the analysis did not evaluate if this direct effect in turn impacted expected behavioral outcomes. In other words, additional analyses had to be run to understand if there is evidence to suggest that competence mediates the relationship between social model endorsement and passive behaviors (passive facilitation and passive harm). In order to test this, supplemental analyses were performed. Two additional simple mediation models (see figures 7 and 8) were run using Hayes (2013) model 4 Process macro for IBM SPSS Statistics.

Results of these analyses suggest that perceptions of employee competence mediate both the relationship between a) social model endorsement and passive facilitation behaviors and b) social model endorsement and passive harm behaviors. The indirect effect of social model endorsement on passive facilitation behaviors through competence perceptions was significant, effect = .20, 95% CI = [.09, .31]. The relationship between social model endorsement and passive harm behaviors through competence perceptions was also significant, effect = -.13 95% CI = [-.20, .-07].

For the purposes of being thorough, I also performed two additional mediation models (see figures 9 and 10) to test if there is evidence to suggest that warmth mediates the relationship between social model endorsement and active behaviors (active facilitation and active harm). The results of these analyses suggest that perceptions of employee warmth mediate both the relationship between a) social model endorsement and active facilitation behaviors and b) social model endorsement and active harm behaviors. The indirect effect of social model endorsement on passive facilitation behaviors through warmth perceptions was significant, effect = .15, 95% CI = [.04, .28]. The relationship between social model endorsement and passive harm behaviors through competence perceptions was also significant, effect = -.07 95% CI = [-.11, .-02].

CHAPTER 11

GENERAL DISCUSSION

Research examining the stereotypes of marginalized groups in the workplace has provided both academicians and practitioners with insight into the types of discrimination that women (Heilman, 2012), sexual minorities (Griffith & Hebl; 2002) and racial minorities (Colella et al., 2017) experience in the workplace. Such discrimination has significant implications for individuals' well-being (Schmitt et al., 2014) and professional success (Colella et al., 2017; Heilman & Parks-Stamm, 2007; Leslie et al., 2014), as well as for organizational diversity and inclusion. Despite this evidence, no research, to my knowledge, had previously been conducted regarding the stereotyping or treatment of neurodivergent employees in the workplace.

The findings suggest that neurodivergent groups are perceived differently across the warmth and possibly competence dimensions of the SCM. Across two studies, I found that those with ASD are generally stereotyped as lower in warmth than those with ADHD or dyslexia. Findings from Study 1 suggest that people with ADHD are viewed as more competent in the workplace than those with ASD or dyslexia; however, this was not replicated in Study 2. These findings support the notion that although ASD, ADHD, and dyslexia are all neurodivergent conditions, there are differences, at least in terms of warmth, in how they are perceived in the workplace. As such, researchers and organizations should be careful not to treat these conditions as interchangeable when it comes to research or organizational practice.

In addition, the present research linked differences in perceptions of the warmth of neurodivergent groups to differential workplace treatment of neurodivergent individuals based

on group membership. In line with our hypotheses, participants reported expecting that individuals with ADHD and dyslexia would experience higher active facilitation (e.g., helping behaviors) and lower active harm (e.g., harassing behaviors) as mediated by higher warmth perceptions as compared to autistic individuals. However, due to the lack of evidence in Study 2 that competence perception of ASD, ADHD, and dyslexic employees differ in the workplace no mediating process could be established between neurodivergent condition and passive facilitation and passive harm behaviors through competence.

There are several possible factors that could explain the null findings regarding differences in competence perceptions between the three neurodivergent groups in Study 2. The first is that there are simply no differences between the three groups, and they are all viewed as similarly (in)competent. However, there are other possible explanations for the significant findings in Study 1 and the null findings in Study 2. It is possible that the demographics samples for these two studies varied in some significant way. In order to address this, I conducted a t-test to test to test for a significant difference in age between the two groups and a chi-square test to test for any significant differences in gender distribution between the two groups. No significant difference in age was found between the two groups, $t(704) = -1.74$, $p > .05$. However, the chi-square test did find a significant difference in gender between the two samples with women being overrepresented in Study 1 as compared to Study 2, X^2 $(2, N = 706) = 72.3$, $p < .05$. Seventy-five percent of the participants in Study 1 identified as female compared to 45% in Study 2. It is unclear why such a gender imbalance would impact the results of Study 1. There is no research, to my knowledge, that indicates that gender would impact the judgement or stereotyping of disabled/neurodivergent individuals.

Alternatively, because participants were asked to rate neurodivergent people bases on the way they would be viewed by others in *their current occupation,* it is possible that the job context of the participants played a role in the mixed findings regarding competence perceptions. Previous research has indicated that perceptions of competence (and warmth) can be influenced by "situational context" (Cuddy et al., 2007). The perceptions of fit between an individual's perceived skills and abilities and the demands of a specific job may in turn influence how competent they are judged to be. Therefore, it is possible that evaluations of the competence of neurodivergent groups are more complex and may also be dependent on job context. In both studies, I asked participants to think of how neurodivergent individuals would be viewed in their workplace. It may be that perceptions of fit varied based on the type of job the participant had and that some neurodivergent conditions are viewed as more competent than others in certain job contexts but not more competent across the board. For example, perceptions that people with autism are detail oriented and skilled at "the thinking or skills needed to analyze and construct systems" (Wei et al., 2014, p. 1) may cause them to be viewed as more competent in certain job fields, such as computer programming or engineering. Indeed, the academic literature has suggested the possibility that autistic people may possess the skills "necessary to perform successfully in many science, technology, engineering, and mathematics (STEM)- related fields" (Wei et al., 2014, p. 1). If these types of interactions between neurodivergent condition and job context are occurring, it is possible that this is partially or fully masking the differences in competence perceptions between neurodivergent groups.

Due to the null competence findings in Study 2 and previous research suggesting that autistic individuals may have a tendency to go into STEM fields (Baron-Cohen et al.,2007; Wei et al., 2014), a supplemental analysis was conducted to test if neurodivergent condition interacts

with job context (STEM vs Non-STEM) to see if such an interaction might mask true differences in competence perceptions among the groups. A two by three factorial ANOVA was run to test this. While this analysis was exploratory in nature, the logic behind it was that competence perceptions might vary across job context (STEM vs non-STEM) for the autistic condition but not for the ADHD or dyslexic conditions. However, there was no evidence of this. The analysis yielded no significant interaction, $F(2,400) = .05$, $p = .95$, so no follow up comparisons were conducted.

The present research also examined the role of individual differences in endorsement of the social model of disability in shaping competence perception of neurodivergent individuals. Study 2 found evidence of a significant positive relationship between social model endorsement and competence perceptions of neurodivergent individuals in the workplace. Further, the results of supplemental analyses found evidence of a mediating relationship between both passive facilitation and passive harm behaviors and social model endorsement through competence perceptions. Further supplemental analyses also found evidence of a mediating relationship between both active facilitation and active harm behaviors and social model endorsement through warmth perceptions.

There are several implications of these findings. First, the finding that endorsement of the social model of disability influences behavioral tendencies towards neurodivergent individuals in the workplace through perceptions of competence suggests that there are individual differences that impact the stereotyping of neurodivergent people. Specifically, it suggests that the lens through which people view disability has an impact on how competent they are viewed to be in the workplace and ultimately may impact how they are treated by others in the workplace. Individuals who view disability as a product of society's failure to adapt to differing needs,

rather than as an inherent defect within a person (Areheart, 2008; Smith, 2008), tend to have more positive stereotypes about neurodivergent people in the workplace and expect that they will be treated more favorably (i.e., be the target of more associative behaviors and less distancing behaviors).

Additionally, previous research suggests that the consequences of competence stereotyping are far-reaching in the workplace and go beyond that of behavioral tendencies towards groups, highlighting the importance of the findings from Study 2 regarding the influence of social model endorsement on competence perceptions. Indeed, Cuddy and colleagues (2011) suggest that, given the nature of work, competence is likely the more salient of the two stereotype dimensions in the workplace. Previous research has shown that groups that are generally viewed as relatively warm but low in competence, such as women or the elderly, are at a disadvantage in the workplace because they are seen as "lacking fit" with many occupations where competence is seen as an essential quality needed to perform the job well (Broverman, 1972). Women, for example, are viewed as less competent and agentic as compared to men and, as a result, are less likely to be hired for jobs in male dominated fields (Cejka & Eagly, 1999; Eagly, 1987: Heilman, 1983) or into leadership positions (Eagly & Karau, 2002; Heilman, 1983; Prentice & Carranza, 2002), where a high-level competence is seen as necessary to successful perform the job.

Extrapolating from this research, it is likely that individuals who view neurodivergent individuals in the workplace context as less competent would also view them to be ill-fitted to many jobs and workplace settings. This, in turn, is likely to disadvantage neurodivergent individuals when it comes to important workplace decisions around hiring, promotion, leadership opportunities, and even workplace task assignment. Therefore, understanding individual and

organizational-level factors, such as endorsement of the social model of disability, that influence competence perceptions can help us understand in what circumstance and by whom neurodivergent workers are likely to experience the most discrimination and poorest workplace outcomes. The findings from Study 2 suggest that social model endorsement in the workplace is likely to have real consequences for neurodivergent individuals and, more generally, people with disabilities.

Increasing social model endorsement will result in better outcomes for neurodivergent people and others with disabilities in the workplace, and organizations wishing to promote neurodiversity and disability diversity, more widely, should target policies and interventions that will increase endorsement of the social model of disability. Organizational initiatives and campaigns promoting disability as differences rather than deficits, highlighting disabled persons as valued and productive members of the organization and encouraging leaders with disabilities to share their disability status, could go a long way in shifting the overall organizational attitude towards disability, as well as promoting viewing disability through the social model lens.

Theoretical Implications

These findings make several important contributions to theory and research. First, the present study provides a first step in understanding how individuals with different neurodivergent conditions are viewed and treated in the workplace. The current research suggests that, like members of other minority groups in the workplace, neurodiversity group membership leads to stereotyping in the workplace. Findings from the present research lay the foundation for studying how such stereotyping influences decision making regarding neurodivergent workers in organizations. As discussed previously, we know that stereotyping of minority groups in the workplace influence a number of important work-related outcomes for

individuals, including workplace bias and discrimination (Heilman, 2012: Stewart & Perlow, 2001), turnover intentions (Von Hippel et al., 2011), performance ratings (Dobbins et al., 1998), career progression (Heilman, 2012), and well-being (Schmitt et al., 2014). Future research should extend the findings from the current research by linking the perception and expected treatment of neurodivergent groups to these more distal outcomes related to workplace success.

Second, this the present research contains the first studies, to my knowledge, testing the SCM in terms of a mediating process. Previous research has largely or entirely tested the SCM in a piecemeal fashion in which the differences in warmth and competence perceptions of different groups were first examined and then subsequent studies examined the link between warmth and competence perceptions and behavioral tendencies (e.g., Cuddy et al., 2007). Evidence from the present study that warmth mediates the relationship between neurodivergent condition and behavioral tendencies suggests that the mediating process implied by researchers from past studies on the SCM does in fact occur.

Practical Implications

The findings from the present research also have several practical implications. Understanding that different types of neurodivergent conditions in the workplace elicit different stereotypes has implications for several considerations that are often of practical concern for organizations. First, and perhaps most obviously, organizations should realize that not everyone in the organization will view neurodiversity or working with a neurominority member positively. The findings from this research suggest that neurodivergent populations that are viewed as low in warmth are likely to not receive as much help in the workplace as their neurotypical counterparts. This could be particularly problematic for individuals who would benefit from accommodations or flexibility from coworkers and managers, as they may be hesitant to act in

ways that they perceive as being “helpful” to neurodivergent individuals. Our findings suggest that, due to their relatively low perceived levels of warmth, individuals whose neurodivergence falls within the realm of ASD (and whose neurodivergent status is known) may be most susceptible to this kind of bias.

From these findings, it seems possible that negative stereotyping and related behaviors associated with some neurodivergent groups could have negative downstream effects for success in the workplace. Previous research suggests that perceptions of warmth and competence are likely to impact a number of employment decisions. For example, according to Cuddy et al. (2011), hiring, promotion, and task assignment decisions are likely influenced by the perceived match in warmth and competence between an individual and the job or task. This may impact opportunities for people in the workplace with neurodivergent conditions. For example, managers might be less inclined to assign someone with ASD (perceived as relatively low warmth) to a customer facing position such as salesman (a position that is typically viewed as high in warmth) than someone that is a member of a group that is stereotypically higher in warmth. Further research is needed to know exactly how such stereotypes of neurodivergent groups impact organizational decision-making, such as hiring and promotion; however, given the extant literature it is likely to impact decision-making in some way. Managers wanting to foster neurodiversity should keep this in mind and use objective criteria as a means to combat bias when making decisions that impact individuals’ career progression and success.

Given the potential negative outcomes associated with being openly neurodivergent in the workplace, organizations wanting to foster neurodiversity may face challenges when it comes to employees’ disclosure of their neurodivergent conditions. Neurodivergent conditions are generally an invisible stigmatized identity in the workplace, meaning that they are not

automatically observable by physical appearance (although there may be certain behavioral cues that indicate neurodivergence; LeFevre-Levy et al., 2023). This means that, in contrast to many other commonly studied minority groups in the workplace (e.g., racial or ethnic minorities), neurominority members are faced with the decision of whether or not share their neurodivergent status.

Given the potential for negative stereotyping, neurodivergent individuals may be hesitant to disclose. As compared to individuals with other concealable stigmatized identities in the workplace (e.g., LGBTQ+, or religious minorities), disclosure may be seen as particularly important for neurominority members because of its ties to accommodation (Kidwell et al., 2023; LeFevre-Levy et al., 2023). Organizations that value neurodiversity will not be able to provide accommodations that can help foster the success of neurodivergent employees if those employees are hesitant to disclose. Further research is needed to understand the "disclosure dilemma" that neurodivergent individuals face in the workplace and how this might vary depending on specific neurodivergent condition. For example, given the lower levels of warmth perceptions of those with ASD, it is possible that members of this neurominority group may be particularly hesitant to disclose. However, the pros and cons of disclosing are likely weighed by each individual and hesitancy to disclose may be overridden out of necessity or the strain of concealing. At this time, there is little research to illuminate the experiences or decision-making process of disclosure for neurodivergent individuals in the workplace. It is possible that those with ASD, ADHD, and dyslexia face different obstacles regarding disclosure given the differences in stereotyping for these groups.

In the meantime, managers should keep in mind that there are undoubtedly individuals within their organizations who are neurodivergent but have chosen not to publicly disclose this

identity. Managers should consider if they can put in place policies that make the workplace more accessible to people with neurodivergent conditions (Silver et al., 2023) without the need for disclosure and formal accommodation. This approach, often referred to as a *universal design approach,* incorporates design principles to create environments that are, "to the greatest extent possible," usable to all people without the need for further adaptation or accommodation (Story et al. 2001). In the context of the work setting, this could include allowing employees to choose between both interactive work spaces and quiet work spaces as needed or using multiple modes of communication (e.g., accompanying oral announcements with written memos) to accommodate varying processing styles.

In addition, as mentioned previously, the findings from the present research suggest that individual differences such as social model endorsement influence how neurodivergent individuals are viewed in the workplace. While certain initiatives, such as disability trainings, diverse hiring practices and emphasizing the role of external environmental factors on disabled persons' ability to function in the workplace, may help promote a social model perspective of disability among employees, additional research should be conducted to see what other individual or contextual differences might play a role in the stereotyping of this group in the workplace. Certain factors such as exposure to or experience interacting with neurodivergent individuals may lead to higher social model endorsement and overall, more positive attitudes towards neurodivergent individuals in the workplace as previous research has found a positive relationship between social interaction with people with disabilities and positive disability attitudes in other settings (Bogart et al., 2019).

Strengths and Limitations

As with any study, there are limitations to the present study and room for further exploration of this topic. First, the present research is experimental in nature and as such has some limitations regarding external validity. I used a survey-based, vignette methodology to manipulate neurodivergent conditions. As such, participants were explicitly asked to consider the perceptions and behaviors of others towards individuals with ASD, ADHD, and dyslexia in their occupation. This means neurodivergent status was the sole consideration in their judgements, which will not be the case in actual workplaces, where these persons will have rich and nuanced personalities. In addition, because the methodology included directly asking participants about the warmth, competence, and behavioral tendencies towards neurodivergent workers, it is possible that social desirability may be a limitation of the present study. In anticipation of this, I sought to reduce the influence of social desirability on participant responses by asking participants to rate how *others* in their occupation would view and treat neurodivergent individuals (i.e., as viewed by *those in your current occupation* vs. as viewed by *you*). However, participants may have been reluctant to respond in a way that could reflect negatively on their occupation.

Conclusion

In summary, through conducting these studies I address an increasingly important but understudied area of inquiry in industrial and organizational psychology (Kidwell et al, 2023; LeFevre-Levy et al., 2023), the experiences of neurodivergent individuals in the workplace. The findings from the present study lay the groundwork for understanding the stereotypes associated with neurodivergent conditions in the workplace and provide some insight into the type of

treatment neurodivergent individuals are likely to experience based on their status as a neurominority.

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Table 1.

Means and Standard Deviations of Dependent Variables in Study 1

	M	SD
1. Competence	3.53	.87
4. Warmth	4.00	.76

Table 2.

Study 2: Descriptive Statistics and Correlations

	M	SD	1	2	3	4	5	6	7	8	9	10
1. Competence	3.33	0.92	--	0.49	0.44	-0.18	0.55	-0.34	0.36	-0.03	0.08	-0.05
2. Warmth	3.83	0.82	0.49	--	0.30	-0.27	0.45	-0.27	0.30	-0.30	0.08	0.21
3. Active Faciliation	3.56	0.99	0.44	0.30	--	-0.22	0.64	-0.31	0.25	0.06	0.10	0.16
4. Active Harm	1.66	1	-0.18	-0.27	-0.22	--	-0.25	0.68	-0.10	0.03	0.05	-0.08
5. Passive Faciliation	3.77	0.94	0.55	0.45	0.64	-0.25	--	-0.43	0.31	-0.13	0.09	0.03
6. Passive Harm	1.84	1.08	-0.34	-0.27	-0.31	0.68	-0.43	--	-0.14	0.14	-0.05	-0.09
7. Social Model Endorsement	3.27	0.77	0.36	0.30	0.25	-0.10	0.31	-0.14	--	-0.02	0.10	0.09
8. Autism	--	--	-0.03	-0.30	0.06	0.03	-0.13	0.14	-0.02	--	-1	-1
9. ADHD	--	--	0.08	0.08	0.1	0.05	0.09	-0.05	0.10	-1	--	-1
10. Dyslexia	--	--	-0.05	0.21	0.16	-0.08	0.03	-0.09	0.09	-1	-1	--

Table 3.

Regression results of mediation model for active facilitation behaviors with autism as the referent group.

		Concequent						
		M (WARMTH)				Y (ACTIVE FACILITATION)		
Antecendent		Coeff.	*SE*	*p*		Coeff.	*SE*	*p*
X_1 (ADHD)	a_1	0.44	0.1	< 0.00	c'_1	-0.26	0.11	0.02
X_2 (Dyslexia)	a_2	0.58	0.09	< 0.00	c'_2	-0.31	0.11	0.01
M (Warmth)		--	--	--	*b*	0.58	0.06	< 0.00
Constant	i_M	3.49	0.067	< 0.00	i_Y	1.73	0.21	< 0.00

Table 4.

Relative indirect and relative direct effects of neurodivergent condition on active facilitation behaviors with autism as the referent group.

	Indirect effects				Direct effects			
	Coeff.	*SE*	*LCL*	*UCL*	Coeff.	*SE*	*LCL*	*UCL*
ADHD	**0.26**	**0.06**	**0.15**	**0.38**	**-0.26**	**0.11**	**-0.48**	**-0.05**
Dyslexia	**0.34**	**0.07**	**0.21**	**0.47**	**-0.31**	**0.11**	**-0.52**	**-0.09**

Confidence levels represent a 95% confidence interval. Effects in bold represent statistically significant effects.

Table 5. *Regression results of mediation model for active harm behaviors with autism as the referent group.*

		Concequent						
		M (WARMTH)				Y (ACTIVE HARM)		
Antecendent		Coeff.	*SE*	*p*		Coeff.	*SE*	*p*
X_1 (ADHD)	a_1	0.45	0.09	< 0.00	c'_1	-0.13	0.12	0.29
X_2 (Dyslexia)	a_2	0.59	0.09	< 0.00	c'_2	-0.02	0.13	0.89
M (Warmth)		--	--	--	*b*	-0.23	0.06	< 0.00
Constant	i_M	3.49	0.67	< 0.00	i_Y	2.48	0.24	< 0.00

Table 6.

Relative indirect and relative direct effects of neurodivergent condition on active harm behaviors with autism as the referent group.

	Indirect effects				Direct effects			
	Coeff.	*SE*	*LCL*	*UCL*	Coeff.	*SE*	*LCL*	*UCL*
ADHD	**-0.1**	**0.04**	**-0.18**	**-0.03**	0.13	0.12	-0.11	0.37
Dyslexia	**-0.13**	**0.05**	**-0.23**	**-0.05**	-0.02	0.13	-0.26	0.23

Confidence levels represent a 95% confidence interval. Effects in bold represent statistically significant effects.

Table 7.

Regression results of mediation model for passive facilitation behaviors with ADHD as the referent group .

	Concequent							
	M (COMPETENCE)				Y (PASSIVE FACILITATION)			
Antecendent		Coeff.	*SE*	*p*		Coeff.	*SE*	*p*
X_1 (ASD)	a_1	-0.51	0.51	0.32	c'_1	-0.23	0.10	0.03
X_2 (Dyslexia)	a_2	-0.11	0.47	0.82	c'_2	0.00	0.10	0.97
M (Competence)		--	--	--	*b*	0.46	0.05	< 0.00
W (Social Endorsement)		0.39	0.09	< 0.00		--	--	--
Social Endorsement X Neuordivergent Condition (ADHD vs. ASD)		0.12	0.14	0.38		--	--	--
Social Endorsement X Neuordivergent Condition (ADHD vs. dyslexia)		0.01	0.13	0.95		--	--	--
Constant	i_Y	2.02	0.34	< 0.00	i_Y	2.3	0.17	< 0.00

Table 8. Relative indirect and relative direct effects of neurodivergent condition on passive faciliataion behaviors with ADHD as the referent group.

	Indirect effects				Direct effects			
	Coeff.	*SE*	*LCL*	*UCL*	Coeff.	*SE*	*LCL*	*UCL*
ASD	-0.03	0.05	-0.13	0.06	-0.23	0.10	-0.43	-0.03
Dyslexia	-0.04	0.05	-0.13	0.06	0.00	0.10	-0.20	0.2

Confidence levels represent a 95% confidence interval. Effects in bold represent statistically significant effects.

Table 9.

Regression results of mediation model for passive harm behaviors with ADHD as the referent group .

		Concequent						
		M (COMPETENCE)			Y (PASSIVE HARM)			
Antecendent		Coeff.	*SE*	*p*		Coeff.	*SE*	*p*
X_1 (ASD)	a_1	-0.51	0.51	0.32	c'_1	0.27	0.13	0.03
X_2 (Dyslexia)	a_2	-0.11	0.47	0.82	c'_2	-0.09	0.13	0.47
M (Competence)		--	--	--	*b*	-0.32	0.06	< 0.00
W (Social Endorsement)		0.39	0.09	< 0.00		--	--	--
Social Endorsement X Neuordivergent Condition (ADHD vs. ASD)		0.12	0.14	0.38		--	--	--
Social Endorsement X Neuordivergent Condition (ADHD vs. dyslexia)		0.01	0.13	0.96		--	--	--
Constant	i_Y	2.02	0.34	< 0.00	i_Y	2.85	0.21	< 0.00

Table 10. *Relative indirect and relative direct effects of neurodivergent condition on passive harm behaviors with ADHD as the referent group.*

	Indirect effects				Direct effects			
	Coeff.	*SE*	*LCL*	*UCL*	Coeff.	*SE*	*LCL*	*UCL*
ASD	0.02	0.03	-0.04	0.09	**0.28**	**0.13**	**0.03**	**0.52**
Dyslexia	0.03	0.03	-0.04	0.09	-0.09	0.13	-0.34	0.16

Confidence levels represent a 95% confidence interval. Effects in bold represent statistically significant effects.

Appendix A

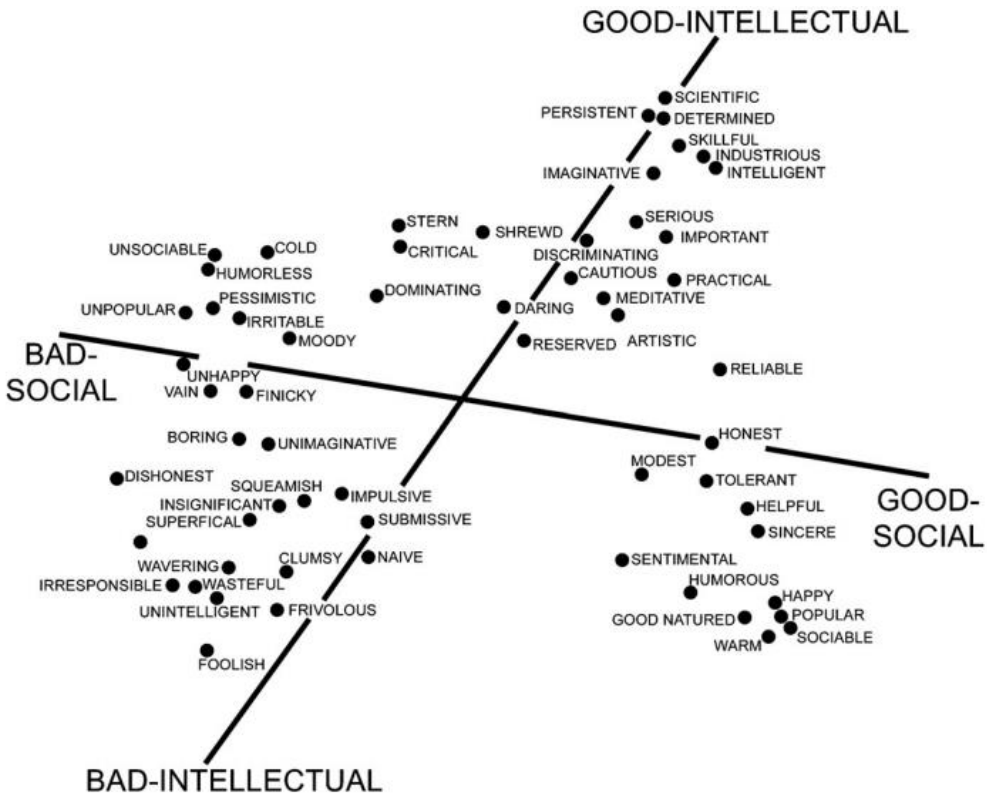

Figure 1. Representation of the social (god-bad) and intellectual (good-bad) dimensions with best-fitting axes found by Rosenberg and colleagues (1968) . Original figure taken from Fiske and colleagues (2007).

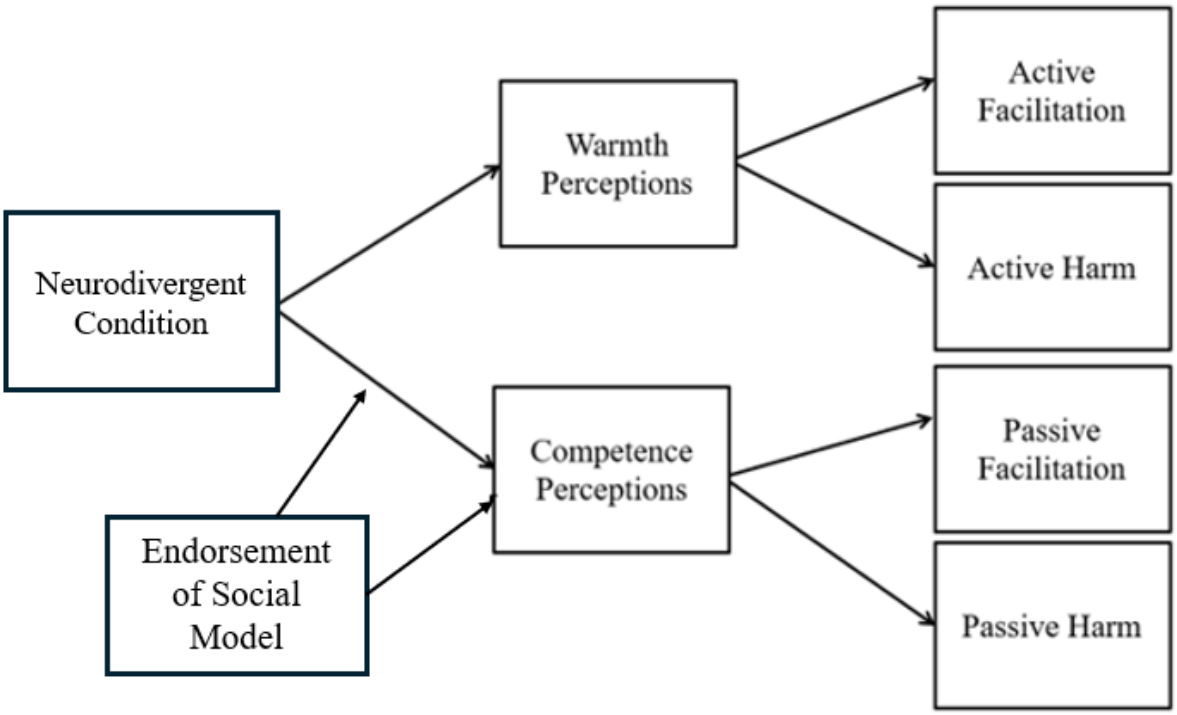

Figure 2. Proposed conceptual parallel mediation model to be tested in Study 2.

Appendix B

Consent Letter

I am a researcher in the Department of Psychology at The University of Georgia. I am asking you to participate in a research study entitled Neurological Disability in the Workplace. The purpose of this study is to better understand the societal perceptions of individuals with neurological disability within the work context. Please take a moment to read the following before you decide whether to consent to participate in the study.

In order to participate, you must be 18 years of age or older, work at least 35 hours per week in paid employment outside of Prolific, and be a current resident of the United States.

The study will take about 12 minutes to complete and will consist of a survey. Your participation in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to stop or withdraw from the study, the information/data collected from or about you up to the point of your withdrawal will be kept as part of the study and may continue to be analyzed.

The results of the research study may be published, but your name or any identifying information will not be used. In fact, the published results will be presented in summary form only.

The findings from this project will provide information on neurological disability in the workplace. There is no anticipated risk or discomfort associated with this research. You will be compensated $1.25 for your participation through CloudResearch.

This research involves the transmission of data over the Internet. Every reasonable effort has been taken to ensure the effective use of available technology; however, confidentiality during online communication cannot be guaranteed.

While the primary purpose of the current data collection effort is to collect data for the Neurological Disability in the Workplace study, it is possible that your deidentified data may be shared with other researchers or used to answer additional research questions in the future.

The principal investigator for this research is Dr. Malissa Clark of the University of Georgia. If you have any questions about this research project, please feel free to email co-researcher, Rose LeFevre-Levy, at rl24119@uga.edu. Questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board, telephone (706) 542-3199; email address irb@uga.edu.

By clicking “I consent to participate” below, you are agreeing to participate in the above described research project.

Thank you for your interest in our study!

Sincerely,

Rose LeFevre-Levy

Eligibility Screening

Are you 18 years of age or older?

[Answer must be yes to continue]

1. Yes
2. No

Do you work at least 35 hours per week?

[Answer must be yes to continue]

1. Yes
2. No

Do you work at least 35 hours a week at a job outside of Mturk?

[Answer must be yes to continue]

1. Yes
2. No

Are you a resident of the United States?

[Must answer yes to continue]

1. Yes
2. No

What state do you live in?

[Open response]

What is your current job title?

[Open response]

What is the highest level of education you have received?

1. Some high school
2. A high school degree
3. An associate's degree
4. A bachelor's degree
5. A post-graduate degree

Appendix C

Main Survey: Study 1 and 2

[Section 1]

Autism spectrum disorder is a neurological difference in which individuals experience difficulty with reading social cues.

> *For ADHD condition: Attention deficit hyperactivity disorder (ADHD) is a neurological difference commonly associated with hyperactivity, difficulty with concentration, and impulsivity.*
>
> *For dyslexia condition: Dyslexia is a neurological difference associated with difficulties in processing language, which typically results in deficits regarding reading, spelling, and writing.*

Take a moment to think about your current occupation.

Please answer the following questions about how individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] are or would be viewed if they worked in your current occupation. We are not interested in your personal beliefs, but in how you think they are viewed by others.

As viewed by those in your current occupation…

***Competence Perceptions** (adapted from Fiske et al., 2002)*

How *competent* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *confident* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately

5. Extremely

How *capable* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *efficien*t are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *intelligent* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Please select 'Moderately' for your response to this question.

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *skillful* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

6. Not at all
7. Slightly
8. Somewhat
9. Moderately
10. Extremely

Warmth Perceptions *(adapted from Fiske et al., 2002)*

As viewed by those in your current occupation …

How *friendly* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *well-intentioned* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *trustworthy* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *warm* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *good-natured* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

How *sincere* are/would individuals with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] be perceived to be by others in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Appendix D

Main Survey- Additional Measures for Study 2

[Section 2]

***Behavioral Tendencies** (adapted from Cuddy et al., 2007)*

Please answer the following questions about how individuals in your occupation generally behave, or would behave, towards a coworker with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia].

Do/would individuals tend to *help* a coworker with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *assist* a coworker with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia] in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *fight* with a coworker with autism spectrum disorder [attention deficit hyperactivity disorder, dyslexia]in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *harass* a coworker with autism spectrum disorder in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *cooperate* with a coworker with autism spectrum disorder in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *associate* with a coworker with autism spectrum disorder in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *exclude* a coworker with autism spectrum disorder in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

Do/would individuals tend to *ignore* a coworker with autism spectrum disorder in your occupation?

1. Not at all
2. Slightly
3. Somewhat
4. Moderately
5. Extremely

[Section 3]
Endorsement of the Social Model of Disability *(Dirth & Branscombe, 2017)*

Please indicate the extent of your level of agreement with the following statements

People with disabilities are the experts on what assistance they need.

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree

5. Strongly agree

Disability is not the problem that needs to be fixed.

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

It is not the disability that is the issue, but rather social factors (e.g. inaccessible environments and negative social attitudes).[4]

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

Disability is a tragedy in need of a solution. (Reversed)

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

[4] This item was changed slightly due to the double-barreled nature of the original item.

Appendix E

Demographics- Study 1 and 2

[Section 4]

You have reached the end of the main part of the study. Thank you for your participation. ***Please continue to the next page to answer some additional questions****.*

Please specify your gender.

1. Male
2. Female
3. Other

What is your age?

[Open response]

Please specify your ethnicity.

1. White
2. Hispanic or Latino
3. Black or African American
4. Asian
5. Native Hawaiian or Pacific Islander
6. Native American or American Indian
7. Other

How many hours do you work per week, NOT counting work of Prolific?

[Open response]

I do not understand a word of English

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

[Section 5]

Do you have any comments or concerns about the study?

[Open response]

[Page break]

Thank you for participating in this study. Your response has been recorded

Appendix F

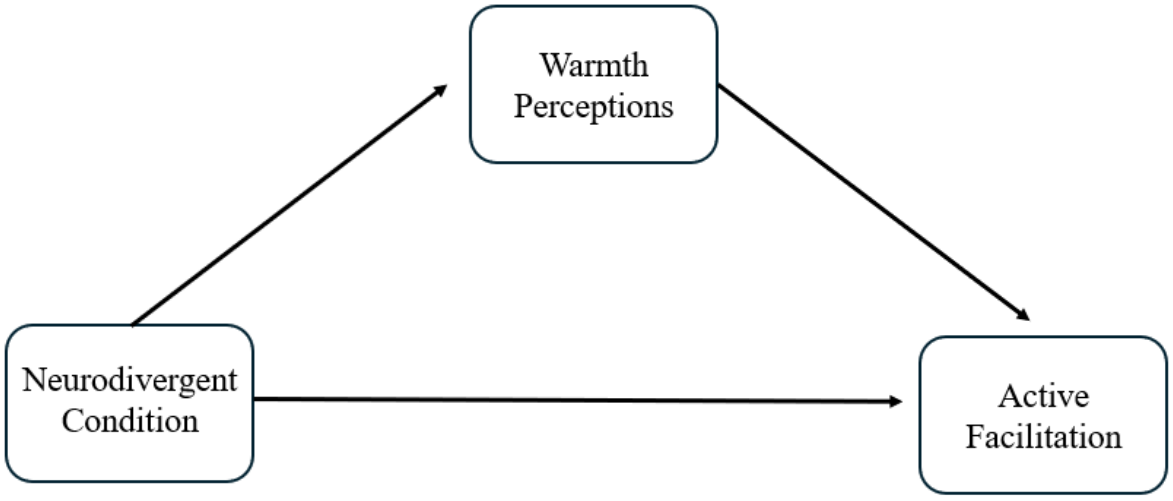

Figure 3. Model A examines the mediating role of warmth perceptions in the relationship between neurodivergent condition and expected active facilitation behaviors.

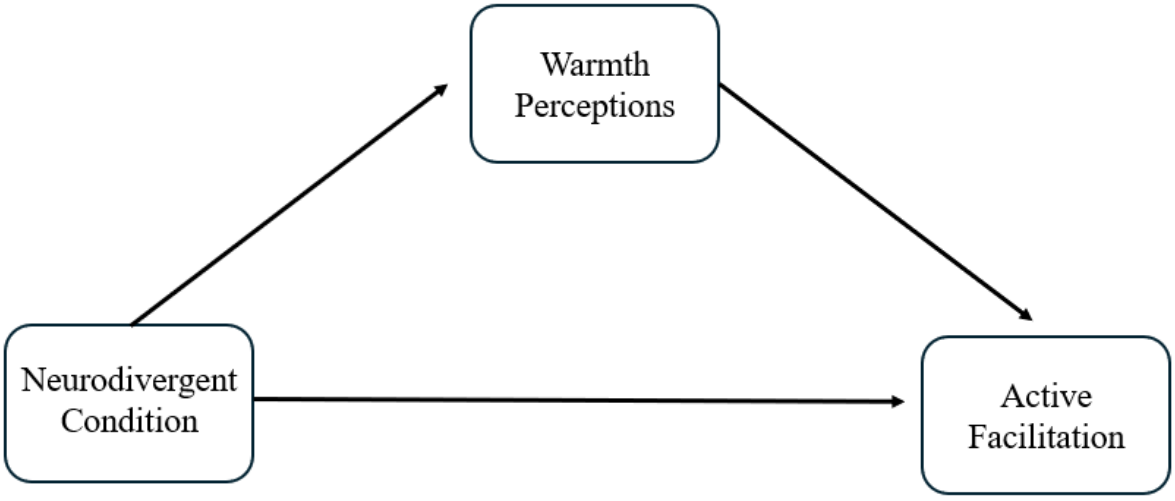

Figure 4. Model B examines the mediating role of warmth perceptions in the relationship between neurodivergent condition and expected active harm behaviors.

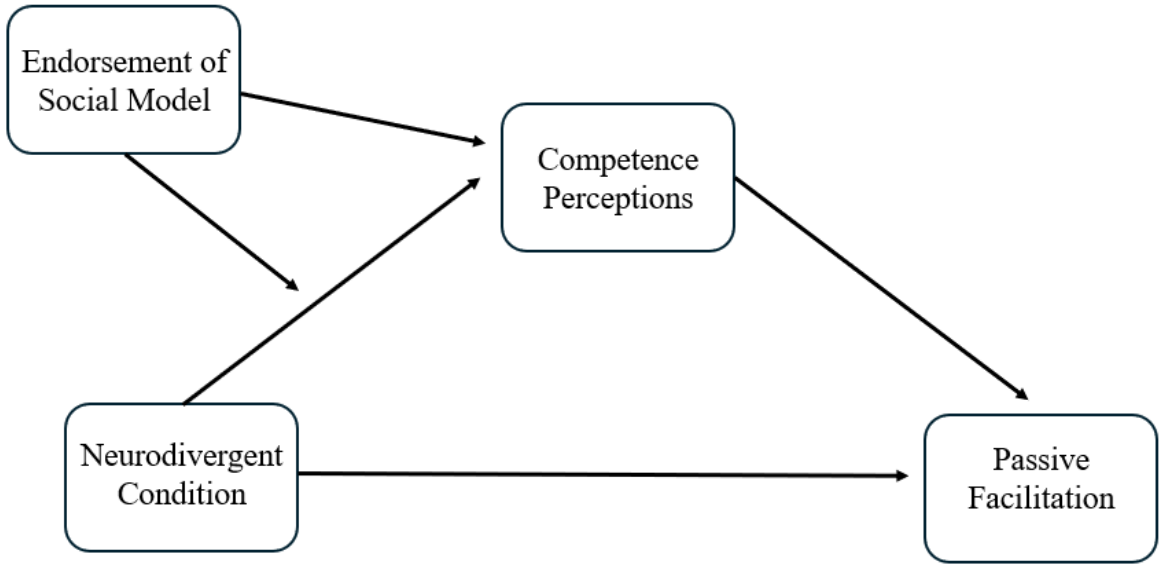

Figure 5. Model C examines the mediating role of competence perceptions in the relationship between neurodivergent condition and passive facilitation. It also examines the moderating role of endorsement of the social model of disability in the relationship between neurodivergent condition and competence perceptions.

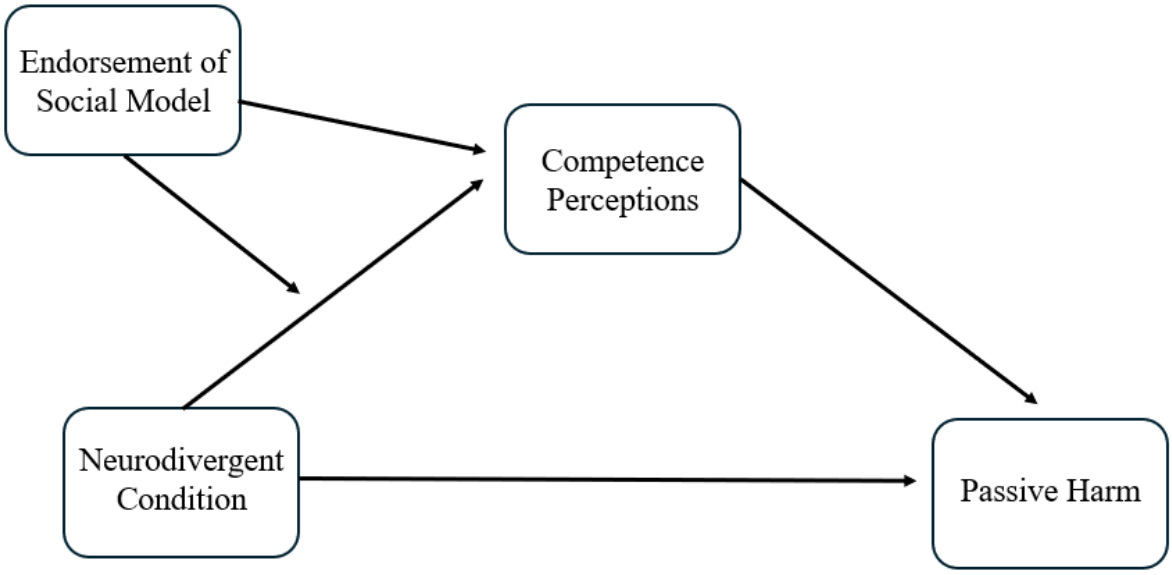

Figure 6. Model D examines the mediating role of competence perceptions in the relationship between neurodivergent condition and passive harm. It also examines the moderating role of endorsement of the social model of disability in the relationship between neurodivergent condition and competence perceptions.

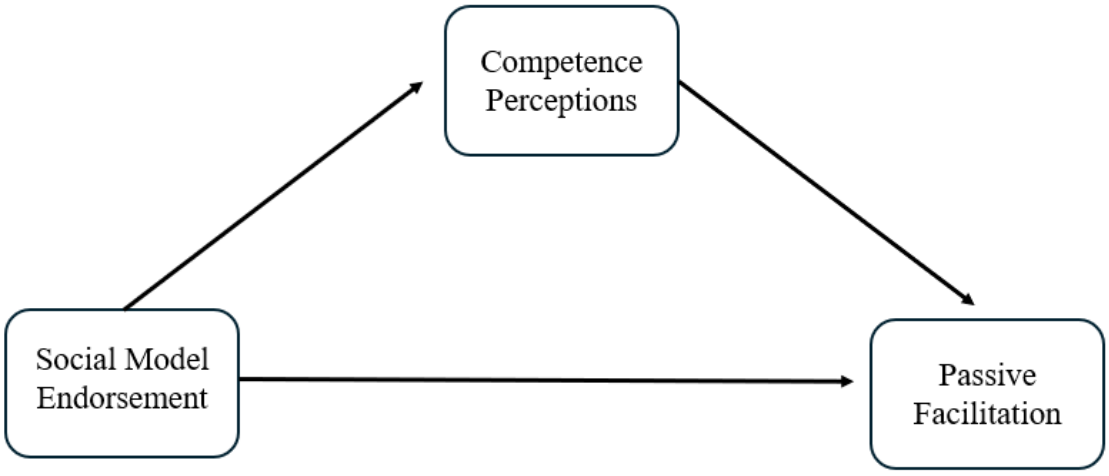

Figure 7. Model E examines the mediating role of competence perceptions in the relationship between endorsement of the social model of disability and expected passive facilitation behaviors.

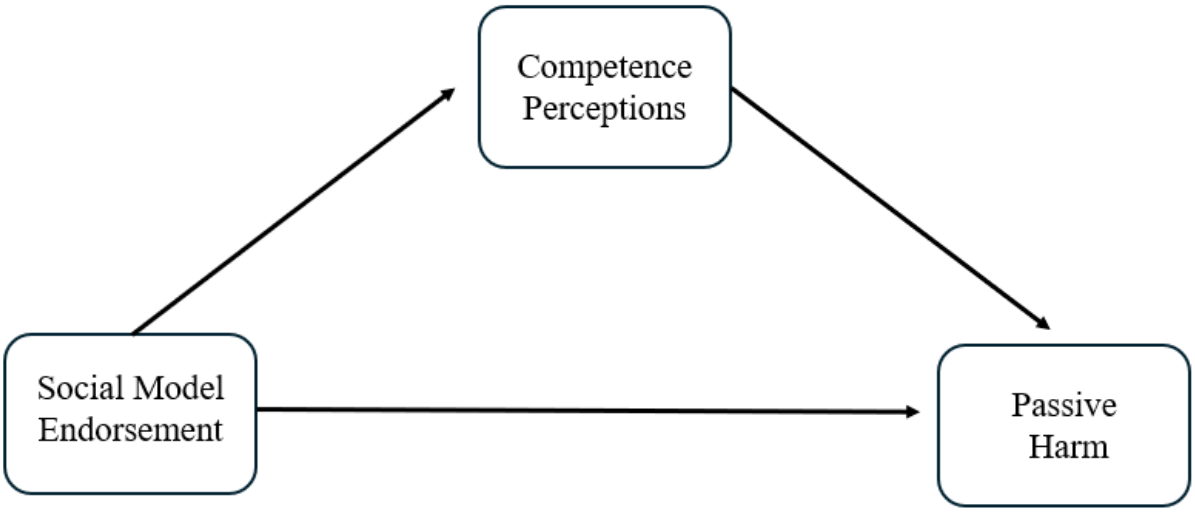

Figure 8. Model F examines the mediating role of competence perceptions in the relationship between endorsement of the social model of disability and expected passive harm behaviors.

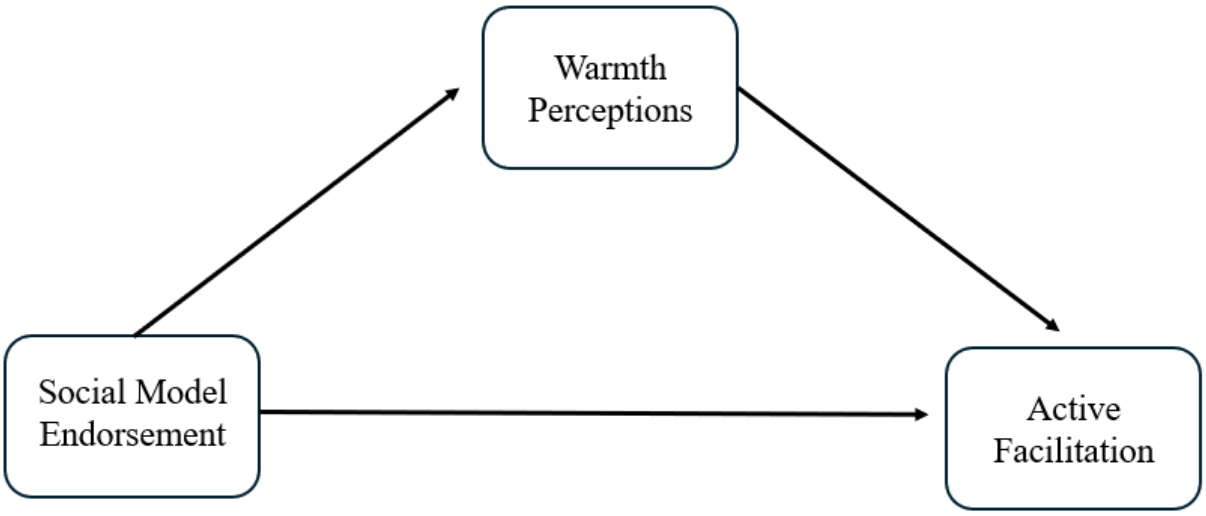

Figure 9. Model G examines the mediating role of warmth perceptions in the relationship between endorsement of the social model of disability and expected active facilitation behaviors.

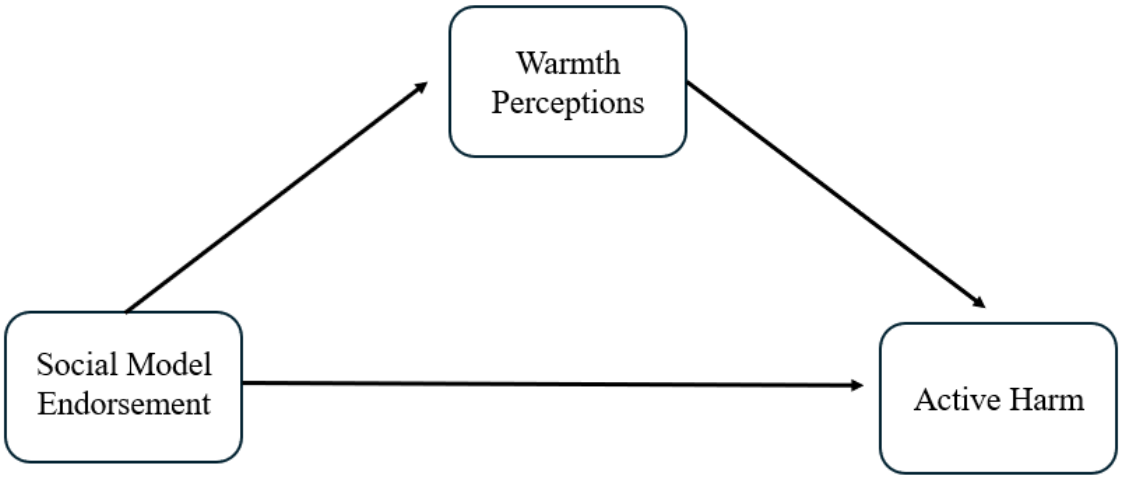

Figure 10. Model H examines the mediating role of warmth perceptions in the relationship between endorsement of the social model of disability and expected active harm behaviors.