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Original Article

Societal Stigma and the Caregiver's Dilemma in Inclusive School Settings

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Abstract

The study explores the impact of societal stigma on caregivers in inclusive school settings in Nepal, highlighting the emotional exhaustion, isolation, and disengagement experienced by those raising neurodiverse children despite progressive educational policies. Using narrative inquiry, the study shows how affiliate stigma, or stigma experienced by association, undermines the wellbeing of caregivers, leading to internalized shame and participate less in support networks. The study offers culturally specific insight into how institutional barriers and deeply held beliefs perpetuate stigma and hinder the progress of inclusive education. Based on the lived experiences of caregivers and educators working in inclusive schools, the study advocates for stigma-informed practices and integrated mental health support. It also assesses Nepali educational resources for caregivers, identifying policy gaps and highlighting the impact of stigma on inclusive education. Finally, the study offers implications for improvements such as enhanced institutional support for caregivers, the creation of safe emotional spaces, and culturally sensitive awareness campaigns to strengthen caregivers' resilience and promote equitable, inclusive education.

Key words: *inclusive education, affiliate stigma, caregiver mental health, neurodiverse learner, educational equity*

Introduction

Having been promoting inclusive education in Nepal for over ten years, I, Shreeya Shah Basnyat, with academic foundations in Sociology from Delhi University, Master's in the same field from Tribhuvan University, founded *Shree Shiva Narsing Shikshyalaya*, an inclusive school in Kathmandu, Nepal, committed to equitable learning opportunities for all children. My commitment to inclusive education was strengthened six years ago when I observed a kindergartener with developmental delays, or, say, an autistic child, progress from complete social withdrawal to confident classroom participation through our individualized support

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approach. This transformative experience motivated me to pursue further training in School Counseling and Inclusive and Special Needs Education, anchoring my commitment to building systems that nurture neurodiverse learners, their families, and communities. My research collaborator, Sharmila Shrestha, contributes equally vital expertise as a school counselor, holding Master's degrees in School Counseling (Kathmandu University) and Child Development and Gender Socialization (Tribhuvan University). Working daily in inclusive educational settings, she regularly observes emotional and psychological burdens faced by both teachers and parents of neurodiverse children, ranging from caregiver burnout to social isolation and the effects of societal stigmatization. These lived and professional experiences shape our inquiry into caregivers' challenges within Nepal's inclusive education frameworks. This study explored the lived experiences of caregivers, both parents and teachers, of neurodivergent children in inclusive school settings in Nepal. Neurodivergent children for this research include those with autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), dyslexia, and other developmental differences that affect learning, behavior, communication, and social interaction. This study adopts a neurodiversity-affirming framework, which recognizes these conditions as natural variations of the human brain rather than pathologies or deficits (Armstrong, 2012; Chapman, 2020).

Inclusive education has gained increasing global attention, particularly under frameworks such as the United Nations' Sustainable Development Goals (SDG 4) and the Convention on the Rights of Persons with Disabilities (CRPD), both of which Nepal has ratified (UNESCO, 2020). In alignment with these, Nepal's School Sector Development Plan (SSDP) 2016–2023 outlines an official commitment to equity and accessibility in education (Ministry of Education, 2016). However, studies indicate that the focus of implementation disproportionately centers on physical or sensory impairments, with less attention given to neurodevelopmental and cognitive disabilities (Lamichhane, 2015).

Despite the increasing visibility of neurodevelopmental conditions globally, awareness in Nepal remains low. A nationally representative study by Shrestha et al. (2021) found that only 26% of caregivers surveyed had ever heard of autism. Even among urban populations, misconceptions and stigma remain widespread, reflecting deep-seated cultural beliefs that equate neurodivergence with behavioral deviance, karmic consequence, or poor parenting (Cottingham & Spear, 2024). Furthermore, a recent psychiatric epidemiology study (Karki et al., 2024) documented that ADHD and autism spectrum conditions are significantly underdiagnosed, despite clear symptomatic presentation in many young people accessing mental health services.

Reports from organizations like Inclusive Futures (2024) highlight that children with disabilities in Nepal face many obstacles to participation such as inaccessible schools, lack of competent teachers, discrimination, and non-inclusive curricula. When systemic supports are lacking, the burden of inclusion often shifts onto the shoulders of caregivers (D'Arcy et. al., 2024). Parents may struggle to find a classroom that accommodates their child's needs, and teachers may be expected to "figure it out" without training or resources. In collectivist societies such as Nepal, social reputation and normative expectations further complicate caregiving experience. Parents often conceal or downplay their child's challenges due to fear of gossip, exclusion, or stigma (Acharya, 2025). Teachers, meanwhile, navigate between curriculum demands and emotional labor, often without specialized training in inclusive pedagogies (Walton et. al., 2014).

This study is timely and relevant, as it addresses a gap in the literature on inclusive education and caregiver experiences. Although inclusive education is widely promoted in educational policy, its practical implementation often remains limited and inconsistent (Miles & Singal, 2010). Caregivers, both parents and teachers, play a vital role in supporting neurodivergent children, yet their voices and challenges are frequently overlooked in research and policymaking (Maufuriyah, 2018). By focusing on the lived experiences of caregivers within Nepal's inclusive school system, this study aims to support the development of more effective, culturally responsive, and sustainable approaches to educational inclusion.

Articulating Research Agenda

Despite policy-level efforts to promote inclusive education in Nepal (UNESCO, 2020), the lived realities of caregivers of neurodivergent children remain underexplored. Caregivers often navigate multiple emotional, social, and institutional challenges while supporting their children in environments not fully equipped for neurodiversity. Many parents lack awareness or access to diagnosis and support services (Materula et al., 2024), while teachers struggle with insufficient training, large class sizes, and rigid curricula that do not accommodate diverse learning needs (Halder, 2023). Social stigma surrounding neurodevelopmental differences remains pervasive, resulting in isolation, blame, and anxiety among caregivers (Chauhan et al., 2024).

Existing research on inclusive education in Nepal often centers on general disability frameworks without adequately addressing the specific needs and experiences of neurodivergent children and their caregivers. This gap limits the development of effective interventions and policies tailored to the neurodiverse population. Understanding the caregivers' perspectives is crucial for designing empathetic, responsive, and sustainable inclusive education practices. To this background, this study explored the lived experiences of parents and teachers as caregivers of neurodivergent children in inclusive school settings in Nepal. Through qualitative inquiry, it navigated how these caregivers perceive and respond to societal stigmas, institutional challenges, and emotional burdens, while also identifying strategies to support their children's educational and social development. To achieve this purpose, the study has addressed three research questions: (1) How does perceived societal stigma influence caregivers' perspectives on inclusive education for their children with disabilities? (2) What is the magnitude of affiliate stigma among caregivers, and how does it affect their psychological well-being and caregiving behaviors? And (3) In what ways do existing support systems and resources alleviate the difficulties encountered by caregivers in inclusive educational environments?

Conceptualizing Stigma

Stigma, as conceptualized by Link and Phelan (2001), represents a complex social process involving labeling, stereotyping, separation, status loss, and discrimination that extends beyond individual experiences to manifest systemically within institutions. This framework is particularly relevant to educational settings, where stigma marginalizes both neurodivergent students and their caregivers through embedded institutional practices and cultural beliefs. Link and Phelan (2014) emphasize that effective stigma reduction requires comprehensive systemic responses, including legal reform, awareness programs, and proactive interventions rather than individual-level solutions alone.

Building on this foundation, Corrigan and Watson (2002) distinguish between public stigma (societal attitudes toward stigmatized groups) and self-stigma (internalized negative beliefs), both of which significantly impact caregivers of neurodivergent children. This dual manifestation is crucial for understanding how stigma operates in inclusive educational contexts, where both external barriers and internal psychological processes shape caregivers' experiences.

Neurodiversity-Specific Stigma in Educational Settings

Unlike general disability stigma, neurodivergent conditions such as autism spectrum disorder, ADHD, and dyslexia face unique stigmatization patterns. Kinnear et al. (2016) found that autism stigma is particularly characterized by misconceptions about causation, prognosis, and behavioral expectations, leading to both overt discrimination and subtle exclusionary practices in schools. Similarly, Mueller et al. (2012) documented how ADHD stigma manifests through beliefs about parental responsibility and medication use, creating additional burdens for families navigating educational support systems.

The invisibility of many neurodivergent conditions contributes to what Mullins and Preyde (2013) term "hidden disability stigma," where children and families face skepticism about their needs and accusations of seeking unfair advantages. This phenomenon is particularly problematic in educational settings where accommodations may be considered special treatment rather than necessary support.

Cultural Dimensions of Affiliate Stigma in Nepal

Affiliate stigma is amplified in collectivist societies like Nepal, where concepts such as “face concern” and family honor play a dominant role. Caregivers of children with special needs may internalize public stigma, leading to disengagement from educational and community involvement (Ng & Ng, 2022; Lovell & Wetherell, 2018). In practice, this is evident at institutions such as Shree Shiva Narsing Shikshyalaya (SSNS), where caregiver participation remains limited due to fears of social judgment and perceived inadequacy. Mak and Cheung (2012) emphasize that internalized stigma among caregivers can hinder their ability to advocate for inclusive education, contributing to a cycle of silence and invisibility. This internalization often manifests in hesitance to engage with educators, reluctance to access services, or avoidance of social situations that may draw attention to the child’s condition.

Caregivers’ Dilemmas

Cheng and Lai's (2023) review highlights that stress, combined with a lack of social support, compounds the burden on caregivers of children with special educational needs. These challenges frequently result in caregiver disengagement, delayed intervention, and worsened educational outcomes. Burke et al. (2016) identify the dual responsibility of caregiving and advocacy that parents shoulder amidst poorly coordinated support systems. Wilson et al. (2025) further highlight emotional isolation, lack of professional guidance, and absence of therapeutic support that characterize many caregivers' experiences.

The tension between inclusion and individual needs adds complexity to the situation. While inclusion is valued for promoting social integration, many parents question whether inclusive settings adequately address their children's specific academic or behavioral needs (Graham & Slee, 2005). In Nepal, where inclusive education is still evolving, such concerns are intensified by perceptions that inclusive schools may lack capacity, leading some parents to prefer segregated institutions (Bhusal et al., 2025).

Teachers are often at the frontline of implementing inclusion but face structural barriers. In Nepal, as in other contexts, under-resourced schools and a lack of specialized training hinder inclusive practices (Pokhrel, 2022). Gray et al. (2017) and Ntoaduro (2021) describe how emotional fatigue, professional inadequacy, and role conflict affect the mental health and instructional effectiveness of teachers and caregivers in inclusive classrooms.

Furthermore, Mitiku et al. (2014) observe that individualized strategies are challenging to implement without sufficient staffing or institutional support. Teachers may also unintentionally reinforce stigma when untrained to address peer dynamics or cultural assumptions about disability (Lalvani, 2015). Studies suggest the urgent need for inclusive education frameworks that empower teachers with the necessary skills, resources, and emotional support.

Impact on Children

Stigma affects caregivers and hinders children's academic and social development._Burke and Parker (2007) find that social stigma perpetuates cycles of disadvantage, limiting children's access to opportunity and reinforcing caregiver distress. This pattern is magnified in marginalized contexts, such as Nepal, where limited access to quality, inclusive education further entrenches these challenges.

During crises such as the COVID-19 pandemic, these vulnerabilities were exacerbated. Schulz and Sherwood (2008) note that caregiving stress increased significantly, heightening the risk of neglect and mental health deterioration among families. In Nepal, the pandemic exposed the inadequacy of educational infrastructure and online learning systems for diverse learners, especially children with neurodiversity.

Anti-Stigma and Support Interventions

Evidence suggests that effective anti-stigma interventions must go beyond awareness to include systemic and community-based strategies. Hehir and Katzman (2012) demonstrate the value of training programs and shared inclusive spaces in reducing stigma. Similarly, Musenda et al. (2023)_advocate for community-driven approaches that leverage local knowledge to enhance inclusion and caregiver support, particularly in resource-limited contexts. In Nepal, more robust and culturally responsive interventions are needed to bridge the gap between inclusive education policies and lived realities. Carer and teacher support, community engagement, and locally grounded stigma-reduction programs remain underdeveloped, revealing a critical research and practice gap.

Methodology

This study employed narrative inquiry to explore the stigmatizing experiences and dilemmas faced by caregivers, specifically parents and teachers, within inclusive school settings. Narrative inquiry is particularly suited for this research as it captures the nuanced, lived experiences of individuals, offering rich insight into how stigma is perceived, internalized, and navigated within specific socio-cultural contexts (Clandinin & Connelly, 2004). We used purposive sampling to recruit four participants: two teachers and two parents actively engaged in inclusive educational environments within the Kathmandu Valley. The selected participants were chosen based on their direct experience supporting neurodiverse children in mainstream classroom settings. Inclusion criteria required that participants had at least two years of experience working within an inclusive education framework to ensure the depth and relevance of perspectives.

Before data collection, the research team (Shreeya Shah Basnyat and Sharmila Shrestha) conducted preparatory sessions to align interview techniques, question phrasing, and the strategic use of probing questions to elicit rich, detailed narratives. A semi-structured interview guide was developed, covering key areas such as perceived societal stigma, experiences of courtesy stigma, emotional and psychological impacts, and experiences with institutional support systems. Each participant engaged in a one-on-one, in-depth interview lasting between 60 to 90 minutes. Interviews were conducted in a private, comfortable setting to ensure participants felt secure and free to share openly. With participants' consent, interviews were audio-recorded for accuracy and later transcribed verbatim. To enhance credibility and reflexivity, both researchers took turns moderating interviews. Regular debriefing sessions were held after each interview to reflect on the process, assess the quality and depth of data collected, and adjust interview strategies as needed (Ekoto et al., 2022). This dual-moderator approach minimized potential interviewer bias and enriched the overall data quality.

Transcribed interviews were analyzed using a thematic narrative analysis approach. Initially, each transcript was read multiple times to gain a holistic understanding of each participant’s story. Subsequently, open coding was employed to identify key themes related to stigma, emotional well-being, institutional dynamics, and coping strategies. Themes were then compared across narratives to identify common patterns and divergences. To ensure trustworthiness, coding and theme development process involved peer debriefing sessions between the two researchers. Discrepancies in interpretation were discussed until consensus was reached, and a member-checking process was conducted by sharing preliminary findings with participants for validation and feedback.

This research adhered to strict ethical standards. The participants were fully informed of the study’s aims, procedures, and their rights, including the right to withdraw at any time without penalty. Oral informed consent was obtained before participation. To ensure anonymity and confidentiality, pseudonyms were used in all transcripts and analyses. Ethical approval for this study was obtained from the Research Ethics Committee at Kathmandu University.

The following pseudonyms were assigned to the participants: Lekha- Mother; Shova- Mother; Rupa- Mother and special educator; Tara- General educator. All participants’ voices are presented with respect, and their narratives have been handled with sensitivity to preserve the authenticity of their experiences while safeguarding their identities.

Findings and Discussions

The main conclusions from in-depth interviews with teachers and parents working in inclusive education settings are presented in this section. With special attention to the availability, accessibility, usefulness, and limitations of support systems, which are crucial in mitigating the effects of societal stigma and fostering carer resilience, the data are thematically arranged to address the research questions of the study.

Perceived Societal Stigma and its Internalization

Carers frequently expressed a keen and agonizing awareness of how society misinterpreted their child's actions and their parenting. Their views were influenced by this external stigma, which also made them less confident in inclusive education, made them retreat from social situations, and made them reluctant to ask for help when it was offered. Lekha, a mother, recounted a powerful experience in a department store when, over a small incident, a passerby immediately labeled him “spoilt” and blamed her as a mother.

> *My son inadvertently knocked some items off a shelf while walking ahead of me. The comments commenced almost immediately. 'What a spoilt child!' 'What type of mother fails to instill courtesy?'... Autism was not observed by them, bad conduct was observed ... They did not observe a mother who was fatigued. They only observed failure.*

She felt paralyzed…stabbed by a blade as strangers stared not with concern but with judgment.

Shova, another mother, shared how stigma manifested in cultural and religious interpretations. Even after diagnosis, she prayed at holy sites and carried the guilt.

> *Why us? Our society instils in us the notion that disabilities are a form of punishment, karma, or fate... Even when you endeavor to unlearn them, those convictions stay with you.*

This social misunderstanding extended into professional spaces as well. Despite their educational backgrounds, caregivers often felt dismissed by medical professionals. As Lekha shared:

> *The doctor said, ‘It must be from watching too much mobile phone. Send him to school, everything will be fine, don't worry.’ But how could I send a 15-month-old child to school?"*

Stigma affected school choice and interaction with the community, sometimes leading to the concealment of the diagnosis:

> *I have concealed his diagnosis from others to circumvent the stares, the pity... I am aware that I should not... However, I have. And each time, it saps a little more of my spirit.* - Lekha

Rupa, a special educator, explained that even in her inclusive school, some parents question inclusion:

> *Even today, there are parents who enquire, ‘Will my child’s academic performance be compromised by spending time with autistic children?*

She interpreted such concerns not as cruelty but as ‘fear of the unknown, a societal apprehension that confirms grip of stigma.’ These narratives show that stigma pervades both family and community levels, outsiders attribute autism to moral failing or bad *karma*, and even fellow parents worry about negative “contamination” of their children.

Affiliate Stigma and the Psychological Toll on Caregivers

The emotional impact of raising a child with disabilities in a stigmatizing society was profound. Many caregivers reported experiencing affiliate stigma: internalizing negative societal beliefs, resulting in shame, guilt, and deteriorating mental health.

Lekha candidly described her descent into depression:

> *I sit alone and cry, then console myself. Sometimes, I get so emotional that tears just fall from my eyes while I'm talking... I’ve crossed that phase. But my mental stress was so severe that my hair was falling out.*

The psychological burden led to moments of despair and suicidal ideation:

> *Sometimes, when things get really difficult, I think about ending both our lives... better if both of us disappear. But then I remember my elder daughter and such thoughts would fade.*
>
> *I have observed that I have been apologizing for my child’s identity…each time, it saps a little more of my spirit. - Lekha*

Shova shared her sense of personal failure and guilt:

> *I would assert, 'He is this way due to your genetics!' And then the guilt consumes you... I must be present. For him. For my own benefit.*

Despite their struggles, caregivers expressed resilience and transformation. Small moments of growth in their children became sources of hope.

Support Systems as Lifelines and their Limitations

In the face of societal stigma and emotional exhaustion, support systems offered caregivers moments of hope, practical assistance, and psychological relief. Yet these systems, be they familial, professional, institutional, or governmental, were often inconsistent, inaccessible, or inadequate. While some participants experienced powerful acts of support, others found themselves navigating caregiving in relative isolation, with intermittent institutional backing and emotional labor that far exceeded the support available.

Emotional support from a partner, when available, acted as a protective buffer against stigma. Shova acknowledged this support early in her caregiving journey:

> *At the time, we were both employed by an international company in Dubai… we were able to afford home-based therapy and early intervention.*

However, her reflections also revealed that emotional reassurance was often temporary or incomplete. After her husband's death, the sense of shared caregiving vanished, leaving her in a space of silent struggle:

> *Although my family was present, there are certain experiences that are solely yours to bear.*

Others, like Lekha, faced resistance even in initiating support. Despite noticing early developmental concerns, her family dismissed her observations:

> *They'd say, 'He walks, eats, runs, can lift the shutters…what's missing except speech?'"*

She emphasized how this persistent denial made her feel alone in advocating for her child. The strain intensified with the logistical scattering of her family, husband in Kawasoti, daughter in Butwal, and herself in Kathmandu with her autistic son. As she noted:

> *Our family is scattered…mother and son in one place, daughter in another, and father somewhere else and we are struggling financially.*

Some caregivers accessed structured support through organizations such as the Avani Foundation, which provided training, therapy, and temporary housing. These spaces allowed caregivers to feel seen, reducing everyday frictions they had become used to. Lekha, who had previously been asked to move out of a hostel due to her son's behavior, recalled the relief of her new arrangement:

> *Now, I stay in a house specifically for six autistic children… I don't have to hear complaints like 'your child disturbed someone' or 'your child broke something.*

However, even in these relatively supportive spaces, the help was not always sustainable. Financial costs remained a major barrier. Lekha shared the magnitude of the sacrifice involved in accessing services:

> *The expenses for my son's therapy and our stay here exceed my household income. I had a small piece of land, which I sold to pay for these therapies.*

Despite these challenges, volunteering at the Avani provided psychological resilience, creating a sense of community and purpose:

> *While I'm taking this training, I'm also volunteering… I don't get paid for that, but it helps me mentally.*

Schools, particularly with inclusive policies, were positioned as critical environments for both growth and misunderstanding. While the intent to support neurodiverse learners was often present, teachers revealed their struggles with capacity, training, and emotional exhaustion.

Tara, a general teacher, expressed her initial anxiety upon learning that autistic students would be placed in her classroom:

> *I smiled... nodded in agreement… But I could feel my chest tighten as I walked out of that room.*

Despite having attended training and workshops, Tara felt the gap between theoretical knowledge and real-time challenges:

> *The situation is significantly different when you are in front of 25 students, one of whom is experiencing a meltdown.*

She candidly acknowledged the disconnect between policy and practice:

> *We have policies in place, and we promote inclusive values... However, are we prepared to implement them in practice?*

For educators like Rupa, who transitioned from a parent to a special educator, the school was both a site of advocacy and vulnerability. She recognized the power of peer modeling and education:

> *Learners are adequately equipped at my institution... they commence assisting. That is the influence of consciousness.*

However, stigma remained even within progressive spaces:

> *Neurodiverse children are susceptible to being misunderstood, victimised, and held accountable for actions they did not commit.*

Caregivers also encountered troubling dismissals from healthcare providers, often at critical early stages of diagnosis. Shova, despite her maternal instincts and educational background, recalled her experience vividly:

> *I can still recall sitting in that frigid clinic room, my fingers firmly grasping the chair. And he said, 'Oh, boys speak late.*

This pattern of professional minimization delayed intervention and deepened the emotional distress of caregivers already grappling with uncertainty.

The need for mental health support for parents themselves was a recurring theme. Rupa reflected on her breakdown:

> *I was compelled to consult with a psychologist and take medication... I was unable to manage the entirety of the situation.*

Similarly, Lekha connected her mental distress to physical symptoms:

> *My mental stress was so severe that my hair was falling out... When I went to Chitwan for a checkup, they would ask if I was having mental difficulties.*

Yet despite such indicators, access to consistent psychological care for caregivers remained limited or self-managed.

Moreover, experiences with state support systems were uniformly marked by confusion, inaccessibility, or lack of follow-through. When Lekha attempted to apply for her son's disability card, she was turned away:

> *The village council sent me back saying that cards cannot be made until the child is five years old.*

Even when documentation was in place, bureaucratic indifference, both from officials and family members, diminished its value:

> *My husband also said, "It's just a disability card anyway."*

These encounters navigate a broader absence of reliable systemic infrastructure, leaving caregivers to piece together a patchwork of personal, institutional, and informal supports, often at great emotional and financial cost.

Transformation and Advocacy

Despite hardship, many caregivers channeled their experience into positive change for themselves and others. Rupa, who began as a preschool coordinator described a clear turning point. After years of helping her own son, she thought:

> *If I can accomplish this for him, why not for others as well?*

She retrained and became a special educator in an inclusive school, now sharing her journey with other parents. She tells them,

> *Each child is unique… We merely need to listen attentively and adjust our teaching methods… It is not an increase in workload; rather, it is an increase in compassion.*

In doing so, she advocates for differentiated instruction and models acceptance. In the classroom, Rupa found quiet moments of hope. She recounted when a neurodiverse student was blamed for a peer's outburst,

> *It struck me once more – neurodiverse children are susceptible to being misunderstood… unless we establish a culture of understanding.*

> *Children take these lessons with them when they return home. This is the method by which we establish a more inclusive community, one step at a time.*

These reflections show that some caregivers took on advocacy roles, fostering awareness among colleagues and parents.

Lekha, who had once chosen to have a son "to show society", she could do anything. But confronting his autism reshaped her outlook. She confided that though she still cries over the challenges, she tells herself,

> *I need to teach him, and he will learn.*

In other words, she shifted focus from trying to prove herself to others toward empowering her child. Across stories, there is a sense of growing resilience. Parents and teachers spoke of small victories, a child completing a task or simply being accepted by peers, and resolved to spread those moments. As educator Rupa put it,

> *We must collaborate as a community… focus on empathy. Strategies and teaching techniques can be learned, but empathy must originate from within.*

These accounts illustrate that even amid stigma, caregivers sought to transform their experience into advocacy and change, laying the groundwork for a more inclusive understanding.

The results show a highly emotional terrain influenced by loss, stigma, and scarce resources, as well as times of growth, transformation, and connection. Carers' wellbeing and confidence in inclusive education are significantly impacted by societal stigma and affiliate stigma. However, they act as lifelines when there are institutional, financial, and emotional support networks available. Important relief is provided by family members, skill-building foundations, responsive educators, and peer networks. These resources are not always available. Full inclusion is still hampered by issues like expense, ignorance, and unskilled personnel. In order to establish learning environments where children and carers can flourish, the study emphasises the necessity of stigma-sensitive training, financial and emotional support networks, and systemic policy reform.

Discussions

Caregivers' narratives revealed pervasive negative beliefs about neurodivergent children, which generated stigma at the community level and shaped caregivers' views on inclusion. For example, when Lekha's son knocked items off a shelf in a department store, strangers labeled him "spoilt" rather than considering autism, a reflection of cultural norms rooted in moralistic or fatalistic explanations (Kohrt & Harper, 2008; Rohwerder, 2018). Caregivers like Shova and Lekha internalized widespread beliefs that autism and similar conditions result from bad karma, divine punishment, or poor parenting, undermining their trust in inclusive institutions. As a result, they concealed their child's diagnosis to avoid pity and criticism ("I have concealed his diagnosis… it saps a little more of my spirit"), illustrating how stigma at the macrosystem level directly interferes with caregiver confidence in inclusive education. Rupa's account, as a special educator who overheard other parents asking, "*Will my child's academic performance be compromised by spending time with autistic children*?", further demonstrates how negative attitudes among parents of neurotypical children can erode community support for inclusive classrooms (Lindsay et. al., 2013).

Affiliate stigma, where caregivers internalize public stigma directed at their children, emerged as a powerful theme that spans both microsystem and macrosystem influences. Within their immediate environments, caregivers described profound guilt, shame, depression, and even suicidal ideation as they tried to reconcile love for their children with societal judgment. For instance, Lekha confessed that she sometimes thought "better if both of us disappear," reflecting severe emotional distress that aligns with affiliate stigma theory (Mak & Cheung, 2008). Zhou et al. (2018) found a strong correlation between affiliate stigma and depressive symptoms among Chinese parents of autistic children. In our study, caregivers frequently reported physical symptoms, "my hair was falling out," and emotional breakdowns that mirror these findings. Teachers were not immune: Tara, a general educator, admitted questioning whether she was "doing enough" for her neurodiverse students, despite having undergone training, showing how professional caregivers can also absorb stigma and doubt their competence (Mak & Cheung, 2008). These experiences confirm that affiliate stigma at the microsystem level profoundly undermines caregivers' mental health and alters caregiving behaviors.

Existing support systems, ranging from family members to NGOs and schools, served as both lifelines and reminders of systemic shortages. At the microsystem level, familial support sometimes provided emotional relief, as when Shova's husband financed home-based therapy ("He was a bedrock in my life"), buffering daily stress. However, when that support vanished (e.g., after his death), Shova felt isolated, stating how uneven family resources influence caregiver wellbeing. At the exosystem level, NGOs such as the Avani Foundation offered critical training, therapy, housing, and community connection. For example, Lekha described relief after moving into a house designated for autistic children: "I don't have to hear complaints like '*your child disturbed someone*' or '*your child broke something*.'" Such spaces reflect the role of supportive developmental settings in strengthening caregiver resilience. Nevertheless, the financial strain remained acute: Lekha sold land to afford her son's therapies, illustrating how economic precarity (macrosystem) and insufficient government services, evidenced by bureaucratic obstacles in obtaining disability cards, exacerbated hardship (Holmes et al., 2018). School-based supports occupied the mesosystem; while inclusive policies existed, their implementation lagged. Tara lamented that policies were "on banners" but not evident in daily practice, echoing Sharma and Das's (2015) findings that underprepared teachers and scarce resources hinder meaningful inclusion. Rupa's role as a special educator enabled her to foster peer awareness, "*learners…develop as a result of this comprehension*", but even she acknowledged that stigma persisted when neurodiverse children were "*held accountable for actions they did not commit*." These narratives demonstrate that family, NGO, and school support can alleviate certain burdens but are often under-resourced, inconsistent, or inaccessible, leaving caregivers to navigate a fragmented network of assistance. Over time, within the chronosystem, caregivers demonstrated adaptive transformation despite adversity. Rupa's evolution from a struggling parent to an informed special educator exemplifies positive change catalyzed by increased knowledge and community involvement. Similarly, small developmental milestones in children, "When I observe him laughing or acquiring new knowledge," provided caregivers with hope, aligning with Weiss et al. (2013) assertion that caregiver adaptation is dynamic and influenced by temporal factors. Thus, the chronosystem illuminates how temporal experiences and accumulated support shape caregiver resilience and advocacy, illustrating that while stigma and resource gaps persist, caregivers can harness moments of growth to foster inclusion. Bronfenbrenner's Ecological Systems Theory is seamlessly integrated by mapping each theme onto micro-, meso-, exo-, macro-, and chrono-level influences, demonstrating the multifaceted nature of caregiver challenges.

Conclusion

The study explored the impact of societal stigma on caregivers in inclusive school settings in Nepal, highlighting the emotional exhaustion, isolation, and disengagement experienced by those raising neurodiverse children. Caregivers, parents and teachers of neurodiverse children in inclusive Nepali schools are facing dilemmas tin navigatingsocietal stigma, psychological burdens, and support systems. This inquiry highlights how societal and affiliate stigmas deeply burden caregivers in Nepal. Caregivers' struggles reflect nested ecological pressures that require multi-level interventions: reducing cultural stigma (macrosystem), expanding government services and teacher training (exosystem/mesosystem), and strengthening family and community support (microsystem). Only by addressing these interconnected layers can caregivers of neurodiverse children find sustainable relief and foster genuine inclusion in Nepali schools. The implications for Nepal's inclusive education are significant. First, efforts to reduce stigma must engage both macro and microsystems. Community education campaigns (targeting cultural beliefs) are needed alongside school-based sensitization. Our teacher participants' strategy of pre-teaching peers about neurodiversity, "*You will have friends who may engage in self-talk or experience meltdowns*", illustrates a mesosystem intervention by arming school children with awareness; she created a bridge between her classroom and families. Such grassroots awareness-raising echoes improving attitude as a crucial aspect of educational journey. Likewise, empathetic school leaders and counselors can help alleviate caregiver burnout. For example, when a hostel owner openly resisted complaints about an autistic child, it demonstrated the value of inclusive attitudes at the exosystem level.

Second, institutions of caregiver support have to be enhanced. The participants called for more government involvement, from early diagnosis to affordable therapy. They talked of selling land and draining money to cover interventions. In an ecological view, this reflects a failure of exosystem supports (health and social services). Policymakers could address this gap by funding mobile therapy units or expanding community-based rehabilitation (CBR) programs, so that urban and rural caregivers alike have access. Teacher preparation also transcends theoretical seminars. Teachers said that "*training does not adequately equip you for all potential scenarios*." Teacher support groups, co-teaching approaches, and on-the-job mentorship would help bring inclusive policies to life. This is consistent with UNICEF's call for awareness-building: "stigma and discrimination were common," and although negative attitudes still exist, changing mindsets via education can help to increase inclusion (UNICEF, 2022). Support groups or mother support circles, for instance, could be investigated for their effects on stigma; school-based awareness programs could be assessed for altering peer perceptions. Using Bronfenbrenner's chronosystem idea, longitudinal studies might also look at how caregiver stigma changes as children develop. Combining grassroots education and empathy-building with policy reform would help Nepal achieve the inclusive schools imagined in theory, a goal requiring both structural support and societal transformation. Caregivers and their children will flourish together only if we encourage understanding in homes, communities, and classrooms.

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Sharmila Shrestha is a psycho-social counselor dedicated to creating safe and supportive spaces where people, especially students, can speak, heal, and grow. Her journey spans from working in UN crisis centers to school classrooms across Nepal. She facilitates workshops, provides one-on-one counseling, and conducts research to understand better the emotional challenges faced by young people, ranging from school bullying to silent loneliness. Sharmila deeply believes in the power of conversation to change lives. Her mission is to make someone feel truly heard and understood because that is where healing begins.

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