RESEARCH PAPER

Center for Creative Leadership

Neurodiversity in Leadership:

IDENTITY, MASKING, AND WELLBEING

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https://doi.org/10.35613/ccl.2026.2078

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Executive Summary

Neurodivergent people are in leadership roles, yet little is known about how they experience leadership or what it costs them to lead. This paper combines a bibliometric analysis of published research with survey data from 416 leaders across neurodivergent and neurotypical groups.

Study 1 revealed that the research base on neurodivergent leadership is thin. Fewer than 30 peer-reviewed articles directly address this topic, and most focus on employees rather than leaders.

Study 2 began to fill this leader-specific gap. Despite prior leadership experience, neurodivergent leaders reported lower confidence in their leadership abilities, weaker psychological resources, and lower overall wellbeing than their neurotypical peers. They also reported substantially higher levels of masking, or adjusting or suppressing their natural behavior to meet workplace expectations, which was directly linked with lower psychological resources and wellbeing.

These patterns varied across neurodivergent groups. Autistic leaders and those with both autism and attention-deficit/hyperactivity disorder reported the most pronounced differences, whereas dyslexic leaders showed fewer, particularly on masking.

The findings point to a disconnect between how leadership is commonly defined and how many neurodivergent leaders actually work. We offer practical guidance for leaders of neurodiverse teams, neurodivergent leaders themselves, and senior organizational leaders. Broadening how leadership potential is recognized, reducing reliance on narrow behavioral norms, and ensuring meaningful access to development and leadership opportunities can create conditions in which a wider range of leaders can succeed.

Introduction

Neurodivergent leaders are already in your organization. They are leading teams, managing projects, and contributing at every level. And yet, despite their experience and demonstrated success, they are less likely than their neurotypical peers to see themselves as leaders, to feel confident in their leadership capabilities, and to feel comfortable bringing their authentic selves to work. These gaps trace back to leadership systems, norms, and development structures that were not built with neurodivergent people in mind. This paper presents findings from one of the first large-scale studies focused on neurodivergent leaders and contributes to an emerging field where foundational research is only beginning to take shape.

Neurodiversity is a term used to describe the natural variation in cognition and how people experience the world (Doyle, 2020). It encompasses everyone, and every workplace is, by nature, neurodiverse. Within that diversity, individuals who are neurotypical have cognitive processes that generally fall within societal norms or expectations, whereas those who are neurodivergent experience and process the world in ways that differ meaningfully from what society treats as standard. Neurodivergence includes, but is not limited to, people with attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, and obsessive-compulsive disorder (OCD). Approximately 20% of workers are estimated to be neurodivergent, and recognition of this population is expected to grow as awareness increases and more people seek or receive diagnoses (Doyle, 2020).

Despite their sizeable presence in the workforce, neurodivergent employees and leaders remain underacknowledged in both research and organizational practice (Doyle & McDowall, 2022; McDowall et al., 2025). Research on neurodiversity at work has focused on hiring, accommodations, and retention, with very little attention paid to what it means to be a neurodivergent leader or how to effectively lead and support neurodiverse teams (Doyle & McDowall, 2022). Emerging work also tends to center on autism

specifically, subsumed under the broader label of neurodivergence. Severe underemployment among autistic individuals (Nicholls, 2025; Wen et al., 2024) may explain this trend, but other neurodivergent individuals receive comparatively little attention in the research despite their relative prevalence. The inner experiences and self-perceptions of neurodivergent leaders remain understudied as well (Doyle & McDowall, 2022; McDowall et al., 2025). We do not yet know empirically how they view themselves as leaders compared to neurotypical peers, how their wellbeing compares in terms of flourishing, or how these constructs differ across groups.

The academic fields of leadership and leadership development include a wide range of models that define what leadership should look like. These frameworks were largely built on samples that reflected neurotypical norms and expectations (Roberson et al., 2021), shaping whose leadership is recognized and whose is overlooked. Research indicates, however, that neurodivergent people perform as effectively as their neurotypical peers (Austin & Pisano, 2017; Emira et al., 2018; Praslova, 2021). They are described by themselves and their colleagues as bringing qualities like pattern recognition, systems thinking, resilience, and advocacy to their work (McDowall & Doyle, 2024). Cognitive diversity in teams has been linked to faster and more effective problem-solving (Reynolds & Lewis, 2017, 2018), and organizations that invest in neuroinclusion have reported gains in innovation, engagement, productivity, retention, and overall performance (Austin & Pisano, 2017; Austin et al., 2025). Given this evidence, we ask: **Have environments built around neurotypical standards allowed neurodivergent leaders to believe they can lead and to be seen as leaders when they do?**

The discrepancy between experience and how people internally view their own leadership capability directly influences who has access to opportunities, who gets developed, and who ultimately advances into leadership roles. Leader identity and self-efficacy grow when critical conditions are present, including leadership experiences, meaningful feedback, and environments that encourage different leadership styles (Day & Harrison, 2007; Lord & Hall, 2005). For neurodivergent leaders, these conditions may be undermined by workplaces designed around neurotypical norms. When these conditions are absent, development stalls regardless of actual ability (Miscenko et al., 2017).

In this paper, we outline a theoretical framework for understanding the leadership development gaps facing neurodivergent leaders, map the current state of the literature through bibliometric analysis, and examine key constructs through a quantitative study comparing neurodivergent and neurotypical leaders. Given that most existing studies rely on small qualitative samples, we intend for the quantitative study to provide a reference point for other researchers in this nascent field.

Theoretical Foundation

Understanding how neurodivergent leaders experience leadership requires first being clear about what leadership means in this context. Leadership is fundamentally a social process and is not based on role or title alone (Day & Harrison, 2007; Lord & Hall, 2005). The psychological process of seeing oneself as a leader, and of others seeing oneself as a leader, develops through accumulated experience, feedback, and recognition rather than through formal appointment.

Framed this way, the relevant questions shift from whether someone holds a management title to whether they have what it takes to guide others toward a common goal. Answering these questions requires an understanding of what a leader is, what leaders do, and whose definition of leadership counts.

Leadership prototype theory proposes that people are recognized as leaders when their behavior matches an implicit cognitive model of what a leader is supposed to look and act like (Epitropaki & Martin, 2004; Epitropaki et al., 2013; Lord & Maher, 1991). These prototypes have been shaped by cultural and organizational norms that reflect neurotypical behavioral expectations. Behaviors like sustained eye contact, linear and confident communication, comfort with ambiguity, and the ability to build relationships rapidly in high-visibility settings all define the implicit standard against which leaders are measured (Roberson et al., 2021).

Leaders who communicate, process information, or relate to others differently may fail to match the prototype and thus receive less recognition and fewer opportunities despite their effectiveness (Epitropaki & Martin, 2004; Lord & Maher, 1991). Signaling theory describes leadership as emerging through a series of claiming behaviors and granting behaviors (DeRue & Ashford, 2010). Aspiring leaders perform leadership behaviors to claim influence in a leadership situation. When others affirm those behaviors, they grant influence to the individual. These cycles of claiming and granting require alignment between the aspiring leaders' behaviors and the expectations of those around them. Followers, therefore, rely on observable cues to infer unobservable leadership qualities (Schimmelpfennig et al., 2026). This dynamic may favor leaders whose communication style fits organizational norms.

Signal credibility depends further on the cost of producing observable leadership cues (Schimmelpfennig et al., 2026). When dominant signals reflect neurotypical norms, neurodivergent leaders may resort to masking, which is to suppress or conceal traits to appear more neurotypical. Even when subconscious, this is a demanding strategy with significant psychological cost (Johnson James et al., 2025; Kidwell et al., 2023). As psychological resources deplete, the effort required to meet prototype expectations increases, which raises the risk of being overlooked or achieving recognition at considerable personal cost.

Other research on speaking time and leader emergence offers concrete examples of how this operates. In group settings, those who speak more

are more likely to be perceived as leaders (Loignon et al., 2025). This can disadvantage neurodivergent individuals who participate in meetings differently, whether due to delayed processing, a preference for written over verbal contributions, or other communication styles that diverge from expected norms (Johnson James et al., 2025).

Given this dynamic, a real disconnect likely exists between what neurodivergent leaders demonstrate and what gets reflected back to them (DeRue & Ashford, 2010). Over time, cumulative underrecognition makes it harder to internalize a leader identity (Emira et al., 2018; Epitropaki et al., 2017; Luria et al., 2014). As a result, there is a likely mismatch between prevailing mental models of effective leadership and what neurodivergent people feel they can achieve. The absence of visible neurodivergent role models in leadership positions removes an important reference for leader identity development (Day & Harrison, 2007).

This framework explains why neurodivergent leaders may struggle to see themselves as leaders and be seen as such by others. What remains absent is empirical data documenting the nature and scale of these differences. The following two studies were designed to address this. Three research questions guided this work:

RQ1: What is the current state of peer-reviewed research on neurodiversity and leadership?

RQ2: How do self-views of leadership and wellbeing differ across neurotypical and neurodivergent leader groups, and among neurodivergent subgroups (ADHD, autistic, dyslexic, AuDHD)?

RQ3: How do neurodivergent leaders navigate their identity and presentation at work?

Study 1: Bibliometric Analysis

To establish an empirical baseline for the state of the field, we conducted a bibliometric analysis prior to designing the quantitative survey. Bibliometric methods allow for systematic mapping of research volume, thematic clustering, and citation impact across large bodies of literature, making them well-suited for assessing the scope and concentration of an emerging research area (Donthu et al., 2021; Rollnik-Sadowska & Grabinska, 2024). Our goal was to determine empirically whether neurodivergent leadership research existed, how large the field was, and where existing work was concentrated.

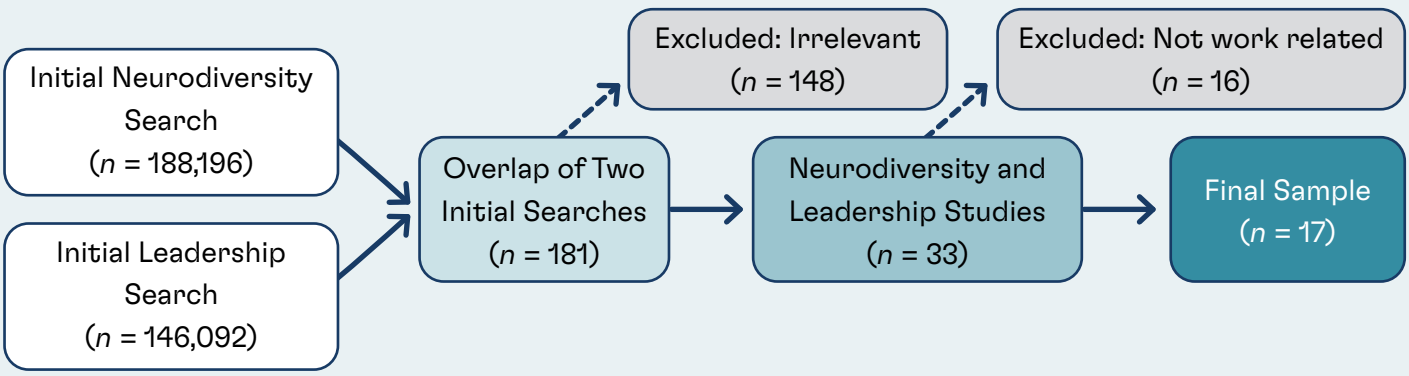
In November 2023, we searched Web of Science using three parallel sets of search terms: condition-specific neurodiversity terms (e.g., ADHD, autism, dyslexia, learning disability), leadership development terms, and workplace terms. Because the terms "neurodiversity" and "neurodivergent" are relatively recent additions to the academic lexicon, we used them alongside condition-specific terminology to ensure comprehensive coverage. We used VOSviewer software to generate citation network maps and identify thematic clusters (van Eck & Waltman, 2022). The analysis proceeded in three stages, beginning with broad individual field counts, followed by pairwise intersection counts, and a final manual title-level screening of the neurodiversity and leadership development intersection for topical relevance.

The individual research fields are expansive. Our search returned 188,196 articles related to neurodiversity, 146,092 related to leadership development, and 113,324 related to the workplace. Each field, on its own, is well-established and active. The intersections, however, tell a different story.

Only 398 articles addressed both neurodiversity and the workplace, and only 181 addressed the intersection of neurodiversity and leadership development. After manually screening those 181 titles to remove irrelevant publications and those focused on non-workplace settings (e.g., education, parenting, or clinical outcomes), only 17 articles were positioned at the intersection of neurodiversity and leadership development (see Figure 1). The mean citation count for these 17 articles was 25.29, compared with 321.47 for the top 17 articles in the broader neurodiversity and

FIGURE 1.

Decision Tree to Identify Relevant Articles on Neurodiversity and Leadership from Bibliometrics Analysis.

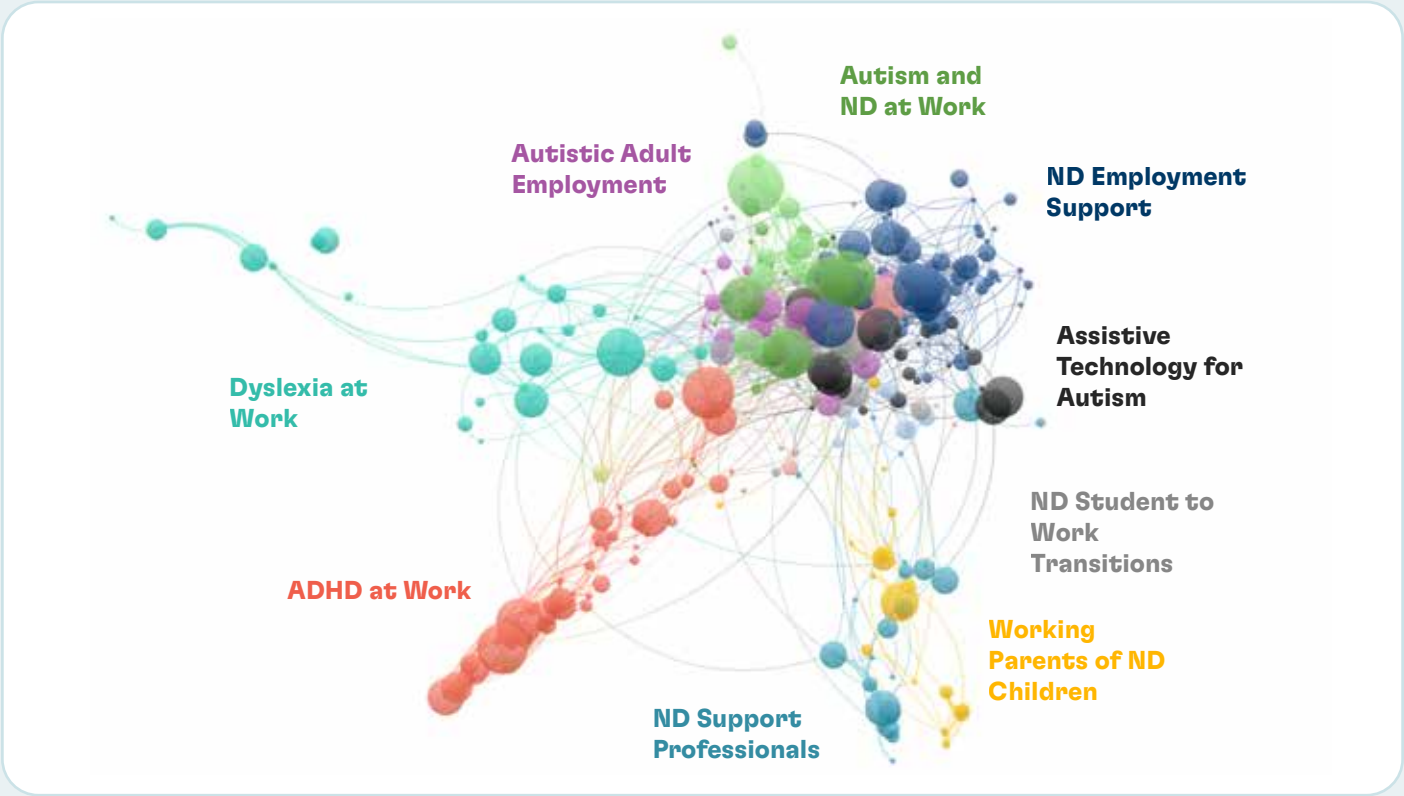


workplace corpus, a nearly 13-fold difference. This difference illustrates that this area of inquiry is still in its infancy. Though citation volume is driven by field size, and citation counts for each field are not directly comparable, this disparity speaks to the limited reach and influence of neurodivergent leadership research to date.

Unable to conduct a thematic analysis on such a small set of articles, we examined the structure of the broader neurodiversity and workplace literature. We generated a VOSviewer citation network map of the 398 articles (see Figure 2). Nine clusters emerged, capturing the primary research streams in this space, ranging from clinical and support-focused topics (e.g., employment support, assistive technologies) to workplace-specific topics (e.g., ADHD in the workplace, autistic employment barriers). Cluster labels and corresponding colors are provided in Figure 2.

FIGURE 2.

Thematic Mapping of Available Peer-Reviewed Articles on Neurodiversity at Work as of 2023.



Note. Each publication is represented by a node (dot). The size of each node represents how often each article has been cited relative to other articles in the map. Edges (lines) connect articles based on citations. ND = neurodivergent. Colors distinguish separate clusters where each color contains articles related to a particular topic as follows: (1) green, autism and neurodiversity in the workplace; (2) dark blue, employment support for neurodivergent adults; (3) black, assistive technologies for autistic individuals; (4) gray, work transition assistance for neurodivergent students; (5) yellow, working parents of neurodivergent children; (6) teal, professionals who support people with neurodivergence and disabilities; (7) coral, ADHD in the workplace; (8) turquoise, dyslexia in the workplace; (9) purple, employment supports and barriers for autistic adults.

Leadership development is notably missing as a central research stream in any of these clusters. Despite nearly 200,000 articles touching on neurodiversity and over 146,000 on leadership development, fewer than 20 studies have examined both together in a workplace context.

To assess whether the field is growing, we conducted a follow-up search in July 2025 using the same methodology, examining only the intersection of neurodiversity and leadership development. This updated search returned 233 articles overall. After closer examination, only 52 articles referred to the workplace, including the original 17 from the 2023 search. Among the new articles, only 9 met our criteria for leadership development relevance. Though growth is minimal in raw numbers, the number of relevant articles grew by 53%, suggesting that scholarly attention to this area is beginning to accelerate.

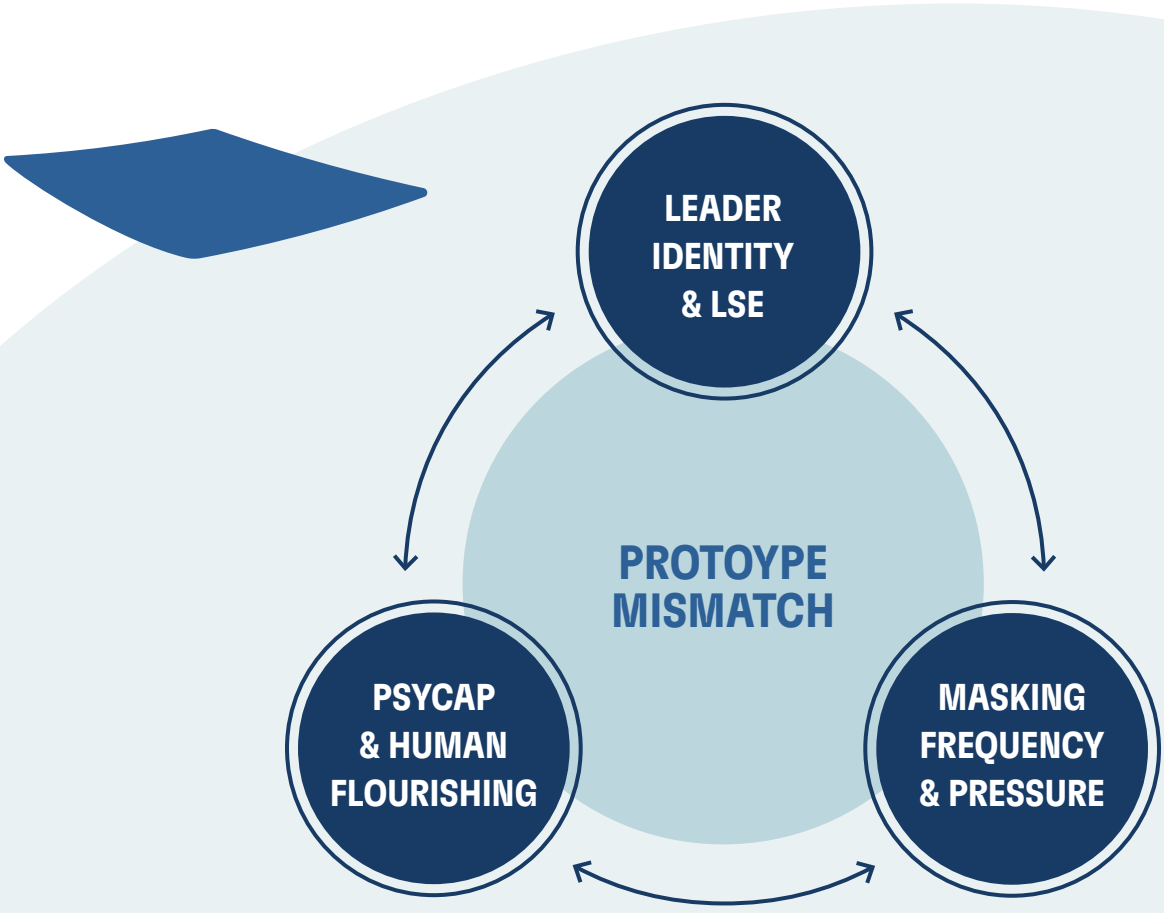
Despite a proportional increase in published research between 2023 and 2025, the field is still at its earliest stages. Across both analyses, nearly all articles meeting our criteria discussed leading neurodiverse employees, which indicates **that neurodivergent leaders themselves remain almost entirely absent from the existing literature**. With roughly 1 in 5 people being neurodivergent, the lack of research on their leadership experiences represents critical underrepresentation that warrants empirical attention.

Study 2: Leader Survey

Study 2 was designed to examine how key constructs related to leadership, wellbeing, and workplace experiences vary across a neurodiverse sample. We draw on prototype mismatch theory as a lens for understanding the results that emerged.

We currently lack an understanding of whether existing leadership frameworks, which are built on prevailing leadership prototypes, function similarly for neurodivergent and neurotypical leaders. Despite their theoretical relevance, motivational and affective outcomes of leadership remain understudied criteria in the empirical leadership literature (Hiller et al., 2011; Lacerenza et al., 2017). To explore these areas, we focused on five constructs that capture the lived experiences of neurodivergent leaders, including their sense of leader identity, confidence in their leadership capabilities, and the psychological resources they draw on at work.

We propose the following: a) **Leader identity** and **leadership self-efficacy** partially represent the extent to which individuals experience a match or mismatch with prototypes; b) neurodivergent leaders engage in **masking** behaviors to navigate mismatch; and c) increased masking likely relates to lower **psychological capital** and **human flourishing**, a measure of overall wellbeing. In the following sections, we define and discuss each of these five constructs, how they relate to prototype mismatch, and the potential implications for neurodivergent leaders.



LEADER IDENTITY

Leader identity is a person's internal sense of themselves as a leader, or the degree to which being a leader is central to who they are, independent of any formal title or role (Day & Harrison, 2007; Lord & Hall, 2005). Unlike positional authority, which is assigned, leader identity is built through social and experiential processes. It develops through leadership opportunities, feedback that confirms one's sense of capability, and social recognition, all of which affect others' capacity to view and treat someone as a leader (Hammond et al., 2017; Miscenko et al., 2017). When these inputs are absent, contradictory, or shaped by factors unrelated to leadership effectiveness, development stalls (Epitropaki et al., 2017).

Each of these inputs can be disrupted for neurodivergent individuals. Leadership opportunities may be withheld based on social characteristics rather than capability. Feedback may reflect neurotypical behavioral expectations rather than substantive evidence of leadership. The social recognition that reinforces a growing leader identity depends, in part, on whether a person matches implicit mental models of leadership that others carry (Kragt & Day, 2020), which are shaped overwhelmingly from neurotypical experience (Roberson et al., 2021). Leader identity, once formed, is an established predictor of leadership attainment, sustained engagement in development, and effectiveness (Epitropaki et al., 2017).

LEADERSHIP SELF-EFFICACY

Leadership self-efficacy (LSE) refers to a person's confidence in their ability to carry out the tasks and responsibilities that leadership requires (Hannah et al., 2008). While identity addresses who someone believes they *are*, efficacy addresses what they believe they *can do*. LSE has been shown to predict leadership emergence, performance, group outcomes, and how people engage with leadership development (Dwyer, 2019; Hannah et al., 2008). Importantly, LSE is developable and is particularly responsive to experience and intervention among leaders from underestimated groups (i.e., populations whose talent is systemically undervalued) (Reichard et al., 2024).

The primary driver of LSE development is mastery experience, which here refers to direct leadership engagement that provides concrete evidence of one's own capability (Bandura, 1977). Two additional sources of self-efficacy are socially derived: Verbal persuasion, which depends on receiving encouraging or discouraging feedback from others about one's ability and performance, and vicarious experience, which depends on self-comparison with others to determine one's own capability, such as seeing successful neurodivergent leaders in action. Performance therefore shapes confidence more than confidence shapes performance, a finding that underscores the importance of genuine opportunities to lead (Sitzmann & Yeo, 2013). When access to those opportunities is limited, or when feedback received is not directly tied to leadership performance, LSE becomes difficult to build and sustain. Neurodivergent leaders may encounter both barriers simultaneously.

Leader identity and LSE together represent the degree to which neurodivergent leaders internalize a sense of themselves as capable leaders within environments built around neurotypical prototypes. When that tension is present, both constructs are likely to be inhibited, and we thus may expect more negative leadership experiences.

MASKING

Masking as a workplace strategy is not unique to neurodivergent people. Black professionals engage in code switching to operate within white-dominant professional settings (McCluney et al., 2019). Yoshino (2006) describes the broader phenomenon of covering as the suppression of any identity that diverges from dominant norms, drawing extensively on LGBTQ+ experiences to frame it as a near-universal condition of organizational belonging.

What distinguishes neurodivergent masking is that it frequently functions unconsciously or involuntarily, driven by neurological differences rather than deliberate strategy (Johnson James et al., 2025; Kidwell et al., 2023). Unlike situational code switching, neurodivergent masking can also persist continuously across most social and professional interactions (Pryke-Hobbes et al., 2023). The psychological costs, however, connect to the same underlying dynamic across groups: Suppressing core aspects of one's identity to belong is costly, regardless of what they are suppressing (Yoshino, 2006). Masking may temporarily reduce prototype mismatch, but it does so at the expense of authenticity, energy, and the conditions that leader identity development requires (Day & Harrison, 2007; Epitropaki & Martin, 2004; Parr et al., 2013).

PSYCHOLOGICAL CAPITAL

Psychological capital (PsyCap) encompasses four related dimensions: hope, efficacy, resilience, and optimism (Luthans et al., 2007). It has been linked to both subjective work outcomes, such as job satisfaction and engagement, and objective performance outcomes, such as sales performance, making it a practically significant resource for leaders at all levels (Avey et al., 2011; Luthans & Youssef-Morgan, 2017). Importantly, like self-efficacy, PsyCap is state-based rather than a fixed trait. It can be built through intentional development experiences, coaching, and stretch assignments (Luthans et al., 2007; Pitichat et al., 2018). While leader identity and LSE describe how people see themselves in relation to leadership, PsyCap captures the motivational and emotional reserves they draw on when leading is difficult. Leadership development depends on the resources that PsyCap provides (Pitichat et al., 2018).

Chronic masking, exclusion, and the sustained cognitive load of working in environments not designed for one's cognitive style deplete PsyCap over time (Hobfoll et al., 2018; McDowall & Doyle, 2024). For neurodivergent leaders, these demands are often continuous. When PsyCap reserves are drawn down, leaders become less able to persevere through challenges, maintain optimism, and engage actively in their own development. This increases the risk that its effects extend into non-work domains.

HUMAN FLOURISHING

Human flourishing provides a broader understanding of whether neurodivergent leaders are thriving across multiple dimensions of life beyond work. The Flourish Index, developed by VanderWeele (2017), encompasses happiness, health, meaning and purpose, character, and relationships as interconnected dimensions of wellbeing. Adding a sixth dimension, financial security, produces the Secure Flourish Index, which we also included in this study. These have been validated in workplace settings, where flourishing is associated with higher job satisfaction, stronger work engagement, and more positive affect (Weziak-Bialowolska et al., 2019).

Flourishing represents the standard against which organizational culture should ultimately be measured. Whether people are well is a critical dimension of organizational success beyond productivity (Tay et al., 2023). We included flourishing as an outcome in this study because it captures a dimension of the neurodivergent leadership experience that self-view measures alone do not. Flourishing serves as a contextual outcome in this study, with a dedicated follow-up study examining underlying mechanisms in greater depth.

At present, researchers, mental health practitioners, and the neurodivergent community disagree about the neurodivergent experience (Dwyer et al., 2025; Layinka et al., 2024). The five constructs above can be helpful when exploring differences among neurodiverse leader groups. Limited existing research with other underestimated groups suggests that neurodivergent people may score lower on these constructs than neurotypical people do (Emira et al., 2018; Luria et al., 2014). Though it may be tempting to attribute scores to personal strengths or shortcomings, context and culture play a substantial role in shaping people's feelings and perceptions (Doyle, 2020; Roberson et al., 2021).

METHODS

Participants and Recruitment

Participants were recruited from two primary sources: Prolific and social media. Prolific is a research recruitment platform widely used in behavioral and organizational science that provides access to a large, diverse pool of prescreened participants and has demonstrated strong data quality relative to other online recruitment methods (Palan & Schitter, 2018; Peer

et al., 2022). We included a social media sample for two reasons. First, social media platforms have become a primary space where neurodivergent people share experiences, shape discourse, and develop shared frameworks for understanding their own identities (Skafle et al., 2024). Recruiting from these communities provided access to individuals actively engaged in neurodivergent discourse regardless of platform. Second, social media recruitment allowed us to reach participants across a broader range of countries than Prolific alone could provide.

In Prolific, we targeted adults (age 18+) residing in the United States or United Kingdom who reported having held a management role at some point in their careers. We implemented screening criteria to recruit a sample broadly representative of the working adult population in each country based on available census data. Though we originally sought a more globally representative sample, insufficient participant pools in other countries led us to narrow our focus. Participants recruited via social media were required only to be at least 18 years of age.

Given that research on neurodivergent leaders to date is primarily conceptual or qualitative in nature, we oversampled neurodivergent leaders to allow for subgroup comparisons, with a neurotypical group included as a reference point. We conducted multiple rounds of data collection across participant sources to achieve roughly balanced samples across groups. Participants were assigned to one of four mutually exclusive neurodivergent identity groups based on their self-reported condition profile, as sampling across all neurodivergent conditions was not feasible given group sizes required for comparison. Autism, ADHD, and dyslexia were categorized separately due to their prevalence, distinctiveness, and representation in the broader neurodiversity research. Throughout the remainder of the paper, we use ND as an abbreviation for neurodivergent and NT for neurotypical.

The fourth group was AuDHD, which was comprised of people with both autism and ADHD. Although AuDHD is not a clinically recognized term in the DSM-5-TR, there is considerable comorbidity between these conditions and growing community attention to the experiential uniqueness of this population (Hours et al., 2022). We therefore included AuDHD as a separate group to examine whether the combined profile produces a unique leader experience. Respondents who identified as neurodivergent but did not match one of these mutually exclusive categories (e.g., dyspraxia, schizophrenia, OCD) were included in the "Other ND" group.

Our final sample consisted of 416 participants. The survey included two embedded instructed response items as validity checks. Individuals who failed both were excluded from the study (n = 2). Nearly all participants (98.1%, n = 408) held at least one leadership role at some point. Three-quarters were currently in a leadership role of some kind (75.7%, n = 315), including those in formal roles, such as management positions (56.5%, n = 235), and informal roles, such as mentoring (30.5%, n = 127). An additional 22.4% (n = 93) held a past leadership role, and only 8 participants (1.9%) reported never having held a leadership position. The sample skewed female and majority White, with participants roughly evenly split between the United States and United Kingdom. The mean age was 42.5 years (SD = 11.0). A full demographic breakdown is provided in Table 1, and additional demographics are given in Appendix B Table B1.

TABLE 1.

Sample Demographic Characteristics (N = 416)

	n	%
Neurodivergent Identity Group		
ADHD	137	32.9
Neurotypical (NT)	82	19.7
Autistic	53	12.7
AuDHD	46	11.1
Dyslexic	42	10.1
Other ND	36	8.7
Unknown	20	4.8
Gender		
Woman	254	61.1
Man	134	32.2
Non-binary	11	2.6
Not reported	16	3.8
Race/Ethnicity		
White	281	67.5
Multiracial/Other	54	13.0
Black	34	8.2
Asian	28	6.7
Latine	19	4.6
Country		
United States	188	45.2
United Kingdom	172	41.3
Other	40	9.6
Not reported	16	3.8
Generation (n = 395)		
Silent/Boomer (born ≤ 1964)	28	7.1
Gen X (1965–1980)	120	30.4
Millennial (1981–1996)	216	54.7
Gen Z (born ≥ 1997)	31	7.8
Leadership Role Status		
Any current leadership role	315	75.7
Current formal role	235	56.5
Current informal role	127	30.5
Past role only	93	22.4

Note. Response counts and percentages are shown for each category. Leadership role status categories are non-exclusive; participants may hold both formal and informal roles simultaneously. n values reflect the number of participants selecting each response option. Percentages are calculated within each section using the relevant denominator. Generation *n* = 395 (4 participants excluded due to implausible age/diagnosis combinations; 17 missing birth year). Mean age = 42.5 years (*SD* = 11.0). Mean age at first ND diagnosis = 27.1 years (*SD* = 14.0; ND participants only, *n* = 314).

Consistent with our sampling strategy, most participants identified as neurodivergent (75.5%, *n* = 314), with the remaining 19.7% (*n* = 82) identifying as neurotypical. Twenty respondents could not be classified because of incomplete response data and were excluded from all group comparisons. Despite our intent to achieve approximately equal group sizes, ADHD respondents were relatively overrepresented, particularly via social media. Autistic, AuDHD, and dyslexic respondents represented smaller but relatively similar proportions of the sample. An additional 8.7% were placed in the Other ND group, reporting neurodivergent conditions or condition combinations not captured by the primary groupings (e.g., dyspraxia, dyscalculia, OCD, co-occurring dyslexia and autism).

Measures

Six primary measures assessed self-views of leadership, wellbeing, and masking. Leadership and work-related constructs consisted of LSE, leader identity, leader experience, and psychological capital. Human flourishing was used to assess wellbeing. Two items developed for this study measured masking at work. Unless otherwise noted, items from each measure were averaged to produce composite scores in accordance with scale validation guidelines.

Leader identity was measured using the descriptiveness and importance subscales from Hiller's (2005) Leader Self-Identity instrument. Both subscales consist of the same four items (e.g., "I see myself as a leader") but differ in their framing. The descriptiveness subscale asks participants how well each item describes them, whereas the importance subscale asks how important each item is to their sense of self. Items were rated on a 7-point scale and combined into a single composite identity score. This scale was highly reliable overall (α = .93) within both the neurodivergent (α = .93) and neurotypical (α = .88) subsamples.

We measured LSE using the Youth Leader Self-Efficacy Instrument, a 5-item scale assessing confidence in carrying out leadership tasks and roles (e.g., "I know how to be a leader"; Rehm & Selznick, 2019). Although this scale was originally developed for use with middle school students, we chose it because of its brevity, its prior use in CCL research, and its use of items drawn from established adult LSE constructs (Bandura, 1977; Hannah et al., 2008). This scale had adequate reliability in our sample (overall: α = .75; ND: α = .76; NT: α = .69).

We included Hiller's (2005) Quantity of Experience subscale from the Experiences as a Leader scale, which consists of four items asking about frequency of leadership emergence and participation (e.g., "How often do others look to you for leadership?" "How often are you involved in leadership, formally or informally?"). Items were rated on a 5-point scale ranging from *Never* to *Nearly All the Time*. This measure was reliable across both neurotypes (overall: α = .87; ND: α = .88; NT: α = .78). Throughout this paper, we refer to this measure as "leader experience."

Psychological capital was assessed using the PCQ-5, a validated 5-item abbreviated form of the Psychological Capital Questionnaire (Szerdahelyi et al., 2024). Items measure hope, efficacy, resilience, and optimism in relation to work and leadership (e.g., "I can think of many ways to reach my current work goals," "Right now I see myself as being pretty successful at work"). Items were rated on a 6-point scale ranging from *Strongly Disagree* to *Strongly Agree*. The PCQ-5 has strong convergent validity with the full 24-item measure across four international samples. Internal consistency was strong in our sample (overall: α = .86; ND: α = .87; NT: α = .76).

We used a 12-item scale, including the Flourish Index (FI) and Secure Flourish Index (SFI), to measure wellbeing (VanderWeele, 2017). The FI consists of 10 items that capture five dimensions: happiness and life satisfaction, mental and physical health, meaning and purpose, character and virtue, and close social relationships. The SFI adds two items on financial and material security. All items are rated on a 0-10 scale. For this study, the 10 FI items were averaged to produce a human flourishing composite score (overall: α = .88; ND: α = .87; NT: α = .87), and the two SFI items were averaged as a separate secure flourishing composite (overall: α = .83; ND: α = .82; NT: α = .81).

Two single items developed for this study captured masking behavior at work. Although commonly used in neurodivergent contexts, masking and camouflaging are not behaviors exclusive to neurodivergent individuals, so these items were administered to all participants. The first item assessed masking frequency ("How often do you mask or camouflage at work?"), and the second assessed masking pressure ("How often do you feel pressure to mask or camouflage at work?").

To ensure shared understanding across participants, we provided the following definition: "Masking is the conscious or unconscious effort to suppress or hide traits or behaviors to conform to societal expectations and norms. Camouflaging is a set of strategies that involves masking, plus behaviors aimed at fitting into societal contexts. People may engage in masking or camouflaging to cover a part of their identity that may be viewed as less socially acceptable." Both items were rated on a 5-point scale, ranging from *Never* to *Multiple times per day*. The two items were positively correlated in our sample (r = .85). Because each item constitutes a single-item measure, internal consistency statistics are not applicable.

Analytic Approach

To reduce individual survey length while capturing data across all measures, we used a planned missing data design (Enders, 2010) in which participants were randomly assigned to subsets of measures within their neurodivergent identity group. To address this planned missing data, we used multiple imputation, a statistical technique that generates multiple complete versions of the dataset and combines results across them to produce stable, reliable estimates (Schafer & Graham, 2002). This approach allowed us to analyze data uniformly across all planned comparisons.

We compared neurodivergent and neurotypical leaders across all primary outcomes, then examined how patterns differed across ND identity groups. The Other ND group was included in broader ND versus NT comparisons but

excluded from ND subgroup analyses because of small group size. Statistical corrections were applied throughout to account for the number of comparisons made. Alongside significance tests, we report effect sizes to convey whether differences exist and how large they are in practical terms: small (d = 0.20 to 0.49), medium (d = 0.50 to 0.79), and large (d = 0.80 and above; Cohen, 1988). For full methodological details, including software, pooling procedures, and demographic analyses, see Appendix A.

We did not conduct multivariate analyses to control for demographic differences because of small subgroup sizes. However, our sampling method allowed us to recruit relatively balanced subgroups based on the demographic information available. The composition of the sample itself reduces concerns about confounding characteristics, but this is a limitation of the study.

We also note that the psychological capital scale includes an efficacy-related item. While conceptually related, LSE is domain-specific, focused on leadership, whereas PsyCap is focused on broader work-related motivational resources. This conceptual overlap should be considered when comparing the two scales in terms of correlations as well as parallel analyses across these scales.

RESULTS

Diagnosis and Disclosure Patterns

Neurodivergent participants were asked to select their conditions, specify whether each was formally or self-diagnosed, and report their age at first diagnosis. Formal diagnosis may be inaccessible owing to cost, availability, or systemic barriers, among other reasons. We accepted self-diagnosis as a valid indicator of neurodivergence, consistent with growing recognition of its legitimacy in research and community contexts (Newton et al., 2025). Across groups, nearly one-third of participants had no formal diagnosis (n = 91, 29%). Dyslexic (70.5%) and ADHD participants (60.3%) reported the highest levels of formal diagnosis. Among autistic participants, approximately half were formally diagnosed (48.6%) and half were self-identified (51.4%). For AuDHD participants, their ADHD (56.5%) was more often formally diagnosed than their autism (42.2%). The full range of diagnosis descriptives is reported in Appendix B Table B2.

Age of first diagnosis signifies the earliest condition identified rather than all conditions someone may have. Across groups, age of first diagnosis was significantly related to neurodivergent condition (M = 27.1, p = .045). More than two-thirds (68.4%) of all participants were first diagnosed after age 18, 40% after age 30, and 16% after age 40. Dyslexic participants had the youngest average diagnosis age (M = 19.2) and were significantly more likely to be diagnosed earlier than were ADHD (M = 27.8, p = .001), AuDHD (M = 29.9, p = .002), and autistic (M = 31.3, p < .001) participants. At least 75% of ADHD, AuDHD, and autistic participants reported an initial diagnosis after age 18 compared to only 38% of dyslexic participants diagnosed as adults.

On average, women (M = 29.2) were significantly more likely to be diagnosed later than were men (M = 24.3; p = .005). This difference also varied by condition (p = .016), driven by differences among dyslexic (p = .03) and ADHD (p = .005) participants among which women were diagnosed approximately 7 and 9 years later, respectively, than men were. Additionally, age of first diagnosis is strongly negatively correlated with birth year (r = −.55, p < .001, R^2 = .30), indicating that overall age of diagnosis is decreasing. These trends suggest that many leaders who now occupy mid-to-senior leadership positions, and women in particular, spent their formative professional years without recognition of or support for their condition.

Beyond when participants came to understand themselves as neurodivergent, the data also reveal how openly they share that identity at work. Disclosure rates among neurodivergent participants indicate that ND identity is shared selectively and unevenly across organizational relationships. Disclosure to managers (42.4%) and to no one (41.1%) were the most common responses, followed by team members (38.9%). Only 18.8% had disclosed to HR. When asked whether they knew of other neurodivergent people at work, 60.3% of participants said yes. Among those, the most commonly reported relationships were with neurodivergent peers (70.1%), clients or customers (46.9%), and direct reports (36.1%), with far fewer reporting neurodivergent managers (22.4%) or senior organizational leaders (21.8%). These diagnosis and disclosure patterns shape the context in which neurodivergent leaders develop, operate, and are compared to neurotypical peers in the analyses that follow.

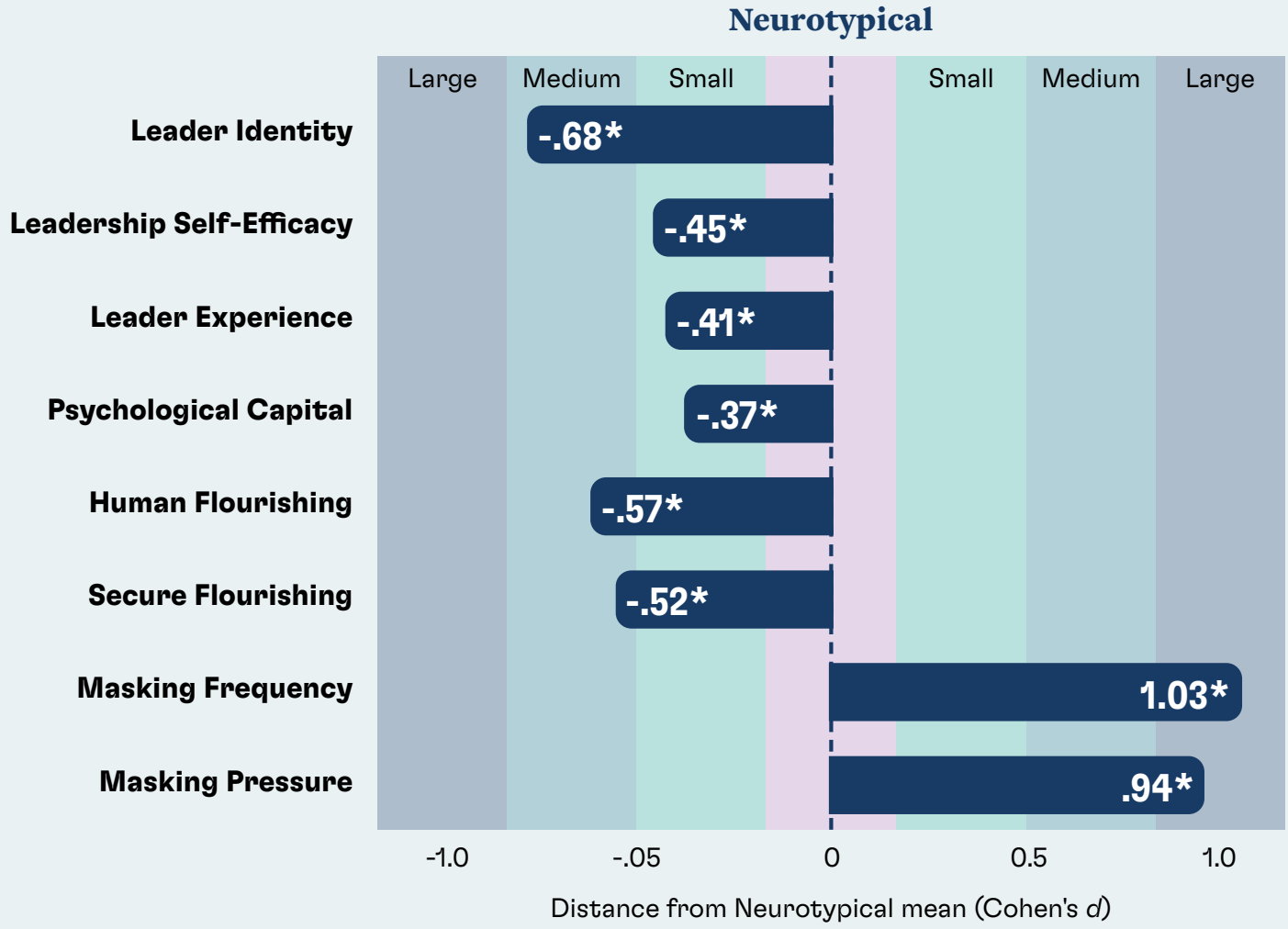
Neurodivergent and Neurotypical Leader Comparisons

To establish a baseline, we first compared neurodivergent and neurotypical leaders across three domains: leadership self-views, wellbeing, and masking. Neurodivergent and neurotypical leaders differed significantly on all outcomes. Across every self-view and wellbeing measure, neurodivergent leaders scored lower than their neurotypical peers, whereas masking scores were significantly higher. Given that 98% of all participants had at least one leadership role, the findings described herein represent how leadership is internalized rather than simply who has been a leader.

Neurodivergent leaders reported lower leader identity (d = −0.68, medium), leadership self-efficacy (d = −0.45, small), and leader experience (d = −0.41, small) than neurotypical leaders (see Figure 3). In other words, they expressed less confidence in their leadership abilities, had less frequent leadership experiences, and were less likely to view leadership as central to who they are. Psychological capital was similarly lower among neurodivergent leaders (d = −0.37, small), demonstrating that the self-view gaps are accompanied by reduced psychological resources needed to address them.

FIGURE 3.

Neurodivergent vs. Neurotypical Comparisons Across Self-Views, Well-Being, and Masking: Distance from Neurotypical Mean



Note. Values shown are pooled Cohen's d effect sizes comparing neurodivergent (ND) and neurotypical (NT) leaders, with NT as the reference group (d = 0). Negative values indicate ND leaders scored lower than NT leaders and positive values indicate ND leaders scored higher. All comparisons were statistically significant after Holm-Bonferroni correction (p < .05) and are displayed with an asterisk (*). Effect size magnitude follows Cohen (1988) conventions: small = .20-.49, medium = .50-.79, large ≥ .80.

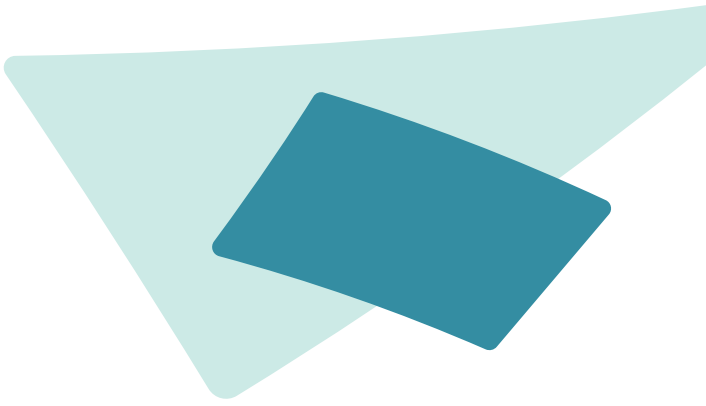
Neurodivergent leaders also had lower scores on flourishing (d = −0.57, medium) and secure flourishing (d = −0.52, medium) than neurotypical leaders, indicating disparities that extend beyond self-perceptions of leadership into daily life. Relative to neurotypical leaders, neurodivergent leaders reported lower happiness, poorer health, less satisfaction in their relationships, a reduced sense of purpose, and greater concern about meeting their basic needs. Flourishing was significantly positively correlated with all leadership self-view measures and psychological capital, revealing a tightly linked set of outcomes that was present only among neurodivergent participants. Neurotypical leaders did not show these same relationships, suggesting that the interdependence of leadership self-views and wellbeing is more characteristic of the neurodivergent experience (see Appendix B Figure B1).

Masking produced the largest effects observed, with neurodivergent leaders reporting significantly higher masking frequency (d = 1.03, large) and masking pressure (d = 0.94, large) than neurotypical leaders. Both measures of masking were significantly negatively correlated with psychological capital and human flourishing for neurodivergent leaders but not neurotypical ones. In this sample, masking was a routine and pervasive feature of neurodivergent leaders' work lives, and the pressure to mask was felt as acutely as the frequency with which it occurred. These findings suggest that the deficits in self-views and wellbeing unfold within the context of a routine, daily demand to suppress core aspects of their identity at work. Full results, including means, standard deviations, and statistical details for all outcomes, are provided in Appendix B Table B3.

Neurodivergent Subgroup Comparisons

Neurodivergence encompasses a wide range of experiences. Within our neurodivergent sample, we compared each primary group against one another and the neurotypical baseline across the same constructs. Among the groups in our sample, 29 of 80 pairwise comparisons were statistically significant after correction. The profiles that emerged were distinct, coherent, and theoretically relevant.

Autistic leaders showed the most pronounced self-view gaps of any group, scoring significantly lower than neurotypical leaders on all four outcomes. The largest single effect in these results was the autistic versus neurotypical comparison on leader identity (d = −1.07, large), whereas autistic leaders were the only group to differ significantly from neurotypical leaders on self-efficacy (d = −0.90, large). AuDHD leaders also showed large effects on leader identity (d = −0.86, large) and reported lower psychological capital than neurotypical leaders (d = −0.61, medium). Dyslexic leaders reported lower leader identity (d = −0.63, medium) and leader experience (d = −0.65, medium) than neurotypical leaders. ADHD leaders differed from neurotypical leaders on identity only (d = −0.62, medium), though they also reported significantly higher leader experience than autistic leaders (d = 0.49, small), which is the only significant difference between ND groups.



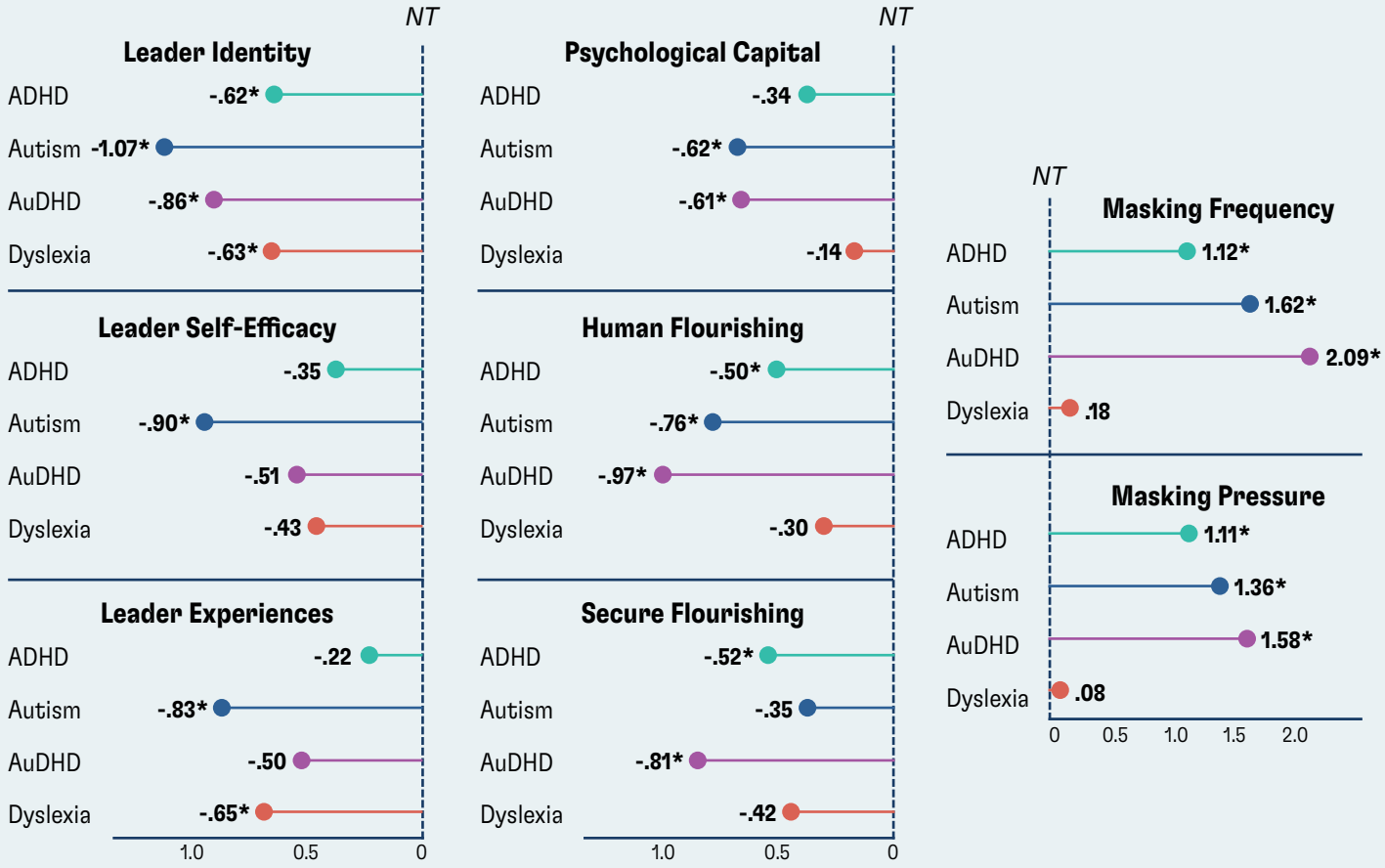
AuDHD leaders had the lowest wellbeing scores and largest effects of any neurodivergent group, scoring significantly lower than neurotypical leaders on flourishing (d = −0.97, large) and secure flourishing (d = −0.81, large). Their secure flourishing scores were also significantly lower than those of dyslexic leaders (d = −0.69, medium), which was the only significant difference among ND groups on wellbeing outcomes. Relative to neurotypical leaders, ADHD leaders scored significantly lower on both flourishing (d = −0.50, small) and secure flourishing (d = −0.52, medium), whereas autistic leaders scored significantly lower on flourishing (d = −0.76, medium) but not secure flourishing (d = −0.35, small. Dyslexic leaders did not differ significantly from neurotypical leaders on either flourishing outcome.

A clear and consistent masking hierarchy emerged across all groups. AuDHD leaders reported the highest masking frequency (d = 2.09, large) and pressure (d = 1.58, large) of any group. Autistic leaders also reported significantly greater masking frequency (d = 1.62, large) and pressure (d = 1.36, large) compared with neurotypical leaders, as did ADHD leaders (frequency d = 1.12, large; pressure d = 1.11, large). ADHD leaders who did not have a co-occurring autism diagnosis reported masking significantly less often than AuDHD leaders (d = −0.57, medium). No significant differences on masking pressure emerged among these groups.

Dyslexic leaders were the only neurodivergent group that did not differ from neurotypical leaders on masking; consequently, they scored significantly lower than the other three ND groups on both masking measures. Social communication and attention regulation differences appear to drive masking demands more than language processing differences do, and these demands compound when both are present. Figure 4 shows the full masking results, and the full pairwise results are in Appendix B Table B4.

FIGURE 4.

Self-Views, Well-Being, and Masking by Neurodivergent Identity Group: Distance from Neurotypical (NT) Mean



Note. Values shown are pooled Cohen's d effect sizes for each neurodivergent identity group compared to neurotypical leaders (NT; $d = 0$, reference line). Negative values indicate the ND group scored lower than NT leaders and positive values indicate the ND group scored higher than NT leaders (masking panels only). Asterisks (*) denote comparisons that were statistically significant after Holm-Bonferroni correction ($p < .05$). Non-significant comparisons are included for completeness. Effect size magnitude follows Cohen (1988) conventions: small = .20-.49, medium = .50-.79, large ≥ .80. N: Autistic = 53, AuDHD = 46, ADHD = 137, Dyslexic = 42, NT = 82 (reference group).

STUDY 2 DISCUSSION

Neurodivergent leaders scored lower than neurotypical peers on every leadership self-view and wellbeing measure while scoring substantially higher on masking. The size of the masking effects, which was the largest of all outcomes, deserves particular attention. Masking was negatively correlated with both psychological capital and flourishing among neurodivergent leaders, which suggests it functions as a symptom of prototype mismatch and as a driver of broader resource depletion, though our methodology cannot confirm a causal effect.

Subgroup analyses revealed that the specific nature of one's neurodivergence affected outcomes as much as neurodivergent status itself. Each group produced a unique profile, shaped by how each condition manifests. The diagnostic and disclosure findings add further context for interpreting these results. Most participants entered and advanced through their careers before receiving a diagnosis, and the majority still did not disclose their neurodivergence to those with the most organizational influence over their development. Years of unrecognized masking, limited affirming feedback, and environments calibrated to neurotypical norms may help explain the differences we observed in how these leaders view themselves and experience flourishing.

General Discussion

Taken together, these two studies establish the absence of a research foundation and begin to lay that foundation. The bibliometric analysis in Study 1 confirms that neurodivergent leadership is almost entirely absent from the published research. The results from Study 2 offer an initial picture of how neurodivergent leaders experience their own leadership and wellbeing, how those experiences compare to neurotypical leaders and to each other, and how they use masking and disclosure to manage their presentation at work.

To date, the empirical literature on neurodivergent leaders remains extremely limited. Study 1 establishes the existence and concentration of this void. The field produced fewer than 30 relevant articles over analyses conducted nearly 2 years apart. Existing research clusters around neurodivergent employees rather than leaders, and autism receives disproportionate attention relative to other conditions. The intersection of leadership, neurodiversity, and organizational psychology offers ample opportunities for replication and extension. The subgroup differences documented in Study 2 suggest those efforts will need to be condition-specific rather than treating neurodivergence as a single category.

Alongside these opportunities are two general challenges. The first is that neurodivergence is an umbrella term representing many different experiences of many different conditions, some of which are clinical diagnoses (e.g., autism, dyslexia) and others that are not (e.g., AuDHD, twice-exceptional, sensory processing disorder). Findings for any given neurodivergent group should be interpreted within their specific context, and researchers should avoid extending findings from one group to the broader neurodivergent population.

The second challenge is that individual neurodivergent conditions generally have low prevalence. Though it is estimated that 1 in 5 people are neurodivergent, each individual condition represents a much smaller share of the population. As Study 2 demonstrated, balanced recruitment and subgroup analyses quickly reduce sample sizes to suboptimal levels. These challenges are inherent to research in nascent areas with low-prevalence populations, and acknowledging the constraints they create is essential to advancing research in this area with appropriate credibility.

With these constraints in mind, Study 2 offers early empirical insight into the leadership experiences of neurodivergent people. Compared with neurotypical peers, neurodivergent leaders reported lower self-views of leadership, fewer leadership experiences, lower wellbeing, and more frequent masking. Variation also emerged across neurodivergent subgroups, with profiles shaped by the specific nature of each group's neurological differences.

Because nearly all participants had held at least one leadership role, these outcomes are unlikely to reflect only whether participants have ever led. Differences in the amount and depth of leadership experience remain a plausible contributing factor. Reported rates of experience indicate that certain groups had fewer opportunities to lead, which was directly related to internalized leadership views. We assert that these findings point to a mismatch between how neurodivergent leaders present and prevailing leadership prototypes that are embedded in society and organizational cultures. Neurodivergent leaders working in environments built around neurotypical leader prototypes may encounter suppressed leader identity development, limited access to mastery experiences, depleted psychological resources, and reduced overall wellbeing.

LEADERSHIP SELF-VIEWS

Neurodivergent leaders in this sample reported participating in leadership less often than neurotypical peers, which was directly related to lower leader identity and leadership self-efficacy. Autistic leaders showed the most pronounced differences of any group on all self-view measures. All participants also reported less awareness of neurodivergent people in senior leadership positions at work. These outcomes are consistent with what prototype mismatch theory and signaling theory would predict. Leader identity and self-efficacy are built through accumulated experience, but two of the key mechanisms through which they develop depend heavily on recognition in addition to individual capability: receiving affirming feedback from others and observing similar others succeed (Bandura, 1977; Day & Harrison, 2007; Lord & Hall, 2005).

Research points to recognition rather than ability as the primary barrier. If dominant leadership prototypes reflect neurotypical behavioral norms, neurodivergent leaders are less likely to receive the granting behaviors that confirm their leadership regardless of performance (Schimmelpfennig et al., 2026). Over time, the absence of sustained granting, affirming feedback, and visible role models makes it harder to claim a stable sense of leadership identity or build confidence in one's leadership capabilities. Neurodivergent leaders whose authentic cognitive and behavioral styles are welcomed can gain access to the experiences and recognition that build a stable leader identity (Loignon et al., 2026; Lord & Hall, 2005).

Experiencing a mismatch between their natural presentation and prototype expectations may drive neurodivergent leaders to mask more. Although masking may temporarily increase the likelihood of being recognized as leaders, it does so at the expense of psychological resources that support leadership.

MASKING

Masking involves effortful, subconscious suppression or concealment of traits and behaviors to conform to social expectations (Johnson James et al., 2025; Kidwell et al., 2023; Pryke-Hobbes et al., 2023). Masking research has developed predominantly around autistic camouflaging, and existing measures and frameworks share that focus (Hull et al., 2019; van der Putten et al., 2024). Our findings extend this work across a broader neurodivergent sample. Neurodivergent leaders reported masking nearly every day on average, significantly more than neurotypical leaders. Dyslexic leaders did not differ from neurotypical leaders, whereas autistic and ADHD leaders masked significantly more. AuDHD leaders reported the highest masking frequency and pressure of any group. This variation between groups reflects differences in how each condition is expressed behaviorally.

For dyslexic leaders, differences involve internal language processing rather than visible behavioral divergence from the leader prototype. In most work contexts, these differences may be less likely to trigger the social presentation demands that drive masking or may not be viewed as masking by these respondents. For ADHD leaders, masking may involve effortful regulation of attention and physical restlessness in settings that require sustained stillness and focus (van der Putten et al., 2024). For autistic leaders, masking may involve consciously producing expected facial expressions, managing sensory responses, or suppressing communication styles that diverge from neurotypical norms (Hull et al., 2019). AuDHD leaders navigate combinations of these demands simultaneously (Hours et al., 2022). These examples are illustrative rather than exhaustive, and the full range of masked behaviors across neurodivergent conditions deserves dedicated future research.

Ultimately, masking requires considerable energy, which diverts cognitive and psychological resources away from leadership itself (Hobfoll et al., 2018). In our sample, masking was significantly negatively correlated with psychological capital and human flourishing. The act of masking itself carries these costs, regardless of whether it succeeds. When masking is unsuccessful, neurodivergent leaders may face social penalties or negative professional consequences because they failed to meet prototype expectations (Epitropaki & Martin, 2004; Pryke-Hobbes et al., 2023). When masking is successful, those consequences may be avoided, but the behavior and expectation are reinforced, making it harder to disengage from the costly strategy. Either way, the sustained demand to suppress authentic behavior creates conditions that make it harder to lead effectively (Epitropaki & Martin, 2004), authentically (Parr et al., 2013), and sustainably (Hobfoll et al., 2018).

PSYCHOLOGICAL CAPITAL AND HUMAN FLOURISHING

Neurodivergent leaders reported lower psychological capital and lower human flourishing than neurotypical peers. The greatest differences on both measures were among autistic and AuDHD leaders, consistent with their reports of greater masking frequency and pressure than other groups. Based on the methods used in our study, we cannot say whether masking causes lower psychological capital and flourishing, or whether all three are co-occurring outcomes of the neurodivergent experience in neurotypical work environments.

In practice, leaders' lower psychological capital is associated with reduced job satisfaction, lower work engagement, higher stress, and diminished job performance (Avey et al., 2011; Pitichat et al., 2018). Research also shows sustained depletion of PsyCap is likely to contribute to broader declines in general wellbeing (Avey et al., 2010, 2011). These dynamics were present among neurodivergent people in our study. For neurotypical leaders, leader identity and flourishing were not linked to PsyCap. For neurodivergent leaders already contending with prototype mismatch and elevated masking demands, lower PsyCap represents a cascading disadvantage. The resources most needed to push through leadership challenges, maintain optimism, and engage actively in development are precisely those most at risk of depletion.

Flourishing scores in our study are consistent with large-scale evidence documenting persistently low wellbeing among neurodivergent workers (McDowall & Doyle, 2024). It is also worth noting that lower flourishing scores have been documented more broadly among women and UK residents (VanderWeele et al., 2025), two groups that comprised a larger portion of our sample. Given the relationship between human flourishing and work outcomes (Weziak-Bialowolska et al., 2019), the differences documented here carry statistical and practical significance.

McDowall et al. (2025) propose that wellbeing is a "vulnerable capability" for neurodivergent employees in that they can only leverage their strengths when a sufficient wellbeing baseline has been met (p. 1219). This positions wellbeing as a prerequisite for effective leadership development rather than a downstream outcome of it. Our findings support this based on the interdependence between leadership self-views and wellbeing, which was present only among neurodivergent respondents. Understanding what needs to occur for neurodivergent leaders to attain and sustain greater wellbeing is therefore a pressing research priority and the focus of planned follow-up work.

THE VISIBILITY FACTOR

Neurotypical leaders and colleagues tend to underestimate the full neurodivergent experience at work, including both its challenges and strengths, particularly those concealed by masking (McDowall & Doyle, 2024). This is explained, in part, by what has been labeled the "double empathy problem," a bidirectional breakdown in communication that arises when people with different neurotypes attempt to interact, reframing what is often attributed to neurodivergent deficits as a mutual challenge in understanding (Milton, 2012). Although most research on this concept has focused on autistic people, the dynamic it describes is relevant across neurodivergent experiences.

Most neurodivergent leaders in our study were diagnosed in adulthood, which likely reflects expanding diagnostic criteria, greater clinical awareness, and growing community-driven self-identification (Doyle, 2020; Newton et al.,

2025). They also disclosed to their manager or to no one, with very few reporting anything to HR. For leaders diagnosed mid-career or later, neurodivergence may still be a relatively new self-concept. Many are also still gaining awareness of previously ingrained masking behaviors and their cumulative toll and so may not yet know what accommodations would help them even if they felt safe disclosing.

The visibility of neurodivergent leaders in senior roles is relevant beyond simple representation. Without recognized neurodivergent leaders in senior positions, emerging neurodivergent professionals lack the models needed to anchor their own leader identity development and self-views, including efficacy, motivation, and sense of possibility (Bandura, 1977; Day & Harrison, 2007; Lord & Hall, 2005). This makes neurodivergent leaders in prominent positions symbolically important and developmentally consequential.

Leaders in our sample reported working with neurodivergent senior leaders less often than with peers, managers, and even clients or customers. This is consistent with the combined effects of higher masking, lower disclosure rates, and generational underdiagnosis described above. The pressures to conform to leader prototypes intensify with seniority. If neurodivergent leaders in those roles are absent, unaware of their condition, or hiding their identity, aspiring neurodivergent leaders have fewer grounds for believing leadership is available to them or imagining what their own futures in leadership could look like.

HETEROGENEITY AND INTERSECTIONALITY

Neurodivergent people are not a homogeneous group, and this is as true within diagnostic categories as it is across them. Our findings reinforce the necessity of treating subgroups and individuals as distinct rather than interchangeable both in research design and in organizational practice. Neurodivergent leaders should also not be typecast into specific roles or fields based on diagnostic stereotypes, a practice that risks reinforcing exclusion in a new form (Praslova et al., 2023).

The compounded profile for AuDHD leaders offers the clearest example of this mechanism. Co-occurring autism and ADHD intensifies both the masking burden and the wellbeing deficit in ways that neither condition alone predicts (Hours et al., 2022). Our findings offer early empirical evidence of a unique experience, supporting the broader community assertions that AuDHD needs more formal research as a neurotype in and of itself.

For individuals whose identities intersect with neurodivergence in multiple ways, the combined effects are beginning to be documented (Gottardello et al., 2025). Race and gender are two particularly important dimensions. The diagnostic criteria for neurodivergent conditions were developed from samples that skewed male and White, leaving many individuals systematically underrepresented in the clinical research that shaped how these conditions were defined and later applied (Calvard et al., 2026; Gottardello et al., 2025; Kooij et al., 2025).

In women and girls, ADHD and autism present differently, and symptoms have been misattributed to anxiety, depression, bipolar disorder, or borderline personality disorder (Kooij et al., 2025). As a result, neurodivergent traits in women may go unrecognized for years, concealed

by compensatory behaviors and positive performance. As hormonal changes associated with pregnancy, perimenopause, and menopause reduce the capacity to suppress natural neurological tendencies, symptoms become more apparent, prompting diagnosis at the precise career stage when leadership development is most consequential (Brady et al., 2024; Kooij et al., 2025; Moseley et al., 2020).

The intersectional nature of neurodivergent experience means that all analyses that treat neurodivergent identity as a single variable risk missing variation in the data that is essential for accessible leadership development (Calvard et al., 2026; Gottardello et al., 2025). Underdiagnosis among people with other underestimated identities has direct consequences, shaping who gets identified, supported, and developed as a leader. Awareness of belonging to stigmatized or underestimated groups can increase the risk of stereotype threat, which can suppress confidence and self-perception even among high performers (Steele & Aronson, 1995). Intersectional analyses are beyond the scope of this study and have been addressed in our limitations.

FRAMING NEURODIVERGENT LEADERSHIP

The diversity across and within neurodivergent groups exposes a tension in how neurodivergent leadership is framed and where the dominant narratives lean toward either deficit or superpower, yet neither reflects lived neurodivergent experience. **Labeling neurodivergence as a superpower can imply that systemic issues do not need to be addressed and places unfair expectations on neurodivergent people to perform exceptionalism as the price of inclusion.** Though this narrative is typically well-intentioned, neurodivergence is better understood as something called a "spiky profile," where people have areas in which they excel alongside areas in which they have legitimate, and sometimes severe, challenges (Doyle, 2020).

Despite common misperceptions that neurodivergent people lack interpersonal skills, are limited to particular domains, or are less effective in leadership roles, available evidence suggests something else (Emira et al., 2018; Praslova, 2021). Neurodivergent workers and leaders perform on par with, and even above, their neurotypical peers when given appropriate systems and support (Austin & Pisano, 2017; Emira et al., 2018).

What Neurodivergent Leaders Bring

- Strong personal values and a deep sense of fairness
- Pattern recognition and systems thinking
- Critical thinking and advocacy for others
- Resilience and tenacity
- Vision and creative problem-solving
- Unique insight into cognitive diversity as coaches and mentors

Some neurodivergent individuals also have higher support needs, and their experiences and perspectives are no less valuable because of them. Leadership takes many forms, and the contributions of people across the full spectrum of neurodivergence, including those who need more support to participate, deserve recognition. In some cases, systemic change alone is not enough and more personalized approaches may be necessary. Regardless, measuring neurodivergent leaders by their organizational returns misses the point. **They deserve environments where they can grow, receive support, face difficulties, and lead.**

Implications for Practice

The gaps documented in this paper are likely shaped by environments, but so are the solutions. The same systems, norms, and development structures that reinforce these gaps can be redesigned to close them, and the practical implications of doing so are addressed in this section. Formal accommodations are important, but recent research shows that the relational qualities of one's workplace matter even more. Psychosocial factors, such as psychological safety and manager support, account for better outcomes beyond what accommodations alone produce (McDowall et al., 2025). Research on specific behavioral signals that leaders can use to foster psychological safety offers a practical framework for creating the conditions neurodivergent leaders need to succeed (Loignon et al., 2026).

The Platinum Rule, originating in intercultural communication research, holds that effective engagement across differences requires treating people as they want to be treated rather than assuming shared preferences (Bennett, 1979). Applied to neuroinclusion, this principle operates as a practical lens that leaders of neurodiverse teams, organizational leaders, and even neurodivergent leaders themselves can use. For each recommendation, the relevant question is whether it is what neurodivergent people need rather than what seems reasonable from a neurotypical default. Additional recommendations for leaders at each level in an organization, along with guidelines for evaluating your efforts toward neuroinclusion, can be found in Pearsall et al. (2026).

FOR LEADERS OF NEURODIVERSE TEAMS

Given the relatively high prevalence of neurodivergence, frequent masking, and low disclosure rates, you are likely to have neurodivergent teammates even if you do not know who they are. The attributes of a good supervisor for neurodivergent employees are the same attributes that benefit everyone on a team: clarity, flexibility, and an orientation toward what enables each person to contribute (Austin et al., 2025). Your role as their leader is to reduce unnecessary barriers, offer equitable opportunities for leader development, and create clear and accessible pathways to lead.

Learn. Understanding what neurodivergence means, how different conditions manifest in work contexts, and how neurotypical norms shape team dynamics lays the groundwork for everything that follows (Austin et al., 2025; Pearsall et al., 2026). Look for potential barriers in your organization and team in their formal policies, informal practices, or unspoken expectations. Examine your own preferences and determine whether they are based on neurotypical defaults or truly allow for alternative ways of contributing and leading. Sharing what you learn along the way tells people on your team that you care about their success and wellbeing and are making an effort to grow.

Communicate clearly. Vague or indirect feedback disproportionately creates barriers for neurodivergent employees. Specific, structured approaches, such as the Situation-Behavior-Impact model, reduce ambiguity and improve feedback utility for everyone (Fleenor et al., 2020; Hamdani & Biagi, 2022). Notice and normalize different ways people choose to communicate or participate. Meeting structures that privilege verbal participation and reward those who speak most may overlook or undervalue neurodivergent contributions (Loignon et al., 2025). Providing alternative options like written input, structured turn-taking, or asynchronous contribution creates more equitable situations for the whole team (Austin et al., 2025; Kidwell et al., 2023).

Create safety. In our sample, disclosure to managers and disclosure to no one were essentially tied as the most common responses among neurodivergent participants. When team members feel they can show up authentically, the benefits extend across wellbeing, performance, and retention. Establishing a culture where masking is not required is essential, but neurodivergent employees should not be responsible for initiating the building of an inclusive environment. Proactively building psychological safety means that when disclosure does happen, employees are met with support rather than judgment and they can trust that you will not share their neurodivergent identity with others. Camera-optional meetings, sharing agendas and questions in advance, flexible participation formats, and asking team members to name what would help them do their best work are small adjustments with universal impact (Austin et al., 2025; McDowall & Doyle, 2024; Pearsall et al., 2026).

Advocate and develop. For LSE specifically, direct leadership experience is the primary developmental lever (Bandura, 1977; Dwyer, 2019). Consistent with this assertion, we found that less leadership experience among neurodivergent people was directly tied to lower identity and self-efficacy beliefs, underscoring the importance of deliberate access. Provide explicit opportunities for stretch assignments, visible project leadership, and other experiences that build concrete evidence of capability. Publicly name your team members' contributions and help their work be seen across the organization, including among senior leaders where possible. Mentoring and coaching are valuable and work best when they come from someone with ND-specific knowledge or experience (McDowall et al., 2023). Advocate for your neurodivergent team members to have access to ND-informed development resources, and follow up to ensure investments are accessible and producing the targeted results.

Reflect. Which of your employee expectations are tied to meaningful outcomes, and which stem from habit, convention, or convenience? What expectations or norms could you adjust or remove that would reduce unnecessary burden on your team? What options are available for team members to participate in discussions, and are they viewed as equally valuable or are some more rewarded than others?

FOR NEURODIVERGENT LEADERS

This section is written directly to you as a neurodivergent leader or professional. Working in contexts where your cognitive style is not always welcomed or supported is a widely shared experience among the leaders in our sample and across the broader workforce. Whether you have known you are neurodivergent for years or are only beginning to understand what that means for you, the patterns we identified in our research are widespread, reflecting systemic issues rather than individual failings.

For those still learning about their own neurodivergence, you are not alone. Late diagnosis is increasingly common, and self-identification is recognized as a legitimate starting point (Brady et al., 2024; Kooij et al., 2025; Newton et al., 2025). Understanding that years of unrecognized masking may have shaped how you see yourself as a leader can itself be a reframe. For those who have known for a long time, the cumulative exhaustion of navigating environments not designed for how your brain works, along with having your identity minimized or misunderstood, is real. While the research and practice landscape continues to evolve, communities of neurodivergent leaders, peer networks, and ND-aware mentorship are worth pursuing for support and connection.

Understand your masking. Masking is not always a conscious or deliberate choice. For many neurodivergent people, suppressing certain traits or behaviors at work became ingrained long before they had language for it. You are not required to mask, and doing so comes at a cost. We also recognize that it is not always safe to unmask and that real consequences can occur in those instances. Environments in which masking is less necessary exist and are worth seeking. As you become more familiar with your masking behaviors, the next step is noticing them when they happen and pausing to ask whether the effort was worth it in that moment.

Know your disclosure options. Disclosure is entirely personal. Both disclosing and not disclosing are valid, depending on context, perceived safety, and your own judgment. Neither choice requires justification. Explore what disclosing in your situation would mean and what channels are available should you want to pursue accommodations (Praslova, 2024). Even if you choose to share your identity with a manager, peer, or HR, you are not obligated to share with everyone. Should you require additional support but do not want to disclose, asking teammates or managers directly for what you need is an option. In many cases, you can seek accommodations without full disclosure, and it is worth looking into what accommodations actually require.

Find your people. Identify people around you whom you can trust. They may be neurodivergent, understand what it means to be, or be curious to learn more. Peer connections and ND-aware relationships can reduce isolation and provide a safe space to unmask, even if you are not comfortable doing so in every situation. Your community can be formal, like a sponsored employee resource group; informal, like an online or external network; or a single individual, like a trusted colleague or manager. Knowing you have someone who sees and accepts you in a natural state can make a meaningful difference.

Invest in yourself. Psychological capital develops through intentional experience and support (Szerdahelyi et al., 2024). The same is true for leader identity, self-efficacy, wellbeing, and other leadership competencies. None of these are determined by neurotype. Seek out ND-informed development opportunities where possible. Coaching and mentoring approaches that account

for the specific ways neurodivergence interacts with leadership contexts are more effective than generalist ones (McDowall et al., 2023). If you want to improve in a particular area or grow your responsibilities at work, pursue projects that target those goals. If you are comfortable with where you are in your leadership journey, that is equally valid. Acknowledging where you excel and where you need support shapes a more honest and useful development plan.

Recognize your limits. Neurodivergent burnout is not the same as traditional work burnout. Emerging research suggests it can be more severe, affect multiple aspects of life, and take longer to recover from (Mantzalas et al., 2022; Raymaker et al., 2020). Learn your early warning signs. Build in recovery before your reserves are fully depleted. Recognize what conditions or demands contribute to your burnout experiences and identify ways to reduce or manage them in the future. Protect the resources that sustain you across work and life.

Reflect. In which aspects of your work do you feel most like yourself, and where do you find yourself exerting the most effort to perform for other people's expectations? Which of your challenges can be solved with developmental opportunities and which could be mitigated through reasonable accommodation? Which habits or strategies have you developed that cost you more than they are worth, and what would it look like to lead more from your natural strengths?

FOR ORGANIZATIONAL LEADERS

Designing a workplace that supports neuroinclusion benefits all employees and can avoid the disclosure problem we observed by making accessibility the default. An accessible environment alleviates pressure on neurodivergent leaders to advocate for needs they may not yet fully understand, particularly those working through a recent or evolving sense of their own neurodivergence. It can also encourage neurodivergent leaders to begin unmasking, which can, in turn, positively impact leadership performance, resilience, and wellbeing. However, neuroinclusion also requires discovering and accommodating individual needs beyond uniform expectations.

Examine your standards. Who gets recognized as a leader in your organization, and why? Leadership prototypes in most organizations were built around neurotypical behavioral norms, and those norms shape who is recognized, who advances, and who does not (Roberson et al., 2021). Ensuring that standard practices work for the full range of your employees begins before they are ever hired. Examine talent recruitment and assessment approaches, interview protocol, job designs, meeting structures, professional development processes, and supervision practices. In each area, ask whether the standard being applied reflects what effective leadership requires or simply what it has historically looked like.

Rethink employee evaluation. Determine whether promotion criteria, high-potential identification, and performance evaluation reward substantive leadership effectiveness. In many organizations, criteria favor neurotypical presentation styles, such as communication confidence, social fluency, and prominence in group discussions, over actual impact. Performance review structures that rely on infrequent, high-stakes evaluations can further disadvantage neurodivergent employees, who may demonstrate their contributions differently across contexts or communicate them in ways that standard formats do not capture well. Replacing or supplementing traditional reviews with ongoing, structured feedback creates a more accurate and equitable picture of performance (Capelli & Tavis, 2016).

Expand access. Leadership behaviors and competencies can be developed across neurotypes when organizations enable that development to happen (Austin et al., 2025; Reichard et al., 2024). Designing leadership development opportunities that everyone can access rather than retrofitting accommodations for individuals ensures that programs work for the full range of how people learn and engage (Austin et al., 2025; McDowall & Doyle, 2024). Leadership development opportunities should not be reserved for those already designated as high potential. High-potential identification processes are themselves subject to neurotypical bias and can disproportionately exclude the very people whose leadership capabilities organizations most want to develop. Formal programs, informal mentorship, coaching, peer learning, and stretch assignments should be broadly accessible and equitably offered.

Diversify pathways. Integrating neurodiversity awareness into existing leadership development programs, rather than creating entirely separate tracks, builds broader supervisory capability across the organization and signals to neurodivergent employees that their development is valued (Austin et al., 2025; Reichard et al., 2024). Create specialist talent pathways that do not assume traditional line management presentation. Innovation networks, project-based leadership roles, and alternative contribution structures open leadership access to people beyond the standard pipeline (McDowall & Doyle, 2024). Avoid channeling neurodivergent employees into narrow roles. Instead, offer flexible options based on individual strengths and interests rather than diagnostic stereotypes (Praslova et al., 2023).

Create safety. Reducing the pressure to mask is a retention strategy. Cultures that do not prompt subconscious masking are more equitable and more stable environments (Ezerins et al., 2026; McDowall et al., 2025). Neurodivergent leaders perform better in organizations that provide psychologically safe environments in which they can be themselves and see other neurodivergent leaders succeed (Henneborn, 2021). Safety cannot, however, be delegated entirely to individual managers. Organizational culture, set and modeled by senior leaders, determines whether cognitive differences are genuinely welcomed or merely tolerated. When neurodivergent leaders are visible at senior levels and leaders openly acknowledge cognitive diversity as a strength, it signals that masking is not a prerequisite for advancement. Organizations must invest deliberately to ensure formal support channels, including HR, are accessible and trustworthy.

Measure progress. Sustained progress on neuroinclusion requires regular measurement of whether and how well leadership systems are working. Track neurodivergent employee experience, access to development resources, and representation at senior levels over time, not just headcount at point of hire (Pearsall et al., 2026). Importantly, include neurodivergent employees in the design of evaluation frameworks to ensure the evaluations assess lived experience rather than organizational assumptions (McDowall & Doyle, 2024).

Reflect. In what ways does your organizational culture signal that cognitive differences are valued? What does your organization currently do to support your neurodivergent leaders? Where in your talent pipeline are neurodivergent employees most likely to be overlooked or screened out?

When neuroinclusion and neurodiverse leadership thrive, organizations see:

- Stronger psychological safety
- Increased feelings of belonging
- Improved team performance
- More effective problem-solving
- Greater innovation
- Higher retention

Limitations and Future Directions

Our research documents a substantial blind spot in the published literature on neurodivergent leadership alongside theoretically grounded differences in leadership-related constructs between neurodiverse groups. The following limitations are relevant to interpreting these results.

This study was self-report and cross-sectional, measuring all variables at a single point in time. While this is an appropriate method for capturing self-perceptions, response bias is possible, though somewhat mitigated by the anonymous online format of the survey. Our design limits our ability to say how the identified gaps develop or what specifically would close them. Longitudinal designs and alternative data sources are needed to understand how leader identity and self-efficacy develop among neurodivergent individuals and whether earlier diagnosis, intentional development experiences, or neuroinclusive environments moderate those trajectories.

The composition of our sample suggests that our findings may represent a conservative estimate of the true differences present in the broader workforce. Participants were recruited through channels that likely overrepresented individuals who are already aware of their neurodivergent identity, engaged with neurodiversity discourse, or connected to leadership development communities. This constraint is broadly shared across emerging literature on neurodiversity at work (McDowall & Doyle, 2024; McDowall et al., 2025).

Screening criteria through Prolific were designed to approximate each country's demographic

composition but reduced the available participant pool and constrained sample diversity. We did not apply screening criteria to social media recruitment, which resulted in a disproportionate number of neurotypical participants from that source. The final sample was predominantly White and female, drawn primarily from the United States and United Kingdom.

Despite the sample including over 400 individuals, the statistical power for categorical subgroup analyses degraded quickly given the smaller subgroup sizes. Our primary analyses compared five subgroups, and additional parsing was likely to complicate more than it helped. The Other ND group collapsed a heterogenous set of neurodivergent conditions, limiting its comparability to the primary subgroups. Certain characteristics, such as age, tenure, country, and current role, may be related to the constructs we measured. Given the already reduced subgroup sizes defined by neurodivergent condition, we did not control for other demographic or contextual factors in the primary analyses, nor did we assess intersectional identities as a factor. We also did not collect data on symptom severity or support needs, which limits our ability to speak to experiences of leaders with more significant differences.

Beyond subgroup constraints, the concentration of participants in two Western, English-speaking countries limits generalizability across cultural and national contexts. Results should therefore be interpreted descriptively rather than causally. Group comparisons, particularly those exploring neurodivergent versus neurotypical leaders, should be considered in light of these sampling differences. Future studies would benefit from either larger samples or balanced sampling strategies that methodologically account for these factors.

Several directions follow from our research. A qualitative companion study is underway to examine how neurodivergent leaders subjectively experience leadership, including the barriers they encounter, their reasons for pursuing leadership, and how they perceive effective leaders. A separate follow-up study will examine wellbeing mechanisms among neurodivergent professionals in greater detail, including contextual factors that support wellbeing and group and team wellbeing in neurodiverse settings.

Future research should also investigate leadership strengths, leadership challenges, and leadership behaviors among neurodivergent leaders and leaders of neurodiverse teams. Motivation to lead among neurodivergent samples also warrants dedicated investigation. Measurement equivalence testing is needed to ensure the validated constructs perform equally well across neurotypes. Adequately powered intersectional analyses examining how gender, race, and neurodivergent identity interact to shape leader self-views, masking, and wellbeing remain a pressing priority, though sample identification will likely remain a challenge for the field.

How neurodivergent leaders are leveraging artificial intelligence (AI) and digital tools to support their work is an emerging area that has not yet been studied. Understanding ableist biases embedded in AI and large language models is equally important, particularly as these tools increasingly drive organizational hiring and talent assessment decisions. Experimental tests of neuroinclusive leadership development interventions would provide the causal evidence needed to move from describing gaps to actively closing them.

Conclusion

Neurodivergent leaders are present, capable, and already contributing. Too many are concealing who they are and leading within systems that were never designed to see them. Leader identity grows through experience, but only when the environment around that experience signals that people belong and their leadership is real.

This paper provides the first large-scale empirical baseline for understanding how neurodivergent and neurotypical leaders differ on self-view and wellbeing constructs central to leadership development. Neuroinclusion means building systems robust enough to support neurodivergent people across the full range of what they need to thrive, including those already leading and those who have not yet had the opportunities to do so.

Inclusion is a precondition for contribution. Expanding who gets recognized as leaders requires expanding what leadership is allowed to look like. When neuroinclusion is genuine, the range of what neurodivergent leaders bring becomes fully visible.

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Appendix A: Supplemental Methods

MISSING DATA AND IMPUTATION

Survey measures were distributed using stratified random assignment within Qualtrics. Within each leader and neurodivergent (ND) identity group combination, pairs of measures were assigned 50/50, and sets of three measures were rotated on a 2/3 basis, such that each measure was completed by an evenly distributed representative subset of participants within each group. Because missingness depended on observed routing variables rather than on the values of the missing items themselves, it can be classified as Missing at Random (MAR; Enders, 2010), making multiple imputation the appropriate analytic approach. Item-level imputation was conducted in Python using multiple imputation by chained equations (MICE; van Buuren, 2018) via scikit-learn's IterativeImputer (Pedregosa et al., 2011). The imputation model included indicators for survey section assignment to account for the structured missingness pattern, as well as all item-level survey variables, design variables governing missingness (i.e., leader status and ND group), and auxiliary variables used in later analyses (e.g., gender). Stochastic posterior draws were enabled, generating 30 multiply imputed datasets to stabilize parameter estimates and standard errors, consistent with contemporary recommendations (Graham et al., 2007; von Hippel, 2020; White et al., 2011). Scale scores were recomputed from imputed items within each dataset (Enders, 2010; Graham, 2009). All subsequent analyses were conducted separately in each imputed data set, and inferential results were combined using Rubin's Rules (Rubin, 1987; van Buuren, 2018).

GROUP COMPARISONS AND EFFECT SIZES

Group comparisons used pooled linear models across the 30 imputed datasets. ND and neurotypical (NT) groups were compared on each of the 8 primary outcomes using a binary group predictor, and Holm-Bonferroni correction was applied across the 8 omnibus tests (Holm, 1979). For subgroup analyses, comparisons were conducted across ND identity groups (i.e., ADHD = attention-deficit/hyperactivity disorder, ASD = autism spectrum disorder, AuDHD = autism and ADHD, DYS = dyslexia, NT), with correction applied within each outcome across the 10 pairwise contrasts using the emmeans package (Lenth, 2023). The Other ND group was excluded due to heterogeneity and small sample size. Effect sizes (Cohen's *d*) were pooled across the 30 imputed datasets using Rubin's Rules. Negative *d* values indicate ND scores lower than NT; positive *d* values indicate higher ND scores. Variables administered to all participants without missing data, including masking frequency, masking pressure, leader experience, and psychological capital, were not included in the imputation model. Pooled results for these variables are equivalent to standard complete-case analysis. Reliability estimates were slightly higher in the ND group across several measures, including leader identity ($\Delta\alpha$ = .05), leadership self-efficacy ($\Delta\alpha$ = .07), leader experience ($\Delta\alpha$ = .10), and psychological capital ($\Delta\alpha$ = .11). While the absolute magnitude of these differences is modest, the pattern is generally consistent.

CORRELATIONS AND DEMOGRAPHIC ANALYSES

Bivariate correlations among all 8 primary outcomes were computed within each imputed dataset and pooled using Fisher's *z* transformation (Fisher, 1915), with Holm-Bonferroni correction applied across the 28 unique pairs (C(8,2) = 28). Correlation analyses required complete data across all 8 outcomes, resulting in a sample of n = 396 after listwise deletion of 20 responses. Note that the psychological capital measure includes an efficacy-related item. While conceptually distinct from leadership self-efficacy, this overlap should be considered when interpreting correlations and parallel findings across the two scales.

Supplemental demographic analyses, including diagnosis age descriptives, a one-way ANOVA of diagnosis age by ND group with Holm-corrected pairwise contrasts, and descriptive counts of disclosure and masking patterns, were conducted as complete-case analyses using the original dataset. These variables were collected as fixed demographic characteristics and did not require imputation. All analyses were conducted in R (version 4.5.2).

Appendix B: Supplemental Tables and Figures

TABLE B1

Additional Sample Demographics

	n	%
Leader Level (*n* = 416)		
Individual contributor	85	20.4
First level	79	19.0
Middle	127	30.5
Upper middle	40	9.6
Executive	36	8.7
Top	29	7.0
Other	17	4.1
Neurodivergent Identity (*n* = 314)		
ADHD	199	63.4
Autism	108	34.4
Bipolar disorder	23	7.3
Dyscalculia	15	4.8
Dysgraphia	2	0.6
Dyslexia	61	19.4
Dyspraxia	13	4.1
Hyperlexia	8	2.5
Intellectual disability	3	1.0
OCD	42	13.4
Schizophrenia	3	1.0
Sensory processing disorder	20	6.4
Social anxiety	100	31.8
Synesthesia	3	1.0
Tourette syndrome	1	0.3
Other	37	11.8
Diagnosis Type (*n* = 314)		
Any formal diagnosis	223	71.0
Any self-diagnosis	161	51.3
Both formal and self-diagnosis	70	22.3

Note. Response counts and percentages are shown for each category. Neurodivergent category counts are non-exclusive; participants may identify with more than one neurodivergent condition, so percentages sum to greater than 100%. Diagnosis type (formal vs. self-diagnosed) is also non-exclusive and is reported at the person level; a participant is classified as formally diagnosed if they hold at least one formal diagnosis across any condition. *n* values reflect the number of participants selecting each response option. Percentages are calculated using the full sample size for leader level and only the neurodivergent sample for identity and diagnosis type.

TABLE B2

Age of First Diagnosis by Neurodivergent Identity Group Descriptives

Group	*n*	*M*	*SD*	Median	Min.	Max.	% After 18	% After 30	% After 40
Dyslexic	42	19.2	12.1	16.5	4	60	38.1	14.3	4.8
ADHD	137	27.8	13.6	28.0	1	66	74.5	43.1	16.8
AuDHD	46	29.9	14.9	30.5	3	64	78.3	50.0	19.6
Autistic	52	31.3	14.5	34.5	6	60	75.0	53.8	25.0

Note. Age of diagnosis data available for *n* = 277 of 314 neurodivergent participants. Groups ordered by mean diagnosis age. Omnibus ANOVA indicated significant differences across groups; pairwise comparisons showed autistic, ADHD, and AuDHD participants were diagnosed significantly later, on average, than dyslexic participants (Holm-Bonferroni corrected). Minimum diagnosis age of 1 year reflects a likely valid early childhood formal diagnosis. *M* = mean age in years; *SD* = standard deviation.

TABLE B3

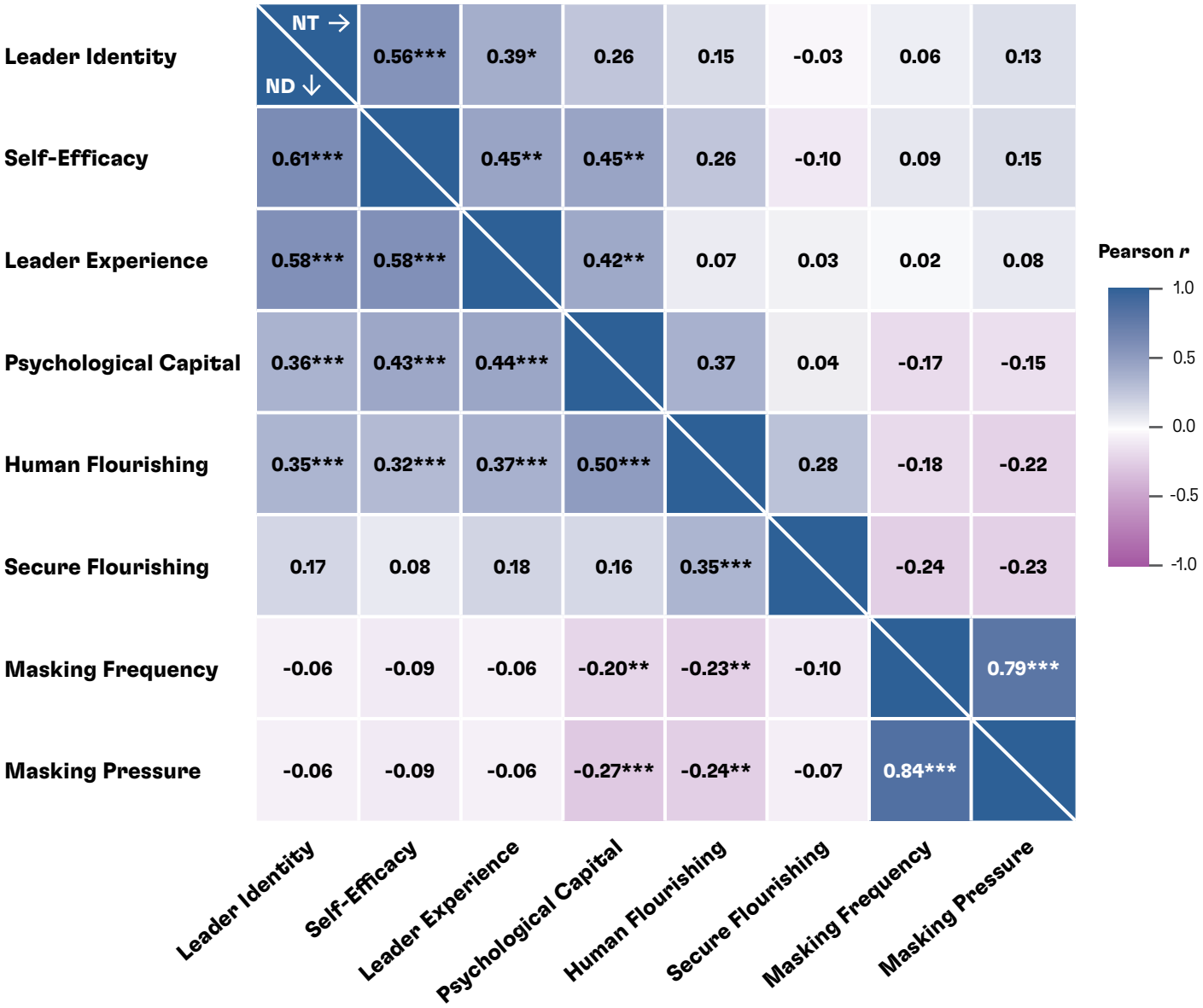
Pooled Comparisons Between Neurodivergent and Neurotypical Leaders Across All Primary Outcomes

Outcome	Scale	ND *M (SD)*	NT *M (SD)*	*F*	*p* (adj.)	*d*	95% CI	Magnitude
Leader identity	1–7	3.05 (0.99)	3.70 (0.79)	24.56	<.001	−0.68	[−0.96, −0.41]	Medium
Leader experience	1–5	3.68 (0.74)	3.97 (0.51)	10.83	.003	−0.41	[−0.65, −0.16]	Small
Leadership self-efficacy	1–5	4.14 (0.61)	4.40 (0.48)	11.86	.003	−0.45	[−0.71, −0.19]	Small
Psychological capital	1–6	4.82 (0.91)	5.14 (0.62)	9.01	.003	−0.37	[−0.62, −0.13]	Small
Human flourishing	0–10	6.59 (1.57)	7.46 (1.30)	15.72	<.001	−0.57	[−0.86, −0.29]	Medium
Secure flourishing	0–10	5.54 (2.98)	7.03 (2.54)	12.04	.003	−0.52	[−0.81, −0.22]	Medium
Masking frequency	1–5	3.64 (1.53)	2.14 (1.12)	68.23	<.001	+1.03	[+0.78, +1.29]	Large
Masking pressure	1–5	3.50 (1.64)	2.04 (1.19)	56.71	<.001	+0.94	[+0.69, +1.19]	Large

Note. Analyses were pooled across 30 imputed datasets using Rubin's Rules. *p* (adj.) = Holm-Bonferroni corrected *p* value across 8 omnibus tests. Effect sizes (*d*) are Cohen's *d* pooled across imputed datasets; negative values indicate neurodivergent (ND) scores lower than neurotypical (NT), positive values indicate ND scores higher. Magnitude labels follow Cohen (1988): small = 0.20–0.49, medium = 0.50–0.79, large ≥ 0.80. Masking frequency and masking pressure were not imputed (complete-case variables); pooled results are equivalent to standard complete-case analysis. Outcomes ordered by *F* statistic.

FIGURE B1

Correlations Among All Measured Outcomes: Neurodivergent (Below Diagonal) Vs. Neurotypical (Above Diagonal) Comparison



Note. Neurodivergent (ND) correlations are shown below the diagonal; neurotypical (NT) correlations are shown above the diagonal. *$p < .05$, **$p < .01$, ***$p < .001$ (Holm-Bonferroni corrected). Darker colors indicate stronger relationships between constructs. Blue shades indicate positive relationships, whereas purple shades indicate negative relationships.

TABLE B4

Significant Pairwise Contrasts Across Neurodivergent Identity Groups (29 of 80 Comparisons)

Group 1 vs. Group 2 Contrast	Group 1 M (SD)	Group 2 M (SD)	Cohen's d	95% CI	Magnitude
Leader Identity⁺					
Autistic vs. NT	2.77 (.98)	3.70 (.79)	−1.07	[−1.50, −0.64]	Large
AuDHD vs. NT	2.99 (.86)	3.70 (.79)	−0.86	[−1.29, −0.44]	Large
Dyslexic vs. NT	3.15 (1.03)	3.70 (.79)	−0.63	[−1.04, −0.21]	Medium
ADHD vs. NT	3.13 (.98)	3.70 (.79)	−0.62	[−0.93, −0.31]	Medium
Leadership Self-Efficacy⁺					
Autistic vs. NT	3.94 (.56)	4.40 (.48)	−0.90	[−1.29, −0.51]	Large
Leader Experience					
Autistic vs. NT	3.48 (.70)	3.97 (.51)	−0.83	[−1.19, −0.47]	Large
Dyslexic vs. NT	3.60 (.68)	3.97 (.51)	−0.65	[−1.04, −0.27]	Medium
ADHD vs. autistic	3.83 (.71)	3.48 (.70)	+0.49	[+0.17, +0.81]	Small
Psychological Capital					
Autistic vs. NT	4.68 (.90)	5.14 (.62)	−0.62	[−0.98, −0.27]	Medium
AuDHD vs. NT	4.71 (.83)	5.14 (.62)	−0.61	[−0.98, −0.24]	Medium
Human Flourishing⁺					
AuDHD vs. NT	6.05 (1.71)	7.46 (1.30)	−0.97	[−1.43, −0.50]	Large
Autistic vs. NT	6.38 (1.60)	7.46 (1.30)	−0.76	[−1.17, −0.35]	Medium
AuDHD vs. dyslexic	6.05 (1.71)	7.08 (1.23)	−0.69	[−1.21, −0.16]	Medium
ADHD vs. NT	6.75 (1.51)	7.46 (1.30)	−0.50	[−0.83, −0.17]	Small
Secure Flourishing⁺					
AuDHD vs. NT	4.83 (3.06)	7.03 (2.54)	−0.81	[−1.27, −0.35]	Large
ADHD vs. NT	5.57 (2.98)	7.03 (2.54)	−0.52	[−0.86, −0.18]	Medium
Masking Frequency					
AuDHD vs. NT	4.44 (1.07)	2.14 (1.12)	+2.09	[+1.65, +2.54]	Large
Autistic vs. NT	4.06 (1.29)	2.14 (1.12)	+1.62	[+1.22, +2.01]	Large
AuDHD vs. dyslexic	4.44 (1.07)	2.37 (1.53)	+1.59	[+1.10, +2.07]	Large
Autistic vs. dyslexic	4.06 (1.29)	2.37 (1.53)	+1.21	[+0.77, +1.65]	Large
ADHD vs. NT	3.65 (1.48)	2.14 (1.12)	+1.12	[+0.82, +1.41]	Large
ADHD vs. dyslexic	3.65 (1.48)	2.37 (1.53)	+0.86	[+0.50, +1.22]	Large
ADHD vs. auDHD	3.65 (1.48)	4.44 (1.07)	−0.57	[−0.91, −0.23]	Medium
Masking Pressure					
AuDHD vs. NT	4.04 (1.41)	2.04 (1.19)	+1.58	[+1.17, +1.99]	Large
Autistic vs. NT	3.85 (1.54)	2.04 (1.19)	+1.36	[+0.97, +1.74]	Large
AuDHD vs. dyslexic	4.04 (1.41)	2.15 (1.53)	+1.29	[+0.83, +1.76]	Large
Autistic vs. dyslexic	3.85 (1.54)	2.15 (1.53)	+1.11	[+0.67, +1.55]	Large
ADHD vs. NT	3.63 (1.56)	2.04 (1.19)	+1.11	[+0.82, +1.40]	Large
ADHD vs. dyslexic	3.63 (1.56)	2.15 (1.53)	+0.95	[+0.59, +1.32]	Large

Note. Only statistically significant contrasts are shown. A plus (⁺) indicates that effect sizes (*d*) were pooled across 30 imputed datasets using Rubin's Rules; Holm-Bonferroni correction applied within each outcome across 10 pairwise contrasts. Negative *d* = first group scores are lower; positive *d* = first group scores are higher. Contrasts are ordered within each outcome by effect size magnitude. Magnitude labels follow Cohen (1988): small = 0.20–0.49, medium = 0.50–0.79, large ≥ 0.80. ND = neurodivergent, NT = neurotypical. AuDHD is defined as co-occurring autism and ADHD.

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