

Philosophy of Medicine

Perspective

The Autism Identity Crisis

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Abstract

The word *autism* is fracturing under two incompatible demands. In the DSM-5, it denotes a disorder that by definition requires clinically significant impairment. In the autistic self-advocacy movement, it denotes an identity not reducible to deficit. This paper argues the conflict is not between advocates and clinicians but a diagnostic crisis: a category built for one purpose confronting a broader reality revealed by science. Network neuroscience increasingly describes autism as a unified pattern of neurological variation whose strengths and differences share one architecture. The paper proposes decoupling ICD-10-CM F84.0 from DSM impairment criteria and redeveloping it as a non-pathologizing record of the neurotype, opening services to all autistic people, while establishing a DSM category of Autism-Related Disorders to capture associated conditions and govern intervention where impairment warrants it.

1. Introduction

There are words that describe, and there are words that define. And then there are words asked to do both at once: words that carry the weight of institutional authority in one register and the weight of lived identity in another, simultaneously, and begin to fracture under the strain. *Autism* is one of those words. But the fracture, examined carefully, turns out to be diagnostic in a deeper sense than its clinical origins suggest. It points not toward an irresolvable conflict but toward a diagnostic framework that has simply outgrown its original architecture, and toward the need to rebuild it on more accurate foundations.

This paper argues that the conflict over the word is not, at its core, a dispute between advocates and clinicians but a diagnostic one: A single category is being asked to serve two incompatible functions. Currently, the International Statistical Classification of Diseases and Related Health Problems (10th Revision, ICD-10) diagnostic code for autism is coupled to the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition, DSM-5) criteria. In addition, the new ICD-11 criteria for autism seem to represent an effort to compromise between the medical model (autism as an observable, behavioral neurodevelopmental disorder) and the social model (autism as neurodiversity/identity), attempting to accommodate both by broadening criteria to include subjective inner experiences, compensation, and retrospective recognition while retaining the framework of a clinical disorder (Kamp-Becker 2024). The result satisfies neither camp: It undermines the



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diagnostic precision demanded by the medical model, while still categorizing autism as a “disorder,” which the neurodiversity camp rejects.

Drawing on emerging network neuroscience and on the depathologization of gender incongruence in the ICD-11 (Reed et al. 2016), this paper proposes a structural resolution, redeveloping the ICD code for autism, F84.0, as a genuinely descriptive, non-pathologizing record of the autistic neurotype, while creating within the DSM a bounded category of Autism-Related Disorders to govern access to additionally necessary clinical services. The aim is to let the neurotype be recognized without pathologizing it, while preserving the impairment criterion where it does necessary work. Not everyone who qualifies under the ICD criteria will necessarily meet the DSM threshold. The result is a stratified, stepped-care model: The ICD code would document the neurotype and open access to a set of universal services—those offered to everyone with the neurotype—while a DSM diagnosis would add indicated services for those whose impairment warrants them.

2. The Stability of Diagnosis

To understand the fracture, it helps to understand what a diagnosis is and what it is asked to do.

The framework offered in the DSM, published by the American Psychiatric Association (2013), is a clinical instrument. It exists to perform specific institutional functions: to justify intervention, allocate resources, guide treatment, and generate the research base upon which medicine depends. Which of these functions a diagnosis is taken to serve—explanation, the legitimization of sickness, or the authorization of care—shapes what is at stake in applying it, and psychiatric diagnoses do not always discharge these functions as diagnoses in bodily medicine do (Maung 2019). Diagnosis, in this system, is not only a description. It is a determination, a threshold judgment that something is going wrong sufficiently to warrant intervention. This is why the DSM leadership will generally say that they do not create diagnoses for things that are not impairing or do not require intervention. They are being internally consistent. The manual’s general definition is admittedly hedged; mental disorders are said to be “usually associated with significant distress or disability” (American Psychiatric Association 2013, 20), and its clinical-significance criterion has been criticized as conceptually uneven (Spitzer and Wakefield 1999). At the level of the autism criteria themselves, however, the requirement is not hedged: A diagnosis of Autism Spectrum Disorder requires that symptoms cause clinically significant impairment in current functioning. In that operative sense, the DSM framework does not name neutral variation; it names things causing problems.

“Autism Spectrum Disorder”—note the word *Disorder*—is therefore, by design, a document of functional impairment, an element specifically sustained in the ICD-11 version. Without that impairment, the diagnosis does not hold. Remove the clinical significance criterion, and the construct dissolves, at least diagnostically. The constraint is structural, built into how the category is defined.

The stakes are higher than they might appear. In the American healthcare context, diagnosis is the gateway to access resources: Insurance coverage, school accommodations, clinical and disability services, and legal protections all flow from a clinical determination. The DSM definition is not merely academic. It is the administrative foundation upon which support is built. Strip impairment from the definition, and you risk stripping access from

those who need it most, particularly those at the high-needs end of an extraordinarily wide spectrum. Autism encompasses a broad range of presentations, from individuals who require intensive, lifelong support to those who are able to function independently but still may experience meaningful challenges. That breadth is already a significant strain on the category's coherence. Further loosening its anchor in impairment risks making it meaningless as a clinical tool for those who need it.

3. The Expansion of Identity

And yet, outside the clinic, something quite different is happening with the same word.

Over the past two decades, a growing autistic self-advocacy movement has claimed *autism* not as a diagnosis but as an identity, something constitutive, integrated, and not reducible to deficit (Kapp et al. 2013). This is not merely a terminological preference. It is a different ontology. Where the clinical framework asks, “What is wrong and how can it be treated?”, the identity framework asks, “Who am I, and how do I belong?”. It echoes a recognized position within the philosophy of diagnosis itself, that diagnosis is less a unilateral expert judgment than a dialogue across the diverse conceptual and experiential frameworks a condition invites, the patient's own self-understanding among them (Hoff et al. 2020).

The shift to identity-first language, “I am autistic” rather than “I have autism,” signals that a characteristic is constitutive rather than afflictive, something that shapes a person's way of being in the world rather than something visited upon them. To say, “I am autistic” is to claim that autism is not separable from the self in any meaningful sense; that you cannot treat it away without treating the person away.

Autistic advocates have also mounted a substantive challenge to the impairment framework itself (Jellett and Muggleton 2022). Their central argument, drawing on the social model of disability, is that impairment is frequently relational rather than intrinsic. An autistic person experiences significant difficulty in a world built around neurotypical norms of communication, sensory tolerance, and social interaction. Change those norms—or change the environment—and much of the impairment diminishes or disappears. The disability, in this reading, is not located in the person. It is located in the mismatch between the person and the world.

These claims can be given a sharper philosophical form. Jerome C. Wakefield posits that a condition qualifies as a disorder only where two conditions hold together: Some internal mechanism fails to perform the function it was shaped by evolution to perform, and that failure is harmful by prevailing social standards (Wakefield 2007). Read through this lens, autism fails at the first condition: The neurodiversity claim holds that the autistic neurotype is a variant form of neurological organization, not a mechanism failing its evolved function. Without dysfunction, the definition is not met, however much difficulty may be present. The relational character of that difficulty makes the same point from the second condition: Much of the associated harm arises in the fit between person and environment rather than in the person alone. Wakefield's criteria may not hold autism to be a disorder, but that conclusion follows from the disorder concept itself, not from the social model pressing against it.

None of this should imply that autistic people have no needs. A neurotype may call for accommodation, support, or even active clinical services, without being, in itself, a harmful

dysfunction; the need for help and the presence of a disorder are separable, and it is their conflation that forces the very choice the single category imposes. Where a genuine harmful dysfunction is present, the disorder label is warranted; where it is not, support may still be owed, but pathology is not the ground of it. Disease-concept pluralism holds that *disorder* need not carry a single definition across every purpose but may be allowed to serve different epistemic and institutional goals in different settings (Powell and Scarffe 2019). The resolution proposed below applies that principle directly: letting one instrument document the neurotype and another adjudicate disorder, with neither forced to answer to the other's purpose.

The stakes of this position are not abstract. The impulse to remove conditions from the domain of pathology has a long history. Mid-twentieth-century critics of psychiatry—among them R.D. Laing and Thomas S. Szasz—argued that psychiatric categories encode social and moral judgment as much as medical fact (Laing 1960; Szasz 1961), and the removal of homosexuality from the DSM in 1973 remains its paradigm case: a reclassification driven, at least initially, by sustained advocacy rather than by new data (Drescher 2010). Several prominent autistic writers and scholars have argued that behavioral intervention programs designed to make autistic children appear less autistic are not therapeutic at all, but suppressive, and that the clinical framing enables such programs by defining the “disorder” as what needs to be corrected (Leadbitter et al. 2021). That history is not lost on autistic advocates, and it gives their challenge to the clinical framework a moral weight that is difficult to dismiss.

That history, however, cautions against treating depathologization as an unambiguous good. Lucienne Spencer and Havi Carel describe a distinct harm they call “wrongful depathologization,” in which a condition is at once stigmatized and trivialized—reduced to a mere personality trait—so that those who genuinely suffer are treated as too unwell to escape stigma yet not unwell enough to be taken seriously (Spencer and Carel 2021; see also Chapman and Carel 2022). The empirical literature on disease labeling points the same way from a different direction: Framing a condition as pathology can reduce attributions of blame, and removing that frame can restore them, so depathologization is not reliably destigmatizing (Sholl and De Block 2024). The casual observation that “everyone is a little autistic” carries precisely this risk. A defensible response to the clinical framing must therefore relieve the neurotype of the presumption of pathology without denying the reality of impairment where it is a genuine harmful dysfunction, a distinction to which this paper returns.

4. What the Neuroscience Suggests

Neither the clinical argument nor the identity argument has paid sufficient attention to a third voice in this conversation—the neuroscience—and what it is increasingly saying complicates both.

Autism is now understood, in the research literature, less as a cluster of behavioral symptoms and more as a neurotype: a recognizable pattern of differences in brain network organization and function (Lord et al. 2018). These differences are not incidental to the behavioral profile; they are its source. And they are beginning to look, under closer examination, less like damage and more like variation.

Research into large-scale brain network organization has identified consistent differences in the default mode network, salience network, interoceptive systems, and frontoparietal control network in autistic individuals (Abbott et al. 2016). Reduced suppression of the default mode network during goal-directed activity, a pattern long interpreted as social disinterest, may instead reflect an alternative organization of self-experience, a persistent internal mentation that coexists with, rather than withdrawing from, external engagement. Differences in salience assignment, in which sensory, interoceptive, and internally generated signals compete without the filtering that neurotypical brains apply automatically, may present as inattention or disengagement while actually reflecting something more like an excess of signal rather than a deficit of attention.

What is most striking is a finding with direct implications for the impairment debate: Many of the cognitive and perceptual strengths consistently associated with autism, such as enhanced capacity for systematizing, attention to detail, visual discrimination, pattern recognition and mathematical and musical skills, arise from the same neural architecture that produces its diagnostic differences (Baron-Cohen and Lombardo 2017). The architecture is not divided into a “good” part that generates strengths and a “bad” part that generates impairments. It is unified. This means that interventions targeting the behavioral differences without regard for this architecture risk suppressing the strengths along with the difficulties, and the research suggests they may do exactly that, with measurable consequences for mental health outcomes.

Understanding these patterns as constrained functional repertoires rather than damaged systems reframes the clinical question fundamentally. The question is no longer primarily, “How do we correct this?” but “How do we expand the flexibility and functional range with which existing systems can be engaged?”. That is a different therapeutic posture, and it is one that the identity advocates have been intuitively arguing for years, without the neurobiological vocabulary to express it.

Crucially, this neuroscience does not vindicate the identity position over the clinical one. What it does is to place pressure on the clinical model from within its own research base. The behavioral paradigm that has defined autism diagnostically and therapeutically for decades is losing ground not because advocates have demanded it, but because the science has moved (Happé and Frith 2020).

5. One Word, Two Jobs

The conflict is not, at its core, about whether autism is impairing; many advocates acknowledge that some autistic people have significant difficulty. What they dispute is the clinical model’s authority to define that difficulty, and the word itself.

The word is being asked to perform two incompatible functions simultaneously.

In the clinical register, the word must stay bounded: The DSM’s threshold rests on impairment and, without it, the category is exposed to the charge of pathologizing human variation.

In the identity register it has tended the other way, toward inclusion, with the contemporary self-advocacy movement widening recognition rather than sharpening criteria (Kapp et al. 2013). Though this tendency is not universal even within autism advocacy (Dwyer et al. 2025), the directional pressure now dominant sits in tension with the clinical need for boundary-keeping.

The result is a term pulled in opposite directions, one requiring impairment, the other resisting it, while the neuroscience pulls toward a third: an underlying neurological reality that exists independently of whether, in any given person or context, it impairs at all.

6. When Words Change Their Meaning

This is not the first time a term has been caught between competing definitions, and history offers instructive parallels, some more useful than others.

Queer is a frequently cited reclamation story (Drescher 2010). Once a slur, it was claimed by the communities it targeted and transformed into an identity, a political stance, and eventually an academic field. The word itself was never a clinical term, unlike homosexuality, and its reclamation did not have to contend with the institutional systems of resource allocation and service delivery that depend on diagnostic stability.

Hacker offers a different model, a word that bifurcated rather than transformed. In computer culture, it originally described extraordinary technical creativity; in law enforcement and journalism, it came to mean unauthorized system intrusion. Both meanings now coexist in different communities without apparent crisis. The technical community maintained their usage; they did not need the journalistic meaning to change. Whether *autism* could achieve a similar stable bifurcation is doubtful; the institutional stakes are higher, and the communities are not so easily separated, but the model demonstrates that dual meaning is not always fatal to a word.

The closest structural analogy, and the most instructive, is the recent history of gender incongruence in diagnostic medicine. “Gender Identity Disorder” appeared in the DSM for decades, pathologizing transgender identity by definitional necessity; if it was in the DSM, it was, by that system’s own logic, a disorder. Subsequent reforms did not eliminate the diagnosis but reframed it. In DSM-5, it became “Gender Dysphoria,” shifting the focus from identity itself to the presence of clinically significant distress. At the same time, ICD-11 relocated “Gender Incongruence” out of the mental disorders chapter altogether, placing it instead within a sexual health framework, retaining clinical utility while attempting to reduce the pathologization of identity (Reed et al. 2016).

The rationale was precise: The condition itself is not classified as a mental disorder, but people with it may have clinical needs that warrant medical attention and access to care. The distress and functional difficulty that some transgender individuals experience became the clinical target; the identity itself was, at least in part, released from the pathology frame. The revised diagnosis requires neither distress nor impairment, and the evidence informing the change indicated that such distress as does occur more often follows from social rejection than from the condition itself (Askevis-Leherpeux et al. 2019). The distinction drawn there is precisely the one at issue here, not between a disorder and no code at all, but between documenting a state and documenting a disorder.

This is not a perfect analogy for autism, no analogy is, but it is a modern, institutionally realized example of exactly the kind of diagnostic reorganization that the autism debate is, in effect, demanding. And it demonstrates that such reorganization is possible within existing institutional frameworks, not merely in theory.

7. The Third Space: A Diagnostic Architecture

Having mapped the tension, it becomes difficult not to notice that it points in a specific institutional direction, one that does not require either side to abandon its core position, but does require medicine to separate two questions that the single word now forces together: whether the autistic neurotype is present and can be documented as such, and whether it is, in itself, impairing; that is, whether it amounts to a disorder.

The separation is not a novelty to be invented; it is latent in how classification already works. A diagnostic system can record that a condition or state is present, and it can, as a distinct matter, record the impairments or disabilities associated with that condition. These are two documentary acts rather than one, and neither compels the other. The ICD records conditions, states, and findings of many kinds without holding that what it records must be impairing (WHO 2019); the DSM, by contrast, is largely an impairment-based instrument, naming disorders: conditions that cause clinically significant distress or functional limitation. Documentation and pathologization are, in this sense, already separable. The only question is whether the separation can be made explicit for autism.

That the boundary between a documented state and a documented disorder is a matter of decision, and not simply of nature, is evident wherever medicine has had occasion to draw or redraw it. A documented state matters not only because it is real, but because it may flag associated risks warranting proactive clinical attention.

Even within the ICD disease chapters the lines are conventional. Hypertension is perhaps the clearest example: a measurable, documentable physiological state that in most cases is not itself symptomatic, but which, while not impairing, warrants clinical documentation due to its associated downstream risks. The threshold that defines hypertension, for instance, is a matter of clinical convention, recalibrated in response to evolving evidence and societal standards; a given reading carries different significance for different individuals according to their broader risk (Whelton et al. 2018).

Elsewhere, the convention is being actively reconsidered. Menopause, a universal stage of reproductive aging, is coded among diseases, yet a recent *Lancet* series argues for treating it as a healthy life stage rather than a deficiency to be corrected (Hickey et al. 2024). In the ICD-10 it is filed within the chapter on diseases of the genitourinary system, a physiological transition placed squarely inside a disease framework. Yet by the field's own account it is no disease: the World Health Organization describes menopause as a natural stage of reproductive aging, and the British Menopause Society's 2024 position statement holds that it "is a life stage and does not represent a deficiency state" (Hamoda et al. 2024, 61).

Obesity makes the point more starkly still, because the classification is actively split. The same body is now documented two ways at once: Body mass index (BMI) is documented with a Z-code, a formal documentation of a nondiagnostic characteristic or circumstance that may affect health status, while severity-graded ICD-10 codes, introduced in 2024, record obesity as a disease, the choice between them left to clinical judgment (Centers for Disease Control and Prevention 2025). A 2025 *Lancet* Diabetes & Endocrinology Commission has since recommended that BMI serve only as a population-level surrogate, and distinguishes clinical obesity, diagnosed on evidence of organ dysfunction, from preclinical obesity, in which confirmation of excess adiposity establishes a physical phenotype and expressly does not constitute a disease diagnosis (Rubino et al. 2025). Even as the coding has moved toward disease, a "body positivity" movement has pushed the other way, its advocates, much like autistic self-advocates, rejecting the disorder framing from

within and claiming body size as a form of human diversity rather than a pathology to be corrected (Franco et al. 2025; Mehl 2023). The conceptual question is under active philosophical scrutiny, and the disagreement runs along the axis this paper identifies: whether the category in question records a dysfunction or a difference from normative expectations (Mehl 2023; cf. Sholl and De Block 2024).

Gender incongruence, discussed earlier, is the case in which this reorganization has already been carried out. Taken together, these cases suggest a direction of travel. As the disorder frame is recognized to fit certain conditions poorly, the classification will need more room to document states and conditions outside that frame. Autism would then belong in an appropriate chapter that acknowledges a stable human characteristic without implying pathology.

The structural proposal that follows is specific, and more achievable than it may appear, because its foundation already exists. A code for autism is already in place, F84.0 in the ICD-10, carried forward into the ICD-11 as 6A02, but it is not yet doing the work this moment requires. In practice, it remains tethered to the DSM's diagnostic criteria, inheriting the pathologizing assumptions of the disorder framework, and it still sits within the classification's own chapter of mental and behavioral disorders. Its redevelopment would follow the path already taken for gender incongruence: not a mere decoupling from DSM criteria, but a re-situating of the code itself, out of the disorders chapter and into a descriptive register, a genuinely non-pathologizing record of the autistic neurotype, an identifiable neurological reality that is neither a disorder nor merely an identity assertion. Alongside it, the DSM would establish a bounded category of Autism-Related Disorders: a diagnosis that captures the downstream impairments that may arise, in particular individuals, either from the interaction between the neurotype and environmental demands it cannot meet without support, or from features of the neurotype itself, independent of environmental mismatch, associated with impairments across cognitive, sensory, communicative, and adaptive domains.

This division speaks directly to a concern that critics of the current trajectory have pressed from the clinical side. The architecture proposed here answers that worry rather than compounding it: The descriptive code absorbs the broad, non-impairing presentations that would otherwise loosen the diagnostic category, while the bounded Autism-Related Disorders tier retains the impairment criterion and, with it, the precision on which access to services depends. The present account holds that such precision cannot be restored while one category is still asked to serve description, identity, and impairment at once, and that once those functions are housed separately, the aim of a clean disorder category becomes attainable rather than obstructed.

The architecture allows two things to be simultaneously true, in different institutional registers:

- An ICD code says: this neurotype is present—a descriptive, neutral statement that documents a clinically recognized condition without pathologizing it, grounding eligibility for the supports the neurotype warrants.
- A DSM diagnosis says: this person has autism-related impairments, requiring a different class of services and supports.

The two registers stop competing for the same word because they operate in genuinely different frameworks, with genuinely different purposes. The clinical machinery that allocates resources retains its impairment criterion, and therefore its coherence and its

ethical justification. The neurotype that identity advocates have claimed is recognized as real and clinically documentable, without their having to prove impairment in order to have their way of being acknowledged.

This does not make an identity claim contingent on the code. Self-identification stands on its own footing; what the code changes is that the clinical record ceases to contradict it, and that accommodation no longer requires a person to be certified as disordered in order to receive it.

The architecture also draws a clinically and ethically meaningful distinction between two kinds of need, sorted not by their cost but by their locus. Some needs arise at the environmental and relational locus, in the fit between a person and their surroundings and the relationships around them and are met by adjusting that environment or supporting the individual's capacity to manage it; others arise at the locus of the person's own functioning and are met by supporting or treating the individual directly. Needs of the first kind—from accommodations in schools, workplaces, and clinical settings to supports that work by adjusting a person's environment and relationships—should be met for anyone with a documented neurotype, without a disorder diagnosis; the indicated care that answers needs of the second kind flows from the DSM diagnosis, where the impairment criterion ensures it reaches those who need it. Some environmental and relational supports are themselves resource-intensive, and the boundary admits gray zones; the point is not that one tier is inexpensive and the other costly, but that triage, where it operates, belongs within the indicated tier rather than at the line between the two.

This also resolves, in part, a problem that neither side has been able to answer cleanly: diagnosis without impairment, a problem the current instrument creates for itself, and the ICD-11 sustains. Under the architecture proposed here, the difficulty does not arise. A clinician faced with an autistic adult who is functioning well, who self-identifies, whose neuropsychological profile is consistent, but who reports no clinically significant distress or functional limitation, is no longer forced to choose between a diagnosis that misrepresents them as disordered and no record at all. The descriptive code documents the neurotype and recognizes the person; the absence of an Autism-Related Disorder diagnosis accurately reflects the clinical picture. What Inge Kamp-Becker (2024) identifies as a defect of the category becomes, once the two documentary functions are separated, the system working as it should.

8. The Call

This paper began as a map of a conflict; it ends with a call to action.

The “autism identity crisis” is not, at its deepest, a conflict between advocates and clinicians. It is a diagnostic crisis, a mismatch between a category constructed for one purpose, at a time when autism was only identified in its most impairing presentations, and a reality that the science has since revealed to be considerably broader and more complex. The behavioral paradigm that shaped the original diagnostic criteria was not wrong for its time. It was simply incomplete, and the accumulating neuroscience has made that incompleteness visible.

The identity advocates who resist the impairment framing are not making a category error. They are responding, often intuitively, and sometimes with considerable precision, to

the fact that the word being used to describe them does not accurately describe them or describes only part of what they are.

The clinicians who defend the impairment criterion are not being obstructionist. They are maintaining the integrity of an instrument that still does essential work for people who need support, and resisting, correctly, the risk that loosening the category will dilute the resources and attention available to those who most require them.

Both are right. Both are also, in the current framework, structurally unable to honor the other's concerns, not because either side lacks goodwill, but because the diagnostic system offers a single word, in a single register, to do two different kinds of work. The failure is architectural: The classification lacks the categories it would need to hold both truths at once.

The solution is not to fight over the word. It is to give the word two institutional homes that correspond to its two genuine meanings: a descriptive home in the ICD, where the neurotype can be recognized without pathologizing, and a clinical home in the DSM, where the downstream impairments that require intervention can be diagnosed, treated, and resourced with the precision that those who need support deserve.

But naming the architecture is easier than building it. The more fundamental challenge, and the more important one, is the development of ICD criteria that fulfill its descriptive promise: severing its current dependence on the DSM's impairment framework and replacing it with something the field has not previously attempted. What is required is criteria written not in the language of deficit and deviation, but in the language of difference and description. This has not, in any meaningful sense, been done before. Psychiatric nosology has descriptive codes, but they were not built from the ground up as neutral characterizations of neurological variation; they were largely inherited from disorder frameworks and reclassified after the fact. What is required now is genuinely new, and it will require a process that is collaborative, multidisciplinary, and inclusive of autistic voices as genuine participants rather than consultees—a requirement that is epistemic as much as ethical, since unexamined assumptions narrow what a field thinks to ask (Mehl 2023; Nicolaidis et al. 2019). The criteria themselves must be capable of identifying the neurotype from infancy through adulthood. The neuroscience already points the way. The network organization differences, the salience processing patterns, the interoceptive profile, and the attentional architecture are describable, measurable, and clinically meaningful without being pathological. The research base to build non-pathologizing criteria already exists. What has been missing is the institutional will to use it. The goal is not merely recognition. It is the identification of those who need accommodation, monitoring, and care.

Autism is not a disorder that occasionally produces strengths. It is a neurotype that can produce, in specific people, in specific environments, under specific pressures, conditions that warrant clinical care. The framework for recognition and care should say so.

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