The art of medicine

Embracing neurodiversity in medicine: insights from the history of psychiatry

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At a time when political leaders in the USA still invoke an "autism epidemic" and recycle discredited theories of causation, it is important to reflect on what it means to be autistic. Despite the politics of autism, there has been an increasing drive to recognise autism as a form of neurodivergence over recent years. In line with the neurodiversity paradigm, to be autistic may be seen as both a disability and a difference—one that may manifest in positive and challenging ways depending on broader, external factors.

One aspect to shed light on is the many positive contributions that autistic people have made towards society and within the medical profession. This goes for those recognised as autistic, and also for those who were perhaps simply accepted for their idiosyncrasies, eccentricities, and differences, but who did not have a formal diagnostic label. Furthermore, with this holistic approach in mind, psychiatry's own potential discomfort with neurological differences deserves renewed scrutiny. It is something of an irony that a profession that has long claimed authority over defining mental disorder, was partly shaped by some individuals whose own cognitive styles often diverged from the norms they codified. Reconsidering such figures through a neurodiversity lens illuminates how ideas of autism, normality, and disorder are historically contingent, reflecting the minds and values of those who defined them.

In his *New York Times* bestseller *Neurotribes* our friend and colleague the late Steve Silberman (1957–2024) outlined the historical development of autism as a diagnostic category. Among those he highlighted as shaping medicine's understanding of autism was Robert Spitzer (1932–2015).

Spitzer is widely considered a trailblazer in the field of psychiatry. In an Obituary of Spitzer, the psychiatrist Allen Frances, Chair of the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV Task Force who had worked with Spitzer on DSM III, wrote that Spitzer "shaped psychiatry far more than anyone else in the past half century". Perhaps some of Spitzer's most pioneering and justice-focused actions were his efforts to lead on having homosexuality taken out of DSM II in 1973. Indeed, Frances described this as "the result of his [Spitzer's] single-minded and almost single-handed crusade to eliminate the psychiatric stigmatisation of difference". Despite this work, decades later, in 2003, Spitzer published a controversial study on gay conversion therapy. He later described the work as "fatally flawed" and issued an unequivocal apology to the gay community in 2012.

From the mid-1970s onward Spitzer was responsible for overhauling the DSM in its next revision. Throughout that time, he had a monotropic focus on the task. According to Frances, "no-one has ever been more passionately focused on his work than Bob Spitzer. He literally lived DSM 24/7 for more than 50 years."

Silberman described Spitzer as "obsessed with the problem of diagnostic unreliability" and related how he had a reputation for not greeting or recognising colleagues and failing to acknowledge others, even when spoken to directly. Spitzer appeared oblivious to the thoughts and feelings of other people. He treated "everyone equally, without respect to rank or previous accomplishment", wrote Frances. In *The New Yorker*, Alix Spiegel quoted a collaborator of Spitzer, Jean Endicott, who said: "he [Spitzer] got very involved with issues, with ideas, and with questions. At times, he was unaware of how people were responding to him or to the issue. He was surprised when he learned that someone was annoyed. He'd say, 'Why was he annoyed? What'd I do?'" Spiegel described how Spitzer himself recognised the challenges he faced: "I find it very hard to give presents…I never know what to give. A lot of people, they can see something and say, 'Oh, that person would like that.' But that just doesn't happen to me. It's not that I'm stingy. I'm just not able to project what they would like." Frances is quoted by Spiegel as saying Spitzer "doesn't understand people's emotions. He knows he doesn't. But that's actually helpful in labelling symptoms. It provides less noise."

To be clear, we are not claiming that Spitzer was autistic, since we do not support the exercise of attributing diagnostic labels retrospectively. Speculation on the possible diagnosis of someone who is no longer alive is fraught with ethical issues. For one, the person is not here to speak for themselves. Second, we do not know if the person would have sought a diagnosis. Third, the biographical evidence is inevitably fragmented. Finally, just because someone exhibits a lot of autistic traits, as Spitzer might have, it does not mean they need a diagnosis of autism. The DSM still retains a clinical diagnostic threshold for when autistic traits interfere with a person's ability to cope or their wellbeing and cause some level of distress or suffering. We, however, do not view being autistic as a disorder, which we consider a very stigmatising term, but we do view it as a both a disability and a difference. Frequently, the disability is a reflection of the mismatch between the person and their environment.

Spitzer's singular focus on DSM for over half a century might be suggestive of autistic traits, but he did not apparently experience significant challenges, and so technically did not need a diagnosis under current criteria. Many individuals with great minds show signs of having a high number of autistic traits, being pattern-seekers

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or hyper-systemisers. Such individuals often have breakthroughs in different ways, driving human progress or invention. The invention and refinement of the DSM might be just one example. Creating a system of classification is a clear example of systemising.

Here, we observe this irony, that the person credited with creating the "bible" that forms the foundation of modern psychiatry might himself have embodied the kind of cognitive difference psychiatry for so long often pathologised. As Silberman wrote: "while Spitzer's eccentricities may have fallen short of meeting the criteria for Asperger's syndrome, the DSM III was the product of a mind that exhibited many classic qualities of autistic intelligence". Recognising this possibility that Spitzer may have been considered, in the present day, to have been high in autistic traits reinforces the need to value neurodivergence within medical research and practice.

Considering psychiatry specifically, there is emerging evidence of not only the existence of autistic psychiatrists, but also the many potential benefits they may bring to the profession. For example, a cross-sectional study two of us conducted (MD and SCKS) explored the demographics and experiences of members of Autistic Doctors International. Among 225 respondents, psychiatrists were the second most represented group of autistic doctors, after general practitioners. The majority of autistic doctors within this study felt that being autistic brought benefits to their work, despite also introducing some challenges. Furthermore, in a qualitative study of autistic psychiatrists, participants explained that being autistic themselves led to more positive relationships with their autistic patients—and that recognising their own autism led to improved abilities to recognise and diagnose autism in other people. Autistic doctors also highlight potential harms, including to mental health, of the traditional deficit framing of autism. However, autistic doctors, and psychiatrists in particular, often feel unable to share with colleagues that they are autistic, commonly due to shame. In our survey of autistic doctors, less than a third had disclosed that they were autistic to their colleagues.

Considering the existence of successful autistic psychiatrists invites the deeper question of what it means to be autistic. The current diagnostic criteria leave no room for autistic people who are thriving in an environment that plays to their strengths and meets their needs. Diagnostic frameworks that require clinically significant impairment cannot recognise autism that is currently well accommodated. Yet when the supportive scaffold is removed autistic needs rapidly become apparent. If people on either side of an arbitrary diagnostic cutoff point have more commonalities than differences, what does that tell us about what it means to be autistic?

As we witness a cultural shift in how autism is conceptualised, the history of psychiatry offers instructive parallels. An example from the gay rights movement is illuminating. More than half a century ago, homosexuality was diagnosable as a mental disorder and criminalised in many jurisdictions. Gay psychiatrists had a vital role in changing this. Psychiatrist John E Fryer (1937–2003) gave a seminal address at the APA Convention, on May 2, 1972, disguised as Dr H Anonymous and declared, "I am a homosexual, I am a psychiatrist." This public pronouncement helped change history for gay people and ultimately led to the de-pathologising of homosexuality and its removal from the DSM.

Although we do not equate the different histories of the gay rights movement and histories of autism, we think there are lessons for the field of autism. Autistic doctors have so much to offer the field, and our hope is that by being visible and vocal, autistic doctors, particularly autistic psychiatrists, can overcome stigma, shame, and career risks on disclosure and be change-makers in the field of autism science.

The nature of autism and its place in psychiatry remain contested. Social change begins in part when those within psychiatry challenge the boundaries it has drawn. As more autistic doctors, and psychiatrists in particular, are recognised and empowered to disclose their identities openly we hope that this will increasingly promote awareness and ongoing positive change for autistic people. It is already the case that there are openly autistic clinicians, such as many members of Autistic Doctors International, autistic psychologists (eg, Tony Attwood and Michelle Garnett), autistic scientists (eg, Holden Thorp, Editor-in-Chief of *Science*, and Temple Grandin, Professor of Animal Science at Colorado State University), and autistic lawyers (eg, Arwen Makin, a Senior Crown Prosecutor at the UK's Crown Prosecution Service), to name just a few.

Reviewing his impact through this lens, Spitzer's legacy might once again contribute to dismantling the psychiatric stigmatisation of difference. Recognising the contributions of autistic psychiatrists, past and present, invites the profession to re-examine long-standing assumptions about competence, empathy, and authority—and to envision psychiatry as a field that is strengthened by neurodiversity.

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This essay draws on some ideas explored in MD's PhD thesis. MD is founder and Director of Autistic Doctors International and AutDoc Solutions. SCKS is research lead for Autistic Doctors International. We are deeply grateful to the late Steve Silberman for his groundbreaking work *Neurotribes: The Legacy of Autism and the Future of Neurodiversity*; he was a true ally, and he is sorely missed.

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