



**The End of Asperger’s: An Analysis of the Decision to Remove
Asperger’s Disorder from the DSM-5
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Abstract

Since first formally classified in 1994, Asperger’s disorder (AD) has been a highly controversial diagnosis. Some researchers have argued that it is indistinguishable from high-functioning autism; some have maintained that AD warrants its own diagnosis; and a final group of scholars have claimed that AD should not be considered a disorder but rather should be thought of as a normal human difference. The upshot of this controversy was the decision to eliminate the AD diagnosis from the fifth revision of the Diagnostic and Statistical Manual (DSM-5). This paper explores the question of whether or not this removal of the AD diagnosis is warranted first by reviewing the research that has addressed the legitimacy of the AD diagnosis. The second part of the paper explores the idea that creating the AD label may have been—metaphorically speaking—equivalent to opening Pandora’s box, which implies that an enduring imprint has been left behind. Some scholars have provided evidence of such a long-term impact by arguing that the creation of the AD label has given rise to a new way to be a

person. This paper ultimately contends that the position taken by the DSM-5 in eliminating the AD diagnosis is sound because AD should never have been considered a disorder in the first place. However, due consideration needs to be given to the enduring impact of the AD label. Without the AD label, individuals will need another way to define themselves. This paper advocates for the invention of a new term (e.g., *Aspergian*) that can be used to denote non-pathological instances of AD.

Keywords: Asperger's disorder, autism, DSM-5, neurodiversity

Introduction

In early December 2012, the American Psychiatric Association (APA) issued a press release announcing that its proposed revisions to the upcoming fifth edition of the Diagnostic and Statistical Manual (DSM-5) had been approved (Rudow, 2012). Included in these revisions was the elimination of *Asperger's disorder* (AD), a syndrome characterized by “severe and sustained impairment in social interaction” (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), “restricted, repetitive patterns of behavior, interests, and activities” (DSM-IV-TR, 2000), and, typically, a normal to above average level of cognitive ability. AD was first formally classified as a disorder in 1994, based on research originally done fifty years earlier by a German physician named Hans Asperger (Volkmar & Klin, 2000). Derived from work with four boys who had good language and cognitive skills but marked problems in social interaction, Asperger created the term *autistic personality disorder*. Though they were unaware of each other's work at the time, American psychiatrist Leo Kanner published a year earlier than Asperger about a condition he called *early infantile autism*. Asperger's work was not translated into English until 1981, by which point *autism* had already been established in North America as a severe disorder that was widely recognized. Asperger's work was translated by a British psychiatrist named Lorna Wing, who renamed the condition *Asperger syndrome* and called for some modifications to its conceptualization. Wing changed the term to place some distance between Asperger syndrome—which was far less severe and not associated with impaired intellectual functioning—and autism, which was fixed in the public

eye as an acute disorder with a poor prognosis (Eyal, Hart, Onculer, Oren, & Rossi, 2010). It was Wing's characterization of Asperger Syndrome that formed the basis for the formal classification of AD as a disorder in the DSM-IV in 1994. Since then, research on AD and the number of people that have come to identify with the AD label has grown substantially; yet AD has always been a controversial diagnosis.

The APA claims that the new DSM-5 classification *Autism Spectrum Disorder* (ASD) will inclusively encompass several distinct disorders currently subsumed under the category of *Pervasive Developmental Disorders* (PDDs)—namely *autistic disorder*, *Asperger's disorder*, *childhood disintegrative disorder*, and *pervasive developmental disorder* (not otherwise specified). However, several recent studies (e.g., Mattila et al., 2011; Worley & Matson, 2012) have shown that many individuals with a current PDD diagnosis will no longer be considered disabled under the new criteria, especially those with normal to high cognitive ability. McPartland, Reichow, and Volkmar (2012) found that only 25% of those currently diagnosed with AD would qualify as having an ASD according to the DSM-5. With current estimates of the prevalence of AD at approximately 3 in every 1000 individuals in the United States (Mattila et al., 2011), the impending revision of the DSM will thus likely have an impact on a considerable number of people.

This paper evaluates the APA's decision to remove AD from the DSM-5 by initially reviewing research that has explored the contentious question of whether or not AD is a legitimate diagnosis. Broadly speaking, three groups of researchers have addressed this issue. First, there are those who claim that AD cannot be differentiated from autism and should therefore not be a separate diagnosis (herein collectively referred to as constituting the *conflation position*). Second, there are those who maintain that AD should be considered a disorder distinct from autism (herein collectively referred to as constituting the *distinction position*). A third group of researchers purport that AD should not be considered a disorder, but rather should be regarded as a difference (herein collectively referred to as constituting the *neurodiversity position*). The second part of the paper will propose the idea that the creation of the AD label may have been tantamount to opening *Pandora's box*. In the Greek myth, by the time Pandora closed

the box, the impact of its contents had already been turned loose. Some scholars (e.g., Eyal et al., 2010) have suggested that the AD label actually created a new way to be a person, which provides evidence of an enduring impact that the label has had on society. Analysis of the research that has explored the validity of the AD diagnosis as well as evidence that the AD label has left a significant impact on society will enable a well-rounded discussion around the overarching question, *Is the decision to remove Asperger's disorder from the upcoming revision of the DSM justified?*

The Legitimacy of the Asperger's Disorder Diagnosis

In evaluating the elimination of AD from the DSM-5, it is first necessary to consider the three groups that have taken a stance as to whether or not AD is justified as a diagnosis: the conflation, neurodiversity, and distinction camps. In general, the conflation position has held that AD is not distinguishable from autism because the two disorders do not demonstrate significant differences in symptomatology, and that it is furthermore nearly impossible to meet the DSM criteria for AD if they are strictly followed. The distinction position has maintained that AD warrants its own label separate from autism; this position is supported by empirical evidence demonstrating differences between the two disorders as well as arguments for the clinical utility of the AD label. Finally, the position of the neurodiversity group has been that AD should be considered a normal human difference rather than a disorder conceptualized under the medical model.

The Conflation Position

Advocates of the conflation position generally contend that AD should not be a diagnosis because it is not distinguishable from autism, and having two separate diagnoses causes unnecessary confusion. There are two main types of evidence to support this argument. First, several studies have shown that there is no significant difference in symptomatology between individuals with AD and autism. Miller and Ozonoff (2000) compared a group of 14 children with AD with a group of 26 children diagnosed with high-functioning autism and found no significant differences between the two groups in motor, visual-perceptual, or executive functioning skills. The

researchers accordingly contend that AD is simply a high-functioning form of autism and that separate classifications are confusing to parents, policy makers, and treatment providers. Ozonoff, South, and Miller (2000) compared the symptomatology—cognitive function, executive functioning, language, current behaviour, social skills, and repetitive behaviour—of 23 children with high-functioning autism with 12 children with AD. The study concluded that the two groups differed only in degree or severity, leading the researchers to suggest that the same fundamental symptomatology is involved. Moreover, no differences in executive functioning—assessed through tasks that tested such things as verbal fluency, short-term memory, cognitive flexibility—were discovered between 75 children with autism and 37 children with AD in a 2006 study by Verte, Geurts, Roeyers, Oosterlaan, and Sergeant. The researchers conclude that distinguishing between different subtypes of ASD is not useful. Ritvo, Ritvo, Guthrie, and Ritvo (2008) also found that 19 adults with autism and 25 adults with AD exhibited similar symptomatology, with respect to social interaction, communication, and restricted patterns. Suggested by Ritvo et al. (2008) is that the two disorders share a common etiology and that AD should be considered a mild form of autism. Finally, a literature review by Freeman, Cronin, and Candela (2002) determined that there is a great deal of overlap between the symptomatology of AD and autism, especially with regard to social skills.

A second source of support for the argument that AD is indistinguishable from autism has been provided by studies showing that if DSM criteria are strictly followed, a diagnosis of AD is nearly impossible. AD has only been an official diagnosis in two versions of the DSM—the DSM-IV and the DSM-IV-TR—and there is evidence under both definitions that an individual will almost always be diagnosed with autism over AD. Miller and Ozonoff (1997) analyzed Hans Asperger's original four cases and found that all four met the criteria for autism, not AD, using the DSM-IV criteria. In 2001, Mayes, Calhoun, and Crites analyzed a sample of 157 children with clinical diagnoses of either autism or AD and found that none met the DSM-IV criteria for AD. The researchers claim that presenting AD and autism as distinct diagnoses is confusing for parents and professionals. A subsequent study by Mayes and Calhoun (2004) again analyzed a sample of children with clinical diagnoses of autism or AD and found further

support that the criteria for AD as defined by the DSM-IV are invalid. In this study, the focus was specifically on the use of normal cognition as one criterion for distinguishing between autism and AD. It was found that differences in intelligence were not related to the diagnosis but rather could be accounted for by IQ and age. Finally, Tryon, Mayes, Rhodes, and Waldo (2006) found that almost all (95%) of the 26 parents of children with a clinical diagnosis of AD did not meet the DSM-IV-TR criteria for AD. The researchers claim that most experts are now in agreement that AD is actually a high-functioning form of autism. To account for the prolific use of the AD diagnosis, some of these researchers (e.g., Mayes et al., 2001; Tryon et al., 2006) contend that clinicians do not strictly follow the DSM-IV criteria for AD but rather base their decisions on popular belief about the disorder; hence, they argue, the AD label is redundant and causes unnecessary confusion.

The Distinction Position

The second group of researchers maintain the distinction position, which holds that AD should be a separate diagnosis from autism. The distinction position has been supported in two main ways. First, some studies have found empirical support for qualitative and quantitative differences between the two disorders. For example, a meta-analysis conducted four years after AD was established as a diagnosis, found that individuals with AD performed better on measures of cognitive functioning and adaptive behaviour than individuals with autism, thus supporting the idea that the two disorders are fundamentally different (McLaughlin-Cheng, 1998). A 2001 study by Rinehart, Bradshaw, Moss, Brereton, and Tonge found evidence for a deficit in shifting from local to global processing in 12 individuals with high-functioning autism but not in those 12 with AD. The researchers accordingly suggested that AD may have a unique neurobiological underpinning that differs from that of autism. Ghaziuddin (2008) demonstrated that individuals with AD may have a pattern of social impairment that can be distinguished from individuals with autism. More specifically, Ghaziuddin (2008) found that individuals with AD were described as “active but odd” (p. 141), whereas the individuals with high-

functioning autism were characterized as passive and aloof. Distinctions were furthermore discovered between the cognitive profiles of children with AD and children with high-functioning autism in a study by Planche and Lemonnier (2011). It was shown that there were differences between the two groups in terms not only of language abilities but also of other developmental markers. A meta-analysis of MRI studies on the differences between AD and autism found that the distribution and direction of grey matter in the brain were distinctive among individuals with autism versus individuals with AD (Yu, Cheung, Chua, & McAlonan, 2011). Drawing on research that has found qualitative and quantitative differences between AD and high-functioning autism, such as that of Ghaziuddin (2008), Kaland (2011) argues that it is too early to definitively conclude that the two disorders are the same. Kaland calls for a modification of the diagnostic criteria for AD but contends that it should be retained in the DSM.

The second source of support for the distinction position comes from those researchers that have argued for its clinical utility. Several of these researchers contend that the AD label has clinical utility regardless of whether or not it is considered related to autism. For example, before AD had even been established as a diagnosis in the DSM-IV, Jonathan Green made a case for it as a separate label from autism in his 1990 article entitled *Is Asperger's a Syndrome?*. Green admits the two conditions are similar but claims that there are good clinical reasons for keeping a distinction. He asserts that individuals with AD are quite different from those with autism and so it is useful to have a different way of describing their unique difficulties and outcomes. Bishop (2000) argues that AD has clinical utility as a diagnosis separate from autism because there is so much diversity among those with autism. He additionally contends that there are many children whose deficits resemble high functioning-autism but who do not have the characteristics associated with AD. In 2011, in a letter to the editor, Ghaziuddin claims that the main reason most studies have been unable to find a difference between AD and autism is because the DSM-IV criteria were vague and difficult to use. He maintains that the diagnoses of autism spectrum disorders not be based solely on diagnostic validity but also clinical utility, and that AD should remain a viable category in the DSM-5 because it has become a clinically useful term. Similarly, Lorna Wing—the

researcher who first coined the term Asperger's Disorder—and her colleagues agree that there is value to the AD label, despite believing that it is likely on a spectrum with autism (Wing, Gould, & Gillberg, 2011). Wing et al. (2011) argue that ASD sub-categories, especially AD, should be retained for humanitarian reasons. They claim that individuals currently labeled as having AD along with their families want to dissociate themselves from the autism label because of its negative connotations, and because of a risk of jeopardizing their eligibility for medical or social services in the future.

The Neurodiversity Position

Neurodiversity is a broad position that postulates different, and equally valid, ways for the brain to be neurologically wired. Researchers in the neurodiversity camp argue that AD should be considered a human difference rather than a disorder and that a medical conceptualization is not appropriate for AD. One of the first neurodiversity advocates for AD was prolific autism researcher Simon Baron-Cohen. In 2002, Baron-Cohen contended that the term *difference*, as opposed to *disability* or *disorder*, is a fairer and more value-free description to apply to AD. He points out that disability is relative to the environment, and that if environmental expectations were to change, individuals with AD would not be perceived as disabled. Baron-Cohen also claims that to focus on the disability aspect of AD is to focus only on the negative. He points out that there are positive aspects to AD, as well, and that they need to be recognized. Also in 2002, Molloy and Vasil explored the social construction of AD as a disorder and claimed that AD has been a case of pathologizing mere difference. They furthermore criticize using the medical model approach to developmental disorders, as it is a deficit model that focuses on weakness and attempts to *normalize* the individual. Molloy and Vasil urge that the undetermined social impact on a child's life of the AD label needs to be a serious consideration.

Building on the work of Baron-Cohen and Molloy and Vasil are scholars Marc Wheeler and Sarah Allred. Wheeler (2011), a scholar who has been diagnosed with AD, critically reviewed the literature on the medical conceptualization of AD. He concludes that the medical conceptualization of

AD does not fully account for the complexity of individuals with the condition and that AD should thus be reconceptualized as an accepted social difference. Wheeler moreover poses an interesting question when he asks if the deficits associated with AD would still exist if placed in a context where it was advantageous to speak frankly. Moreover, Allred (2009) supports the neurodiversity position by first showing that the clinical criteria for AD are not reliable and lack measurement validity. She demonstrates that AD should not be in the DSM because it does not meet the criteria for a mental illness. Allred uses the evolving perceptions of homosexuality as an example of how AD can be reframed as a socially constructed difference rather than a disorder. Allred (2009) says that both homosexuality and AD are examples of “differences [that] remain laden with subjective, culturally relative judgments about normality” (p. 353) and calls for AD to be demedicalized (i.e. not regarded as a disorder under the medical model).

Finally, more recent support for the neurodiversity position comes from Jaarsma and Welin. In their 2012 article, they discuss the neurodiversity movement and its application to ASD. In accord with Allred’s argument that a parallel can be drawn between AD and homosexuality, Jaarsma and Welin (2012) point out that “in a homophobic society nearly all homosexuals will appear pathological. The cure for these problems has simply been a wider acceptance of homosexuality” (p. 25). They furthermore claim that many individuals with AD likely have mental illnesses due to the *autism-phobic* character of our society. Concluded by Jaarsma and Welin is that it is morally wrong to include individuals with AD under the broad diagnostic category of ASD because society should not stigmatize them as being disabled.

Closing Pandora’s Box

Thus far, what has been presented are the three positions—conflation, distinction, and neurodiversity—that have taken a stand as to whether or not the DSM-5 is justified in eliminating the AD diagnosis. Now we will turn briefly to Greek mythology—the story of Pandora and her box. Given the box as a wedding gift, she is told never to open it. However, one day, overcome by curiosity, Pandora opens the box and all the evils of the world

are released. *Opening Pandora's box* then is a phrase that signifies a seemingly small action giving rise to serious and far-reaching consequences. In 2000, Lorna Wing equated her creation of the AD label with opening Pandora's box. Insofar as millions of individuals all over the world have come to identify with the label, thousands of studies have explored AD, and it has become an increasingly popular characterization in books, television, and movies, its creation as a diagnostic label has clearly had significant and extensive consequences. In the Greek myth, Pandora slams the box shut after she opens it, but it is too late—its contents have been released to take on a life of their own in the world. If the metaphor of Pandora's box does indeed apply to AD, it is worth exploring what enduring imprint has been left on society in the establishment of AD as a diagnosis. Support for the validity of this metaphor as applied to AD comes from Eyal et al. (2010), who argue that one fundamental corollary to the creation of the AD label is that it created a new way to be a person.

Using a critical historical approach rooted in the work of modern philosopher Ian Hacking, Eyal et al. (2010) showed that the AD label has had a *looping effect*, which is the term Hacking (2007) uses for the interaction between a label and the people to whom the label is applied. Hacking (2002) says that social change creates new categories of people, which in turn “creates new ways for people to be....People spontaneously come to fit their categories” (p. 100). Wing (2005) notes that growing publicity of AD led more and more people to question if AD could provide an explanation for the difficulties they or a loved one had been experiencing in the social realm. Increasingly, therefore, individuals began to interpret themselves and their experience through the lens of AD. According to Eyal et al. (2010), moreover, media portrayals and public representations of ASD shape the prototypes that are later reflected in changes in the DSM. For example, they say that Temple Grandin (who is arguably the most famous representative of AD) “stretched the autism prototype, making room on the spectrum for others who may not have shown such classic autistic traits as children but identified with her circumscribed interests, visual thinking, or particular sensory experience of the world” (p. 228). This looping effect, in which the label changes alongside the people labelled, is involved in what Hacking (2007) calls *making up people*. Eyal et al. (2010) accordingly

contend that the AD label has essentially created a new way to be a person and that with this has come “new ways of acting, speaking, and representing” (p. 229).

If it is indeed correct that the AD label has created a new way to be, the implications for individuals who identify with the label may be significant when it no longer exists. As a faction of the neurodiversity movement, a unique subculture has arisen around AD. Many independent organizations have been established, and a spate of AD websites has been created. Individuals with AD network with each other online and offline, and affectionately refer to themselves as *Aspies*. The end of AD could, in effect, undermine the identity of people with Asperger’s Disorder.

Discussion

In considering the conflation, neurodiversity, and distinction positions, all three of these arguments may have some truth to them. There is validity to the conflation position—AD and autism do seem to have considerable overlap. Several researchers of the conflation group (e.g., Freeman et al., 2002; Ozonoff et al., 2000; Ritvo et al., 2008) indeed found that AD and autism share similar symptomatology. Miller and Ozonoff (2000) and Verte et al. (2006) may thus be correct in saying that having separate labels for AD and autism causes confusion. Given the vast amount of information—sometimes conflicting—available on autism and AD, it would certainly be a puzzling situation for an individual and his or her family to be diagnosed by one clinician as having AD and by another as having high-functioning autism. Furthermore, it is curious that several studies (e.g., Mayes et al., 2001; Tryon et al., 2006) have demonstrated that a DSM-IV or DSM-IV-TR diagnosis of AD is nearly impossible. If the criteria are strictly adhered to, an individual who demonstrates characteristics of AD is likely to be diagnosed with autism. This does suggest, as it has thus far been formally classified, the AD diagnosis is redundant. However, lack of support for prior diagnostic attempts does not necessarily negate altogether the validity of an AD diagnosis, but rather could be interpreted as grounds for a revision of the criteria.

In conflict with the findings of the conflation camp is evidence from the distinction camp (e.g., Planche & Lemonnier, 2011; Yu et al., 2011) that demonstrates qualitative and quantitative differences in the symptomatology of AD and autism. It has become fairly well-established that the diagnostic line between AD and high-functioning autism is blurry. The point made by conflation researchers is that AD diagnoses may be more often based on a clinician's impression of what AD is rather than strict adherence to diagnostic criteria. This calls to question the results of any research that has compared AD with autism. Some supporters of the distinction position (e.g., Ghaziuddin, 2011; Green, 1990; Wing, 2005) concede that AD and autism are likely related, but argue nonetheless that it should remain a label due to its clinical utility. Lorna Wing has contended from the start that AD should be considered on the ASD spectrum but should be retained for the sake of the individuals being labeled as well as their families. In 2011, upon threat of the elimination of the AD label, Wing et al. (2011) put forward that "many people with the diagnosis of Asperger's syndrome object very strongly to the possible loss of their label, which they much prefer to that of autism spectrum disorder or just 'autism'" (p. 771). Wing et al. (2011) furthermore raise a good point when they question what will happen to those individuals currently diagnosed with AD who no longer qualify under the DSM-5 criteria.

There is also truth to the neurodiversity position. Baron-Cohen (2002) and Wheeler (2011) are correct in pointing out that disability is relative to environment and that in a different context, individuals with AD may not be considered disabled. According to philosopher Ian Hacking (2009), first-person awareness of emotional states is a relatively modern phenomenon that came into being slowly over time, and so hundreds of years ago, individuals with AD-like qualities would not have stood out the way that they do at present. It therefore seems erroneous to say that there is something medically abnormal about individuals with AD. Molloy and Vasil (2002) moreover raise a valid concern in highlighting the potential impact on a child's quality of life by being involuntarily labeled as having AD. Wheeler (2011), who was diagnosed with AD at a young age, says that he noticed a big difference in the way people treated him following his diagnosis. While a child and young adult, Wheeler (2011) says he felt that,

“every behaviour he exhibited was attributed to his condition and he was defined not as a person, not as an individual, but as a label” (p. 848). Labels in the medical model reduce an individual to their peculiar weaknesses and obscure their strengths and their uniqueness. Therefore the medical model may not be the best approach for conceptualizing AD.

Ultimately, the APA’s decision to eliminate the AD diagnosis in the DSM-5 indicates a success for the conflation group, with potential benefits for the neurodiversity camp (in that the new criteria appear to pathologize a narrower band of symptoms). However, even if either of these two positions is theoretically correct, final consideration should be given to the possibility that in creating the AD label, Pandora’s box may have been opened. Eyal et al. (2010) suggest that over the past 19 years, a new way to be a person has developed, which would suggest that a significant imprint has been made on society in the creation of the AD label. What will it mean to those individuals already diagnosed with AD when the label no longer exists? Of further concern is the effect there will be on high-functioning individuals in the future who would have been diagnosed with AD under the DSM-IV criteria but are now seen as having ASD. Will it affect such individuals’ quality of life to identify themselves through the label of ASD rather than AD?

In light of the above discussion, the issue of whether or not the DSM-5 is justified in eliminating the AD diagnosis is clearly complex and not conducive to a simple answer. It is ultimately the contention of this paper that, in line with the neurodiversity position, AD should never have been considered a disorder, but should have always been seen as a normal human difference. It may be for the best, and thus warranted, that the DSM-5 criteria for ASD appear to pathologize a narrower band of symptoms. However, it also needs to be remembered that just because they are no longer considered pathological by the DSM, AD characteristics may still be poorly perceived by the majority of the population. To successfully reframe AD as a normal human difference, according to neurodiversity advocates like Allred (2009) as well as Jaarsma and Welin (2012), society will need to become more accepting of AD symptoms (as was witnessed over the past forty years with the reframing of homosexuality).

Furthermore, though the elimination of the AD diagnosis may be justified, Pandora's box has been opened in the creation of the AD diagnosis. A new way of being has been created. It would be remiss to eliminate the AD label without due acknowledgment of the considerable social imprint left by its 19-year tenure as a DSM diagnostic label. In a sense, this way of being—described as AD—will be invalidated in eliminating the diagnosis. In one fell swoop, all of the research that has been done and all of the organizations that have been established will be, according to the DSM, rendered defunct. Consideration should be given to those individuals who have come to see themselves through the AD lens. Will such individuals keep the AD identity alive, even when the diagnosis no longer exists? Or will individuals currently diagnosed with AD embrace a new way of being under the ASD label? Perhaps high-functioning individuals could create an alternative. Many abnormal conditions are examples of normal characteristics gone somewhat awry—for example, shyness is a normal trait, but at the pathological level it is considered to be social anxiety disorder. It might be useful to invent an adjective (for example, *Aspergian*) to describe non-pathological instances of AD. That way, individuals could still have a term with which to interpret and describe themselves, without dysfunction and abnormality necessarily being inferred.

Conclusion

The foregoing evaluated the recent decision that was made by the APA to remove the AD diagnosis from the DSM-5. First, consideration was given to the three positions that have generally been taken as to whether or not AD is justified as a diagnosis: the conflation position, the distinction position, and the neurodiversity position. This paper ultimately sides with the neurodiversity position and posits that AD should have never been considered a disorder to begin with; thus, the paper argues that the APA is justified in eliminating AD. It has also been argued, however, that the creation of the AD label has essentially created a new way to be a person, which provides evidence that an enduring impact has been left on society. It would be unfair to remove the AD diagnosis without considering the implications of invalidating the AD way of being. In time, people who have

come to see themselves with reference to the AD label will need some other way to define themselves. This paper advocates for the creation of a new adjective (e.g., Aspergian) that can be used to describe non-pathological instances of AD so that the behaviour and characteristics can be described without necessarily implying disorder.

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