

A Neurodiverse Perspective on Autism Spectrum Disorder and the Medical Necessity of Applied Behavior Analysis

To the Editor:

Historically, autism spectrum disorder (ASD) has been conceptualized by clinicians, payers, researchers, and policymakers through a biomedical model.¹ As with physical conditions, the biomedical model of disability emphasizes pathology and characteristics associated with a diagnosis that result in deficits that impede functioning. Accordingly, funding and interventions aimed at supporting autistic individuals have targeted remediation of deficits, arguably to mirror the functioning of neurotypical peers.² We describe and advocate for a neurodiversity framework in the context of the medical necessity of Applied Behavior Analysis (ABA) in support of autistic individuals and conclude with recommendations for delivering neurodiversity-affirming ABA.

A NEURODIVERSITY FRAMEWORK

In contrast to the biomedical perspective, we advocate for practitioners and payers to adopt a broader view of ASD. We suggest blending developmental, behavioral, and social frameworks by incorporating a neurodiversity perspective ensuring value, support, and understanding of autistic individuals.

The term neurodiversity, first popularized by psychologist Judith Singer in 1998,³ refers to ASD as 1 variation among a diversity of minds. The neurodiversity paradigm posits natural variation in how people perceive and process information and interact with others. It encompasses a range of cognitive, sensory, and behavioral differences across several conditions, such as ASD, attention-deficit/hyperactivity disorder, dyslexia, and Tourette's syndrome. The neurodiversity movement's advocates acknowledge symptoms and challenges commonly associated with diagnoses such as ASD, while emphasizing that differences in perception and behavior are necessary and valuable.⁴ Although some aspects of ASD pose significant impediments, including profound presentations and co-occurring conditions that therefore may warrant treatment, the neurodiversity perspective highlights neurodivergence as positive to the individual and society.⁵

Proponents of neurodiversity as an element of biodiversity emphasize the need to create an "ecological community" that supports the conservation of neurodivergent individuals.⁶ Paralleling the benefits of biodiversity, neurodiversity may confer both individual and evolutionary advantages to species survival.⁷ Although conjectural, in ancient farming societies in which heads-down attention to sowing was essential, so too perhaps was the genotype of more distributed attention (eg, attention-deficit/hyperactivity disorder) that would enable detection of distant predators. For ASD, advocates of the neurodiversity movement highlight beneficial attributes associated with the diagnosis, including hyperacute focus for an extended time, less sensitivity to social norms, keen focus on specific topics, and a well-developed moral compass (Table 1).⁸ Similarly, preferences of some neurodivergent people for alternative modes of communication have powered computer science, work processes (eg, remote work), and advancements in other disciplines.¹¹

As awareness of the neurodiversity movement has increased, a dichotomy has emerged between the disorder-focused biomedical model and a model of intervention that celebrates individual differences.⁴ Whereas different bodily states such as fatigue, hunger, or inebriation can impact functioning, more deeply rooted traits such as left-handedness¹² and sexual orientation¹³ that historically were pathologized under the biomedical model have only in the last few decades been recognized by the mental health and medical communities as natural examples of human diversity. Similarly, although many aspects of the ASD diagnosis require clinical attention and are more likely to comprise the cases treated within psychiatric practices, we suggest that some so-called deficits may benefit more from public support, acceptance of difference, and societal adjustments and accommodations.

MEDICAL NECESSITY AND ABA

Grounded in the science of learning and behavior, ABA is one of the most common evidence-based practices in supporting autistic individuals, insurance coverage for which is mandated in all 50 states and Washington, DC, when medically necessary for ASD.² ABA practitioners focus on creating meaningful behavior change centered on the needs of each person receiving services. Structured, personalized approaches help in understanding and reducing interfering behaviors, while promoting key

TABLE 1 Examples of Neurodiverse Perspectives on Autism Spectrum Disorder (ASD) Traits in *DSM-V-TR*

DSM-V-TR ASD diagnostic trait	Neurodiverse perspective	Potential opportunities for neurodiversity-informed treatment
Fixated interest, abnormal intensity and focus	Hyperacute focus for an extended time, thoroughness, concentration	Use the specific interest to build rapport and practice new skills.
Difficulty adjusting behavior to suit social contexts	Less sensitivity to social norms that may exert undue influence, unique perspectives Less susceptibility to the bystander effect, greater likelihood to identify and report inefficient or dysfunctional processes ⁹	Offer support/caregiver training to parents, teachers and community members to better understand perspectives of autistic individuals.
Strong preoccupation with unusual objects	Keen focus on specific topics, in-depth knowledge and expertise, creativity and innovation	Build in self-driven breaks within therapy centered around patients' interests. Encourage patients to choose options based on interest.
Rigid thinking patterns	"Super moral" cognitive style, ⁹ attention to detail, analytical	Identify strengths and how thinking patterns impact quality of life. If practicing flexibility, introduce gradually, with self-defined breaks.
Abnormal social approach, failure of back-and-forth conversation	Ability to empathize with other neurodivergent individuals better than neurotypical peers can, ¹⁰ honesty, integrity	Request billable time to support and coach parents, teachers and relevant stakeholders to better understand autistic individuals. Provide opportunities for neurodivergent patients to work with other neurodivergent individuals. Support social connections with other neurodiverse peers.

Note: Adapted with permission from American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th ed, text rev.* Washington, DC: American Psychiatric Association; 2022.

functional areas in social, communication, leisure, and adaptive skills.¹⁴

Although fundamentally individualized, with an emphasis on promoting autonomy, ABA is often criticized as associated with the medical model, particularly when funded through insurance.⁴ Payers' expectations emphasizing interventions targeting the individual's deficits compared with neurotypical peers can conflict with the guiding principles of ABA to implement services with respect, dignity, and in accordance with the rights and welfare of the individual.² Critics raise concerns that emphasis is placed on minimizing deficits, which may be viewed as autistic traits that do not conform to societal norms and expectations, and prioritizing compliance with directives, potentially at the expense of the autistic individual's sovereignty.

NEURODIVERSITY-AFFIRMING ABA

Neurodiversity-affirming ABA accepts the autistic individual while focusing on person-centered treatments to improve quality of life. To this end, clinicians and researchers who truly aim to empower the autistic

community must accept and promote a shift from a biomedical model of disability to a social model in which characteristics commonly associated with neurodivergence are experienced as impairments only when society fails to recognize, involve, and adapt.⁴ When intervention is necessary to enhance the lived experience of the individual, resources will then be more readily available to promote self-determination and the individual's preferences for goals and skills.¹

We recommend that clinicians avoid potentially ableist practices of encouraging masking (ie, inhibiting autistic responses and presenting alternatives thought to be socially normative) or code switching (ie, adjusting one's communication and behavior to match social expectations), higher levels of which have been associated with worse mental health outcomes.¹⁵⁻¹⁷ Instead, clinicians may focus on helping caregivers and community members understand the adaptive nature of these behaviors and create accommodating environments. This perspective does not dismiss the range of clinical presentations of ASD, including those with components that contribute to concerns for safety and basic functioning in which targeted behavior reduction strategies may be warranted.⁵

Practitioners, including many ABA providers, have reflected on services previously identified as best practices and created space for autistic voices to be heard in the development of programs, research, and policy agendas.¹⁴ However, uncertainties persist, particularly in the availability of services for autistic individuals that depend on funding through insurance, where medical necessity must be demonstrated through diagnostic deficits, and intervention is aligned with the remediation of these identified impairments. For this reason, funders must also become active participants in supporting a neurodiversity paradigm. By working together, the autistic community, practitioners, and payers can ensure that intervention focuses on the needs and desires of the autistic individual. Whereas the biomedical model may still be appropriate for addressing meaningful behavior changes that promote autonomy, integration of strength-based approaches can remain at the forefront of intervention.

Implementing Neurodiversity-Affirming ABA

Although treatment recommendations, implementation strategies, and funding determinations should be individualized, the following general practices are suggested to align neurodiversity-affirming approaches with medically necessary ABA services. This list is not exhaustive, prescriptive, or universally applicable and should be adapted based on individual context:

- Prioritize socially valid skill development and strength-based approaches that promote self-determination, autonomy, and independence.
- Consistently arrange opportunities for assent, choice making, collaboration, and self-advocacy in skill expansion targets, goals, and treatment objectives.
- Incorporate behavior reduction strategies and targets only when there is a clear safety risk or potential for harm, and balance any reductive goal with strength-based approaches.
- Use tools and data to guide decisions regarding implementation and continuation of intervention strategies that prioritize benefits to and preferences of the autistic individual.
- Include modifications that enrich the individual's environment; convey support and understanding; and increase awareness, acceptance, and inclusion.
- Use affirming, respectful, and nonpathologizing language when communicating with and about the autistic indi-


vidual (eg, "behavior targeted for reduction" instead of "problem behavior," strength-based descriptions, age-appropriate explanations).


- Continuously evaluate whether the strategies employed meaningfully support the autistic individual's autonomy, values, goals, and quality of life.
- Emphasize autistic voices and perspectives in the development of policies and procedures that influence provision of treatment, research practices, prioritization of resources, and definitions of medical necessity.
- Include neurodiverse viewpoints in training, supervision, and continuing education of behavior analysts.

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This article is part of a special series devoted to the subject of the mental health of autistic children and adolescents. The series was edited by Guest Editors Ellen Hoffman, MD, PhD, David Cochran, MD, PhD, Meng-Chuan Lai, MD, PhD, and Emily Simonoff, MD, FRCPsych, Consulting Editor Jean Frazier, MD, Associate Editor Robert R. Althoff, MD, PhD, and Editor-in-Chief Douglas K. Novins, MD.

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Accepted December 19, 2025.

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The authors have reported no funding for this work.

The authors thank Eileen Chen, MLIS (University of California San Francisco), for assistance searching the literature. We are grateful for comments on the manuscript from our colleagues at Evernorth, namely, Lisa Kay, MSW, MBA, Douglas Nemecek, MD, MBA, and Laura Marko, BA, and from Courtney Tarbox, MS, BCBA, at First Steps for Kids, Inc. We are especially grateful to Jacqueline Gainer, MBA, from Cigna Healthcare for her comments from a neurodivergent perspective.

Disclosure: Darren J. Sush is a paid employee of Evernorth Health Services. Stuart L. Lustig is a paid employee of Cigna Healthcare. Lauren Presti Morrison is a paid employee of Evernorth Health Services.

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0890-8567/\$36.00/©2025 American Academy of Child and Adolescent Psychiatry

<https://doi.org/10.1016/j.jaac.2025.12.012>

REFERENCES

1. Donaldson AL, Krejcha K, McMillin A. A strength-based approach to autism: neurodiversity and partnering with the autism community. *Perspectives of the ASHA Special Interest Groups*. 2017;1(2):56-68. <https://doi.org/10.1044/persp2.SIG1.56>
2. Council of Autism Service Providers (CASP). ABA Practice Guidelines (Version 3.0). Applied behavior analysis practice guidelines for the treatment of autism spectrum disorder: guidelines for healthcare funders, regulatory bodies, service providers, and

- consumers (Clinical practice guidelines). 2024. Accessed July 20, 2025. <https://www.casproviders.org/asd-guidelines>
3. Singer J. *Odd People In: The Birth of Community Amongst People on the Autistic Spectrum: a Personal Exploration of a New Social Movement Based on Neurological Diversity*. Honours thesis. Sydney: Faculty of Humanities and Social Science, University of Technology; 1998.
 4. Schuck RK, Tagavi DM, Baiden KMP, *et al*. Neurodiversity and autism intervention: reconciling perspectives through a naturalistic developmental behavioral intervention framework. *J Autism Dev Disord*. 2022;52(10):4625-4645. <https://doi.org/10.1007/s10803-021-05316-x>
 5. Leadbitter K, *et al*. Autistic self-advocacy and the neurodiversity movement: implications for autism early intervention research and practice. *Front Psychol*. 2021;12:635690. <https://doi.org/10.3389/fpsyg.2021.635690>
 6. Chapman R, Botha M. Neurodivergence-informed therapy. *Dev Med Child Neurol*. 2023;65(3):310-317. <https://doi.org/10.1111/dmcn.15384>
 7. Jaarsma P, Welin S. Autism as a natural human variation: reflections on the claims of the neurodiversity movement. *Health Care Anal*. 2012;20(1):20-30. <https://doi.org/10.1007/s10728-011-0169-9>
 8. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, text rev. Washington, DC: American Psychiatric Association; 2022.
 9. Hartman LM, Farahani M, Moore A, *et al*. Organizational benefits of neurodiversity: preliminary findings on autism and the bystander effect. *Autism Res*. 2023;16(10):1989-2001. <https://doi.org/10.1002/aur.3012>
 10. Chapman R. Neurodiversity and the social ecology of mental functions. *Perspect Psychol Sci*. 2021;16(6):1360-1372. <https://doi.org/10.1177/1745691620959833>
 11. Austin RD, Pisano GP. Neurodiversity as a competitive advantage. *Harv Bus Rev*. 2017; 95(3):96-103.
 12. Callinan S, Leggat G, Van Egmond K, Lindell A. The impact of handedness on health risk behaviours and socio-economic outcomes. *Pers Individ Dif*. 2022;187:111411. <https://doi.org/10.1016/j.paid.2021.111411>
 13. Robles R, Real T, Reed GM. Depathologizing sexual orientation and transgender identities in psychiatric classifications. *Consort Psychiat*. 2021;2(2):44-52. <https://doi.org/10.17816/CP61>
 14. Mathur SK, Ellie R, Tarbox J. Affirming neurodiversity within applied behavior analysis. *Behav Anal Pract*. 2024;17(2):471-485. <https://doi.org/10.1007/s40617-024-00907-3>
 15. Pearson A, Rose K. A conceptual analysis of autistic masking: understanding the narrative of stigma and the illusion of choice. *Autism Adulthood*. 2021;3(1):52-60. <https://doi.org/10.1089/aut.2020.0043>
 16. Cook J, Hull L, Crane L, Mandy W. Camouflaging in autism: a systematic review. *Clin Psychol Rev*. 2021;89:102080. <https://doi.org/10.1016/j.cpr.2021.102080>
 17. Roberts J. Ableism, code-switching, and camouflaging: A letter to the editor on Gerlach-Houck and DeThorne (2023). *Lang Speech Hear Serv Sch*. 2024;55(1):217-223. https://doi.org/10.1044/2023_LSHSS-23-00037

All statements expressed in this column are those of the authors and do not necessarily reflect the opinions of the *Journal of the American Academy of Child and Adolescent Psychiatry*. See the Guide for Authors for information about the preparation and submission of Letters to the Editor.