

Masking Is Not an Exhaustion Symptom

How Psychiatric Diagnostics Reduce Autistic Existence to Failure

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Abstract

In current psychiatric and diagnostic practice, masking in autistic persons is predominantly interpreted as an exhausting act of adaptation, whose pathological relevance is assumed to manifest above all in visible failure, breakdown, or burnout. This reading has become established not only in everyday clinical contexts, but also in parts of neurodiversity-oriented research. The present paper argues that this interpretation rests on an implicit, normative ontology that treats neurotypical forms of existence as an unquestioned reference and renders autistic existence legible only in relation to deviation, deficit, or exhaustion.

Starting from an ontological perspective on masking, the paper shows that masking is not primarily to be understood as self-denial or an attempt at adaptation, but as a situational act of translation, protection, and interface-work within structurally asymmetrical world architectures. The clinical reduction of masking to an indicator of exhaustion leads to a diagnostic short circuit: autistic competence, stability, and functional simulation are systematically interpreted as deception or compensatory over-adaptation, while autism is acknowledged as “authentic” only at the moment of decompensation.

The paper analyses the resulting dynamic as an iatrogenic structure: diagnostic recognition is bound to visible failure, thereby generating an implicit pressure toward decompensation. In this framework, autistic burnout appears not merely as an individual consequence of masking, but as a structurally produced harm of a system that can read autistic existence only in the mode of dysfunction. The focus thus shifts from individual vulnerability to institutional responsibility.

In conclusion, the paper argues for a fundamental revision of diagnostic concepts of masking. Masking must be understood as an ambivalent, context-dependent competence, not as a pathological condition. Without such a revision, psychiatry reproduces precisely those dynamics of exhaustion and breakdown that it claims to recognise and treat. Autistic burnout thus becomes visible less as a symptom of autistic existence than as a marker of an ontologically inadequate diagnostic practice.

This paper is situated within the context of:

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This contribution is an interface text within a broader operator-based research program. Core concepts are employed here in application rather than re-derived. The underlying research corpus operates in a non-linear, rhythmically recursive mode of structural analysis that cannot be fully rendered in standardized academic English without loss of epistemic resolution. The author's primary research practice is grounded in an autistic mode of structural perception; the present text provides an interface translation of this work for academic contexts.

1. Introduction: Masking as a Clinical Key Problem

In recent years, the concept of masking has assumed a central position in clinical and social-scientific engagements with autism. Originally introduced to make visible adaptive strategies used by autistic persons in dealing with neurotypical social environments, masking has increasingly come to function as a diagnostic marker. In psychiatric practice, it is frequently understood as the expression of an overburdening adaptation effort, whose pathological relevance is assumed to manifest particularly in exhaustion, breakdown, or burnout.

This shift is not trivial. It marks a transition from a descriptive to a normative use of the concept. Masking is no longer primarily regarded as a situational, context-dependent performance, but as a latently pathological condition that must “sooner or later” necessarily become exhausted. Within this logic, autistic burnout appears as the moment in which masking visibly fails—and thus simultaneously as the moment in which autism becomes diagnostically unambiguous.

The present paper argues that this clinical reading of masking rests on an implicit ontological presupposition that takes neurotypical forms of existence as an unquestioned reference frame. Within this frame, masking is read exclusively as deviation, self-denial, or over-adaptation. Autistic competence, stability, or functional simulation thus come under systematic suspicion. They do not appear as expressions of an autonomous mode of existence, but as temporary deception whose dissolution is diagnostically anticipated.

The aim of this paper is to critically analyse this diagnostic logic. This is not a moral critique of individual practitioners, nor a blanket rejection of psychiatric diagnostics. Rather, the paper seeks to show that the prevailing interpretation of masking produces a structural short circuit: it binds diagnostic recognition to visible failure and thereby generates dynamics that themselves contribute to the emergence of autistic burnout. Masking thus shifts from an analytical concept to a clinical trap.

2. The Implicit Norm: Neurotypical Existence as the Reference Frame

Psychiatric diagnostics does not operate in a norm-free space. Even where it understands itself as descriptive and objective, it rests on implicit assumptions about what counts as functional,

stable, or desirable. In the case of autism, neurotypical existence functions largely unquestioned as the reference frame. Perception, communication, affect regulation, and social interaction are measured against neurotypical standards, without these standards themselves being reflected as specific, historically and culturally situated forms of existence.

Within this frame, autism appears primarily as deviation. Autistic behaviours are not understood as expressions of an autonomous ontological logic, but as deficient variants of a supposedly universal model of subjectivity and sociality. This assumption usually remains implicit, yet it decisively shapes the interpretation of diagnostic phenomena. Against this background, masking is inevitably read as an attempt to approximate a normal state assumed to be superior.

The result is an asymmetrical interpretation: neurotypical functioning is regarded as authentic, autistic functioning as secondary or compensatory. When an autistic person succeeds in acting stably, in a controlled manner, or with apparent competence in certain contexts, this is not read as an expression of their own competence, but as an indication that “actual” autistic difficulties are being concealed. Visible dysfunction thus becomes the implicit criterion of truth.

This logic has far-reaching consequences. It narrows the view of autism to those moments in which deviation, overload, or breakdown becomes visible. Autistic existence is not diagnostically recognised as a continuous reality, but only where it can no longer fulfil the neurotypical frame of expectation. In this context, masking does not function as a description of a performance, but as a moment of suspicion: as long as someone functions, they are considered not truly visible.

In this way, the ground is prepared for an interpretation of masking that implies exhaustion not merely as a possible consequence, but as a necessary endpoint. Autistic burnout appears in this perspective less as a contingent risk than as the expected culmination of an “inauthentic” mode of existence.

3. The Problematic Counterfigure: Unmasking as a Supposedly Healthy Solution

Parallel to the pathologisation of masking, the notion has increasingly become established in clinical and activist discourses that unmasking represents the healthy, authentic, or long-term desirable form of autistic existence. Within this opposition, masking appears as a harmful act of adaptation, while unmasking is framed as liberation, self-discovery, or a therapeutic goal. This dichotomy, however, is as reductive as it is problematic.

The assumption that unmasking is healthy per se presupposes that social, institutional, and material environments are capable of sustaining autistic existence in an unmasked state. This is precisely not the case in most societal contexts. Labour markets, educational systems, medical institutions, and bureaucratic procedures are largely structured around neurotypical norms and respond to unmasked autistic existence not with acceptance, but with sanction, exclusion, or pathologisation. Under these conditions, unmasking is not a neutral act of self-care, but is often associated with significant risks.

The clinical idealisation of unmasking ignores this structural reality. It shifts responsibility from the system onto the individual by implicitly suggesting that health emerges through disclosure and self-exposure, rather than through changed conditions. Autistic persons are thereby placed in a double bind: masking is deemed harmful, while unmasking is considered dangerous. The choice between these two options is not a therapeutic one, but an existential one.

In addition, unmasking is frequently misunderstood in diagnostic contexts. When masking is read as deception, unmasking appears as the revelation of an “authentic” self. This implies an essence presumed to be hidden beneath the mask and made visible through its removal. Such an assumption is ontologically problematic. It equates authenticity with immediacy and fails to recognise that unmasked behaviour, too, is always situational, relational, and context-dependent. There is no presuppositionless, pure self beyond all social mediation.

In practice, this idealisation gives rise to new forms of clinical violence. Autistic persons are encouraged or pressured to abandon masking without the environments in which they live being transformed at the same time. Unmasking thus becomes another demand for adaptation—this time not to neurotypical norms, but to a therapeutic ideal of authenticity. The consequences are frequently social isolation, economic precarity, or renewed pathologisation.

From a diagnostic perspective, a further problem emerges: unmasking is read as proof of authenticity and thus of diagnostic truth. Those who suffer while unmasked are considered “truly” autistic; those who remain stable while masking are seen as not yet visible or not honest. In this way, the previously described requirement of failure once again becomes the condition of recognition—this time not through masking, but through its abandonment. The structural pressure toward dysfunction remains in place; only its form changes.

The present paper therefore argues that both masking and unmasking can only be meaningfully understood diagnostically if they are removed from the logic of health versus pathology. Both are context-dependent modes of navigating existence within structurally asymmetrical environments. Neither masking nor unmasking is healthy or pathological per se. What is pathogenic, rather, is a system that recognises autistic existence only under conditions of visible suffering.

4. The Diagnostic Short Circuit: Masking, Unmasking, and the Logic of Representability

The dynamics described so far—the pathologisation of masking and the simultaneous idealisation of unmasking—converge in diagnostic practice into a shared structural short circuit. Regardless of whether autistic existence appears masked or unmasked, it is recognised as diagnostically relevant only when it becomes visible, legible, and usable in a particular form. This form is not neutral, but bound to the representational logic of psychiatric systems.

Diagnostics necessarily operates through representations: symptom descriptions, categories, scales, and codes. These instruments are functional, but they presuppose that what is to be captured can be translated into standardised signs. Within this framework, masking becomes recognisable only where it can be represented as a symptom—typically in the form of exhaustion, overload, or breakdown. As long as masking functions, it remains diagnostically invisible or is read as deception. Competence, stability, or situational control do not appear as expressions of autistic existence, but as indications that “actual” difficulties are being concealed.

The counterfigure of unmasking is subject to the same logic. Unmasking is evaluated positively where it can likewise be rendered unambiguous: as visible dysfunction, social conspicuousness, or suffering. Here too, representability functions as a silent criterion. Unmasking that does not culminate in diagnostically usable forms—for example because it leads to a different, yet viable mode of navigating existence—remains unnoticed or is again

problematised. Recognition is granted not on the basis of existence, but on the basis of displayability.

It thus becomes clear that the decisive distinction does not lie between masking and unmasking, but between representable and non-representable existence. Autistic existence is not read diagnostically as a continuous, autonomous reality, but is mediated through its replaceability by symptomatic formats. What cannot be translated into these formats without loss disappears from the diagnostic field of vision. In its place appears the representation: the symptom profile, the diagnosis, the file.

This mechanism can be described as a form of representational violence. This does not refer to an intentional act of harm, but to a structural effect: systems that can process only what can be represented eliminate those forms of existence that resist such translation. Autistic existence is not misrepresented, but replaced by its representation. Representation functions—and precisely through this functioning, reality is lost.

The diagnostic short circuit thus consists in autism appearing either as masked deviation or as unmasked dysfunction, while a third possibility is systematically excluded: the recognition of autistic existence as a competent, situationally modulated, and not necessarily exhausting reality. Masking and unmasking become opposing poles of a false dichotomy, within which only that which fails, suffers, or collapses is considered “real.”

Within this structure, autistic burnout is not merely recognised, but actively prepared. When diagnostic visibility is bound to representability, and representability to dysfunction, an implicit pressure toward decompensation emerges. Burnout then appears not as a contingent consequence of individual overload, but as a structurally expected point at which existence finally fits into the diagnostic grid. The resulting harm is therefore not only individual, but systemically co-produced.

5. The Pressure Toward Decompensation: When Recognition Is Bound to Dysfunction

From the diagnostic logic described in Section 4 emerges a dynamic that is highly problematic for autistic persons: diagnostic recognition is effectively bound to visible dysfunction. Not explicitly, not intentionally, but structurally. Autistic existence becomes clearly legible only where it fails, becomes overwhelmed, or collapses. Stability, control, or functional adaptation, by contrast, remain suspicious or invisible.

This linkage generates an implicit pressure toward decompensation. Those who remain stably masked over longer periods in everyday life, work, or institutional contexts risk not being taken seriously diagnostically. Symptoms must be amplified, burdens emphasised, and resources downplayed in order to become recognisable at all. The diagnostic process thus actively shapes how autistic persons speak about themselves, present themselves, and relate to their own functioning.

This is not a matter of conscious deception, but of structural adaptation to diagnostic horizons of expectation. Autistic self-descriptions become strategically distorted—not out of dishonesty, but out of necessity. What does not fit expected narratives does not count. What functions too well is regarded as inauthentic. The boundary between self-description and self-erasure becomes dangerously blurred.

Particularly problematic is the fact that this dynamic produces long-term, real effects on how existence is lived. When masking is persistently interpreted as deception and unmasking only as dysfunction, autistic persons are left with little space in which functional but non-normative modes of existence can be lived sustainably. The pressure either to suffer visibly or to negate oneself operates continuously. It does not merely exhaust psychologically, but intervenes in the very structure of self-perception and agency.

In this sense, decompensation is not merely an individual risk, but a systemically induced option. Breakdown becomes the condition of visibility. Autistic burnout then appears not as an unexpected event, but as the logical endpoint of an arrangement that ties recognition to loss. The longer functional masking is maintained, the greater the discrepancy between lived reality and diagnostic legibility—until it can be resolved only through collapse.

This pressure toward decompensation is particularly strong in institutional contexts where access to support, accommodations, or legal recognition is tied to diagnosis. Autistic persons face a paradoxical demand: in order to gain access to support, they must relinquish or call into question precisely the functional capacity that has thus far enabled their survival within these structures. Assistance is granted only once existence has already been damaged.

This dynamic once again shifts responsibility from the system onto the individual. Burnout appears as a personal failure to meet demands, rather than as the result of a diagnostic framework that recognises only dysfunction. The structural involvement of diagnostics in the production of autistic burnout remains invisible—even though it is functionally effective.

6. Autistic Burnout as an Iatrogenic Harm

Against the background of the preceding analysis, autistic burnout can no longer be understood solely as an individual consequence of masking or as the result of personal overload. Rather, it becomes apparent that burnout in many cases has an iatrogenic character: it arises not only despite, but through diagnostic and institutional practices that systematically misread autistic existence.

Iatrogenic here does not mean that burnout is intentionally caused. It denotes a structural co-production through procedures, categories, and horizons of expectation that operate in a way that produces harm while functioning formally correctly. Psychiatric diagnostics contributes to autistic burnout by tying recognition, support, and legitimacy to conditions that destabilise autistic existence over the long term.

The central mechanism at work is the coupling of visibility and dysfunction. As long as autistic persons function while masking, they remain diagnostically marginal or are considered “not severely affected enough.” When they function stably while unmasked, they lose legibility or are once again problematised. Only in states of exhaustion, overload, or collapse do they become unambiguously recognisable. Burnout thus becomes the paradoxical entry ticket into diagnostic reality.

This logic has serious consequences. It produces a situation in which autistic persons are compelled to turn their own existence against itself in order to be recognised. Functional competences are suppressed or devalued, stability is interpreted as deception, and limits are exceeded in order to signal seriousness. The system does not reward sustainability, but collapse.

Within this context, autistic burnout appears not as an accidental or unavoidable endpoint of autistic adaptation efforts, but as a structurally expected event. Breakdown is the moment at which existence finally passes into diagnostically usable forms. What previously appeared too complex, too contradictory, or too functional now becomes unequivocal: exhausted, dysfunctional, in need of treatment.

Particularly problematic is the retrospective naturalisation of this dynamic. Burnout is subsequently read as evidence that masking was “always” harmful. The system’s involvement in producing burnout remains invisible. Harm appears as a property of the autistic person, rather than as an effect of a framework that does not permit sustainable forms of existence.

In this sense, autistic burnout is less an expression of individual failure than a marker of the ontological inadequacy of diagnostic models. It indicates that a system can recognise autistic existence only under conditions that undermine that existence itself. Burnout is therefore not merely a clinical phenomenon, but a structural symptom—pointing to the fact that the conditions under which autism is diagnostically conceived are not viable.

7. Ontological Inadequacy of Diagnostic Models

The preceding analysis makes clear that the problem does not lie primarily in individual misinterpretations or a lack of sensitivity, but is more deeply rooted. The dominant diagnostic models of psychiatry lack a viable ontology of autistic existence. They operate with logics of deviation rather than logics of existence. Within these models, autism is not understood as an autonomous mode of being-in-the-world, but as a deviation from an implicitly posited normal state.

This ontological presupposition has immediate consequences for the interpretation of masking and unmasking. Masking necessarily appears as self-denial because the model provides no category for situational, context-dependent navigation of existence. Unmasking necessarily appears as the revelation of an “actual” state because authenticity is equated with immediacy. Both readings presuppose the existence of a stable, normatively defined mode of functioning against which health is measured.

What these models lack is the capacity to think complexity without pathologisation. Forms of autistic existence that are neither clearly dysfunctional nor norm-conforming evade diagnostic capture. They are neither sufficiently ill nor healthy in the expected sense. It is within this void that the short circuits arise which distort both masking and unmasking and facilitate burnout.

Ontological inadequacy becomes particularly evident where diagnostics are oriented toward long-term assessment. Models that primarily conceive autism as a disorder or deficit cannot describe a sustainable form of autistic existence. They recognise only two states: compensated deviation or manifest dysfunction. Everything in between remains theoretically underdetermined and practically invisible.

As long as diagnostic systems grasp autism exclusively in relation to neurotypical norms, every form of autistic competence remains precarious. It is always provisional, always suspect, always potentially revocable. Stability is not regarded as an expression of a viable mode of existence, but as a fragile equilibrium that must sooner or later collapse. Burnout is thus not read as a warning signal of systemic misconditions, but as the expected confirmation of a deficit-oriented model.

This contribution does not aim to establish a new ontological norm of autistic existence, but to expose the implicit ontology through which diagnostic recognition is systematically bound to failure.

8. Consequences: Revising Diagnostic Categories Rather Than Optimising Adaptation

From the present analysis, a clear consequence follows: the problem cannot be resolved through better education, increased sensitivity, or individualised therapeutic approaches. Such measures fall short as long as the underlying categories remain unchanged. What is required is a revision of the diagnostic concepts themselves—particularly where masking and unmasking function as markers of health or pathology.

Masking must no longer be diagnostically understood as an exhaustion symptom per se. Nor should unmasking be idealised as a therapeutic goal. Both are context-dependent modes of navigating existence within structurally asymmetrical environments. Their evaluation cannot be separated from the conditions under which they become necessary. Health, in this context, is not a property of behaviour, but a question of the viability of the environment.

Without this categorical shift, autistic burnout remains a systemically produced harm. It continues to be treated as an individual problem, even though it points to structural incompatibilities. Diagnostic frameworks that can recognise autism only in the mode of failure actively contribute to the production of that failure.

A future-oriented diagnostic practice would therefore need to cease understanding autism exclusively as deviation from a norm and instead recognise it as an autonomous mode of existence with its own conditions of stability. Only then can masking be understood for what it is: neither illness nor virtue, but a situational response to conditions that themselves ought to be called into question. Within such a framework, autistic burnout would no longer be the price of recognition, but a signal that recognition comes too late.

Conclusion

The present paper has shown that the prevailing psychiatric interpretation of masking and unmasking is not merely imprecise, but structurally inadequate. Masking is diagnostically read as a symptom of exhaustion, unmasking as a sign of authenticity or therapeutic progress. Both interpretations rest on the same implicit assumption: that autistic existence is real, legitimate, or recognisable only when it can be rendered in dysfunctional or suffering forms.

This logic binds diagnostic visibility to representability, and representability to failure. Autistic competence, situational stability, and functional navigation of existence remain invisible under these conditions or are treated as deception. Recognition is granted not on the basis of existence, but on the basis of loss. The diagnostic framework thus produces precisely those dynamics of breakdown that it subsequently interprets as clinical findings.

Against this background, autistic burnout no longer appears as a mere consequence of individual adaptive effort, but as an iatrogenic harm produced by a system that lacks a sustainable category for autistic existence. Burnout marks the point at which existence finally fits into diagnostically usable formats. It is less an expression of autistic vulnerability than an indicator of the ontological limitation of diagnostic models.

The central consequence is therefore not a better balance between masking and unmasking, but the necessity of a categorical revision. As long as diagnostics primarily understands autism as deviation from a neurotypical norm, it remains incapable of recognising autistic existence beyond deficit or collapse. Under these conditions, masking and unmasking are not health markers, but responses to structural incompatibility.

A diagnostic practice that does not wish to continue co-producing autistic burnout must therefore cease treating failure as a condition of truth. It would need to recognise autistic existence as an autonomous, competent, and context-dependent reality—not only where it collapses. As long as this does not occur, burnout remains not an individual problem, but a systemic symptom.

The dynamic described here does not apply to all diagnosticians, but to the structure of diagnostic logic itself.

The analysis developed here is categorical in nature. It describes conditions of diagnostic visibility and is not designed as an outcome study. Its empirical testability depends on the existence of diagnostic systems that do not operationalise autism primarily in the mode of dysfunction.

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