NeuroFX
Changing Minds

WOMEN, HORMONES AND NEURODIVERGENCE · 11.3

Autistic Girls: The Recognition Gap and What to Look For

Autism in girls is consistently under-identified. The historical clinical ratio of 4:1 boys to girls is now thought to be closer to 3:1, with the missing cases concentrated in girls without intellectual disability whose autism has been masked, missed or recoded as anxiety.

FOR
Parents and carers of girls

AUDIENCE AGE
6-17

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IN SUMMARY

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Why it gets missed

- **The boy-template misses the girl-version.** Limited speech, visible early social difficulty and trains-and-timetables interests is one expression of autism. It is not the only one. Verbally fluent, socially observant, mimicking girls do not trigger that template.
- **The data shows the gap is structural.** Loomes 2017 meta-analysis estimates the true sex ratio at around 3:1, with the additional female cases concentrated in girls without intellectual disability. The improvement in UK diagnosis rates over the last twenty years has been driven largely by better recognition of these missed cases.
- **Anxiety, depression and eating difficulty often come first.** Many autistic girls reach CAMHS or the GP via the mental health front door long before autism is on the table. Treating the symptoms without addressing the underlying autism often produces partial response and recurrent relapse.

What it actually looks like

- **Social mimicry from early childhood.** Watching, copying, scripting. A daughter who appears socially competent but is exhausted by the effort. Often replays social interactions afterwards in obsessive detail.
- **Intense interests in socially acceptable topics.** Animals, books, fictional characters, a celebrity, social media, psychology. The intensity is the same as the boy-template interests; the content does not flag autism.
- **The home-vs-school discrepancy is often the giveaway.** Quiet and well-presented at school all day, distressed or explosive once the school door closes. Teacher reports and parent observations often look like two different children.
- **Sensory profile managed privately.** Clothes labels, seams, specific foods, busy supermarkets, school assemblies. Often visible to family, often invisible to teachers.
- **Adolescence usually makes it more visible.** Social complexity rises, masking becomes harder to sustain, burnout emerges, hormonal change comes in. Many autistic girls reach the diagnostic conversation in early-to-mid teens.

How we can help

- **GP first; raise autism explicitly in CAMHS.** If your daughter is in CAMHS for anxiety, low mood or an eating disorder, raise the autism question explicitly. NICE CG170 covers the under-19s pathway.
- **School recognition and identity-first language.** Once she is on SEN Support or an EHCP, sensory breaks, a named adult and predictable arrangements do useful work. Ask explicitly for identity-first language in the support plan.
- **Private assessment where the NHS wait is not workable.** NeuroFX offers private paediatric autism assessment. Connection with other autistic girls (peer support, autism-literate therapy) is often the most consistently helpful single intervention.

WHEN TO SPEAK TO A PROFESSIONAL

Speak to your GP if you recognise your daughter in this picture and want to start the NHS pathway. Where she is in CAMHS for anxiety, low mood or an eating disorder, raise the autism question explicitly. For self-harm or suicidal thinking, NHS 111 (mental health option), CAMHS crisis team via your GP, or 999 / A&E for immediate risk; Samaritans 116 123. NeuroFX offers private paediatric autism assessment where the NHS wait is not workable.

SOURCES

Bargiela 2016; Lai 2015; Loomes 2017; Russell 2022; Hull 2017; NICE CG170; NAS