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# Neurodiversity: bridging the gap between the disabled people's movement and the mental health system survivors' movement?

*Steve Graby*

### **Introduction**

This chapter traces the origins and evolution of the neurodiversity movement, which consists of people with conditions (such as autistic spectrum 'disorders', AD(H)D, dyspraxia, or dyslexia) which have been positioned somewhere between the traditional categories of 'disability' and 'mental illness'. The neurodiversity movement has roots in, and, as will be argued, has new insights to offer to, both the disabled people's and survivor movements.<sup>1</sup> Therefore, it should be of interest to those seeking to bridge conceptual gaps between the disabled people's and survivor movements – such as the sticking point between them over the concept of 'impairment' (Plumb, 1994).

Writers and activists within the neurodiversity movement are acutely aware of, and concerned with, the social construction of both 'distress' and 'disability', and have developed their own distinct analysis of these concepts. This chapter gives an overview of some of that thinking. It draws on my own experience within the neurodiversity movement, as well as on published literature from all three movements, to illustrate the convergences and divergences between them, and finally offers some suggestions for ways forward.

### **Disabled people and mental health system survivors: two movements**

The relationship between the disabled people's movement and the survivor movement is complex. In its early stages, the modern disabled people's movement was overwhelmingly focused on physical

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impairment. This is reflected in the names of seminal groups such as the Union of the Physically Impaired Against Segregation (UPIAS), in whose founding policy statement ‘people who are called...mentally ill’ were classed among ‘other oppressed groups’ with which it was felt that the physically impaired ought to ally, while retaining a separate identity (UPIAS, 1974). The movement’s ‘big idea’ was the social model of disability (Hasler, 1993). As a broader understanding of this was developed, however, survivors increasingly became considered part of the movement and of the category ‘disabled people’. Included within this group were other ‘non-physically’ impaired groups such as d/Deaf people and people with learning difficulties, which groups have also notably remained somewhat separate in their self-organisation from the ‘broader’ disabled people’s movement.

Reactions to this from the survivor movement have been mixed. Some survivor activists have welcomed the social model because of its attribution of disability to social exclusion and oppression, rather than to something inherent in individuals. For many, however, the concept of impairment as distinct from disability has been a major stumbling block, with some survivor activists arguing that to categorise mental distress as an impairment is to return to the medical and pathological models of ‘mental illness’ from which their movement seeks to escape (Plumb, 1994; Wilson and Beresford, 2002). Other survivor activists, such as McNamara (1996), regard the ‘impairment debate’ as divisive and detrimental to the movement, arguing that survivors are ‘disabled’ by the stigma and material oppression they experience, whether or not they are regarded as having an impairment. This does, however, raise the question of the limits of the term ‘disability’: as Plumb (1994) points out, if disability is defined solely as oppression and impairment is not regarded as a prerequisite for it, many other groups could be considered ‘disabled’ who would not ordinarily be defined as such.<sup>2</sup>

## Neurodiversity: a new perspective on the debate

A more recent development potentially provides a new and significant intervention into this debate: the neurodiversity movement. This movement encompasses people with a variety of diagnostic labels (such as autistic spectrum conditions, dyslexia, dyspraxia and AD(H)D), and arguably has roots in both the disabled people’s and survivor movements. The neurodiversity movement grew primarily out of self-advocacy by autistic people, which began to emerge in the 1990s in response to the growth of a parent-dominated ‘autism advocacy’ lobby. In response to the latter’s search for a ‘cure’ for autism, neurodiversity

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activists argued that it and similar conditions should be seen not as pathologies needing a ‘cure’ but as natural differences which should be accepted and accommodated.

Significantly, the diagnostic categories generally put under the umbrella of ‘neurodiversity’ fall somewhat between the broader categories of ‘mental illness’ and ‘disability/impairment’. Like the former, they are included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and primarily diagnosed by psychologists and/or psychiatrists. However, they are also linked to the latter; first due to their overlap with categories of ‘learning difficulty’/‘learning disability’, and second due to being typically defined as congenital and permanent. This contrasts with most categories of ‘mental illness’ which are typically regarded as first occurring in adolescence or adulthood, often caused by traumatic life events, and episodic and/or ‘curable’.

The term ‘neurodiversity’ started to be used around the late 1990s, primarily by the emerging generation of autistic adults writing first-person accounts of their experience. It possibly had more than one independent origin at around the same time (Meyerding, 2002). One often-cited ‘first published usage’ is Judy Singer’s chapter in the 1999 book *Disability Discourse*, edited by Marian Corker and Sally French. Drafts of this chapter were circulated among online autistic spectrum groups before its publication, leading to online usages of the word pre-dating the book and generating other usages which may be traced back to Singer (1999), despite earlier publication dates (Savarese and Savarese, 2010). Moreover, neurodiversity perspectives were articulated by autistic activists, such as Jim Sinclair, Larry Arnold and Martijn Dekker, before the word itself was used. Sinclair’s 1993<sup>3</sup> article ‘Don’t mourn for us’, for example, despite not using the term ‘neurodiversity’, is often regarded as one of the founding documents of the neurodiversity movement (Boundy, 2008; Sinclair, 2012a).

While people with diagnoses on the autistic spectrum were certainly the main originators of the term and the concept – and the neurodiversity movement continues to be centrally focused on autism, with many regarding it as synonymous with the ‘autistic rights movement’ – other conditions such as AD(H)D, dyslexia, dyspraxia, and in some cases the broader field of ‘developmental disabilities’ or ‘learning difficulties’ were acknowledged as being part of neurodiversity from the start. The representation of people with such diagnoses in the neurodiversity movement has increased in more recent years.

In addition, some people are beginning to identify with the concept of neurodiversity who have been classified by psychiatry in categories more commonly associated with ‘mental health’ than with ‘disability’

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(such as ‘schizophrenia’ and ‘bipolar disorder’). For example, Suzanne Antonetta, who was diagnosed with ‘bipolar disorder’, gave her 2005 book *A Mind Apart* – which describes her experience, and that of autistic author, Dawn Prince-Hughes, as well as those of friends with diagnoses such as ‘dissociative identity disorder’ (formerly known as ‘multiple personality disorder’) – the subtitle ‘Travels in a Neurodiverse World’. An online community of self-defined ‘multiples’ also exists, who see their separate ‘personalities’ not as a dissociative pathology but as different ‘people’ sharing a brain and body, each of whom has a right to exist. This has links to, and overlaps with, the autistic and broader neurodiverse communities (Baggs, 2006).

A core principle of neurodiversity is that conditions such as autism, AD(H)D, and so on, are ‘real’ and neurological in nature. This contrasts with the view held by many in the ‘anti-psychiatry’ and ‘critical psychiatry’ communities that AD(H)D is a category constructed by pharmaceutical companies to pathologise behaviour in children who may previously simply have been seen as ‘naughty’, in order to promote the sale of drugs such as Ritalin (see, for example, Timimi, 2002). Similarly, the neurodiversity movement opposes the beliefs, held by many ‘autism parents’ and ‘alternative’ medical practitioners, that autism is an ‘epidemic’ caused by any number of factors such as diet, environmental pollutants or, most notoriously, vaccinations such as that against measles, mumps and rubella (Waltz, 2013).

These conditions are seen as constituting a variety of minority ‘neurotypes’ of equal validity to the majority (so-called ‘normal’) human neurotype, which should be neither pathologised nor ‘cured’. In fact, if minority neurotypes are not ‘illnesses’, by definition no ‘cure’ for them can exist. Therefore, some of the movement’s most visible activism has been in opposing charities such as Autism Speaks whose objectives are to ‘cure’ or eliminate autism. Alongside public bodies such as the New York University Child Study Center, these charities’ advertising campaigns portray autism (and, in the latter case, other psychiatric diagnoses) as a monstrous, villainous entity, requiring a metaphorical ‘war’ to ‘defeat’ it (Kras, 2010; Gross, 2012; Sequenzia, 2012). This parallels the portrayals of disabled people by, and the disabled people’s movement’s activism against, charities such as Leonard Cheshire in the UK and the Muscular Dystrophy Association’s Telethon in the US (Johnson, 1994; Clark, 2003; Withers, 2012).

Neurodiversity activists thus seek social acceptance and equal opportunity for all individuals regardless of their neurology (Ventura33, 2005), believing that neurological diversity should be celebrated and appreciated, and there is no one type of neurology which is ‘the best

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and the only way' (AS-IF, 2007). People who experience difficulties in society due to their cognitive or behavioural differences from the norm therefore need to be recognised and accommodated, with an emphasis on the need to change society rather than the individual.<sup>4</sup> Boundy (2008, unpagged) regards 'the desire to be freed from forced behavioural conformity' as the 'most central concern of the neurodiversity movement and community'. The neurodiversity movement, like the disabled people's movement (Oliver, 1994), is thus strongly critical of 'normalisation' paradigms, and prioritises 'subjective well-being' (as defined by the individual) over functioning in normative ways (Kapp et al, 2013).

Neurodiversity is often described as comparable to ethnic diversity and to the diversity of sexual and gender identities (Antonetta, 2005; AS-IF, 2007). As neurodiversity activist Nick Walker (2012, 156) writes, 'there is no "normal" state of human brain or human mind, any more than there is one "normal" race, ethnicity, gender or culture'. Thus the term 'neurotypical' was coined by neurodiversity activists to refer to the majority neurotype without reinforcing its privileged status and the marginalisation of others (Singer, 1999; Walker, 2012).<sup>5</sup> While a group or a society can be 'neurodiverse', it is generally considered inaccurate to call an individual person 'neurodiverse', as neurodiversity encompasses both the typical and the atypical; however, 'neurodivergent' can be used as a generic adjective to refer to people of minority neurotypes.

It has been argued that the neurodiversity movement was influenced by, and rooted in, the disabled people's movement and, in terms of its identity-construction, particularly the Deaf identity movement (see for example, Dekker, 2004). Others have also argued that it is rooted in the survivor movement and ideas associated with it, such as the 'anti-psychiatry' of critical authors such as RD Laing and Thomas Szasz (Boundy, 2008).<sup>6</sup> For those with an interest in bridging conceptual gaps between the disabled people's and survivor movements, such as the sticking point over whether the concept of 'impairment' applies to survivors, the neurodiversity movement should therefore be of great interest as an already-existing fusion of both.

Activists in the neurodiversity movement seek to reclaim impairment labels (such as 'autism') from the authority of the medical and psychological professions, and to re-value them, in positive terms, as components of a self-determined identity (Sinclair, 2012b; Meyerding, 2002). In this, the neurodiversity movement takes a stance similar to the 'affirmation model of disability' proposed by Swain and French (2000), and further developed by Cameron (2008; 2011). The latter

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argues that an affirmative model of ‘disabled’ identity that is consistent with, and complementary to, the social model affirms not disability but impairment. Impairment, in turn, is re-defined as ‘difference to be expected and respected on its own terms in a diverse society’ (Cameron, 2008, 24). This position is associated with movement slogans such as ‘celebrate difference with pride’ and closely parallels the ‘Mad Pride’ stance of some radical strands within the survivor movement (for example, Curtis et al, 2000). The affirmation model offers a way of understanding disability as oppression, without necessarily assigning negative value to the physical or mental differences conventionally categorised as ‘impairment’. This would mean that Plumb’s (1994) warning that ‘admitting to an impairment’ means ‘legitimising and maintaining the link with “illness”’ (p 18) does not necessarily hold true.

### Trauma, oppression and the problematics of distress

The experience of distress is, however, difficult to fit into an affirmation model. Arguably, by definition, the term ‘distress’ can only describe something bad and unwanted. For this reason, the concept of ‘Mad Pride’ is one with which many survivors do not identify, and there are considerable tensions within the survivor movement between, on the one hand, those who see their ‘madness’ as positive or neutral and, on the other, those who consider ‘distress’ as a problem requiring a solution, albeit not a medical or psychiatric one. It could be easy to dismiss the neurodiversity perspective as not at all helpful for the latter group, who may see their experiences of distress as rooted in trauma, oppression and the impossible demands of life in a profoundly alienating society, rather than to do with any ‘difference’ to which a positive value could be ascribed. However, writers and activists within the neurodiversity movement are acutely aware of, and concerned with, issues around distress, and have developed a considerable analysis of it, within a framework that distinguishes it clearly from (unproblematic) ‘difference’.

Neurodiversity activists are also keen to point out that many people with conditions such as ADHD or ‘high-functioning’ autism go undiagnosed into adulthood – particularly if they present in ways that do not fit psychiatrists’ stereotypes of those conditions – and that this experience very frequently results in mental distress and/or involvement with the ‘mental health’ system. This can include misdiagnosis, with labels such as ‘schizophrenia’, which also has gendered aspects, as women are arguably more likely than men to be misdiagnosed or to go undiagnosed (Baker, 2004). Neurodiversity activists contend, however,

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that the distress experienced by these people is usually not a product of their actual neurotype, so much as a (fully reasonable) reaction to being continually misunderstood and rejected by a neurotypical-normative society; an example of what Thomas (1999) describes as psycho-emotional disablism (see Reeve, 2012a; and also, Donna Reeve, Chapter 7, in this volume). Thus, what is needed to alleviate distress is not 'medical' intervention, but a transformation of society. This position fits well with Plumb's (1994) conceptualisation of distress as 'dissent', as well as with the central contention of the social model of disability: that a disabling society, rather than a disabled individual, is 'the problem'.

In a vicious irony, this distress may then itself be regarded as 'pathology' by society, resulting in the involvement of the psychiatric system, where it is then further pathologised within a 'symptom'-focused 'illness' paradigm. Indeed, some neurodiversity activists suggest that many of those characteristics currently considered to meet diagnostic criteria for conditions such as autism are – rather than markers of 'innate' difference – the traumatic effects of on-going psycho-emotional oppression experienced by neurodivergent people. Such reactions are even more likely to be pathologised if that 'innate' difference results in reactions to trauma that are different enough from those of neurotypical people not to be easily recognised as such – and seen instead as 'unintelligible' behaviour (Pilgrim and Tomasini, 2012) – and/or if situations are experienced as traumatic that a neurotypical person would be unlikely to recognise as such; for example, an autistic person with hypersensitivity to sound may find the noise of crowds or traffic unbearable, and might therefore react to it in similar ways to physical pain, such as crying or screaming, running away from the noise in apparent panic, or using repetitive movements (such as hand-flapping or head-banging) as a counter-stimulus to help cope with it.

From a neurodiversity perspective, therefore, the concept of 'mental illness' can be seen as a socially constructed category including both 'neurodivergence pathologised' and distress experienced as a result of psycho-emotional disablism or other forms of oppression.

Proponents of neurodiversity would tend to accept that certain aspects of some divergent neurotypes may be distressing (for example, the sensory intolerances and/or auditory processing difficulties experienced by many autistic people, or difficulty following a conversation as experienced by someone with ADHD).<sup>7</sup> They would simultaneously question whether these differences are 'inherently' distressing, however, or more a matter of social and environmental surroundings not being suited to the individual. Most would also accept



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the possibility that, for some (although certainly not all) people who experience mental distress, that distress may be caused by some form of physical or chemical factor, and thus not originate from, though it may well be exacerbated by, social or environmental conditions. In such cases, however, self-definition and self-determination, rather than paternalistic medical authority, would still be regarded as the preferred basis for any social response to distress. Therefore, the neurodiversity framework can enable the inclusion of both those who identify their mental distress as purely biochemical, and those who regard it as purely 'socially reactive'. It is not necessarily mutually exclusive to conceptualise distress both as part of some 'impairments' and as the result of unfair and oppressive social conditions.

Neurodiversity activists tend to accept that wide-ranging social change is too ambitious and long-term a goal to be useful to an individual in acute distress, of whatever origin. They thus generally support a pragmatic, libertarian response to individual distress, based on whatever 'treatment' a given individual determines to be useful to them. For example, while neurodiversity activists oppose the routine prescription of psychotropic drugs for 'normalising' purposes (such as stimulants like Ritalin for ADHD), and non-consensual drugging (either directly against the will of the 'patient' or of children too young to give informed consent), most would support the right of the individual to choose to take such drugs, if they find their effects useful. This position fits well with ideas supported by the survivor movement, such as the 'drug-centred model' of psychoactive drug action, which has been proposed by the critical psychiatrist, Joanna Moncrieff (2007), as a replacement for the 'disease-centred model' of mainstream biomedical psychiatry. By conceptualising drugs in terms of the effects that they produce and whether they are helpful, rather than as the 'cure' or 'treatment' for a 'disease', Moncrieff's model empowers people experiencing mental distress to make their own decisions about whether or not to use drugs (or other 'treatments').

### Convergences and divergences

The neurodiversity movement's idea of a spectrum of equally valid neurotypes, deserving of recognition and accommodation rather than pathologisation, are echoed by those of some authors within the survivor movement. For example, the American feminist survivor, Kate Millett, author of *The Loony Bin Trip*, an autobiographical account of her experience of coercive treatment in the US and Irish mental health systems, wrote:

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Let sanity be understood to be a spectrum that runs the full course between balancing one's checkbook on the one hand and fantasy on the other. Possibly higher mathematics as well. At one end the humdrum but exacting work of the mind, at the other, surrealism, imagination, speculation...A spectrum. A rainbow. All human. All good or at least morally indifferent. Places within the great, still-unexplored country of the mind. None to be forbidden. None to be punished. None to be feared. If we go mad – so what? We would come back again if not chased away, exiled, isolated, confined. (Millett, 1990, 314)

This could be seen as 'foreshadowing' of the concept of neurodiversity almost a decade before it was invented. However, one significant difference remains. While neurodiversity activists focus on their 'differences' being permanent and biological in nature, many mental health system survivors strongly reject the idea that there is any fundamental neurological difference between them and other ('normal'/'typical' or non-psychiatrically-labelled) people; arguing rather that they have 'natural' reactions to traumatic and/or oppressive experiences that they have lived through. Plumb (1994), for example, cites an analogy used by the survivor activist, Mike Lawson, who deemed the mental state pathologised as 'paranoid schizophrenia' to be like a hedgehog curling up into a ball in response to danger; yet this is actually an analogy to which many autistic people who experience 'shutdown' as a response to stress, including myself, can definitely relate to! Some of this difference in perspective may have to do with the particular experiences of people placed in different diagnostic categories. Many autistic people, for example, have suffered greatly from assumptions that either they themselves, or their families, are 'to blame' for their differences and/or difficulties, or that there must be a traumatic cause, which needs to be 'uncovered' and 'processed' by psychoanalytic or other forms of 'talking therapy', aimed at 'healing' this non-existent 'damage'.<sup>8</sup> For some people, it can be a massive relief to find out that their divergence from the social norm is due to an innate neurological difference; that they are not a formerly 'normal' person who has been 'broken', but were a different – and equally 'whole' – type of person from the beginning.

Conversely, many mental health system survivors associate ideas of biological difference with medical models, and biologically-based 'treatments' such as psychotropic drugs, by which they have often been profoundly oppressed and violated (harms of which, it should be noted,

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the neurodiversity movement is also keenly aware). Many survivors have never had their social environments examined as a 'cause' of their distress, the label of 'mental illness' being used to deny the reality of their experiences of violence and oppression. While some in the survivor movement regard psychoanalysis or other 'talking therapies' as much more positive responses to 'problems in living', autistic activists – such as Judy Singer (1999) and Mel Baggs (2006)<sup>9</sup> – are often strongly critical of such paradigms as unhelpful and inappropriate responses to their needs. This critique is, in part, because of the 'parent-blaming' paradigm mentioned above – shared by some 'anti-psychiatry' authors, such as Alice Miller (1991) and Peter Breggin (1994) – but is also in part due to fundamental issues with the paternalistic and unequal therapist–client relationship. Similarly suspicious perspectives on 'talking therapies' are shared by other strands of the survivor movement, such as therapy survivor groups.

The experiences and perspectives of people in the survivor movement and the neurodiversity movement may here seem opposed to one another. However, both result from having been misunderstood and mistreated by a paternalistic psychiatric system, which assumes that it knows and understands the minds, experiences and needs of its 'patients' better than they do themselves, and focuses on 'curing' or 'normalising' the person, rather than changing the society in which the person lives into one in which they can be happy and accepted. Some people may find psychotropic drugs harmful and 'talking therapies' useful; others may find 'talking therapies' harmful and drugs useful; yet others may find both equally harmful and prefer to be simply 'left alone'. The most important issues, however, regardless of such individual choices, are self-determination over what (if any) 'treatment' or 'assistance' is appropriate for individual needs, and an understanding of difference, distress and dissent as all being located within social and political contexts (rather than simply being 'pathologies' of the individual). If such self-determination and understanding was available for all then the question of whether the origin of a person's social or emotional difference is 'traumatic' or 'congenital' – while it may 'matter' profoundly to the individual in terms of self-perception and self-understanding – would not necessarily 'matter' to society in terms of how that person should be 'treated' or responded to. In all cases, the person's own understanding of their needs would be accepted, and their needs accommodated.

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### Conclusions

I believe that the ideas of the neurodiversity movement can provide a useful 'bridge' across some of the conceptual and practical divergences between the disabled people's movement and the survivor movement. Some members of both older movements may disagree – with one another and with the neurodiversity movement – over some of the ideas and terminology used. I believe, however, that insights from neurodiversity can enrich the perspectives of both in ways that illuminate the common ground they share with each other. This is particularly the case if it is approached with the recognition that all terms and definitions are imperfect and can be contested.

I think that activists in the neurodiversity movement, by virtue of their identities and experiences overlapping with both the disability and survivor movements, have an important role to play in expanding possibilities for dialogue and collaboration between them. The fact that there is overlap between the people and experiences involved in all these movements is also a reminder that categories such as 'disabled' and 'survivor' do not necessarily have strict, definable boundaries. However, this does not mean that these categories are not 'real' or important in terms of both theorising and actively fighting inequality and oppression.

I suggest that the neurodiversity movement is particularly well placed to bring together broader categories of marginalised people(s) into a (necessarily loose, but nonetheless potentially hugely important) solidarity network of movements fighting for radical acceptance of all types of human diversity, under a broad banner of 'anti-normalisation' (Bumiller, 2008) and challenges to supposedly 'universal' assumptions about 'human nature' that privilege majority and historically dominant groups. In the current political and economic climate, in which welfare cuts driven by neoliberal ideology threaten the very survival of disabled or otherwise underprivileged people in the UK and many other 'western' societies, and the segregation of 'the poor' into separate categories is used by governments and the mass media to 'divide and rule' and prevent effective opposition, such networking and collaboration is ever more acutely necessary.

The experiences of people placed in different categories, or who identify with different movements, necessarily differ, and their differences should not be erased in the name of unity; however, nor should they be essentialised in ways that lead to divisive separatism. A fundamental principle of the neurodiversity movement is that people and their perspectives can be radically different from one another,

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but that all can be part of an inclusive society that recognises the – sometimes difficult, but often positive – reality of such differences without stigmatising or pathologising them. This realist but anti-essentialist respect for difference and diversity can, I believe, be the basis of working together for all our liberation.

### Notes

<sup>1</sup> There are a large number of different terms used to refer to the social movement of people who have been labelled with ‘mental illness’ which, as Peter Beresford (2004) points out, are all opposed or regarded as offensive by some sections of the movement. I have somewhat arbitrarily decided to use the term ‘survivor movement’ in this paper, mostly for the sake of simplicity – my apologies to those who prefer other terms.

<sup>2</sup> It is worth noting here that there is some disagreement within the disabled people’s movement on the subject of impairment, with some, particularly feminist and post-structuralist, disabled writers arguing that the distinction between impairment and disability is not as clear-cut as it seems in simplistic readings of the social model; particularly given that impairment itself can be regarded as socially constructed (see, for example, Thomas, 1999; Thomas and Corker, 2002; Tremain, 2002).

<sup>3</sup> Sinclair’s article ‘Don’t Mourn for us’ was originally published in 1993 in the Autism Network International newsletter, *Our Voice*, Volume 1, Number 3, [www.autreat.com/dont\\_mourn.html](http://www.autreat.com/dont_mourn.html)

<sup>4</sup> This is of course also a core element of the social model of disability.

<sup>5</sup> This is parallel to the usage of terms such as ‘cisgender’ as a contrast to ‘transgender’ in the LGBT community. While outside the scope of this chapter, the LGBT and/or ‘queer’ rights/liberation movement is also concerned with the acceptance of identities as valid parts of human diversity which were previously pathologised as ‘mental disorders’. As such, it has significant overlap with the neurodiversity movement (see, for example, Lawson, 2005; Bumiller, 2008).

<sup>6</sup> It should be noted, however, that – while parts of the survivor movement, particularly in North America, certainly have been inspired by anti-psychiatry – the anti-psychiatric body of theory was primarily developed by academics and dissident members of the ‘psy’ professions, rather than by survivors themselves. It cannot therefore be regarded as the theory of the survivor movement.

<sup>7</sup> Within the framework of the social model of disability, these would be examples of what Thomas (1999, 42–3) calls ‘impairment effects’ (as distinct from disability, including psycho-emotional disablement).

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<sup>8</sup>The most notorious, and arguably the most influential, such theory in the field of autism is that of the mid-twentieth-century child psychologist, Bruno Bettelheim, who argued that autism was caused by emotionally neglectful ‘refrigerator mothers’ (Waltz, 2013). While, in the English-speaking world, his theories have been largely superseded by biomedical paradigms, they are still arguably dominant in some other countries, such as France (Jolly and Novak, 2012).

<sup>9</sup>The autistic writer and activist, Mel Baggs, previously wrote under the names Amanda or AM Baggs, under which names she is still arguably better known (in particular for her writings on the website, [autistics.org](http://autistics.org), and her video ‘In My Language’).