

Steve Graby: Presentation given at Mad Studies and Neurodiversity: Exploring Connections symposium, 17th June 2015, Lancaster University.

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As my [chapter](#) has been circulated to everyone here to read before this event, I am going to assume that most of you have read it (although of course I won't shame anyone for not having read it!). So, I will start this by briefly going over the main arguments I make in the chapter. I will then talk about a few issues that I think arise out of it, partly influenced by things people said to me in response to reading (either draft or final versions of) my chapter, drawing on the online writings of some neurodiversity activists.

(here it is important to say none of this is really new to me - either in my chapter itself, or particularly in this presentation, and in particular I have been very heavily inspired and influenced by the online writings of Mel (formerly and probably still more widely known as Amanda) Baggs, but also by many other activist-writers outside the academy)

In my chapter, I argue that the perspective of neurodiversity can be a way to bridge some of the gaps between the survivor movement and the disabled people's movement, particularly the sticking points over the concept of impairment, and help to build closer alliances between those movements without requiring either to compromise on its analysis of how natural human difference intersects with oppression. Some of the key points I make in it are:

- the concept and movement of neurodiversity has roots in both the Disabled People's Movement and 'survivor'/anti-psych movements
- "neurodiversity" is often treated as synonymous with autism, but in fact covers the whole spectrum of differences in cognitive and emotional functioning
- the neurodiversity movement is part of a politics of affirmation, in which it closely resembles both the 'Mad Pride' movement and the 'affirmation model of disability' adopted by many Disabled People's Movement activists, particularly in the 'arts and culture' wing of the movement
(I will talk a bit more about this later)
- it is also part of a politics of what Bumiller (2008) calls 'anti-normalisation' - deconstructing assumptions and cultural imagery about what is a 'normal' person or 'normal' functioning and pushing for radical acceptance of difference and whatever social transformations are necessary for difference to be accepted - in this it has common ground with queer and feminist movements.

In my chapter I also address how a neurodiversity perspective can be useful for people whose experience of mental distress is subjectively negative, for whom affirmation and anti-normalisation may not immediately seem useful. Undiagnosed or unrecognised neurodivergence and the subtle psycho-emotional disablement that goes with it often leads to distress and/or involvement, whether voluntary or not, with the 'mental health' system - this distress is not in itself an 'illness', or a direct result of differences in neurotype, but a response to oppression in a neuro-normative society, which is then pathologised by that society, resulting in further oppression. So the category of 'mental illness' includes both differences that are unproblematic for the individual, and only problematised by society, and distress that is a result of social oppression - and I leave open the question of whether distress can also be produced directly by an impairment, such as chemical abnormalities in the brain, as even if it is, it does not really matter what the origin of an individual's distress is for how we deal with it - the same principle applies of acceptance of the individual's desires and wishes, whether they wish to use medical 'solutions' or not.

So now I will move onto some further things that can be drawn out of these arguments:

one thing several people have raised in conversation with me about this chapter and about neurodiversity in general is that the "neuro" in "neurodiversity" is somewhat arbitrary - both in terms of many impairments that are not generally treated under the umbrella of "neurodiversity" - such as cerebral palsy or multiple sclerosis - actually being neurological in nature although they are primarily physical rather than cognitive in effect, and in terms of *what i mentioned*, that the "neurodiversity" perspective on mental or cognitive diversity doesn't actually require believing that the causes of such diversity are (exclusively) neurological.

Here I am going to quote from a recent post on a blog called "Stims, Stammers and Winks: A Catalogue of Awkward Gestures", which is written by someone known only as "An Anonymous Newtown Autistic" (and I will state openly here that I don't always understand what this person says, but I still think a lot of it is very interesting and important):

"Very little of the rhetoric of neurodiversity actually discusses neurology, as in psychology and psychiatry, the neuron is just a model that allows an intangible aggregate of differences to be located within a tangible imagined place within the body. The "Neuro-" is almost entirely then, a metaphor within mental disability politics, in a way not dissimilar from the curious place of the "psyche" within psychology or the ego within psychoanalysis.

What the writing on neurodiversity does talk about, is a loose model for body-diversity and more broadly, for disability diversity. Neurodiversity argues that what may be seen as deficit contributes to the broader quilt of human complexity. But there is nothing about this kind of argument that is explicitly or specifically neurological. If a diversity of impaired ways of existing can also contain a diversity of cultural knowledges and a diversity of alternative fluencies and unusual skill sets, there is nothing about the neuron that makes differences in the brain more tolerable than other kinds of impairment."

"Disability activists do not have to limit their analysis because of the scientific disagreements of quacks and officially sanctioned medical scientists. Disabled people can ask for changes in society based on their experience of impairment without requiring their advocacy to be based in a specific material manifestation of their situation."

(from <http://stimmstammersandwinks.blogspot.co.uk/2015/05/enterodiversities-sensodiversities.html>)

So does this mean we shouldn't be using the term 'neurodiversity'? I think there is a good argument that it would be less confusing or less open to misinterpretation if we used a different term - such as, perhaps, "cognitive diversity", which, I think, more accurately covers what is most commonly talked about as "neurodiversity" - but I think whichever term we choose would be fairly arbitrary, and "neurodiversity" is an established term which now has over 15 years of usage, so I think probably more harm would be done by having to come up with a new term (which people very probably would not agree on) and re-establishing it in the public consciousness, than by continuing to use the term that is in use, even if it is etymologically inaccurate (a parallel would be that we continue to talk about "autism" despite its etymology of the Greek word for "self" being potentially misleading and/or negatively stereotyping)

A second issue:

In my chapter I argue that neurodiversity fits with the affirmation model of disability, which was first coined by John Swain and Sally French in a journal article from 2000, and further developed by people such as Colin Cameron. This model is associated with the 'cultural' side of the DPM, involving disability arts and a focus on changing perspectives about disability and disabled people, both in the general public and among disabled people themselves (internalised oppression, consciousness raising), associated with movement slogans such as "celebrate difference with pride"

- this is not meant to replace the social model of disability (although perhaps sometimes misunderstood as such) but to go alongside it as another tool in the movement's anti-oppression toolbox
- I think it's fairly obvious how this also relates to 'mad pride'
- However some issues with this - firstly, in this politics of affirmation, what are we actually affirming? I think the phrase "affirmation model of disability" is potentially misleading and even dangerous as it uses the word "disability" very differently to how the social model uses it - we can and should be affirming difference and diversity, including the diverse forms of human embodiment and cognition that may be classified as "impaired", "mad", "queer" or anything else, but we shouldn't be affirming **disability**, because disability is oppression
- also, not everyone may want to celebrate or affirm their own particular experience of difference, particularly when that experience is primarily one of pain, discomfort, or distress (*which connects to what I've already said about distress, as well as I think being related to the concept used by writers in Disability Studies such as Carol Thomas of 'impairment effects'*). For example, some mental health system survivors reject or are uncomfortable with 'mad pride' because for them distress or 'madness' is not something they can celebrate or see as positive, because for them it is either an 'inherently' painful and distressing experience and/or one that is inextricably bound up with oppression, either because it is a result of oppression and/or because society responded to it with (further) oppression.
- this raises the question of what 'pride' can or should mean for disabled/mad/neurodivergent people
- for some it could be pride in their 'difference' itself, for others it could be pride in surviving and resisting oppression, for yet others 'pride' might not be a useful concept
- we need a place in the movement both for those who can easily identify with concepts such as 'pride' and 'affirmation' and for those who can't - and I think it is possible to experience your own impairment or 'difference' (and possibly therefore to want medical 'solutions' for themselves) as wholly or primarily negative to still fight for a society that accepts the diversity of human being, that doesn't force treatment or 'cure' on anyone who doesn't want it, and that accommodates everyone's support and access needs - this is not necessarily contradictory to a social model and/or a neurodiversity perspective
- *how does this relate to current political circumstances for us?*
- *there have been some divisions in the DPM that have related to the concept of 'pride' - for example, recent activism aimed at defending benefits against austerity cuts has been criticised for portraying disabled people as 'helpless victims' and going against principles of 'pride' and being as capable as non-disabled people, while simultaneously portrayals of disabled people as 'super-achievers', such as advertising for the 2012 Paralympics, have been criticised for playing into the hands of government and media demonising of disabled people who are not 'super-achievers' as 'lazy', 'benefit scroungers', etc - so asserting that 'pride' is neither necessary nor universally possible (both because of the effects of oppression and in some cases because of the particularities of impairments) is important for the inclusion of all disabled people in activist agendas and visions of the world we want to live in*

This question leads into my final and probably most important consideration: what would a practical support system based on principles of diversity and affirmation look like?

here I am going to draw heavily on some [recent online writings by Mel Baggs](#), which I will quote a bit here, but I have put some longer excerpts from the posts in a handout - I think the whole posts are very much worth reading as they address the issues of psychiatry, anti-psychiatry movements and alternatives to psychiatry in a very practical way and from the perspective of an autistic and multiply, including physically, impaired person who is a survivor of psychiatric institutionalisation and lives in the intersection of disabled people's, neurodiversity and survivor movements

Some people need medications in order to survive, function, or live comfortably. They should be able to have it. They should also be able to have full access to current

knowledge of said medications, including the risks, and including the medications where they're not even sure why they work or if they work.

(this connects well with Joanna Moncrieff's 'drug-centred', as opposed to 'disease-centred', model of psychoactive drug use)

I have absolutely nothing against people making use of the psychiatric system if that is what they want to do. I regard it as a fundamentally broken system, but even a stopped clock can be right twice a day, and sometimes a broken system is better than no system. But people who are trying to get out of the system should have every kind of help available to them to get out of it.

As for psychiatric "treatment":

We need places for people to go who are in crisis. Mental institutions as currently constituted, aren't that, at all. They mostly make things worse. People who go to them and get better tend to be the ones with straightforward problems and very short hospital stays. Anyone who needs to use what we have right now should be able to use it. But what we have right now needs to be replaced by something better. Somewhere people can actually go that is truly safe, that is not run like a prison.

We need to stop pretending that mental illnesses are just like physical illnesses, only mental. Mental illness is a metaphor that has outlived its usefulness. There are some things classified as mental illness that are, surely, neurological conditions or chronic physical illnesses with mental components. However, there's lots of things that don't fit into the illness metaphor and shouldn't be forced to.

When treatment works, we need to be honest about why, and why not. This includes saying "We don't know why this works. We just know that in 17% of patients, it does, to a certain extent. We're still looking for why. It could even be the placebo effect, we're not sure yet."

People in these movements need to stop being afraid of the idea that people can differ from each other neurologically. The fear is that if we admit neurological difference we will open the way to forced drugging. But I *know* my brain is different than normal. It responds to both prescription and street drugs massively differently than normal, something that is important to know about a person before you go prescribing anything to them anyway.

And it is *never a good thing* to think backwards like that "If we believed X, then we'd have to do Y, and we don't want to do Y, so we can't believe X." Generally you'll find the if/then statement isn't accurate in the first place. And you'll also find that thinking backwards is sloppy thinking and won't help you find the truth if you even care about the truth.

and in a second post, which i'm not going to quote due to length/time, Baggs writes about what services for people with so-called 'mental illnesses' should look like instead of psychiatry, based not on medical notions but on the kind of services that exist for (and were developed as a result of demands and campaigning by) disabled people with other types of impairments - her fundamental points in that post are:

- what determines the services people get should be assessment of need, not diagnosis - thus whether or not a person has an 'impairment' doesn't really matter, what matters is what assistance they need (to live their life autonomously and to counter the unfair/unreasonable things done to/required of them by society)

- services need to change their emphasis to focus not on 'curing' or 'fixing' the individual, but on giving them whatever practical support they need - and it is perfectly acceptable to continue needing that support for the rest of your life (thus 'recovery' is a false paradigm)

- it is still possible to have a happy, successful and autonomous life while needing such support, whether it is for 'physical' reasons or 'psychiatric' ones

So I will end by saying I would be very interested in what people here think of these practical suggestions - but also feel free to respond with any other questions or comments (if time permits).