Kristien Hens succeeds in weaving together experiential expertise of both people with autism and their parents, scientific insights and ethics, and does so with great passion and affection for people with autism (with or without mental or other disabilities). In this book she not only asks pertinent questions, but also critically examines established claims that fail to take into account the criticism and experiences of people with autism.

Sam Peeters, author of *Autistische Gelukkig* and *Gedurfde vragen*; blog @ Tistje.com

What does it mean to say that someone is autistic? *Dynamics of Autism* explores this question and many more. Kristien Hens conducts a thoughtful, wide-ranging examination of psychiatric, biological, and philosophical perspectives on autism, as well as its meanings to those who experience it, diagnose it, and research it. Hens delves into the history of autism to inform a contemporary ethical analysis of the models we use to understand autism and explores the various impacts of a diagnosis on autistic people and their families, the relevance of disability studies, the need to include autistic people fully in discussions about (and research on) autism, and the significance of epigenetics to future work on autism.

Rich, accessible, and multi-layered, this essential reading for philosophers, educational scientists, and psychologists who are interested in philosophical-ethical questions related to autism, but it also has much to offer to teachers, allied health professionals, and autistic people themselves.
In 2016, I attended a two-day conference for researchers of autism in Gent, Belgium. This conference was explicitly geared at autism researchers in the biomedical field. One of the speakers showed videos of a fruit fly and mouse that were supposed to exhibit autistic traits. In both animals, the researchers had changed or switched on or off a candidate gene for autism. The fruit fly exhibited autiform behaviour, so they said, i.e., behaviour that is similar to autistic behaviour, because when the researcher put the male fly in a petri dish with a female fly, he kept to himself rather than exhibiting “normal” excessive courting behaviour. Whereas the mouse exhibited extreme digging behaviour: she preferred spending her time digging holes and hiding marbles. I was intrigued about the underlying assumptions of this study: first, that these animals’ behaviour is the direct result of genes. These studies suggest that a genetic explanation is a sufficient explanation for a complex phenomenon such as behaviour. However, in my opinion, behaviour is also a reaction to specific circumstances. Indeed, mice and even fruit flies have reasons for what they do, beyond merely a difference in genetic makeup. Secondly, we may wonder why we call such behaviour autistic: why do we assume that the behaviour of the mouse or the fruit fly is the same as that of autistic children? After all, we do not understand the motivations of these animals, and we may even wonder whether we properly understand the motivations of autistic children for their behaviour.

In what follows, I shall dig deeper into the question of the relationship between our mind and our body, between what is considered biological and psychological. Indeed, the relationship between psychiatric
diagnoses and underlying biological essences such as our brains and our genes has been the subject of fierce debate. Let us set aside the nature of autism for the moment and look at how scholars have talked about mental phenomena in general. When we talk about psychiatry, we talk about the clinical discipline with the most family resemblance to philosophy. Psychiatry is not neurology: we do not merely speak about brain diseases but also about mental processes, thoughts and their meaning. Nevertheless, it is not easy to distinguish a cognitive function from a physical process in the brain. We may even wonder whether it makes sense to make this distinction. Some commentators suggest that we are simply our brains and that our mental processes are mere illusions. Along the same lines, they argue that psychiatry will eventually turn out to be neurology. Surely, this cannot be the whole truth. We think about ourselves as having a mind and a self. Things have meaning for us. In mental disorders, it seems our mind has become disordered, not merely our biology.

**Minds and Brains**

If we want to discuss psychiatric diagnoses, we have to briefly discuss the relation between body and mind. It is not my intention here to provide a complete account of the philosophy of mind. However, a brief sketch of the discussion is necessary, as it sheds light on why our biological conceptions of autism exist. Autism seems to sit uncomfortably between the fields of psychiatry and neurology. The question ‘are we our brain’ has probably occupied human thoughts since the beginning of human self-consciousness. People have always asked how the mental and the corporeal relate. We have asked ourselves whether cognitive processes are merely the results of what happens in our neurons or whether, on the contrary, mental processes can also influence our brains. By the time of the ancient Greeks, people already knew that brain disorders also affect our mental processes, as is demonstrated by a quote from the *The Holy Disease*, attributed to Hippocrates: ‘And men ought to know that from nothing else but (from the brain) come joys, delights, laughter and sports,

---

and sorrows, grieves, despondency, and lamentations.² The holy disease is epilepsy, and according to Hippocrates, there is nothing sacred about it at all. The delusions that are associated with this disease are the result of biological processes as well. However, the fact that Hippocrates deemed it necessary to point this out to his fellow Greeks already demonstrates that viewing oneself and one’s mental processes as functions of the brain was not self-evident even then. Phenomenologically speaking, we are also cognitive functions, despite all neurological images and genetic findings. I shall later argue that the solution to this conundrum does not lie in reducing experiences to biological processes. We will have to concede that many present-day views on biology are too reductionist.

The idea that there is a distinction between body and mind was stressed by René Descartes (1596–1650) in his famous distinction between res cogitans (mind) and res extensa (matter).³ This distinction brings about a couple of conceptual problems. If res cogitans and res extensa are genuinely different things, how can they interact? The philosopher Gilbert Ryle (1900–1976) mockingly called the idea of a separate mind the ghost in the machine.⁴ There are different variants to dualist thinking: one can see mind and body as separate substances and also as the same substance with distinct characteristics. The question of how such separate substances can interact occupies philosophers of consciousness even today. Some take up a radically different perspective and argue that all is matter. To some extent, I agree with the viewpoint that we are our body, and that even mental processes are matter. However, as I will argue in this book, this does not mean we can reduce mental processes to their underlying biological processes.

The challenge seems not to lie in materialism itself but in a reductionist or deterministic conception of what this materialism entails. People with a psychiatric diagnosis may display atypical behaviour. Therefore, it is often implied that dysfunctioning brains and neurons direct this behaviour entirely and in a linear fashion. We only have to look at animal models of autism, such as the mouse obsessively digging holes or the male fruit fly that is not interested in female fruit flies, to see an

² Hippocrates, De Morbo Sacro, Section 1, http://www.perseus.tufts.edu/hopper/text?doc=Perseus%3atext%3a1999.01.0248%3atext%3dMorb.+Sacr
³ René Descartes, Discours de la méthode (Quebec: Collection Résurgences, 1995).
illustration of this. We do not know why these animals behaved as they did and to extrapolate from the behaviour of one animal to that of another (in this case, autistic humans) seems premature. I will come back later to the caveats of genetic research. However, materialist explanations of behaviour do not necessarily have to be causal-deterministic. For example, the physician Roger Penrose, a self-declared materialist, has a theory about our consciousness that builds on quantum physics and explains consciousness based on quantum processes.\(^5\) Chapter nine will introduce new materialism, a line of thought that also allows for a non-deterministic view on the matter. Nevertheless, for many, materialism and determinism seem to be concepts that are inextricably linked.

Views on the nature of psychiatric disorders and mental processes are also relevant to our discussion about the ethics of autism and psychiatric diagnosis in general. A mere materialistic-deterministic approach seems to suggest that, in order to understand our experiences and behaviours, we should first look for causal explanations in our brains and our blueprint — our genes. However, this neglects our phenomenological experience that we are more than our neurons. It is almost impossible to imagine ourselves as something different than an ‘I’. Is this ‘I’ merely an illusion? Moreover, such a deterministic-materialistic approach also seems to suggest that free will is an illusion. How can we indeed be free if what we want is merely a function of our brains? This question is hugely relevant to the ethics of psychiatry. It seems to be the case that most psychiatrists, and most human beings in general, do not assume a reductionist and materialistic conception about mind and body but make a distinction between the different psychiatric diagnoses. Woo-kyoung Ahn and colleagues have discovered that clinical professionals also make such a distinction.\(^6\) In their studies, their respondents seem to consider autism as a ‘very biological condition’. Moreover, the more people believe that a condition is anchored in biology, the more they deem those with the condition not to be responsible for their behaviour. Marc Miresco and Laurence Kirmayer write, in response to a survey

---


they conducted with 270 psychiatrists and psychologists, that the more respondents considered a specific behaviour ‘psychological’, the more a person was deemed responsible for it:

The more a behavioural problem is seen as originating in “psychological” processes, the more a patient tends to be viewed as responsible and blameworthy for his or her symptoms; conversely, the more behaviours are attributed to neurobiological causes, the less likely patients are to be viewed as responsible and blameworthy.\(^7\)

Philosopher of science Ian Hacking wrote in this respect that ‘biology is exculpating’.\(^8\)

In our interview study with adults with a recent diagnosis of autism, we also found such mechanisms.\(^9\) Some of our female participants had already received a Borderline Personality Disorder (BPD) diagnosis before receiving their autism diagnosis. They accepted the latter diagnosis more readily. They had the impression that when clinicians still considered them to have ‘borderline’, unreasonable demands were made of them. For example, they had to take part in group therapy which did not work for them. As people consider autism to involve a ‘different kind of brain’, there was more consideration given to these women’s behaviour, and they were less expected to adapt. I could not find any studies that would prove that BPD is more of a mental disorder than autism, although there is more research into the genetic basis of autism. It is difficult to grasp what it would mean for a condition to be more mental or biological. So although these distinctions are readily made and do normative work, their fundamental ontological basis may be flawed.

Biological conceptions about psychiatric disorders also have disadvantages for those diagnosed. Matthew Lebowitz and Wookyung Ahn describe how biological explanations can have an impact on a clinician’s empathy. If one considers a disorder to have a physical cause, people diagnosed with it are seen as less responsible for their


\(^8\) Ian Hacking, Historical Ontology (Cambridge, MA: Harvard University Press, 2004).

\(^9\) Kristien Hens, and Raymond Langenberg, Experiences of Adults Following an Autism Diagnosis (Chambersburg: Palgrave Macmillan, 2018).
behaviour. However, they can also count on less empathy being shown towards them. Lebowitz and Ahn suspect that this is because people with a mental disorder that is seen as very ‘biological’ are considered categorically different from so-called ‘normal people’. People with such diagnoses are then looked at more as mechanisms than as individual patients. Moreover, such assumptions also lead to pessimism about the prognosis: it is assumed that ‘biologically based’ diagnoses are less dynamic and changeable than psychological ones.\textsuperscript{10}

The Nature of Psychiatric Disorders

What, in fact, are psychiatric disorders? As we have described above, whether people think something has a biological (rather than psychological) cause is not a sufficient criterion to demarcate psychiatric disorders from somatic illnesses. Dementia, for example, is described in DSM-5, and we assume that this is first and foremost a neurological condition. Let us accept that a psychiatric disorder is something that is described in a diagnostic handbook such as DSM-5. To know which diagnosis suits a specific person, one can use the guide’s descriptions and consider to what extent we can apply these to the person who exhibits certain behaviours or who experiences specific challenges. The descriptions in the diagnostic manuals are not directly the result of or the report of scientific findings and are susceptible to changes and societal evolutions.\textsuperscript{11} Let us, for a moment, look at the description of autism across the decades. We then see, for example, that only the DSM-5, the latest version of the DSM, mentions the idea of ‘hyper or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment’ as a diagnostic criterion. However, since Kanner, it is considered a part of the autistic phenotype. This late addition presumably has to do with the growing voices of autistic people themselves in autistic research, who think this to be an essential aspect of their experiences. Whether the diagnostic manual describes a disorder has significant consequences.


\textsuperscript{11} Trudy Dehue, \textit{De depressie-epidemie: over de plicht het lot in eigen hand te nemen} (Amsterdam: Atlas Contact, Uitgeverij, 2015); Trudy Dehue, \textit{Betere mensen: over gezondheid als keuze en koopwaar} (Amsterdam: Atlas Contact, Uitgeverij, 2014).
For example, an official diagnosis is often needed to receive adequate help and support.

The reasons why a specific manual mentions certain disorders and does not mention others are not always easy to explain. Nevertheless, psychiatric diagnoses and their description become more than a mere report or a guideline for clinical action. In principle, in the DSM or other manuals, diagnoses describe clusters of behaviours and symptoms that often co-occur. Therefore, they are usually reliable, which means that different diagnosticians tend to agree on a diagnosis in an individual, but they are not necessarily valid. This means that there is no guarantee that another diagnosed person’s behaviour has the same underlying explanation. However, as these clusters often co-occur, it is suspected that they could potentially represent a ‘true’ underlying essential disorder and be valid.

Nonetheless, for most disorders in DSM, there is no hard proof that this is the case. Besides this clustering of symptoms, a diagnostician’s experience with a treatment, and the treatment’s effectiveness play a role. For example, despite lobbying by stakeholders, Sensory Processing Disorder (SPD) was not retained as a separate diagnosis because the American Psychiatric Association (APA) that publishes the DSM was not convinced that this diagnosis could be a guideline for efficient therapy. Many of the children who would qualify for the proposed SPD will now either not get a diagnosis or be diagnosed with ASD or ADHD (Attention Deficit Hyperactivity Disorder) and follow these diagnoses’ treatment plans. Diagnostic classification is first and foremost a clinical classification. Although scientific findings related to genetics and neurology will contribute to the categorisation of psychiatric disorders, the DSM’s authors do not claim that these categories correspond to underlying biologically delineated entities. They do not claim ‘to carve nature at its joints.’

Still, this cannot be the entire story. We may agree that psychiatric classifications and the diagnoses based on these classifications do not

---


necessarily correspond one-on-one to underlying biological or natural kinds. Suppose we only look at the many studies that search for the biological causes of exactly these psychiatric classifications. We then realise that they are often interpreted as referring to a fundamental underlying cause. For example, in the search for autism genes, participants are often selected based on diagnostic criteria. We might wonder why we want to use something that has a clinical finality as a basis for research into causes. How can we explain this Verdinglichung (reification)? Why do we conceive of human kinds (the diagnostic classifications described in the DSM) as natural kinds (biological kinds with fixed characteristics)?

Pieter Adriaens and Andreas De Block suggest some explanations in their paper ‘Why we essentialise mental disorders’.\(^\text{14}\) People could be, by nature, prone to essentialism. Moreover, the fact that specific medication, such as Ritalin, is helpful to treat someone with a specific psychiatric diagnosis, such as ADHD, suggests that it is indeed a brain disease that can be cured by medication. Trudy Dehue, in her book *Betere Mensen*, also analyses why we tend to essentialise psychiatric diagnoses: we as humans have the urge to consider something that has a name to exist in itself.\(^\text{15}\) Psychiatric conditions that are considered real tend to work in a deculpabilising manner: they suggest that neither the person diagnosed nor their parents or immediate environment are to blame for the behaviour. However, this essentialising tendency also often leads to the fact that challenges become disorders, something inside an individual. Moreover, the description of the behaviour then transforms into the explanation of the behaviour. If a child is diagnosed with ADHD, this is based on the fact that she has problems concentrating and exhibits hyperactivity. However, ADHD will also function as the explanation for the behaviour (‘she cannot sit still because she has ADHD’). By such shortcuts, one risks ignoring the contexts of and reasons for specific behaviour.

People often interpret discussions about the reality of psychiatric disorders as a denial of the reality and the impact of the suffering


\(^{15}\) Dehue, *Betere Mensen*. 
experienced by the person diagnosed. Many autistic persons object to the idea that autism is not ‘real’. They reject social constructivist conceptions of autism. I will discuss this in more depth in chapter four. However, it must be possible to think beyond the dichotomy of biological disease versus construct-in-language, or natural kind versus humankind. Psychiatrists, parents, children, and adults with a diagnosis testify to the reality of their experiences with autism. We do not need a fixed and straightforward biological truth to acknowledge the reality of experiences. The fact that cultural and familial contexts strongly influence specific experiences, that in a particular era of history a concept of autism may not have been applicable, and that it may not exist or be used in the future, does not take away from this. It is possible to maintain autism as a real and shared experience while at the same time acknowledging that there will probably never be a simple biological explanation. I will return to this possibility later.

Concepts of Disease

Why does some behaviour qualify for a psychiatric diagnosis? What does it mean to say that something deviates from the norm? Here we can also distinguish between naturalistic assumptions and constructionist ones. The ideas of philosopher Christopher Boorse have found much resonance in applied ethics. For Boorse, illness is deviance from the statistical mean. He believes that we can draw a definite line between disease and health, and that this line is not merely the result of a value judgement. He has laid down the concept of species-typical functioning: a level of functioning that a typical member of a species would exhibit. This species-typical functioning is defined in relation to reference classes based on age and sex. We find this idea in psychiatry as well: diagnoses are often given after extensive examinations, including psychological tests. One can assess whether someone is psychologically deviant from the mean concerning social behaviour or concentration.

There are some problems associated with this approach. We can find examples where deviation from a statistical norm is not an illness, such

---

as height or intelligence, a fact that Boorse acknowledges. Moreover, it is not clear what it means to function in a species-typical way. Think about social behaviour: in Western societies, eye contact is seen as normal social behaviour, whereas in some other cultures, it is seen as impolite. Still, having ‘appropriate’ eye contact is part of the diagnostic assessment for autism. Moreover, we may wonder whether a completely value-free concept of disease is possible. Boorse has argued that homosexuality is a disease based on his idea of species-typical functioning. As he considers ‘disease’ as a value-free concept, this does not imply that it is either something terrible or that we should try to cure it. However, most would intuitively feel that ‘homosexuality is a disease’ conveys a normative claim and one we should reject.

Psychiatrist Jerome Wakefield takes a naturalistic approach, and he also makes the distinction between mental illness and health by deploying the idea of harmful dysfunction. He explicitly links disease with evolution, but allows value judgements to be part of the analysis through the use of the word ‘harmful’. Something is a dysfunction if there is a defect in an internal mechanism that prevents the proper execution of a biological function. A fear of spiders, for example, can be explained using the concept of evolution, but it becomes a disorder if it results in a paralysing phobia that severely hampers everyday functioning. The idea of dysfunction is also part of the present-day definition of autism. To receive a clinical diagnosis of autism, one should not merely exhibit specific behavioural characteristics, but, as I have discussed in the prologue, there should also be sufficient impact on the quality of life. We might ask ourselves whether we can ever explain this impact in evolutionary terms. Even today, many psychiatric disorders do not have clear-cut evolutionary explanations.

Furthermore, even the idea of dysfunctioning is not clear. Who gets to decide whether someone is dysfunctioning? Does dysfunctioning involve specific behaviour that is a nuisance to others? Does a child experience challenges if a particular educational system is not a good fit for her? The diagnosis of autism is often given during childhood by child psychiatrists, and this makes it even more challenging to decide whether a particular behaviour can be considered dysfunctional. In this

---

context, Courtenay Norbury and Alison Sparks state that ‘the point at which normal variation converges on disorder is largely an arbitrary decision and is highly likely to be influenced by cultural values and expectations.’ They note that the vast majority of therapists in Western society are white and female. However, the children with whom they work have a very diverse background concerning language and cultural experiences. For some of these children, playing with dolls is not self-evident, for example. Autism research has primarily focussed on Western culture and reflects only a small minority of the world’s population. In this respect, the search for evolutionary explanations or statistical means may be a lost cause from the start. Perhaps we should accept that psychiatry will never be neurology, and that value judgments will always play a role in diagnostics.

The Values of Psychiatry

The idea that psychiatry is not value-neutral has been elaborated extensively in the writings of Michel Foucault. I do not aim to discuss his arguments in much depth here, but I think it is still helpful to describe some of them. In his *Madness and Civilization: A History of Insanity in the Age of Reason*, Foucault explains that we cannot merely describe psychiatry’s history as one of evolving insight: specific historical periods influence how people look at madness. Until the end of the eighteenth century, madness was a social and a moral problem. Only later did it become a medical problem. Later on, Foucault discusses, through his description of the panopticon, the function of discipline. Discipline is not the same as oppression, as it is self-imposed, and its relations of power also create productive and valuable knowledge. In later writings, he describes how by opposing and partly assuming imposed identities, alternative forms of subjectivity and identity are possible. We can see these mechanisms at work if we look at how adults come to terms with their diagnosis of autism. Rather than being oppressed by a psychiatric

---


19 Michel Foucault, *Geschiedenis van de waanzin in de zeventiende en achttiende eeuw* (Amsterdam: Boom, 1982).
label, autism becomes something with which one identifies. Nevertheless, this identification is not total: autism becomes an explanation for one’s functioning, but at the same time, these adults also reject an overly narrow definition of what it is. Someone can identify with autism but, at the same time, say that they are empathic and social. Autism is not only something that is solely shaped by the psychiatric profession, but it acquires a life of its own as an identity.

The birth of the anti-psychiatry movement in the 1960s is, to some extent, influenced by the thoughts of Foucault. However, Foucault himself had a more nuanced view of psychiatric diagnosis. The anti-psychiatry movement, with thinkers such as psychiatrists Ronald Laing and Thomas Szasz, asserts that psychiatric diseases do not exist, as they have no biological ground. It characterises psychiatry as an authoritarian system, in which the medical profession suppresses the experiences and identities of patients. People with a psychiatric condition are not ill, and psychiatry only exists to maintain existing conceptions of normality. Hence, according to this view, psychiatry is, by definition, oppression. An oft-cited example is that of drapetomania, a presumed mental illness described in the nineteenth century by the physician Samuel Cartwright (1793–1863): drapetomania is the urge of slaves to run away from their masters. The nineteenth-century concept of hysteria might also be an example of the pathologising of justified frustrations of women in a society that suppresses them. Nowadays, the anti-psychiatry movement has been relegated to the background. Some people even use ‘anti-psychiatry’ as an insult aimed at those in psychiatry who advocate for change within the discipline. Nevertheless, it has led to the insight that psychiatric patients can also actively contribute to their care, rather than the psychiatrist having sole input into their treatment. Moreover, even today, there are psychiatrists and other medical professionals who question the validity of diagnoses. For example, some argue that ADHD is not a real disorder but a means to discipline normal but boisterous children with drugs. Furthermore, in the autism world, some voices want to do away with the label autism altogether. I will return to this in chapter four.

The problem with anti-psychiatry approaches is that they start from the same naive assumption as mere reductionist-biological approaches, namely that discoverable biological essences should support psychiatric
classifications to be real. This idea, however, neglects how diagnoses work, and it also denies the fact that shared experiences can also have a claim to the truth. Moreover, we could ask ourselves why we would need a theory about psychiatric disorders or diagnoses. Maybe it is possible to take a pragmatic approach and claim that illness is that which brings people to the medical doctor or the psychiatrist. We could simply say that illness or disorder is that which makes people suffer. Along the same lines, perhaps we can see psychiatric classifications as a clustering of phenomena that we know how to treat. Although I have some sympathy for this pragmatic approach, it is probably insufficient. We need a theory about psychiatric classifications to serve as a legitimisation for treatment plans or medication. For a psychiatric diagnosis to work, people need to experience it as real. A pragmatic solution could then be that psychiatrists and child psychiatrists pretend to their clients that scientists know a lot about the neurological and genetic underpinnings of autism: for many people, the idea of a biological essence or cause is therapeutic. However, given the lack of knowledge about its causes and the physical and social complexity of autism, this seems a dangerous route. We will have to find an approach that does not fall into the trap of a naive-deterministic model or a naive-constructionist model, and which, at the same time, acknowledges the multi-layeredness of the meanings and experiences of psychiatric disorders.

However, first, we shall investigate how mental disorders differ from somatic disorders.

Nomy Arpaly and the Nature of Mental Illness

In her paper ‘How It Is Not Just Like Diabetes’, Nomy Arpaly describes how today, mental disorders are considered more and more to be like somatic diseases. According to this view, a mental disorder is fundamentally different from other human conditions, such as love, fear, and hate. We do not consider the latter as diseases. Arpaly thinks this is not correct. She concedes that there are analogies between mental disorders and somatic disorders such as diabetes. For example,

---

medication often works very well in treating mental conditions such as depression. Moreover, you cannot decide with willpower alone not to be depressed anymore, just as this is not possible with diabetes.

Nevertheless, the most common reason people think that mental illnesses are equivalent to somatic illnesses is that people assume that mental illnesses are also located in the body. Mental illnesses are disorders of the brain, just as the body causes diabetes by being incapable of producing insulin. However, Arpaly argues, if we assumed such a materialist approach to specific mental disorders, this would apply equally to things like love and hate. If mental illnesses are brain diseases, we can also reduce love and hate to brain functionality. Although Arpaly does not deny that mental illnesses and other mental states are probably located in our biology, she still sees a difference between mental states and other biochemical conditions such as diabetes. To begin with, you can say about mental conditions that they are justified or not. For example, you can believe that a specific piece of fruit is an apple, and that can be justified or not. We can say something about whether someone’s feelings of guilt are justified or unjustified. We cannot say that about purely biochemical states such as diabetes: they just ‘are’. Mental states are also about something; they have content efficacy. Arpaly explains this very well using an analogy with coffee:

Consider becoming anxious because of having had too much caffeine vs becoming anxious because there is talk of downsizing in one’s company. The first case is “just like diabetes” in a way that the second case is not. This cannot be, as psychiatrists sometimes say, because the caffeine-anxiety is “biological” and the downsizing-anxiety is “not biological”. Humans are biological entities, anxiety is in the brain, so presumably all anxiety is biological. However, there is still a strong difference: when the thought “I may lose my job” causes anxiety, the content or the meaning of the thought “I may lose my job” is causally efficacious in the creation of the anxiety. Unlike the thought “I may lose my job”, caffeine has no content, it is not about anything, and so when it causes anxiety, it is causation that involves no content efficacy.\footnote{Arpaly, ‘How It Is Not “Just Like Diabetes”’, p. 286.}

This quote is also relevant in the context of autism. It makes clear why the distinction biological/not biological does not adequately elucidate the differences between mental and somatic disorders if we assume...
that what we consider mental is biologically anchored. In the context of autism, it is presumed by some that because it is biological, it is also really almost a somatic disease that we should prevent or cure, and that explaining autism by referring to genetics or neurology is sufficient. Nevertheless, it makes sense to say that autistic behaviour also has content and is about something. It is not merely the result of an infection or mutated genes but a meaningful reaction to context. That does not mean that genes or neurology could not partly explain why people exhibit a particular behaviour, just as with bipolar disorder, for example. However, the behaviour itself is not the direct result of a flaw in genes or brains.

To illustrate her point, Arpaly uses the distinction between narcissistic personality disorder and Tourette Syndrome (TS). A narcissist who behaves arrogantly and feels superior does this because he is in fact arrogant and genuinely feels superior. In the case of TS behaviours (tics, involuntary expressions), these are the direct result of failing biology without content efficacy: TS symptoms do not indicate that a person with TS has a desire to insult you or is ill-mannered. However, in my opinion we do not know enough about people’s experiences with TS to make an absolute distinction in this way. A child psychiatrist once told me about a client with a diagnosis of TS. She was Jewish and had a specific tic, the urge to say ‘Hitler’, which she could suppress only with great difficulty among individual family members. Although we cannot blame her for the tics, of course, it is clear that the tics do have some mental content. We probably do not know enough about the relation between soma and psyche to say, based on diagnosis, something about the extent to which someone’s thoughts, experiences, and intentions interact with one’s biology. Maybe it is even the case that somatic disorders, to some extent, are about something and also have mental content. I shall not elaborate on this thought further here, however.

Arpaly ends the paper by explaining why many people would like mental disorders to be like diabetes. The suggestion that a mental disorder is really like a somatic disorder implies that the suffering caused by the disturbance is real:

I think being told that one’s mental troubles are like diabetes satisfies a simple, at times desperate, need: the need to have it recognised that one’s
problem is real, as painful and debilitating as diabetes can be, and as unlikely to be wished away.\footnote{Ibid., p. 295.}

Nevertheless, she also writes:

Often, one has to pay dearly for the recognition that one’s suffering is real. For being taken seriously in one way (being acknowledged as a real sufferer) one risks paying with giving up the privilege of being taken seriously in another way, to be taken as someone whose mental states can be meaningful and warranted. I am not referring here to the often-described experience of stigma, of being regarded as a ‘lunatic’, but to a type of slight, or dehumanisation, that one can encounter from the most ‘enlightened’ people, and which is aggravated rather than alleviated by the medical model.\footnote{Ibid., pp. 296–7.}

This is also true for autism. In my research, I have noticed that people who receive a diagnosis of autism often see this as acknowledging that their problems are real, not imaginary. The recognition of one’s suffering is often inherently linked to the medicalisation of suffering precisely because the recognition is dependent on the fact that a mental disorder is considered to be biologically real. This idea is supported by the empirical studies I mentioned earlier, which shows that people diagnosed with something that is considered genetic and biological are considered to be less responsible for their deeds than people with a personality disorder.\footnote{Stephen Buetow and Glyn Elwyn, ‘Are Patients Morally Responsible for Their Errors?’, \textit{Journal of Medical Ethics}, 32:5 (2006), 260–62, \url{https://doi.org/10.1136/jme.2005.012245}; Marc J. Miresco and Laurence J. Kirmayer, ‘The Persistence of Mind-Brain Dualism in Psychiatric Reasoning about Clinical Scenarios’, \textit{The American Journal of Psychiatry}, 163:5 (2006), 913–18, \url{https://doi.org/10.1176/ajp.2006.163.5.913}; Daniel Navon and Gil Eyal, ‘Looping Genomes: Diagnostic Change and the Genetic Makeup of the Autism Population’, \textit{AJS; American Journal of Sociology}, 121:5 (2016), 1416–71, \url{https://doi.org/10.1086/684201}} Moreover, the more clinicians consider a disorder to be biological, the more often they consider medication to be the best option.\footnote{Woo-kyoung Ahn, Caroline C. Proctor, and Elizabeth H. Flanagan, ‘Mental Health Clinicians’ Beliefs About the Biological, Psychological, and Environmental Bases of Mental Disorders’, \textit{Cognitive Science}, 33:2 (2009), 147–82, \url{https://doi.org/10.1111/j.1551-6709.2009.01008.x}} One study suggests, surprisingly, that clinicians and other professionals may feel less empathy towards those with a diagnosis they
consider biological rather than psychological.\textsuperscript{26} According to Arpaly, the trade-off mentioned above is unfortunate: it looks like mental disorders have to be considered as somatically ‘real’, like diabetes, before the suffering of people with mental conditions is taken seriously. Psychiatric diagnoses, therefore, become a kind of compensation for lack of moral imagination. People seem to have difficulties believing someone if they speak about their psychic suffering unless a diagnosis officially determines this suffering.

Nevertheless, we risk losing an opportunity to understand this suffering better. I think this is also the case with autism. The diagnosis of autism and the accompanying connotations of it being a neurological (and hence quasi-somatic) condition makes the challenges of the autistic person real, for themselves and for others. It is a confirmation that their ‘being different’ is not imaginary. However, reducing one’s own ‘being different’ to a condition ‘like diabetes’ increases the risk that mental content, and the person’s experiences, are considered less relevant.

To conclude, let us look at different models of psychiatric practice. It is interesting to examine them in light of the distinction between Erklären and Verstehen, as the philosopher Wilhelm Dilthey (1833–1911) described it.\textsuperscript{27} Erklären (explaining) means looking for causal explanations, as practised by the pure sciences. Verstehen (understanding) gives us access to the greater whole: it allows us to understand another person and the context in which they live and function in a network of meaning of which we are also part. Verstehen, according to Dilthey, is practised in the humanities.

The differences between a psychoanalytical approach and a neurobiological approach in psychiatry are well known. Psychoanalysis stresses the importance of language, of the subconscious and early experiences from childhood. Psychoanalytic therapy can take years and


Towards an Ethics of Autism

is often concerned with looking for insight rather than finding practical solutions and causal explanations. In some aspects, the psychoanalytical approach is usually not that different from the neurobiological approach. In some schools, finding explanations is at least as important as understanding one’s functioning. Autism is an especially good example here: psychogenic explanations of autism have blamed mothers and led to the institutionalisation of children. Still, a psychoanalytic approach has the advantage that clients are considered more than their diagnoses. Such an approach searches for meaning in experiences.

Theoretically, according to a purely neurobiological approach, psychiatric conditions are assumed to be diseases in our brain. Psychiatry becomes a way to understand the world of neurons and genes. I concede that neurology is an essential aspect of understanding psychiatric illnesses. Nevertheless, such an approach may entail situating the disorder merely in the individual and may risk neglecting the context. Moreover, such a neurobiological approach would seem to suggest that medication is the best option. In Belgium, at least, many present-day psychiatrists do not work merely in a psychoanalytic way and do not consider themselves purely neuropsychological psychiatrists either. George L. Engel’s bio-psycho-social model tries to think several aspects through together and states that the different mental phenomena are situated on different levels (biological, psychological, social). We have to approach these different levels in an integrated way. This approach has received some criticism as well: it is eclectic and not sustained by a solid theoretical framework.\(^\text{28}\) I still think that in this approach, understanding is an integral part of treatment.

It is refreshing to consider the ideas of psychiatrist and philosopher Karl Jaspers (1883–1969). He opposed the psychoanalytic approach of his time because he thought that, rather than understanding patients, such a system sought to unmask them and their disorder. His phenomenological-hermeneutic practice of psychiatry championed an empathic understanding of the patient. In his work *Allgemeine Psychopathologie* (1913), he stresses the importance of being able, as a clinician, to take different perspectives, including biological perspectives, and incorporating the greater context of culture as a

A psychiatrist must search for a comprehensive understanding of phenomena, not merely reduce them to mechanistic explanations. However, he did see a role for explanation in psychiatry. According to Jaspers, some mental phenomena, such as psychosis, are so strange and different that they are beyond Verstehen. We should explain these phenomena biologically. Jaspers’ Allgemeine Psychopathologie is a strikingly modern read and should, in my view, be compulsory literature in training for psychiatrists. In a phenomenon such as autism, we can wonder where Verstehen ends, and Erklären begins. Autistic children and adults are still often considered to be strange and incomprehensible. Nevertheless, it may be the duty of medical professionals, and ourselves, to continue to attempt to understand behaviour that appears bizarre and incomprehensible at first. The autistic person who does not speak and does not score highly on an IQ test has a reason for his or her behaviour, which we must strive to understand.

The first meaning of autism is that it is defined as a psychiatric disorder in a diagnostic manual. In this chapter, we have investigated what a psychiatric disorder is. We investigated the relationship between mind and brain, psychology and biology. We saw how biological explanations for mental disorders can take away feelings of guilt and open up routes towards healing. However, reductionist approaches that merely give a causal biological explanation of mental disorders neglect the importance of understanding the meaning and context in which phenomena occur. To understand this better, let us investigate what kinds of explanations have been given for autism. In the next chapter, I shall describe several theories that have attempted to explain the specific behaviour associated with autism. I shall demonstrate that these theories have normative import as well. Deciding upon the theory that is presumed to underlie certain behaviour is also a moral choice.
